U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

February 20, 2026

TO: Daniel Brillman
Deputy Administrator and Director
Center for Medicaid and CHIP Services

FROM: /John D. Hagg/
Acting Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership With the Office of the Utah Inspector General: Inspector General's Report *Audit of Capitation Payments Made Concurrently With Another State* (A-07-23-05136)

This memo transmits the findings of the Utah Office of Inspector General (UOIG) audit report *Audit of Capitation Payments Made Concurrently With Another State*, issued November 17, 2025. UOIG conducts examinations, analysis, inspections, and audits of all public offices to make Utah government more efficient, effective, and transparent by placing checks and balances on State and local governments for taxpayers. This audit was conducted as part of UOIG's oversight of Utah's Medicaid program.

The objectives of UOIG's audit were to determine: (1) whether Utah Medicaid continued to make capitation payments on behalf of Medicaid beneficiaries who enrolled in other States' Medicaid programs or were determined a resident by another State, at a date after the Utah Medicaid start date; and (2) the average length of time following enrollment in another State before closure of Utah Medicaid.

As part of the U.S. Department of Health and Human Services Office of Inspector General's (HHS OIG's) efforts to partner with State auditors and expand oversight coverage of the Medicaid program, HHS OIG assisted UOIG with its audit by:

- Matching Medicaid claims from the Centers for Medicare & Medicaid Services' (CMS's) Transformed Medicaid Statistical Information System to identify capitated payments that Utah made on behalf of enrollees for whom another State also made capitated payments in the same months

- Performing data validation procedures of the matched Medicaid claims

- Providing the resulting Medicaid matches to UOIG

- Meeting routinely with UOIG auditors to discuss audit work

- Monitoring the progress of UOIG's audit

To accomplish its audit objectives, UOIG analyzed the results of HHS OIG's data match and reviewed two samples from a population of Utah recipients concurrently enrolled in another State's Managed Care Plan (MCP) for the entire 4 months and those who did not receive any health care in Utah during the 4 months. The first sample consisted of 231 concurrently enrolled recipients with capitation payments for dates of service between September through December 2021, and the second sample consisted of 226 concurrently enrolled recipients with capitation payments for dates of service between February and May 2024.

UOIG also researched case and program history using Electronic Resource and Eligibility Product (eREP)[1] and Public Assistance Reporting Information System (PARIS) reports referencing Utah recipients enrolled in other States' Medicaid programs, as well as reports from Federal assistance programs such as Social Security. UOIG reviewed select Utah Medicaid eligibility processes and procedures, interviewed State employees involved in the administration of Medicaid services, and researched Federal and State laws and regulations pertaining to Medicaid enrollment.

UOIG's analysis of the Transformed Medicaid Statistical Information System data revealed that Utah Medicaid paid MCPs $101,852,694 in capitation payments for recipients concurrently enrolled in other States between September through December 2021, all of calendar year 2022, and February through May 2024.[2] However, UOIG did not audit calendar year 2022 and used the data for analysis purposes only. During September through December 2021 and February through May 2024, Utah paid MCPs $31,184,402 in capitation payments for recipients concurrently enrolled in other States. UOIG estimated that Utah Medicaid:

- Made minimum estimated unallowable capitation payments of $14,291,280 for recipients enrolled from September through December 2021

- Made minimum estimated unallowable capitation payments of $3,457,347 for recipients enrolled for calendar year 2022

- Made minimum estimated unallowable capitation payments of $6,506,136 for recipients enrolled from February through May 2024

UOIG stated that concurrent enrollment occurred because Utah Medicaid did not have adequate controls, to include policies and procedures, in place. Specifically, UOIG found the following: (1) during the public health emergency the eREP programming systematically reopened recipient cases, (2) there was a lack of immediate notification to case workers of an interstate benefit

[1] eREP is Utah's Medicaid eligibility system that is a combination of an online, real-time application and a batch processing application, which administers, produces, maintains, and tracks, among other programs, Medicaid benefits to Utah clients.

[2] UOIG did not request a dataset for calendar year 2023 due to the Public Health Emergency unwinding.

match, (3) the Division of Workforce Services' (DWS)[3] policies and procedures lacked clarity regarding PARIS usage, (4) DWS did not require proof of Utah residency or closure of other State benefits to receive benefits in Utah, and (5) application forms lacked clarity regarding prior Medicaid coverage.

UOIG made nine recommendations to the Utah Department of Health and Human Services (UDHHS), including three to improve application and eligibility processes, two to benchmark best practices, and one each to implement automated notifications, train caseworkers, update overpayment procedures, and strengthen residency enforcement. The full recommendations are in the report. In its comments on UOIG's report, UDHHS agreed with the recommendations and described actions that it planned to take.

UOIG is responsible for the attached audit report and the conclusions expressed in it. UOIG agreed to conduct the audit in accordance with Generally Accepted Auditing Standards and provided us with documentation to support the independence, objectivity, and qualifications of the UOIG staff assigned to this audit. We are not expressing an opinion on the report or its results; however, we encourage CMS to consider this report and its results, and to work with State Medicaid agencies to prevent payments resulting from concurrent enrollment from occurring in the future.

This memo and the UOIG report, including UDHHS written comments, will be posted on the OIG website.

If you have any questions or comments about this memo, please do not hesitate to contact Patrick Cogley, Acting Assistant Inspector General for Audit Services, at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-23-05136 in all correspondence.

Attachment

cc:

Anne Marie Costello
Deputy Director
Center for Medicaid and CHIP Services

Sara Vitolo
Deputy Director
Center for Medicaid and CHIP Services

[3] Utah Medicaid contracts with DWS to receive applications for Medicaid benefits directly from the public. DWS processes applications and determines whether the applicant qualifies under the Federal and State requirements for medical assistance. DWS administers and reviews beneficiary eligibility throughout the term of assistance.

Kimberly Brandt
Deputy Administrator/Chief Operating Officer
Center for Program Integrity

Jerry Andersen
Director, Division of Audit Management and Resolution
Office of Financial Management

Audit of Capitation Payments Made Concurrently with Another State

Report Number A2023-03

November 17, 2025

Utah Office of
Inspector General

Neil Erickson
Interim Inspector General

November 17, 2025

To: Utah Department of Health and Human Services

Please see the attached report, *Audit of Capitation Payments Made Concurrently with Another State*, Report 2023-03. An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 10 of this report.

Sincerely,

Neil Erickson

Neil Erickson
Interim Inspector General
Utah Office of Inspector General

cc: Sen. Keven J. Stratton, 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
Ivan Djambov, Legislative Fiscal Analyst, Finance Manager
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Tracy Gruber, Executive Director, Utah Department of Health and Human Services, DHHS
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EXECUTIVE SUMMARY

The State of Utah Office of Inspector General (UOIG) entered into an agreement with the US Department of Health and Human Services Office of Inspector General (HHS OIG) to jointly perform an audit of Utah Medicaid regarding Utah recipients enrolled in other states. HHS OIG made available special data using a nationwide database referred to as the Transformed Medicaid Statistical Information System (T-MSIS). The T-MSIS special data matched capitations paid by Utah to the Managed Care Entities (MCE) with other States' capitation payments for the same recipient and the same date of service (DOS).

UOIG requested datasets for the following periods based on DOS:

1. September through December 2021 (four months)
2. January through December 2022
3. February through May 2024 (four months)

UOIG did not request a dataset for calendar year 2023 due to the Public Health Emergency (PHE) unwinding. The Utah Medicaid website reported that by January 2024 the number of open cases needing to be reviewed diminished to 71,687 total, or 25% of the original number. The unwinding continued until April of 2024. The audit team requested the T-MSIS concurrent enrollment special data for DOS February through April 2024 to evaluate potential improvement that may have occurred subsequent to the earlier time periods.

During the PHE for Coronavirus Disease 2019 declared on March 6th, 2020, which is during our audit scope, States made changes to their eligibility and enrollment operations to comply with the Families First Coronavirus Response Act (FFCRA). Under the FFCRA States must satisfy certain requirements including the continuous enrollment of most individuals through the end of the PHE, unless the recipient:

1. voluntarily requests to terminate Medicaid coverage, or
2. ceases to be a resident of the state, or
3. becomes deceased.

On November 2, 2020, 42 CFR § 433.400(d)(3)(ii) went into effect. This regulation states that an enrollee may be treated as not being a State resident under the FFCRA:

1. when there is a Public Assistance Reporting Information System (PARIS) match indicating concurrent enrollment in two or more States; and
2. the enrollee fails to respond to a request to verify State residency, provided that the State takes all reasonable measures to attempt verification of the enrollee's residency.

UOIG used the T-MSIS data for DOS January through December 2022 for analysis purposes only.

UOIG selected statistically valid test samples from the T-MSIS data for the four months ended December 2021 and the four months ended May 2024 for detail testing:

1. A sample of 231 recipients, capitation payments for DOS between September 2021 through December 31, 2021.
2. A sample of 226 recipients, capitation payments for dates of service between February 2024 and May 2024.

