DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

July 23, 2026

Julie Ewing
Medicaid Director
Utah Department of Health
PO BOX 143101
Salt Lake City, UT 84114

Dear Director Ewing:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Utah's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on June 30, 2025, and a final revised preprint was received on June 1, 2026. The proposal has a control name of UT_Fee_IPH2_Renewal_20250701-20260630**.**

CMS has completed our review of the following Medicaid managed care SDP(s):

- Uniform percentage increase for inpatient hospital services for state teaching hospitals for the rating period covering July 1, 2025 through June 30, 2026, incorporated in the capitation rates through a separate payment term of up to $90,390,149.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

Based on CMS's preliminary determination, this SDP proposal with a control name of UT_Fee_IPH2_Renewal_20250701-20260630 likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment.

Until the phase down required by section 71116 begins, the total dollar amount of $90,390,149 for the grandfathered SDP named UT_Fee_IPH2_Renewal_20250701-20260630 (as specified in item 4 of the current SDP preprint form) cannot increase and a state cannot increase this total dollar amount under any change or revision to the grandfathered SDP, including an amendment to the SDP, or subsequent renewal of this SDP for a future rating period. For rating periods beginning on or after January 1, 2028, grandfathered SDPs must comply with the specified phase down requirements.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

JOHN F. GILES JR -S

Digitally signed by JOHN F. GILES JR -S
Date: 2026.07.23 17:42:15 -04'00'

John Giles
Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2025 - June 30, 2026
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2025
3. Identify the managed care program(s) to which this payment arrangement will apply:
   Accountable Care Organization (Legacy/Expansion) and Utah Medicaid Integrated Care - State Inpatient Hospital
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $90,390,149
   a. Identify the estimated federal share of this state directed payment: $67,278,414
   b. Identify the estimated non-federal share of this state directed payment: $23,111,736

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:
   a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.
   b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.
      i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:
         Most recently for SFY 2025
   c. Please identify the types of changes in this state directed payment that differ from what was previously approved.
      ☐ Payment Type Change
      ☐ Provider Type Change
      ☐ Quality Metric(s) / Benchmark(s) Change
      ☒ Other; please describe:
         Updated #19, #30, #40a., Table 3, Table 7, and Table 8
      ☐ No changes from previously approved preprint other than rating period(s).
7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The state of Utah is proposing to continue directed payments made to the state teaching hospital (University of Utah Hospital) by the plans for the purpose of improving access to care for all Medicaid members and more transparently complying with §438.6(c)(1)(iii)(B).

These payments encourage the state teaching hospital to contract with multiple Medicaid plans. They also encourage the state teaching hospital to provide access to quality care for Medicaid fee for service members. In addition, these payments serve to improve the quality of care rendered by the state teaching hospital. Finally, this will improve access to inpatient services at the state teaching hospital for Medicaid members when they are not enrolled in a plan.

The Utah plans will be directed on how to make these payments to the hospitals through their managed care contracts with the State of Utah for Medicaid.

This program targets all plan Medicaid enrollees covered under the contract. All populations that are required to enroll in managed care in accordance with Utah's 1915(b) Choice of Health Care Delivery Program Waiver in Utah will be directly impacted by this proposal. The state expects the hospitals to provide equal access to care and quality of care to Utah Medicaid fee for service members or plan enrollees who may require services in a hospital in any location in the state.

   a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).
   b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☐ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ■ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☐ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a.						
b.						
c.						
d.						
e.						

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

c. For state-developed measures, please briefly describe how the measure was developed?

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☐ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

15. Use the checkboxes below to make the following assurances:

a. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☐ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ■ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☒ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

218% increase was used in rate development

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

In accordance with 438.6(c)(2)(i)(A), the Department of Health will require each plan to pay a uniform dollar per diem add-on on all state teaching hospital inpatient claims. An identified portion of the actuarially sound per member per month capitation payment to the plans for State Inpatient hospital directed payment amounts multiplied by the member months the plan is paid for the month will form a pool to be used every period to make supplemental add-on payments to the state teaching hospital. At the end of the period, the amount in the pool will be divided by the number of hospital inpatient days included in all inpatient claims' encounters adjudicated in the period. This will determine the amount of the uniform per diem add-on for the period. The additional payments will be sent to the state teaching hospital. Every add-on payment will be directly tied to a paid inpatient day. Encounter claims or alternative documentation approved by CMS submitted to the Department of Health will reflect both the original payment and the subsequent add-on payment. Add-on payments may be reflected in the same encounter claim as the original payment or in a subsequent encounter claim or documentation. In any event, the state and CMS will be able to tie each payment to a specific service to a specific beneficiary through the data consistent with the managed care rule. This methodology applies to the state teaching hospital.