The T-MSIS data referenced below in Exhibit A identified that during the time periods for the three datasets listed above, Utah paid Managed Care Plans (MCP) $101 million in capitation payments for recipients also enrolled in other states who also paid MCPs in their state $86 million for covering the same individuals and the same DOS.

The unallowed payments occurred due to Utah and other States not disenrolling recipients when the recipient moved to another state.

Exhibit A: Summary amounts of concurrent capitations paid
Multiple states paid capitations for the same recipient for the same dates of service for many months. 2023 is excluded.

Test periods (DOS)	Recipients	Utah Capitations Paid	Number of other states	Other States Capitations Paid	See Table
A. September 2021 through December 2021 (4 Months)	14,352	$18,188,964	43	$17,194,165	1
B. January through December 2022 (12 Months)	26,442	$70,668,292	45	$60,534,664	3
C. February 2024 through May 2024 (4 Months)	10,336	$12,995,438	49	$8,719,793	4
Sum		**$101,852,694**		**$86,449,622**	

Audit Objectives:

Our objectives were to determine:

- whether Utah Medicaid continued to make capitation payments on behalf of Medicaid beneficiaries who enrolled in other States MCP or were determined a resident by another State, after the Utah Medicaid start date; and,
- the average length of time following enrollment in another State's public assistance or determined a resident by another State, before closure of Utah Medicaid.

Audit Findings:

Utah Medicaid paid capitations after recipients enrolled in other States MCPs or who were determined a resident by another State for an average 24 months during the PHE (concurrently enrolled September 1, 2021) and for an average of 14 months for recipients after the PHE (concurrently enrolled February 1, 2024).

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 team estimates an additional $3.5 million of unallowable capitation payments were paid to MCEs for Utah recipients enrolled in 2022 for all 12 months but not included in the prior estimates to avoid overlap.

INTRODUCTION

BACKGROUND

The Medicaid Program

Medicaid is a joint state and federal government health insurance program established by Title XIX of the 1965 Social Security Act. The Utah Department of Health and Human Services (DHHS) is the single state agency responsible for administering the Utah Medicaid Program in accordance with federal and state law.[1] The Centers for Medicare and Medicaid Services (CMS) administers the program at the federal level. The State of Utah administers its Medicaid program in accordance with a CMS-approved State plan. Although Utah has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

Utah offers Medicaid benefits on a fee-for-service (FFS) basis and through the MCP of a managed care entity (MCE). Under the FFS model, Utah pays providers directly for each covered service received by a Medicaid enrollee. Under managed care, the State pays a monthly fee to the MCE for each month of enrollment.

Utah Medicaid contracts with 22 MCEs[2] to make services available to Medicaid enrollees, in return for a monthly fee known as a capitation payment. The MCE pays providers for Medicaid services that are included in the MCE contract with Utah. Utah makes the capitation payments regardless of whether the enrollee receives services during the period covered by the payment. If an enrollee's enrollment is not terminated when appropriate, capitation payments may continue automatically. Utah reports these capitation payments on the Quarterly Medicaid Statement of Expenditures for the Federal Medical Assistance Program (Form CMS-64).[3] The Federal Government pays its share of Utah's medical assistance expenditures under Medicaid based on the Federal Medical Assistance Percentage (FMAP), which varies depending on Utah's relative per capita income as calculated by a defined formula.[4]

Federal Requirements

States are required to provide Medicaid services to eligible residents, including residents who are absent from the State, unless another State determines that an enrollee has established residency for

[1] Utah Administrative Code R414-1-3. Accessed 03/19/2025. https://adminrules.utah.gov/public/rule/R414-1/Current%20Rules?searchText=R414-1-3

[2] State of Utah Division of Medicaid and Health Financing Bureau of Managed Health Care Annual External Quality Review Report of Results: March 2024. The report references a total of 25 MCEs however, this audit excludes the three CHIP MCEs. Accessed: 03/24/2025 https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf

[3] Medicaid CMS-64 FFCRA and CAA Increased FMAP Expenditure Data Collected through MBES. Accessed 03/19/2025 https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-medicaid-chip

[4] Rates of FFP for program services 42 CFR §433.10(b). Accessed 03/18/2025. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-A/section-433.10

purposes of Medicaid eligibility.[5] When another State approves a Utah enrollee for Medicaid benefits, the other State has determined the recipient to be a resident of that State.

Ordinarily, States redetermine the eligibility of Medicaid enrollees every 12 months. For Medicaid enrollees whose eligibility is not determined using Modified Adjusted Gross Income (MAGI)-based financial methodologies, States must redetermine eligibility at least once every 12 months. States must also have procedures designed to ensure that enrollees make timely and accurate reports of any change in circumstances that may affect their eligibility such as moving out of state. States must promptly redetermine eligibility when they receive information about changes in enrollee circumstances that may affect eligibility. States may not deny or terminate eligibility or reduce benefits for any individual based on information received unless the State has sought additional information from the individual and provided the individual with a reasonable period to respond and with proper notice and hearing rights. Receiving Medicaid in another State typically represents a potential change in an enrollee's circumstances, which requires the State to contact the enrollee and attempt to verify State residency prior to termination.[6] [7] If "the State establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth" advance notice does not apply but notice must be given no later than the date of benefit termination.[8] The advance notice exception for when the State establishes that the beneficiary has been accepted for Medicaid services by another State as provisioned in 42 CFR 431.213(e) predates the PHE.

> "If the State establishes the fact that the beneficiary has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth" advance notice does not apply but notice must be given no later than the date of benefit termination."
>
> 42 CFR 431.213(e)

During the PHE States made changes to their eligibility and enrollment operations to comply with the Families First Coronavirus Response Act (FFCRA)[9] as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act.[10] To qualify for a temporary 6.2-percentage-point FMAP increase provided under the FFCRA during the PHE, states agreed to satisfy certain conditions. The FFCRA conditions include:

[5] State residence 42 CFR §§ 435.403(a) and (j)(3). Accessed 03/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-E/section-435.403.
[6] Regularly scheduled renewals of Medicaid eligibility. 42 CFR §435.916(a -d) Accessed 03/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR0717d3fdf4a090c/section-435.916.
[7] Use of information and requests of additional information from individuals. Accessed 03/24/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.952.
[8] Exceptions from advance notice. Accessed 4/18/2025. https://www.ecfr.gov/on/2020-04-01/title-42/chapter-IV/subchapter-C/part-431/subpart-E/subject-group-ECFR803dd5eda355b92/section-431.213. Note: Existed from before the PHE to the present.
[9] Families First Coronavirus Response Act. Accessed 3/24/2025 https://www.congress.gov/bill/116th-congress/house-bill/6201/text.
[10] S.3548 - CARES Act. Accessed 3/24/2025 https://www.congress.gov/bill/116th-congress/senate-bill/3548/text.

- maintaining eligibility standards, methodologies, or procedures that are no more restrictive than what the State had in place as of January 1, 2020, and
- ensuring that most individuals who were enrolled for Medicaid benefits as of or after March 18, 2020, are continuously enrolled through the end of the month in which the PHE ends.[11]

During the period October 2021 through September 2022 the FMAP in Utah was 73.03% which includes the 6.2-percentage-point increase provided under the FFCRA.

> An enrollee may be treated as not being a State resident when there is a PARIS match indicating concurrent enrollment in two or more states and the enrollee fails to respond to a request to verify State residency.
>
> 42 CFR 433.400(d)(3)

The FFCRA allows States that received the temporary FMAP increase to still disenroll individuals who request a voluntary termination of eligibility or cease to be a resident of the State.[12] On November 2, 2020, 42 CFR § 433.400(d)(3)(ii) went into effect. This regulation states that an enrollee may be treated as not being a State resident under §6008(b)(3) of the FFCRA when there is a PARIS match indicating concurrent enrollment in two or more states and the enrollee fails to respond to a request to verify State residency, provided that the State took all reasonable measures to attempt to verify the enrollee's residency.[13] All reasonable measures should include but are not limited to reviewing the beneficiary's records, checking available data sources such as DMV records, and coordinating with agencies in other states.[14]

The state may not deny or terminate eligibility or reduce benefits for any individual on the basis of information received from electronic sources unless the agency sought additional information from the individual and provided proper notice and hearing rights.[15]

If a beneficiary's enrollment is terminated based on a PARIS data match and the state subsequently obtains information verifying residency, the state must reinstate the beneficiary's Medicaid enrollment retroactive to the date of termination.[16]

[11] Families First Coronavirus Response Act. Accessed 3/24/2025 https://www.congress.gov/bill/116th-congress/house-bill/6201/text.
[12] Families First Coronavirus Response Act. Accessed 3/24/2025 https://www.congress.gov/bill/116th-congress/house-bill/6201/text.
[13] Continued enrollment for temporary FMAP increase. Accessed 8/14/2023 https://www.ecfr.gov/on/2020-11-30/title-42/chapter-IV/subchapter-C/part-433/subpart-G/section-433.400.
[14] CMS published an interim final rule (IFR) on 10/28/2020 with request for comments entitled "Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency. The IFR was published in the Federal Register (85 FR 71142) on 11/06/2020. Accessed 8/25/2025. https://www.cms.gov/medicaremedicare-fee-service-paymentacuteinpatientppsipps-regulations-and-notices/cms-9912-ifc.
[15] Use of information and requests of additional information from individuals 42 CFR § 435.952(d). Accessed 8/28/2025 https://www.ecfr.gov/current/title-42/section-435.952.
[16] Continued enrollment for temporary FMAP increase. Exceptions. 42 CFR § 433.400(d). Accessed 8/25/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-G/section-433.400.

Federal regulations also provide an exception in meeting the States' timeliness standards for processing Medicaid eligibility redeterminations and changes in an enrollee's circumstances for Medicaid eligibility during an emergency, such as the PHE.[17]

The FFCRA's continuous enrollment requirement ended April 1, 2023. The PHE ended May 11, 2023. However, effective January 1, 2024, under the Consolidated Appropriations Act (CAA), 2023 states are required to provide 12 months of continuous eligibility for children under the age of 19 in Medicaid and the Children's Health Insurance Program (CHIP). Prior to the FFCRA, states had the option to provide children with up to 12 months of continuous eligibility in Medicaid and CHIP. [18]

The FFCRA and CAA excluded from continuous enrollment recipients who cease to be a State resident or become deceased.

States must generally provide advance notice when the State agency terminates a Medicaid enrollee's covered benefits or eligibility at least 10 days before the date of action.[19] However, if a State establishes that the enrollee has been accepted for Medicaid services by another State, the original State may send notice of the termination of the enrollee's benefits or eligibility no later than the date of the termination.[20]

State Requirements

The State agency revised its Medicaid verification plan and implemented temporary policies and procedures to satisfy the provisions of the FFCRA. Specifically, the State agency suspended the closing of Medicaid coverage for enrollees who failed to renew and suspended the closure of enrollees' Medicaid coverage. Under the State's temporary policies and procedures, Medicaid would close coverage if the enrollee requests a voluntary termination of eligibility, ceases to be a state resident, or dies. An applicant to any State's Medicaid program must be a resident of that State to be eligible.[21]

An applicant to any State's Medicaid program must be a resident of that State to be eligible.

State agencies must provide Medicaid services to eligible residents of that State. If a resident of one State subsequently establishes residency in another State, the beneficiary's eligibility in the previous State should end.[22]

[17] Timely determination and redetermination of eligibility. Accessed 4/02/2025. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435#435.912(e)(2).
[18] Consolidated Appropriations Act, 2023 (P.L. 117-328): Medicaid and CHIP Provisions. Accessed 3/20/2025. https://crsreports.congress.gov R47821
[19] Advance notice Accessed 3/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-E/subject-group-ECFR803dd5eda355b92/section-431.211
[20] Exceptions from advance notice. Accessed 3/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-E/subject-group-ECFR803dd5eda355b92/section-431.213
[21] Eligibility Policy: Accessed 05/12/2025 https://www.medicaid.gov/medicaid/eligibility-policy
[22] State residence. Accessed 3/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-E/section-435.403. See (J)(3)

Transformed Medicaid Statistical Information System (T-MSIS)

The Center for Medicare and Medicaid Services (CMS) maintains the T-MSIS. Its primary purpose is to establish an accurate, current, and comprehensive database of standardized enrollment, eligibility, and paid claim data about Medicaid recipients that is used for administrating Medicaid federally and to assist in detecting fraud, waste, and abuse in Medicaid. States submit their T-MSIS data to CMS monthly.

T-MSIS contains enhanced information about eligibility, beneficiary and provider enrollment data, service utilization data, claim and managed care data, and expenditure data. HHS OIG has full access to T-MSIS data for all States. However, CMS limits States' access to other States' T-MSIS data, except for the T-MSIS Analytic Files (TAF).[23] The TAF does not reveal personally identifying information that is needed to identify enrollees with concurrent Medicaid enrollment.

UOIG contacted HHS OIG and requested special T-MSIS data necessary to identify enrollees with concurrent Medicaid enrollment. UOIG signed a memorandum of understanding confidentiality agreement with HHS OIG.

Public Assistance Reporting Information System (PARIS)

As a condition of receiving Medicaid funding for their automated data systems, States are required to have an eligibility determination system that provides data matching through PARIS.[24] States are expected to determine whether such beneficiaries should continue to be eligible in their State and take whatever case action is appropriate.[25] [26]

States submit a data file of enrollee information to the HHS Administration for Children and Families (ACF) service provider under a computer matching agreement. The service provider matches State and Federal public assistance eligibility data including Medicaid data, to provide States with enrollee information that they can use to identify possible concurrent enrollment and incorrect payments. The three parts of PARIS are the Veterans Administration Match, Department of Defense/Office of Personnel Management Match, and the Interstate Benefit Match. The programs that use PARIS include Medicaid, Temporary Assistance for Needy Families (TANF), Workers' Compensation, Child Care, and the Supplemental Nutrition Assistance Program (SNAP). [27]

[23] The TAF is available to all States upon request and approval from CMS but does not contain personally identifiable information that is needed to identify enrollees with concurrent Medicaid enrollment. The TAF is a research-optimized version of T-MSIS data and serves as a data source tailored to meet the broad research needs of the Medicaid and Children's Health Insurance Program (CHIP) data user community. These files include data on Medicaid and CHIP enrollment, demographics, service utilization, and payments.

[24] General Requirements. Accessed 3/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.945

[25] Use of information and requests of additional information from individuals. Accessed 03/24/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFRc649656b2ed45a8/section-435.952

[26] Regularly scheduled renewals of Medicaid eligibility. 42 CFR §435.916(a -d) Accessed 03/20/2025 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-J/subject-group-ECFR0717d3fdf4a090c/section-435.916

[27] ACF is the office of HHS that promotes the economic and social well-being of families, children, youth, individuals and communities with funding, strategic partnerships, guidance, training, and technical assistance.

Each quarter the service provider matches the enrollment records submitted by the States using personally identifying information and produces a data file customized to that State advising of the concurrent enrollment in other States. Concurrent enrollment information provided by the PARIS match identifies the concurrent State, the public assistance program(s), year and quarters matched, the start date and end date.[28]

The data matching agreements do not prescribe which of the three PARIS matches State Medicaid agencies must conduct, nor the frequency with which any match must be conducted. States do not always include all the available data fields. CMS could improve the matching process by requiring greater frequency and consistency of data submission and data matching to diminish delay in reporting matched records. CMS issued a press release on July 17, 2025, stating it will partner with states to reduce duplicate Medicaid enrollment and will provide a list of individuals for states to recheck eligibility. UOIG suggests that Medicaid contact CMS and report the issues associated with PARIS and seek improvements in obtaining the necessary information.

PARIS provides contact information (phone, email and fax) for each State's Medicaid representative responsible for interstate benefit match questions by other states if needed.[29]

Application for Public Assistance

Utah Medicaid contracts with Utah Department of Workforce Services (DWS) to receive applications for Medicaid benefits directly from the public. DWS processes applications and determines if the applicant qualifies under the federal and state requirements for medical assistance. DWS administers and reviews beneficiary eligibility throughout the term of assistance.

A. Application Availability: Online or Hardcopy

Applicants to the State for public assistance may apply online or by submitting a printed application. DWS indicates approximately 75% of all applications are received online. Applications can be completed and submitted online to Utah Medicaid from anywhere within North America and the location is not revealed. Starting in November 2023 DWS collects the internet protocol (IP) address but does not regularly make it available to case workers. If an investigation is initiated the investigator can obtain the IP address.

B. Eligibility Administration: Electronic Resource and Eligibility Product (eREP)

Utah Medicaid's eligibility system, known as eREP, was fully deployed in Utah in early 2010 after several years of development and iterative releases. Currently, the eREP system is a combination of an online, real-time application and a batch processing application, which administers, produces, maintains and tracks Financial, SNAP, Child Care, Home Energy Assistance Target Program, Medicaid and CHIP benefits to Utah clients. The development of eREP was managed by DWS, closely coordinated with DHHS and the State Department of Technology Services. Workers from the DWS, DHHS and the Office of Recovery Services use eREP.

eREP maintains documentation of the recipient case history including the forms of evidence supporting eligibility decisions. DWS eligibility workers use eREP to generate special reports interfaced with Federal, State and other commercial systems providing financial, employment, address and credit information.

[28] Not all States report an end date; California does not include a specific start date.
[29] State Administrative Representatives. Accessed 04/09/2025. https://acf.gov/paris/map/state-interstate-match-contact

The PARIS data matches described above in the section titled, Public Assistance Reporting Information System (PARIS) are all viewable including history, in eREP.

e-Verification and the PARIS Interstate Benefit Match

The PARIS Interstate Benefit Match by recipient, both current and prior quarters are available for DWS case workers if the worker manually initiates the eREP electronic verification (e-Verify) process and selects the full search or PARIS query function. This generates the search and reporting of the Interstate Match for the one recipient. The information reported includes Medicaid enrollment dates by State and specific quarter of the match to the Utah enrollment. Utah Medicaid must make a capitation payment and submit the record quarterly to the ACF service provider before another State can report a match. Hence, generating a PARIS report at the start of the Utah Medicaid benefit does not result in a match for new applicants until a subsequent quarter.