By dividing the pool of funds by all inpatient days from all claims encounters for the state teaching hospital adjudicated by the plans in the period, the state teaching hospital receives the same per diem amount for all claims from that plan in that period.

Notes:

Period, as used above, is typically a month, quarter, etc., as agreed with the plans and hospitals.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

The directed payments made to the state teaching hospital (University of Utah Hospital) by Medicaid plans are for the purpose of improving access to care for all Medicaid members and more transparently complying with §438.6(c)(1)(iii)(B).

These payments encourage the state teaching hospital to contract with multiple Medicaid plans. They also encourage the state teaching hospital to provide access to quality care for Medicaid fee for service members. In addition, these payments serve to improve the quality of care rendered by the state teaching hospital. Finally, this will improve access to inpatient services at the state teaching hospital for Medicaid members when they are not enrolled in a plan.

The plans will be directed on how to make these payments to the hospitals through their managed care contracts with the State of Utah for Medicaid.

This program targets all plan Medicaid enrollees covered under the contract. All populations that are required to enroll in managed care in accordance with Utah's 1915(b) Choice of Health Care Delivery Program Waiver in Utah will be directly impacted by this proposal. The state expects the hospitals to provide equal access to care and quality of care to Utah Medicaid fee for service members or plan enrollees who may require services in a hospital in any location in the state.

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☒ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ☐ Other:

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

State teaching inpatient hospital

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The state uses the same classification groups as defined by CMS for upper payment limit tests (e.g., State owned, Non-state government owned, Privately owned).

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

see response to 19-c

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. State teaching hospital (ACO legacy)	45.20%	54.80%	0.00%	0.00%	100.00%
b. State teaching hospital (ACO Expansion)	49.30%	50.70%	0.00%	0.00%	100.00%
c. State teaching hospital (UMIC)	46.30%	53.70%	0.00%	0.00%	100.00%
d.	0.00%	0.00%	0.00%	0.00%	0.00%
e.	0.00%	0.00%	0.00%	0.00%	0.00%
f.	0.00%	0.00%	0.00%	0.00%	0.00%
g.	0.00%	0.00%	0.00%	0.00%	0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☐ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☒ Other; Please define: Average commercial rates

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

Response from Milliman: "Methodology used to incorporate into the capitation rates: Milliman repriced the qualifying claims in the SFY 2024 base data to 100% of the average commercial rate. The amount was then adjusted for expected changes in utilization, unit cost, and acuity. We distributed the amount among the ACOs according to each ACO's total risk-adjusted capitation payments. Within each ACO, the payment is distributed by rate cell in proportion to each rate cell's projected total inpatient expenses. The rate cell-specific amount is divided by projected member months to calculate the PMPM amount added to the capitation rates."

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

This directed payment is in Utah statute. It has remained static until the 2023 General Session wherein the legislature directed Medicaid to seek approval for the "...maximum amount that could be paid for those services..." Accordingly, we're seeking approval for 100% of the average commercial rate.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☐ Yes ☒ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

b. If no, please estimate when the state will be submitting the contract actions for review.

A draft copy of the related contracts were submitted to CMS on 6/27/2025. The drafts included the directed payment language in Section 5.6. The state is still in the process of finalizing the fully executed versions of the contracts and anticipates submitting them the end of May.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i.. Utah_ACO_20250701-20260630_Certification_20251008	01/29/2026	Yes	pages 39-43; Appendices H, I, L
ii.. Utah_ExACO_20250701-20260630_Certification_20250703	10/05/2025	Yes	pages 36-40; Appendices F, G
iii.. Utah_ExUMIC_20250701-20260630_Certification_20250703	10/05/2025	Yes	pages 37-41; Appendices F, G
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☒ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☐ Other, please describe:

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.

This methodology allows the state to have rates target the amounts desired. This methodology has been used for many years.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☐ State general revenue
- **b.** ☒ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i. University of Utah Hospital and Clinics	State	$ 23,111,736.00	No	Governmental funds are used for all local match, regardl	Yes
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☒ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

The state is not aware of any additional written agreements with healthcare providers to support or finance the non-federal share of the payment arrangement.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ■ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/Final%20OMH%20Quality%20Strategy%2
- **b.** The effective date of quality strategy. March 1, 2025

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Enhance member experience	Improve member experience and access via the universal measure of the CMS Child and Adult Core Set and via CAHPS overall rating measures	24
b. Reduce all-cause re-admission and emergency room utilization	Smarter spending via the VBP Alternative Payment Model (APM)/Learning and Action Network (LAN) model	25
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

Medicaid revenue is key to maintaining the infrastructure that supports delivery of quality inpatient and outpatient hospital services for Utah residents. Based on receipt of these funds Utah hospitals are making a commitment to the state to provide access to quality care and improve member experience for Medicaid (and CHIP) members covered under the contract.