Objective, Scope and Methodology

Objectives:

Our objectives were to determine:

- whether Utah Medicaid continued to make capitation payments on behalf of Medicaid beneficiaries who enrolled in other States MCPs or were determined a resident by another State, at a date after the Utah Medicaid start date; and,
- average length of time following enrollment in another state before closure of Utah Medicaid.

Scope:

The scope of the audit covered Utah capitations paid for recipients concurrently enrolled in another state. The audit team selected two statistically valid samples from a population of Utah Recipients concurrently enrolled in another State's MCP for the entire four months and those who did not receive any healthcare in Utah during the four months:

1. A sample of 231 concurrently enrolled recipients, capitation payments for dates of service between September 2021 through December 2021.
2. A sample of 226 concurrently enrolled recipients, capitation payments for dates of service between February 2024 through May 2024.

Recipient case records were researched using the DWS information systems and online archives available in eREP. The case history for each recipient was reviewed from the start date to closure or up to the current test date. The unallowable amounts were calculated based on Utah capitations paid for recipients who enrolled in another State after enrolling in Utah Medicaid. Unallowable payment calculations for test sample recipients still open at the time of measurement were calculated to April 30, 2024, for the first test sample of 231, and December 31, 2024, for the second test sample of 226.

Methodology:

The target population consists of beneficiaries enrolled in the Utah Medicaid program for whom Utah Medicaid made capitation payments to an MCE for the same dates of services for which other States also made capitation payments for the same beneficiary enrolled in a Medicaid MCP in another State. Utah OIG collaborated with HHS OIG to identify recipients concurrently enrolled in Medicaid. The role of each agency is listed as follows:

HHS OIG

- matched Medicaid claims from the Centers for Medicare & Medicaid Services' (CMS) Transformed Medicaid Statistical Information System (T-MSIS) to identify capitated payments that Utah made on behalf of enrollees for whom another State also made capitated payments for the same enrollees in the same months;
- performed data validation procedures of the matched Medicaid claims;
- provided the resulting Medicaid matches to UOIG; Data files of the matched records were provided based on dates of service as follows as requested by the UOIG:
    1. September 1, 2021, through December 31, 2021 (four months);
    2. January 1, 2022, through December 31, 2022;
    3. February 1, 2024, through May 31, 2024 (four months).
- routinely met with UOIG auditors to discuss audit work and monitor the progress of UOIG's audit.

Utah OIG (UOIG)

- added to the HHS OIG matched record healthcare information available in the Medicaid data warehouse;
- identified and eliminated any duplicate capitation payments;
- eliminated capitation payments for Utah recipients who received healthcare in Utah during the period of scope;
- selected two statistically valid, random test samples by recipient for detail testing of online case records maintained in the eREP eligibility system;
- researched eREP case and program history, document files (Content Navigator), notices, benefits issued, system logs (case note entries) and case note narration by case workers.
- reviewed recipient location information reported by various sources, such as employment records, motor vehicle registration, Department of Corrections, other;
- researched eREP PARIS reports referencing Utah beneficiaries enrolled in other States Medicaid and public assistance programs including benefit enrollment start dates;
- reviewed eREP query reports of federal assistance programs such as Social Security, Veterans Administration containing beneficiary addresses and payment dates;
- reviewed select Utah Medicaid eligibility processes and procedures;
- interviewed Utah Medicaid and DWS employees; and
- researched federal and state laws and regulations.

UOIG used the special T-MSIS data representing DOS January 2022 through December 2022 for Utah recipients concurrently enrolled in other States for analysis purposes only and did not select a statistical sample to research case histories as performed for the other datasets. See Finding One for additional details.

CONCLUSION

DWS case workers do not have the necessary tools, and the available tools are not deployed effectively to respond efficiently to concurrent enrollment. Audit tests (see test sample one) indicate that during the PHE the length of time Utah Medicaid recipients remained enrolled in a Utah MCP following new or renewed enrollment in another state averaged 24 months of capitation payments.

After the PHE (see test sample two) the length of time Utah Medicaid recipients remained enrolled in a Utah MCP following new or renewed enrollment in another state, decreased from 24 months to 14 months of additional capitation payments. Up to one month is the permissible length of concurrent enrollment since Utah Medicaid does not pro-rate capitation payments.

The delay in disenrollment caused millions of dollars of wasted taxpayer funded capitation payments for duplicate coverage and improper payments to the MCEs.

Not included in our Utah unallowed payments estimates are Utah Medicaid recipients who did not notify their prior State's Medicaid upon their move to Utah, who subsequently returned to the prior State without notifying Utah. If the prior State continuously maintained MCP enrollment during Utah enrollment and upon return to the prior State, without notification from the recipient Utah also continued capitation payments.

Audit Team Comments:

The audit team wishes to remind the reader that our calculations of unallowed payments were made with the advantage of looking historically, after relevant information became available. Case workers often do not have the same advantage since PARIS reports are not available in a real time system and information regarding enrollment in other States incurs considerable delay.

Throughout the report the terms enrollee, beneficiary, member and recipient are used interchangeably to match agency language. Separately, "other states" means "other single state agencies" to include the District of Columbia and the US territories.

FINDING 1	Utah Medicaid Paid Capitations for Recipients Concurrently Enrolled in Other States MCPs

In September 2022 HHS OIG released a report stating that Medicaid recipients enrolled in more than one state is a nationwide issue. HHS OIG recommended to CMS that T-MSIS data reporting concurrent enrollment in multiple states be made available to the states on an ongoing basis. CMS did not agree with the HHS OIG recommendation. CMS expressed, "States, as the direct administrators of their programs, are responsible for conducting accurate and timely eligibility determinations, and following up with beneficiaries regarding potential changes in circumstance, if needed."[30] [31] UOIG found PARIS to be useful, but not adequate to completely prevent concurrent enrollment of recipients in two or more states without using additional tools. The PARIS quarterly match occurs up to four to five months from the recipient's Utah Medicaid first enrollment start date for a case worker to query and view the matched results.

UOIG signed a Memorandum of Understanding (MOU) with HHS OIG making available special datasets generated from the T-MSIS data originally submitted by all the Single State Agencies to CMS. HHS OIG matched capitations paid by Utah Medicaid to capitations paid by other States concurrently for the same recipient. The datasets contained the capitations matched by DOS, date paid and recipient identifying information. UOIG and HHS OIG MOU expires following the completion of this audit.

Test Populations: Data Preparation
The UOIG audit team selectively eliminated recipients from all datasets for who/whom:

1. Received any healthcare in Utah at any time during the four months of DOS, or twelve months for the 2022 dataset; and
2. The period of concurrency was less than every month during the DOS indicated by the three datasets.

UOIG generated two statistically valid, random test samples using the HHS OIG software known as "Rat Stats".[32] The statistically valid test samples were randomly selected from two test populations each representing the two four-month date ranges listed as dataset one and three, less all recipients who had received healthcare in Utah or were concurrent less than all four months. The audit team researched case histories in eREP of all recipients in the test sample.

[30] US HHS OIG Audit A-05-20-00025, Issued: September 2022. Title: "Nearly all states made capitation payments for beneficiaries who were concurrently enrolled in a Medicaid managed care program in two states." Accessed 03/31/2025. https://oig.hhs.gov/reports/all/?search=A-05-20-00025&hhs-agency=all&issue-date=all#results
[31] The CMS response to the HHS OIG audit report continues with "The PARIS Interstate Match already allows states to compare eligibility with other state Medicaid programs to identify beneficiaries that may be concurrently enrolled in more than one state. Most states are already relying on this system and investing resources to use it, and the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to states, especially considering the existing statutory and regulatory framework underlying state monitoring of concurrent enrollments through PARIS."
[32] Rat-Stats is a free statistical software package that providers can download to assist in a claims review. The package, created by HHS OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services. The UOIG selected the two samples at a 90% confidence level. Accessed 4/22/2025 https://oig.hhs.gov/compliance/rat-stats/

Test Samples: Research Performed
Using eREP the auditors reviewed information sourced from multiple systems to identify indications of where the sample recipient lived, moved, and enrolled in another State's Medicaid and public assistance including the dates and the quarter matched.

The auditors reviewed the detail case history in eREP of the test sample recipients using the following information:

- case narratives are logged by the DWS worker; DWS workers are directed to narrate in the case notes all significant events and actions taken;
- case entries logged by the system automatically regarding batch processes;
- e-Verification search results reported by multiple sources including PARIS, Social Security Administration including Supplemental Security Income, US Veterans Administration, Utah State agencies such as the Department of Motor Vehicles, Utah and out of state Department of Corrections;
- past and current employment records;
- documents received from other agencies and other states;
- communications from DWS to recipients and from recipients to DWS.
- communications from other states Medicaid to DWS; and
- DWS communications to other state Medicaid agencies.

Statistical Test Sample One: 231 Recipients having concurrent capitations paid for DOS September 2021 through December 2021 (4 Months)
UOIG identified a test population of 1,166 recipients from the total T-MSIS data linked to other states for whom Utah paid capitations exceeding $1,000 during the four months that did not receive healthcare in Utah, totaling $3,116,521 and at the same time other States paid capitations for the same recipients and DOS amounting to $2,444,028 to MCPs for coverage in those states. See Tables 1 and 2 below.

Table 1 relates the statistically valid random sample to the test population, the recipients who received no healthcare in Utah during the four months, and as a subset of the larger dataset containing all Utah recipients concurrent with other states.

Table 1: Based on Dates of Service September 01 to December 31, 2021				
Ref	**Description**	**Recipient Count**	**Utah Caps**	**Other States Caps**
1	T-MSIS Data Linked to UOIG data sources of capitations paid by Utah.	14,352	$18,188,964	$17,194,165
2	Recipients who received no healthcare in Utah during September through December 2021 and concurrent all four months.	1,570	$3,264,844	$3,026,915
3	Test Population: Utah capitations during September 2021 through December 2021 exceeded $1,000 per recipient.	1,166	$3,116,521	$2,444,028
4	Statistically valid test sample	231	$620,258	$508,679

5	Test Sample Results– Minimal estimate of Utah unallowed payments: a. 170 (74%) of recipients in the test sample of 231 enrolled in another state after the Utah enrollment date. b. Average months from enrollment in another state (post-Utah enrollment) until Utah disenrollment.	170 / 231 (74%) 24 months		
6	***Minimum Estimated Unallowable Capitations*** Test Sample unallowable Utah capitations paid after enrollment in other States average 24 months	**$2,927,827**		

Table 1 Discussion

Information contained within eREP identified 170 of the 231 test sample recipients as residents of other states, having enrolled in other States after the Utah Medicaid enrollment start date. The 170 Utah Medicaid recipients determined by other states to be residents continued enrollment in a Utah MCP an average of 24 months prior to Utah Medicaid closure. Concurrent enrollment for one month is expected to allow for transition to another State's Medicaid enrollment.

Table 2 Discussion

The audit team estimates the minimum unallowable payments by Utah Medicaid for recipients concurrently enrolled in Utah and other States September 1, 2021, were $14,291,280.

Table 2: Test sample results applied to test population (see lines 3 to 5 in Table 1 above):			
The Test Sample and Test Population were comprised of Utah Recipients enrolled at 09/01/2021 who did not receive any healthcare in Utah 09/01/2021 through 12/31/2021 and who continued enrollment despite subsequent enrollment in other states.			***Minimum estimated preventable overpayment for Utah recipients enrolled*** **09/01/2021 (a * b * c)**
1	Test sample results applied to the test population: a. Test Population 1,166, multiply 74% (see Table 1) subsequently enrolled in another state for a total of 863 (74%) of the 1,166. b. Average Monthly Utah Capitation Amount per recipient (Test Sample Average). Test sample Utah capitation during the 4 months test period divided by 4, divided by 170	**863** **$690**	(863 x $690 x 24) **$14,291,280**

	c. Average months from enrollment in another state (post-Utah enrollment) until Utah disenrollment.	**24**	

January through December 2022 (12 Months)
The auditors also received a separate T-MSIS dataset of Utah recipients with capitations paid for recipients enrolled in other states MCPs for dates of service during calendar year 2022. This data was a continuation of the PHE period for other recipients using the same criteria as 2021 test sample. It reflected concurrent enrollment for 12 months with no Utah healthcare received making the estimated results applied over a longer period with an estimated cost of $3.5 million in tax dollars, which is 74% applied from the 2021 test data. This identifies a continuing need for change in processes.

UOIG sorted the 2022 dataset and removed Utah recipients:

- previously analyzed in the September through December 2021 DOS dataset;
- concurrent in another state during 2022 less than all twelve months; and
- who received healthcare in Utah at any time during 2022.

The 2021 test results found that Utah Medicaid paid unallowable capitations for 74% of the test population recipients (see Table 1, row 5a).

Table 3: Based on Dates of Service January through December 2022				
Ref	**Description**	**Recipients**	**Utah Caps**	**Other States Caps**
1	T-MSIS Data	26,442	$70,668,292	$60,534,664
2	T-MSIS Data After removal of all 2021 recipients to avoid overlap in unallowable payments.	14,816	$24,389,367	$20,472,467
3	*Utah Recipients who did not receive healthcare in Utah at any time during 2022 and were concurrent in another state all twelve months*	1,589	$4,672,091	$2,961,227
Minimum Estimated Unallowable Capitations *(74% of $4,672,091) See Table 1, row 5a, for calculation of 74%*			**$3,457,347**	

Statistical Test Sample Two: 226 Recipients having concurrent capitations paid for DOS February 2024 through May 2024 (4 Months)
UOIG received a T-MSIS dataset for DOS February 01, 2024, through May 31, 2024.

UOIG sorted and analyzed the 2024 dataset. UOIG removed Utah recipients:

- previously analyzed in the September through December 2021, and the January 2022 through December 2022 DOS datasets;
- concurrent in another state less than all four months; and
- who received healthcare in Utah at any time during the four months.

A statistically valid sample of 226 recipients of the 1,064 test population were randomly selected and the case history files examined. The auditors reviewed the case history of the 226 recipient cases documented in eREP and subsystems.

The T-MSIS dataset representing DOS of February 2024 through May 2024 included Utah recipients that were present in the previous datasets for DOS 2021 and 2022, and the audit team removed these recipients to avoid overlapping calculations. Table 4 relates the test sample of 226 Utah recipients to the test population of 1,064 recipients, to the T-MSIS dataset.

UOIG verified a test population of 1,064 recipients for whom Utah paid capitations during the four months totaling $2,605,711 and other States paid capitations of $1,503,699 for the same recipients and DOS.

Table 4 reports the Minimum Estimated Unallowed Payments only for the sample of 226 recipients.

Table 4: Based on Dates of Service: February 2024 through May 2024 (4 Months)				
Ref	**Source Data & subset filters**	**Recipients**	**Utah Caps**	**Other States Caps**
1	T-MSIS Data Utah recipients and capitations matched concurrent capitations paid by other states	10,336	$12,995,438	$8,719,793
2	T-MSIS Data: Removed all 2021 & 2022 Recipient IDs. This was to avoid overlap in unallowed payment estimates.	6,214	$10,514,401	$5,089,196
3	Removed all recipients who received healthcare in Utah during the four months.	1,699	$3,462,646	$1,666,552
4	Same as 3 above with capitations over $300 total for the four months. *This became the test population.*	1064	$2,605,711	$1,503,699
5	Statistically valid random Test Sample:	226	$578,067	$320,437
6	Test Sample Results– Minimal Estimate of Utah Unallowed Payments: a. 150 (66%) of recipients in the test sample of 226 enrolled in another state after the Utah enrollment date. b. Average months from enrollment in another state until Utah disenrollment.	150 / 226 66% 14		
	Minimum Estimated Unallowable Capitations Test Sample unallowable Utah capitations paid after enrollment in other States average 14 months		**$1,375,283**	

The audit team researched the eREP case history for all 226 recipients in the test sample. Of the 226, 150 (66%) recipients enrolled in a public assistance program in another state after the enrollment start date in Utah Medicaid. The 150 remained enrolled in Utah for an average of 14 months following enrollment in another State or move to another State.[33]

[33] Of the 150, 87% are based on the other State's Medicaid enrollment date, another 11% are based on the other State's SNAP enrollment date usually just prior to enrolling in the other State's Medicaid.

The audit team estimates the minimum unallowable payments by Utah Medicaid for recipients concurrently enrolled in Utah and other States on February 1, 2024, was $6,508,622. See Table 5 below.

Table 5: Estimated Utah unallowed payments applied to test population (line 4 in Table 4 above):		
Utah Recipients enrolled at 02/01/2024 who did not receive any healthcare in Utah 02/01/2024 through 5/31/2024 who continued enrollment despite enrolling in other states	***Minimum Estimated Unallowed Payments for Utah recipients enrolled* 02/01/2024 (a * b * c)**	
a. Test Population (66% of 1,064) b. Average Monthly Capitation Payment per recipient in the Test Sample: c. Average months from enrollment in another state (post-Utah enrollment) until Utah disenrollment of recipient.	**702** **$662** **14**	(702 x $662 x 14) = **$6,506,136**

Age and Sex Demographics

The demographics represented in our random test samples indicate the recipients to be primarily working age who may have coverage elsewhere, who are not using health care and who are mobile.

The dataset DOS September 2021 through December 2021 statistical test sample of 231 recipients were 57% males, 43% females. Overall, 82% of all recipients were between the age of 19 and 49 years of age.