These payments encourage all Utah hospitals to contract with at least one and possibly multiple Medicaid ACOs. It allows access to a greater number of hospitals and all types of hospitals for Medicaid enrollees. It allows access to all types of hospital services statewide and maintain and increase quality of care for all Medicaid members. This is particularly important for more rural areas of the state. It also encourages hospitals not in the service areas of the ACOs to accept patients who happen to be outside their service area when they need care.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ■ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. PCR (All Cause, Unplanned Acute Readmissions – 30 days)	CY 2023	8.9%	Improve (decrease) by 0.5% from the prior year	For 2024, it's 11.17%
ii. Total Cost of Care PMPM	CY 2023	$35.76, 53.34% of FFS	Percentage of total cost of care for managed care compared to FFS will decrease by 0.5% over the prior fiscal year	For 2024, it's $43.41, 40.75% of FFS
iii.				
iv.				

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

In the SFY 2024 preprint document, the state indicated its intent to retire the two prior evaluation measures (Plan All Cause Readmissions and Total Cost of Care) and move to a new set of evaluation measures and as stated in previous preprint: "The State is retiring these two measures and adopting three new hospital quality measures as noted in Table 8 on page 20 of the preprint document. As part of the change in how directed payments are calculated, Utah 26B-3-707 codified 2023 legislation requiring the identification of specific hospital quality measures and tying directed payments funds to measure performance. Year one (SFY 2024) will be a baseline development year for the hospitals to develop the reporting capacity for the identified measures, however, up to one percent (1%) of a hospital's total directed payment dollars will be at risk and tied to the preparation activities conducted by the hospitals. Subsequent fiscal years will require performance measure reporting and up to three percent (3%) of a hospital's total directed payment dollars will be at risk based on their performance on the three measures."

Over the past year, the state has worked with the hospitals to solidify the new evaluation measures for consideration in the hospital quality project. As noted in the SFY 2024 preprint, the initial measures were intended to be a selection from IQR, OQR, and HCAHPS. After research and working with our recently contracted quality vendor, it is necessary for the state to continue to report on our two previous evaluation measures, PCR (All Cause, Unplanned Acute Readmissions – 30 days) and Total Cost of Care PMPM. Note that the inpatient hospital measure will continue to be PCR which was one of the measures we had planned to retire. We initially intended to use the IQR READM 30 HWR, however, the criteria for that measure is based on the Medicare population but more importantly, PCR aligns with the Core Set measure tracking and reporting and the data is available in our claims and encounters system. The baseline for PCR and Total Cost of Care will be CY 2023. The state will be exploring additional measures to add to the list for SFY 2026.

The State transitioned to a new MMIS system called PRISM in April of 2023. This transition from the State's old MMIS to the new MMIS included a new PRISM data warehouse. With the PRISM data warehouse now fully functional, the State is now amending the measures with updated performance data for 2024. Below is the performance data through CY2024.

For Total Cost of Care PMPM the State, the State saw an overall increase from 2023 to 2024. Health plans are continuously working on quality improvement projects. In addition, with Utah 26B-3-707 requiring tying quality measure performance to directed payment funds, the state anticipates that this will drive improvement to the total cost of care.

Total Cost PMPM	2018	2019	2020	2021	2022	2023	2024
ACO Average	$45.36	$49.30	$42.65	$41.62	$40.16	$35.76	$43.41
ED	$17.65	$18.26	$14.30	$16.10	$16.93	$12.86	$15.89
Inpatient	$86.66	$97.65	$84.81	$81.46	$76.94	$67.18	$85.42
Outpatient	$31.78	$32.00	$28.85	$27.29	$26.62	$27.23	$28.93
FFS Average	$109.41	$101.16	$102.06	$102.12	$83.54	$67.04	$106.52
ED	$27.86	$26.64	$20.97	$21.21	$19.24	$16.71	$19.09
Inpatient	$260.43	$238.66	$248.30	$250.02	$197.13	$162.60	$274.76
Outpatient	$39.95	$38.19	$36.92	$35.13	$34.26	$21.80	$25.73

For Plan All Cause Readmissions all hospital types saw an increase from 2023 to 2024, except for the NSGO hospitals. With Utah 26B-3-707 requiring tying quality measure performance to directed payment funds, the State anticipates that this will drive improvement to the PCR measure rates and see it trend down again.

Plan All Cause Readmissions	2018	2019	2020	2021	2022	2023	2024
ACO	11.09%	11.31%	11.55%	11.03%	9.64%	8.9%	11.17%
Private Hospital	11.11%	11.30%	11.61%	17.22%	9.23%	8.6%	10.75%
State Teaching Hospital	10.94%	11.53%	11.25%	8.27%	12.22%	10.0%	12.71%
NSGO Hospital	0.00%	0.00%	0.00%	4.44%	14.29%	0.0%	0.00%
FFS	10.32%	10.38%	13.15%	7.87%	10.85%	9.7%	2.19%
Private Hospital	10.53%	10.40%	13.11%	8.59%	10.28%	9.0%	1.96%
State Teaching Hospital	8.28%	12.23%	14.33%	9.62%	13.46%	11.3%	14.02%
NSGO Hospital	10.34%	4.35%	9.23%	4.97%	13.48%	23.0%	35.29%

Limitations

Tab 1
Utah Department of Health & Human Services (DHHS)
Hospital State Directed Payment Development
July 1, 2025 through June 30, 2026 (FY 2026) Period
Total Payment Rate Demonstration

	A	B	C	D	E = B + C + D	F = E / A	G	H = F / G
Provider Class	**Projected SFY 2026 Medicaid Utilization**	**SFY 2026 Medicaid Managed Care Base Payments**	**Proposed State Directed Payment (SDP)**	**Other SDPs**	**Total Medicaid Managed Care Payments**	**Average Medicaid Managed Care Payment Per Day (IP) or Claim (OP)**	**ACR Per Unit**	**Average Medicaid Payment Per Unit as % of ACR**
Private Hospitals								
Inpatient Services - ACO Legacy	16,628	$252,019,778	$138,832,964	$0	$390,852,742	$23,648	$23,648	100.0%
Inpatient Services - ACO Expansion	602	$15,955,048	$6,252,647	$0	$22,207,694	$36,869	$36,869	100.0%
Inpatient Services - UMIC (Utah Medicaid Integrated Care)	5,979	$120,547,221	$54,668,218	$0	$175,215,439	$29,308	$29,308	100.0%
Outpatient Services - ACO Legacy	198,810	$104,078,706	$172,893,895	$0	$276,972,601	$1,393	$1,393	100.0%
Outpatient Services - ACO Expansion	21,773	$12,177,868	$24,779,100	$0	$36,956,968	$1,697	$1,697	100.0%
Outpatient Services - UMIC (Utah Medicaid Integrated Care)	76,913	$49,545,412	$93,718,714	$0	$143,264,126	$1,863	$1,863	100.0%
Public Hospitals								
Inpatient Services - ACO Legacy	2,850	$42,849,919	$51,986,409	$0	$94,836,327	$33,270	$33,270	100.0%
Inpatient Services - ACO Expansion	100	$2,675,387	$2,750,579	$0	$5,425,965	$54,162	$54,162	100.0%
Inpatient Services - UMIC (Utah Medicaid Integrated Care)	1,496	$30,760,511	$35,653,162	$0	$66,413,673	$44,406	$44,406	100.0%
Outpatient Services - ACO Legacy	128,820	$26,766,390	$49,815,182	$0	$76,581,571	$594	$594	100.0%
Outpatient Services - ACO Expansion	5,187	$1,609,863	$3,004,600	$0	$4,614,463	$890	$890	100.0%
Outpatient Services - UMIC (Utah Medicaid Integrated Care)	71,542	$18,719,644	$34,504,156	$0	$53,223,799	$744	$744	100.0%

1) Medicaid utilization (days for inpatient and visits for outpatient) is based on managed care claims with first dates of service in the months spanning July 2023 through June 2024. Claims for Medicare and Medicaid dual-eligible individuals and claims with any reported third-party liability are excluded.

2) Medicaid base payments reflect Medicaid managed care plan inpatient and outpatient hospital unit cost trend assumptions used in actuarial capitation rate setting for the Utah managed care program for FY 2026.

3) Estimated commercial payment equivalent amounts are calculated using commercial claims experience for inpatient and outpatient services for hospitals located in Utah to individuals residing in Utah from CY 2022 – CY 2023 from Milliman's Consolidated Health Cost Guidelines Sources Database (without inflation or trend). This experience is adjusted to reflect the Medicaid mix of services by MSA based on the relative difference between the commercial and Medicaid experience when both are repriced to comparable Medicare levels.