The dataset DOS February 2024 through May 2024 statistical test sample of 226 recipients were 49% males and 51% females. Overall, 54% of all recipients were between the age of 19 and 49 years of age; 34% were aged 18 or younger.

Cause Analysis:

The total months comprising the gap between a Utah recipient's subsequent enrollment in another state and the date that Utah closed the Medicaid case during the first test sample during the PHE, averaged 24 months. The total months comprising the gap between a Utah recipient's subsequent enrollment in another state and the date that Utah closed the Medicaid case during the second test sample, averaged 14 months. The second test sample representing DOS 02/01/2024 through 05/31/2024 indicated significant improvement, however, a large amount of preventable unallowed payments is still being incurred. See Table 5.

The UOIG found the following factors contributed to the long periods of concurrent enrollment that often occurred before DWS closed enrollment for Utah recipients who enrolled in another state.

During the PHE eREP programming systemically re-opened recipient cases.
During the PHE the eREP programming ran a batch process that automatically re-opened recipients whose coverage case workers manually closed for reasons allowed by the law.[34]

This created confusion and caused cases that were intended to be closed to reopen.

The PARIS System does not report on a real time basis. (CMS responsibility)
The PARIS data interstate benefit match includes delays of up to four to five months, or as little as five or six weeks from the Utah benefit start date if enrollment occurred at a quarter end. At the time of first enrollment, PARIS does not report enrollment in other states because no match has yet been reported. States generally report four times annually but may choose less frequently. The delay causes cases to remain open longer.

Ineffective Use of PARIS
Lack of Immediate Notification to Case Workers of an interstate benefit match:
DWS management indicates a PARIS state enrollment match triggers a task for the assigned case worker. UOIG performed a detailed review of eREP case notes and other records of 457 recipient cases randomly selected. None of the 457 recipient cases indicated automated notifications in the task history or elsewhere, of an interstate benefit match. UOIG interviewed a senior case worker who stated she had never seen a notification or task generated by the system of the interstate benefit match. The senior case worker also stated that people can apply for Medicaid even if the member is in Utah for two days and they will receive benefits for the entire year unless the member notifies DWS, or the caseworker somehow discovers that the individual did in fact move out of state. One of the responsibilities of members is to notify DWS of changes that affect eligibility including moves out of state.[35]

> "People can apply for Medicaid even if they are in Utah for two days and they will receive benefits for the entire year unless [the member] notifies DWS, or the caseworker somehow discovers that the individual did in fact move out of state."
> Caseworker Interview

Management indicated in March 2025 the average load per case worker to be 389 per full-time-employee. Caseworkers who manage 389 cases, even with some variation in total caseloads, may not have awareness of a Utah recipient's enrollment in another state in the absence of automated notification.

During the PHE the test results indicated an average of 24 months gap from the time of enrollment in another state until Utah Medicaid closure.[36] In the second test period of Utah

[34] During the PHE, the FFCRA provided the following reasons for continuous enrollment to not apply, and Medicaid coverage may be closed if the enrollee:

1. requests a voluntary termination of eligibility,
2. ceases to be a state resident, or
3. dies.

The above three reasons also apply to Section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023) for continuous enrollment of children for 12 months to not apply and Medicaid coverage may be closed.
[35] UOIG reviewed online materials available to applicants and members. UOIG noted inconsistencies regarding how member responsibilities are listed on Medicaid's website, applications, and Utah Medicaid Member Guide.
[36] See Table 1

recipients enrolled on February 01, 2024, the test results indicated an average of 14 months before Utah Medicaid benefit closure. In the absence of an automated control that immediately notifies case workers of enrollment in another state, it will not be acted on until the annual review or later.

Automatic notification to case workers of a PARIS match is imperative to taking action and closing the case as soon as possible due to other State enrollment.

DWS policies / procedures lack clarity regarding PARIS usage:
Approximately one-third of Utah's Medicaid recipients also receive SNAP benefits. One method DWS uses to monitor Medicaid recipients who may have moved permanently out of state is the SNAP usage more than 60 days out of state report.

DWS policies and procedures instruct case workers to use "recent" PARIS enrollment in other states for evaluation without being specific as to the meaning of "recent". Enrollments in other state's benefits with a start date that is not recent is still effective until the program expires or until other reasons become known.[37]

The term, "recent" is ambiguous and may cause relevant information regarding other State enrollment to not be considered.

DWS does not require proof of Utah Residency to receive benefits;
Medicaid applications can be accepted from anywhere in the US, Canada and Mexico based on intent to live in Utah.[38]

Management indicates that 70% of applications are received electronically (this includes computers in the DWS branch lobbies). Also, about 70% of recipients opt to receive DWS notifications – communications electronically. Only residents of Utah legally qualify for Medicaid in Utah. However, recipients are not regularly verified to be residents of Utah. Using electronic communication then allows that they may not be in Utah while claiming to be present. Returned mail and returned mail with a forwarding address are electronically scanned and recorded, however, this only applies to 30% of applicants except for special mailings by DHHS, who did not opt in for electronic communications.

> DWS does not require proof of Utah residency to qualify for Medicaid. Medicaid applications can be accepted from anywhere in the US, Canada and Mexico
>
> DWS Management

Every case in the 457 cases randomly selected and reviewed illustrates the ability to be mobile and to travel to or from other states including Hawaii. Recipients enrolled in more than one state may not realize that enrollment in more than one state is not permissible. The initial application form includes a list of changes that must be reported including change of address and moves out of state. The changes that must be reported are not communicated again until after the annual review and renewal. Application forms do not state that enrollment in multiple states Medicaid is not permitted.

[37] ESD Operations Manual; Out of state SNAP report with Attached Medical Programs. Accessed 04/07/2025; 11/02/2023; https://dws.utah.gov/Infosource/esdOperationsManual/
[38] DHHS policy 207-5 (E) states, "A person may choose to become a Utah resident by stating that he or she intends to live in the state…"

If recipients intentionally maintain enrollment in Utah and another State, the use of electronic verification without proof of Utah residency can be misrepresented as living in Utah.

DWS does not require closure of other state Medicaid benefits.
DWS does not require closure statements from other states to receive Medicaid in Utah, the UOIG observed that there are some examples of closure statements being requested and some received. DWS does require closure statements for other programs, for example the federal SNAP and TANF programs in other states prior to approving SNAP and TANF.

DWS does not require closure of other state Medicaid benefits prior to Utah Medicaid approval.

Utah should require closure of other States enrollment of Utah residents to avoid duplicate coverage and wasted resources.

Application Forms lack clarity regarding prior Medicaid coverage.
The ESD-61APP (Application Form) lacks clarity regarding prior Medicaid coverage. For example:

Question 77 states "Does whoever is applying for coverage, **currently have** Medicaid, CHIP or Medicare?" See Appendix C.

Application forms lack clarity regarding prior Medicaid coverage

The application does not explain what is meant by "**currently have**" in question 77. Since the applicant is now a resident of Utah the applicant is no longer a resident of the former state and no longer legally "has" Medicaid in another State even while still enrolled. The Utah application does not ask if the applicant had Medicaid in the prior State. The term "currently have" could be clarified by adding a separate section specifically requesting the applicant to disclose enrollment in prior states Medicaid. The Utah application does not ask for the prior State's closure statement or whether the applicant requested closure. The former states may continue coverage until a match in PARIS or until the recipient or Utah Medicaid contacts the former state; this causes significant ongoing waste.

The application form for Medicaid advises that address changes and moves out of state must be reported within 10 days. One year later as part of the program renewal the beneficiary receives a notification of changes needing to be reported to Medicaid including moving out of state.

Once a year notification advising enrollees to report moves out of state as one item of a list, may not be adequate since so many moves out of state are not being reported.

Subsidized Adoption Title IV-E
The State of Utah and Utah Medicaid participates with the Title IV-E Adoption Assistance Program, a federal program that provides funds to states and participating territories and tribes to facilitate the timely placement of children, whose special needs or circumstances would otherwise make them difficult to place with adoptive families.

The test sample of 226 Utah Medicaid beneficiaries concurrently enrolled in other states MCPs included 13 beneficiaries on the Subsidized Adoption Title IV-E program. Of the 13, 11 or 85% enrolled in other States MCPs and determined residents of the other state on dates after Utah Medicaid start dates and still enrolled in Utah's MCP. 85% represents a high percentage and may indicate DWS case workers may not uniformly understand that Title IV-E children who move to another state are no longer eligible for a Utah MCP.

Recommendations: Utah Medicaid

We recommend Medicaid:

1.1 Improve the application forms for clarity regarding prior Medicaid coverage in the applicant(s) former state(s) of residence. The form should be clear regarding Medicaid coverage in other states previously; and separately, whether the recipient requested closure. This could be accomplished by adding a new section or by adding questions to the current sections.

1.2 Strengthen DWS procedures to ensure eligibility workers properly address out-of-state benefits whenever individuals report receiving them in another state or when electronic data sources report members are receiving out-of-state benefits.

1.3 Strengthen procedures to ensure coverage does not precede the actual date the applicant became a Utah resident especially for applications completed and approved based on the applicant's intent to live in Utah.