Tab 2
Utah Department of Health & Human Services (DHHS)
Hospital State Directed Payment Development
July 1, 2025 through June 30, 2026 (FY 2026) Period
ACR Rate Demonstration: Case Mix Adjusted ACR for MCS and Provider Class

				A	B	C = A/B	D	E	F = E/D	G = F x C	H	I	J = H x I	K	L = K/H	M	N = J x M	O = G x J
Provider Class/Service Category			MSA	Unadjusted Commercial Spend (SFY22-CY23)	Unadjusted Commercial Units (Admits/Cases)	Unadjusted ACR per Admit/Case	Commercial Claims Repriced to Medicare per Admit/Case	Medicaid Claims Repriced to Medicare per Admit/Case	Case Mix Adjustment	Case Mix Adjusted ACR per Admit/Case	SFY24 Medicaid Admits/Cases	Medicaid Utilization Adjustments	Projected SFY26 Medicaid Admits	SFY24 Medicaid Paid Amount	SFY24 Medicaid Paid per Admit/Case	Projected SFY26 Medicaid Paid per Admit/Case	Projected SFY26 Medicaid Paid Amount	Estimated Payments Under ACR
Inpatient Facility	Private	ACO Legacy	30860	$28,887,047	1,410	$20,487	$9,532	$8,002	0.839	$17,198	640	1.0632	680	$3,920,253	$6,127	$6,408	$4,359,398	$11,700,628
Inpatient Facility	Private	ACO Legacy	36260	$119,934,364	5,600	$21,417	$10,222	$10,485	1.026	$21,968	2,942	1.0632	3,128	$34,384,058	$11,687	$12,224	$38,235,738	$68,716,938
Inpatient Facility	Private	ACO Legacy	39340	$113,175,893	5,736	$19,731	$9,930	$10,741	1.082	$21,344	2,692	1.0632	2,863	$28,577,451	$10,614	$11,101	$31,778,679	$61,100,463
Inpatient Facility	Private	ACO Legacy	41100							$21,853	1,119	1.0632	1,190	$10,687,689	$9,551	$9,990	$11,884,917	$25,998,615
Inpatient Facility	Private	ACO Legacy	41620	$238,352,691	11,818	$20,169	$11,367	$14,906	1.311	$26,448	7,553	1.0632	8,031	$142,714,867	$18,895	$19,762	$158,701,694	$212,397,691
Inpatient Facility	Private	ACO Legacy	49999	$58,943,262	2,849	$20,689	$10,598	$8,801	0.830	$17,181	599	1.0632	637	$6,348,228	$10,602	$11,088	$7,059,353	$10,938,407
Inpatient Facility	**Private**	**ACO Legacy**	**Composite**			**$20,526**	**$10,658**	**$12,279**	**1.152**	**$23,648**	**15,545**	**1.0632**	**16,528**	**$226,632,548**	**$14,579**	**$15,248**	**$252,019,778**	**$390,852,742**
Inpatient Facility	State	ACO Legacy	30860	$28,887,047	1,410	$20,487	$9,532	$0	1.000	$20,487	0	1.0675	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Legacy	36260	$119,934,364	5,600	$21,417	$10,222	$0	1.000	$21,417	0	1.0675	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Legacy	39340	$113,175,893	5,736	$19,731	$9,930	$0	1.000	$19,731	0	1.0675	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Legacy	41100							$24,327	0	1.0675	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Legacy	41620	$238,352,691	11,818	$20,169	$11,367	$18,751	1.650	$33,270	2,670	1.0675	2,850	$38,110,750	$14,273	$15,032	$42,849,919	$94,836,327
Inpatient Facility	State	ACO Legacy	49999	$58,943,262	2,849	$20,689	$10,598	$0	1.000	$20,689	0	1.0675	0	$0	$0	$0	$0	$0
Inpatient Facility	**State**	**ACO Legacy**	**Composite**			**$20,526**	**$10,658**	**$17,275**	**1.621**	**$33,270**	**2,670**	**1.0675**	**2,850**	**$38,110,750**	**$14,273**	**$15,032**	**$42,849,919**	**$94,836,327**
Outpatient Facility	Private	ACO Legacy	30860	$69,765,142	48,851	$1,428	$464	$430	0.926	$1,322	11,354	1.0018	11,374	$4,128,661	$364	$375	$4,262,715	$15,041,877
Outpatient Facility	Private	ACO Legacy	36260	$162,553,902	131,989	$1,232	$481	$539	1.121	$1,380	36,447	1.0018	36,512	$17,053,648	$468	$482	$17,607,363	$50,399,967
Outpatient Facility	Private	ACO Legacy	39340	$134,203,985	96,755	$1,387	$556	$531	0.955	$1,324	26,869	1.0018	26,917	$12,424,454	$462	$477	$12,827,864	$35,645,946
Outpatient Facility	Private	ACO Legacy	41100							$1,501	18,558	1.0018	18,591	$7,439,785	$401	$413	$7,681,347	$27,902,889
Outpatient Facility	Private	ACO Legacy	41620	$385,279,216	426,390	$904	$380	$601	1.580	$1,427	89,750	1.0018	89,910	$52,563,698	$586	$604	$54,270,391	$128,342,863
Outpatient Facility	Private	ACO Legacy	49999	$82,965,827	62,856	$1,320	$434	$416	0.960	$1,266	15,479	1.0018	15,507	$7,195,398	$465	$479	$7,429,025	$19,639,059
Outpatient Facility	**Private**	**ACO Legacy**	**Composite**			**$1,101**	**$431**	**$546**	**1.266**	**$1,393**	**198,457**	**1.0018**	**198,810**	**$100,805,644**	**$508**	**$524**	**$104,078,706**	**$276,972,601**
Outpatient Facility	State	ACO Legacy	30860	$69,765,142	48,851	$1,428	$464	$0	1.000	$1,428	0	0.9947	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Legacy	36260	$162,553,902	131,989	$1,232	$481	$0	1.000	$1,232	0	0.9947	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Legacy	39340	$134,203,985	96,755	$1,387	$556	$0	1.000	$1,387	0	0.9947	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Legacy	41100							$1,541	0	0.9947	0	$0	$0	$0	$0	$0

Tab 2
Utah Department of Health & Human Services (DHHS)
Hospital State Directed Payment Development
July 1, 2025 through June 30, 2026 (FY 2026) Period
ACR Rate Demonstration: Case Mix Adjusted ACR for MCS and Provider Class

Outpatient Facility	State	ACO Legacy	41620	$385,279,216	426,390	$904	$380	$250	0.658	$594	129,502	0.9947	128,820	$25,985,614	$201	$208	$26,766,390	$76,581,571
Outpatient Facility	State	ACO Legacy	49999	$82,965,827	62,856	$1,320	$434	$0	1.000	$1,320	0	0.9947	0	$0	$0	$0	$0	$0
Outpatient Facility	**State**	**ACO Legacy**	**Composite**			**$1,101**	**$431**	**$233**	**0.540**	**$594**	**129,502**	**0.9947**	**128,820**	**$25,985,614**	**$201**	**$208**	**$26,766,390**	**$76,581,571**
Inpatient Facility	Private	ACO Expansion	30860	$28,887,047	1,410	$20,487	$9,532	$15,805	1.658	$33,971	121	1.0227	124	$1,954,618	$16,180	$16,734	$2,067,604	$4,197,293
Inpatient Facility	Private	ACO Expansion	36260	$119,934,364	5,600	$21,417	$10,222	$16,645	1.628	$34,873	109	1.0227	111	$2,971,255	$27,330	$28,267	$3,143,008	$3,877,504
Inpatient Facility	Private	ACO Expansion	39340	$113,175,893	5,736	$19,731	$9,930	$15,656	1.577	$31,109	52	1.0227	54	$935,096	$17,850	$18,462	$989,149	$1,666,703
Inpatient Facility	Private	ACO Expansion	41100							$48,250	46	1.0227	47	$1,137,086	$24,548	$25,389	$1,202,815	$2,285,846
Inpatient Facility	Private	ACO Expansion	41620	$238,352,691	11,818	$20,169	$11,367	$22,992	2.023	$40,795	195	1.0227	200	$6,567,221	$33,624	$34,777	$6,946,838	$8,148,876
Inpatient Facility	Private	ACO Expansion	49999	$58,943,262	2,849	$20,689	$10,598	$15,556	1.468	$30,367	65	1.0227	67	$1,517,893	$23,206	$24,002	$1,605,634	$2,031,473
Inpatient Facility	**Private**	**ACO Expansion**	**Composite**			**$20,526**	**$10,658**	**$19,143**	**1.796**	**$36,869**	**589**	**1.0227**	**602**	**$15,083,169**	**$25,610**	**$26,488**	**$15,955,048**	**$22,207,694**
Inpatient Facility	State	ACO Expansion	30860	$28,887,047	1,410	$20,487	$9,532	$0	1.000	$20,487	0	1.0361	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Expansion	36260	$119,934,364	5,600	$21,417	$10,222	$0	1.000	$21,417	0	1.0361	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Expansion	39340	$113,175,893	5,736	$19,731	$9,930	$0	1.000	$19,731	0	1.0361	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Expansion	41100							$24,327	0	1.0361	0	$0	$0	$0	$0	$0
Inpatient Facility	State	ACO Expansion	41620	$238,352,691	11,818	$20,169	$11,367	$30,525	2.685	$54,162	97	1.0361	100	$2,496,522	$25,820	$26,706	$2,675,387	$5,425,965