1.4 Facilitate automatic notification to the case worker of all recipients that the PARIS interstate benefit matched to another State's public assistance, or Federal or Veteran assistance to an out of State address. Each match reported by PARIS should trigger a priority follow-up procedure that includes up to notice of program termination in accordance with Federal law, unless current proof of Utah residency is provided and a closure statement requested from the other State public assistance dated on or after the PARIS match date. Make this pre-requisite for continuing coverage in accordance with Federal law.

1.5 Require training to all DWS case workers that any Medicaid enrollee who is determined by another State to be a resident by enrolling in the other State's public assistance (usually identified by the PARIS match during ex-parte review or other times) and verified according to federal law, is no longer eligible for Utah Medicaid including children in the Title IV Subsidized Adoption Assistance program.

1.6 Benchmark with other states best practices to obtain higher levels of compliance by recipients to report moves out of state, prior to, or upon moving. This should include DWS action to terminate the public assistance at the correct date.

1.7 Federal law states that the State Medicaid agency must refund the federal share of overpayments to comply with 42 CFR 433.312. Benchmark with other states best practices to ensure Utah Medicaid's overpayment policy aligns with other states best practices.

1.8 Develop or update the Standard Operating Procedures (SOP) for identifying and remediating capitation overpayments for members who at the time were no longer residents of Utah, such as for payments made during concurrent enrollment as reported by PARIS.

FINDING 2 — State Of Utah Processes Should be Strengthened for Residence Requirements

Federal requirements and the Utah State Medicaid Plan both require recipients to be Utah residents to receive benefits in Utah. However, the Utah Medicaid policy contains ambiguity and lack of clarity regarding intent to be a resident versus being physically present while also accommodating temporary absences that are out of the State of Utah.

Utah Medicaid Eligibility Policy 207-1 states that the person must be physically present in the state or temporarily absent to be a resident of Utah:[39]

1. A resident need not have a permanent residence or a fixed address.
2. Temporary absences after a person has been residing in Utah do not affect residency, if the individual intends to return to Utah when the reason for the temporary absence is accomplished. Reasons for temporary absences may include schooling, medical care, visits, temporary employment, military service, or temporary religious or other volunteer services such as the Peace Corps.
3. Do not deny or terminate Medicaid because of a temporary absence if the person **intends** to return to Utah, unless another state has decided the person is a resident in that state for the purpose of Medicaid eligibility.
4. To decide if the absence is temporary, you may need to find out if:
    a. the absence is for a specific period-of-time,
    b. the person is maintaining his home in Utah, or
    c. other factors exist that indicate the person intends to return to Utah when the reason for the absence ends.

The policy statement listed in the last part of item 3 above is key and supersedes most other criteria.

Utah Medicaid Eligibility Policy 207-5 states "a person may choose to become a Utah resident by stating he or she intends to live in the state..."

Utah Medicaid beneficiaries who enrolled, or re-enrolled in other states Medicaid or SNAP program were determined by the other state at the time of enrollment to be residents of that State and no longer eligible for public assistance in Utah.

The audit team found that 66% (during the PHE 74%) or more of the statistical random sample of 457 Utah Medicaid recipients tested had enrolled in other States Medicaid or SNAP programs after their Utah State Medicaid program start date and, Utah Medicaid continued their enrollment and made capitation payments to the MCEs during the PHE for an average 24 months, and the post-PHE test period an average of 14 months.

[39] DHHS Medicaid Policy Manual, policy 207 Utah Residence, 207-1 Determining Residency, effective January 1, 2023.

Recommendation

We recommend Medicaid:

2.1 Strengthen processes for situations where Utah Medicaid recipients are determined by another state to be a resident, to result in the closure of the recipient's enrollment in Utah. Include examples to help clarify situations.

Appendix A: Statistical Sample Demographics

The 231 Utah recipients randomly selected in the first test sample representing DOS 09/01/2021 to 12/31/2021, ranged in age from 19 to 64 as of December 31, 2021; 82% were age 19 to 49. Men totaled 131 or 57% and women totaled 100 or 43%.

Age Range (Years of Age)	**Males**	**Females**	**Total**	**Percentages**
19-49	103	86	189	**82%**
50-64	28	14	42	**18%**
Total	131	100	231	
Percentages	**57%**	**43%**	**100%**	

The 226 Utah recipients randomly selected in the second test sample representing DOS 02/01/2024 to 5/31/2024, ranged in age from 1 to 83 as of May 31, 2024; A full 34% or one third were minors; 54% were age 19 to 49, and only 12% age 50 and older. Men totaled 111 or 49% and women totaled 115 or 51%.

Age Range (Years of Age)	**Males**	**Females**	**Total**	**Percentages**
1-18	40	37	77	34%
19-49	56	66	**122**	**54%**
50-64	13	10	**23**	**10%**
66-**83**	2	2	4	2%
Total	**111**	**115**	**226**	
Percentages	**49%**	**51%**	**100%**	

Differences:

Both test samples are statistically valid, random samples generated using the HHS OIG prescribed "Rat Stats" software. Each statistically valid random sample was representative of the larger population. The first test population having DOS of September 1, 2021, through December 31, 2021, and the second test sample representing DOS post PHE, from February 1 through May 31, 2024.

The test populations that the randomly selected statistically valid samples represent were comprised solely of Utah recipients concurrently enrolled in other states for all four months and who had not received any healthcare in Utah during the DOS being examined.

A. Test sample one with DOS during the PHE represents a population of 82% between age 19 and 49, and 57% male.
B. Test sample two with DOS after the PHE, after unwinding, represents a population of 54% between age 19 and 49, and 49% male.

Appendix B: Statistical Samples Concurrent States Count

The test samples below are statistically valid, random samples that are representative of the populations tested. The populations tested are Utah Medicaid recipients who did not receive healthcare in Utah during the DOS and were concurrent with other states MCP Medicaid enrollment during all four months.

1. Test Sample One: The 231 Utah recipients randomly selected from the test population with DOS of September 2021 through December 2021, were concurrent in multiple states while enrolled in Utah Medicaid. One of the 231 was concurrent in 9 states, however 77% of the sample were concurrent with only one other state.

Ref	Sex	Total Test Sample Recipients	Concurrent States During Utah Enrollment	Total / Concurrent States %
1	F	78	1	77
2	M	100		
3	F	19	2	20
4	M	26		
5	F	2	3	2
6	M	3		
7	F	1	5	1
8	M	1		
9	M	1	9	
10	M 131 F 100	231		100%

2. Test Sample Two: The 226 Utah recipients randomly selected from the test population with DOS of February 2024 through May 2024, were concurrent in multiple states while enrolled in Utah Medicaid. One of the 231 was concurrent in 9 states, however 77% of the sample were concurrent with only one other state.

Ref	Sex	Total Test Sample Recipients	Concurrent States During Utah Enrollment	Total / Concurrent States %
1	F	105	1	91.5
2	M	102		
3	F	10	2	7.5
4	M	7		
5	F	0	3	1
6	M	2		
7	M 111 F 115	226		100%

Differences:

A. Test sample one with DOS during the PHE represents a population having more spread in the number of other states concurrently enrolled per person. 77% were enrolled in only one other state while 23% were enrolled in more than one other state concurrent with Utah.

B. Test sample two with DOS after the PHE, after unwinding, represents a population with 92% being concurrently enrolled in one other state. Only 8% were concurrently enrolled in 2 or more other states plus Utah Medicaid.

Appendix C: Medical Application Examples

Everyone who just moved to Utah can correctly say "No" in the questions below for Medicaid and CHIP because they are no longer resident in the prior state, even though they are still enrolled in the prior state, i.e. will be concurrently enrolled on approval in Utah. The form should be clear regarding Medicaid coverage in other states previously, and separately, whether the recipient requested closure. This could be accomplished by adding a new section or by adding questions to the current sections.

Source: Medical Application 61MED

H HEALTH INSURANCE INFORMATION

D11324900050621

☐Yes ☐No 1. Does anyone in your household who is applying for coverage currently have Medicaid, CHIP, or Medicare?
If yes, check the type of coverage and write their names next to the coverage they have.
☐Medicaid: _____
☐CHIP: _____
☐Medicare: _____

☐Yes ☐No 2. Has anyone who is applying for coverage been injured in an accident or been a victim of assault in the last 12 months?

☐Yes ☐No 3. Is someone outside your home required to pay for your household's medical services?

☐Yes ☐No 4. Is anyone who is applying for coverage enrolled or eligible for COBRA coverage or continued health insurance through an employer? If yes, complete the chart below.