Inpatient Facility	State	ACO Expansion	49999	$58,943,262	2,849	$20,689	$10,598	$0	1.000	$20,689	0	1.0361	0	$0	$0	$0	$0	$0
Inpatient Facility	**State**	**ACO Expansion**	**Composite**			**$20,526**	**$10,658**	**$28,123**	**2.639**	**$54,162**	**97**	**1.0361**	**100**	**$2,496,522**	**$25,820**	**$26,706**	**$2,675,387**	**$5,425,965**
Outpatient Facility	Private	ACO Expansion	30860	$69,765,142	48,851	$1,428	$464	$541	1.165	$1,664	6,514	1.0538	6,865	$2,989,827	$459	$469	$3,221,412	$11,421,956
Outpatient Facility	Private	ACO Expansion	36260	$162,553,902	131,989	$1,232	$481	$633	1.316	$1,621	3,007	1.0538	3,169	$1,710,092	$569	$581	$1,842,552	$5,137,374
Outpatient Facility	Private	ACO Expansion	39340	$134,203,985	96,755	$1,387	$556	$1,106	1.989	$2,759	318	1.0538	335	$319,828	$1,006	$1,028	$344,602	$924,587
Outpatient Facility	Private	ACO Expansion	41100							$3,222	800	1.0538	843	$695,347	$869	$888	$749,207	$2,717,443
Outpatient Facility	Private	ACO Expansion	41620	$385,279,216	426,390	$904	$380	$799	2.102	$1,899	2,807	1.0538	2,958	$1,936,857	$690	$705	$2,086,881	$5,619,199
Outpatient Facility	Private	ACO Expansion	49999	$82,965,827	62,856	$1,320	$434	$482	1.110	$1,465	7,214	1.0538	7,602	$3,650,457	$506	$517	$3,933,214	$11,136,410
Outpatient Facility	**Private**	**ACO Expansion**	**Composite**			**$1,101**	**$431**	**$665**	**1.542**	**$1,697**	**20,661**	**1.0538**	**21,773**	**$11,302,408**	**$547**	**$559**	**$12,177,868**	**$36,956,968**
Outpatient Facility	State	ACO Expansion	30860	$69,765,142	48,851	$1,428	$464	$0	1.000	$1,428	0	1.0419	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Expansion	36260	$162,553,902	131,989	$1,232	$481	$0	1.000	$1,232	0	1.0419	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Expansion	39340	$134,203,985	96,755	$1,387	$556	$0	1.000	$1,387	0	1.0419	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Expansion	41100							$1,541	0	1.0419	0	$0	$0	$0	$0	$0
Outpatient Facility	State	ACO Expansion	41620	$385,279,216	426,390	$904	$380	$374	0.984	$890	4,979	1.0419	5,187	$1,510,982	$303	$310	$1,609,663	$4,614,463
Outpatient Facility	State	ACO Expansion	49999	$82,965,827	62,856	$1,320	$434	$0	1.000	$1,320	0	1.0419	0	$0	$0	$0	$0	$0
Outpatient Facility	**State**	**ACO Expansion**	**Composite**			**$1,101**	**$431**	**$348**	**0.808**	**$890**	**4,979**	**1.0419**	**5,187**	**$1,510,982**	**$303**	**$310**	**$1,609,663**	**$4,614,463**