☐Yes ☐No 5. Does anyone in your household currently have health insurance (including Veterans, Tricare, or Peace Corps.), have insurance available but not enrolled, or has had insurance in the past 6 months? If yes, complete the chart below. If you marked no, you do not need to complete Attachment C

INSURANCE 1
(Do not list Medicaid, Medicare, or CHIP)

☐ Enrolled, start date: _____ ☐ Not enrolled, but available ☐ Ended, date ended: _____

Source: DWS 61APP

77. Does whoever is applying for coverage, currently have Medicaid, CHIP or Medicare? ..... ☐ Yes ☐ No
If yes, check the type of coverage and write the person(s) name(s) next to the coverage they have.
☐ Medicaid: _____
☐ CHIP: _____
☐ Medicare: _____

Appendix D: Table of eREP Information Sources

The auditors reviewed the detailed history in eREP of the recipient cases using the following information:

- Case narratives logged by the DWS worker;
- Case narratives logged by the system automatically regarding batch processes;
- e-verification searches:
    - Types of Searches using e-Verif: Examples of combination searches. These include a variety of information resources:
        - Full Search
        - New Program Search
        - Reopen Program Search
        - Manual Search
        - Add Person
        - other
    - Search Sources, databases, for the search type examples include:
        - Motor Vehicle (Utah)
        - New Hire (Utah sources)
        - National New Hire
        - Unemployment
        - Office of Recovery Services (Utah State)
        - PARIS
        - Wages (Employer, Wages, Quarters)
        - Prisoner
        - Citizenship & Identify
        - SSN Verify
        - Social Security (Benefits history)
        - other
    - Source Databases Information Available
        - PARIS Information System (includes all states matched)
            - Recipient name, contact phone, address, SSN;
            - Quarter, State, State Contact email, Start Date, End Date of the following assistance types:
            - Financial, General Assistance, Food Stamps (SNAP), SSI, Medicaid, Child Care, Workers Comp.
        - Social Security
        - Supplemental Security Income (SSI) benefits and addresses
        - Federal Agencies,
        - Veteran Administration,
        - Other

GLOSSARY OF TERMS

Term	Description
ACF	HHS Office of the Administration for Children & Families (ACF) is responsible for the Public Assistance Reporting Information System.
CAA	Consolidated Appropriations Act of 2023: HR 2617 - 117th Congress
CARES	Coronavirus Aid, Relief, and Economic Security Act
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DHHS	Utah Department of Health and Human Services
DOS	Dates of Service. Capitation payments cover a span of time for coverage. In most instances, not always the payment covers from the start of the month to the last day of the month.
DWS	Department of Workforce Services
eREP	Electronic Resource and Eligibility Product
e-Verif	e-Verification
FFCRA	Families First Coronavirus Response Act
FFS	Fee-for-service
FMAP	Federal Medical Assistance Percentage
HHS OIG	US Department of Health and Human Servies, Office of Inspector General
IFR	Interim Final Rule
MAGI	Modified Adjusted Gross Income
MCE	Managed Care Entity
MCP	Managed Care Plan
PARIS	Public Assistance Reporting Information System
PHE	Public Health Emergency for coronavirus disease 2019 (COVID-19)

Rat Stats	A free statistical software package developed by the US Department of Health and Human Services Office of Inspector General (HHS OIG) to assist providers in claims review.
SNAP	US Department of Agriculture - Supplemental Nutritional Assistance Program. SNAP provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and well-being.
SOP	Standard Operating Procedure
TANF	Temporary Assistance for Needy Families (TANF) is a block grant through the ACF that provides $16.6 billion annually to states, territories, the District of Columbia, and federally-recognized Indian tribes. These TANF jurisdictions use federal TANF funds to provide income support to families with children with low-income, as well as to provide a wide range of services (e.g., work-related activities, child care, and refundable tax credits).
TAF	T-MSIS Analytic Files
T-MSIS	Transformed Medicaid Statistical Information System
UOIG	Utah Office of Inspector General

MANAGEMENT RESPONSE

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

DR. STACEY BANK
Executive Medical Director

TONYA HALES
Deputy Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

October 31, 2025

Neil Erickson
Interim Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Erickson:

On behalf of the Department of Health and Human Services, thank you for the opportunity to respond to the audit titled *Audit of Capitation Payments Made Concurrently with Another State (Report Number A2023-03)*. I appreciate the effort and professionalism of you and your staff in this review. The final product reflects a significant effort and time of the DHHS staff collecting information for OIG review, answering questions, and planning changes to improve the program. This audit and its responses will result in a better, more efficient program.

DHHS agrees with the recommendations in this report. DHHS is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need improvement.

Sincerely,

Jennifer Strohecker (Oct 30, 2025 12:02:03 MDT)

Jennifer Strohecker, PharmD, BCPS
Medicaid Director
Director, Division of Integrated Healthcare

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Response to Recommendations

Finding 1: Utah Medicaid Paid Capitations for Recipients Concurrently Enrolled in Other States MCPs

Recommendation 1.1

We recommend Medicaid improve the application forms for clarity regarding prior Medicaid coverage in the applicant(s) former state(s) of residence. The form should be clear regarding Medicaid coverage in other states previously; and separately, whether the recipient requested closure. This could be accomplished by adding a new section or by adding questions to the current sections.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will propose adding additional questions on residency to all eligibility applications, and work with CMS to receive approval for the Medicaid application changes. The estimated completion date below reflects potential delays with CMS approval.

When: September 30, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.2

We recommend Medicaid strengthen DWS procedures to ensure eligibility workers properly address out-of-state benefits whenever individuals report receiving them in another state or when electronic data sources report members are receiving out-of-state benefits.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will work with DWS to review and strengthen procedures related to out-of-state benefits. These procedures will be included in training for DWS eligibility workers by the date below.

When: February 28, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.3

We recommend Medicaid strengthen procedures to ensure coverage does not precede the actual date the applicant became a Utah resident especially for applications completed and approved based on the applicant's intent to live in Utah.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will work with DWS to review and strengthen procedures related to the date of application. These procedures will also be included in training for DWS eligibility workers by the date below.

When: February 28, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.4

We recommend Medicaid facilitate automatic notification to the case worker of all recipients that the PARIS interstate benefit matched to another State's public assistance, or Federal or Veteran assistance to an out of State address. Each match reported by PARIS should trigger a priority follow-up procedure that includes up to notice of program termination in accordance with Federal law, unless current proof of Utah residency is provided and a closure statement requested from the other State public assistance dated on or after the PARIS match date. Make this pre-requisite for continuing coverage in accordance with Federal law.

Department Response:

DHHS agrees with this recommendation.

What: DHHS agrees that a PARIS match should trigger a notification to the eligibility worker to take appropriate action according to federal law and state policy. DHHS and DWS will work together to ensure the system is generating a notification, and will update the procedures for actions a worker should take.

When: February 28, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.5

We recommend Medicaid require training to all DWS case workers that any Medicaid enrollee who is determined by another State to be a resident by enrolling in the other State's public assistance (usually identified by the PARIS match during ex-parte review or other times) and verified according to federal law, is no longer eligible for Utah Medicaid including children in the Title IV Subsidized Adoption Assistance program.

Department Response:

DHHS agrees with this recommendation.

What: DHHS and DWS will work together to ensure all DWS eligibility workers receive training on the appropriate actions to take when an individual is identified as residing in another state.

When: February 28, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.6

We recommend Medicaid benchmark with other states best practices to obtain higher levels of compliance by recipients to report moves out of state, prior to, or upon moving. This should include DWS action to terminate the public assistance at the correct date.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will review best practices from other states to improve recipient compliance in reporting moves out of state. DHHS will work with DWS to review and strengthen procedures related to the timely termination of benefits at the correct date.

When: July 31, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.7

Federal law states that the State Medicaid agency must refund the federal share of overpayments to comply with 42 CFR 433.312. We recommend Medicaid Benchmark with other states best practices to ensure Utah Medicaid's overpayment policy aligns with other states best practices.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will compare its overpayment policies with those of other states to improve policy. DHHS will work with DWS to review and strengthen policy and procedures related to Medicaid overpayments.

When: July 31, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 1.8

We recommend Medicaid develop or update the Standard Operating Procedures (SOP) for identifying and remediating capitation overpayments for members who at the time were no longer residents of Utah, such as for payments made during concurrent enrollment as reported by PARIS.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will work with DWS to review and strengthen procedures related to overpayments. Additionally, DHHS and DWS will review overpayment collections to ensure that capitation overpayments are included as appropriate.

When: July 31, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

Recommendation 2.1

We recommend Medicaid strengthen processes for situations where Utah Medicaid recipients are determined by another state to be a resident, to result in the closure of the recipient's enrollment in Utah. Include examples to help clarify situations.

Department Response:

DHHS agrees with this recommendation.

What: DHHS will work with DWS to review and strengthen procedures related to handling cases in which another state determines an individual to be a resident. In strengthening policy, examples will be included to clarify how workers should handle these situations.

When: July 31, 2026

Contact: Jennifer Meyer-Smart, Director, Office of Eligibility Policy

EVALUATION OF MANAGEMENT RESPONSE

DHHS agrees with all the recommendations. The response specifies the person responsible for implementing the recommendation and the target date for implementation. UOIG will monitor the corrective action following implantation.

UOIG appreciates the response provided by DHHS to this audit.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

Ron Sufficool
Lead Auditor

Rachel Buchi
Audit Manager

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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