Tab 2
Utah Department of Health & Human Services (DHHS)
Hospital State Directed Payment Development
July 1, 2025 through June 30, 2026 (FY 2026) Period
ACR Rate Demonstration: Case Mix Adjusted ACR for MCS and Provider Class

Inpatient Facility	Private	UMIC	30860	$28,887,047	1,410	$20,487	$9,532	$12,182	1.278	$26,183	30	0.9877	30	$368,555	$12,198	$12,616	$376,501	$781,389
Inpatient Facility	Private	UMIC	36260	$119,934,364	5,600	$21,417	$10,222	$14,551	1.423	$30,485	1,452	0.9877	1,434	$26,740,848	$18,422	$19,054	$27,317,364	$43,707,339
Inpatient Facility	Private	UMIC	39340	$113,175,893	5,736	$19,731	$9,930	$12,686	1.278	$25,208	1,161	0.9877	1,147	$17,741,902	$15,277	$15,801	$18,124,407	$28,913,857
Inpatient Facility	Private	UMIC	41100							$36,008	401	0.9877	396	$7,126,479	$17,784	$18,394	$7,280,121	$14,251,671
Inpatient Facility	Private	UMIC	41620	$238,352,691	11,818	$20,169	$11,367	$16,598	1.460	$29,450	2,984	0.9877	2,947	$65,460,735	$21,937	$22,689	$66,872,028	$86,797,557
Inpatient Facility	Private	UMIC	49999	$58,943,262	2,849	$20,689	$10,598	$15,743	1.485	$30,732	25	0.9877	25	$564,627	$22,444	$23,213	$576,800	$763,625
Inpatient Facility	**Private**	**UMIC**	**Composite**			**$20,526**	**$10,658**	**$15,217**	**1.428**	**$29,308**	**6,053**	**0.9877**	**5,979**	**$118,003,146**	**$19,495**	**$20,163**	**$120,547,221**	**$175,215,439**
Inpatient Facility	State	UMIC	30860	$28,887,047	1,410	$20,487	$9,532	$0	1.000	$20,487	0	1.0002	0	$0	$0	$0	$0	$0
Inpatient Facility	State	UMIC	36260	$119,934,364	5,600	$21,417	$10,222	$0	1.000	$21,417	0	1.0002	0	$0	$0	$0	$0	$0
Inpatient Facility	State	UMIC	39340	$113,175,893	5,736	$19,731	$9,930	$0	1.000	$19,731	0	1.0002	0	$0	$0	$0	$0	$0
Inpatient Facility	State	UMIC	41100							$24,327	0	1.0002	0	$0	$0	$0	$0	$0
Inpatient Facility	State	UMIC	41620	$238,352,691	11,818	$20,169	$11,367	$25,027	2.202	$44,406	1,495	1.0002	1,496	$29,736,250	$19,886	$20,568	$30,760,511	$66,413,673
Inpatient Facility	State	UMIC	49999	$58,943,262	2,849	$20,689	$10,598	$0	1.000	$20,689	0	1.0002	0	$0	$0	$0	$0	$0
Inpatient Facility	**State**	**UMIC**	**Composite**			**$20,526**	**$10,658**	**$23,057**	**2.163**	**$44,406**	**1,495**	**1.0002**	**1,496**	**$29,736,250**	**$19,886**	**$20,568**	**$30,760,511**	**$66,413,673**
Outpatient Facility	Private	UMIC	30860	$69,765,142	48,851	$1,428	$464	$725	1.562	$2,231	271	0.9878	268	$166,472	$614	$628	$168,124	$597,477
Outpatient Facility	Private	UMIC	36260	$162,553,902	131,989	$1,232	$481	$716	1.487	$1,832	18,711	0.9878	18,482	$11,546,996	$617	$631	$11,661,580	$33,856,017
Outpatient Facility	Private	UMIC	39340	$134,203,985	96,755	$1,387	$556	$727	1.307	$1,813	13,968	0.9878	13,797	$8,720,378	$624	$638	$8,806,913	$25,016,712
Outpatient Facility	Private	UMIC	41100							$1,965	10,260	0.9878	10,134	$5,418,646	$528	$540	$5,472,417	$19,917,118
Outpatient Facility	Private	UMIC	41620	$385,279,216	426,390	$904	$380	$786	2.068	$1,868	33,628	0.9878	33,217	$22,405,562	$666	$681	$22,627,899	$62,064,361
Outpatient Facility	Private	UMIC	49999	$82,965,827	62,856	$1,320	$434	$587	1.353	$1,786	1,027	0.9878	1,015	$800,535	$779	$797	$808,479	$1,812,440
Outpatient Facility	**Private**	**UMIC**	**Composite**			**$1,101**	**$431**	**$730**	**1.692**	**$1,863**	**77,866**	**0.9878**	**76,913**	**$49,058,587**	**$630**	**$644**	**$49,545,412**	**$143,264,126**
Outpatient Facility	State	UMIC	30860	$69,765,142	48,851	$1,428	$464	$0	1.000	$1,428	0	0.9946	0	$0	$0	$0	$0	$0
Outpatient Facility	State	UMIC	36260	$162,553,902	131,989	$1,232	$481	$0	1.000	$1,232	0	0.9946	0	$0	$0	$0	$0	$0
Outpatient Facility	State	UMIC	39340	$134,203,985	96,755	$1,387	$556	$0	1.000	$1,387	0	0.9946	0	$0	$0	$0	$0	$0
Outpatient Facility	State	UMIC	41100							$1,541	0	0.9946	0	$0	$0	$0	$0	$0
Outpatient Facility	State	UMIC	41620	$385,279,216	426,390	$904	$380	$313	0.823	$744	71,928	0.9946	71,542	$18,407,884	$256	$262	$18,719,644	$53,223,799
Outpatient Facility	State	UMIC	49999	$82,965,827	62,856	$1,320	$434	$0	1.000	$1,320	0	0.9946	0	$0	$0	$0	$0	$0

Tab 2
Utah Department of Health & Human Services (DHHS)
Hospital State Directed Payment Development
July 1, 2025 through June 30, 2026 (FY 2026) Period
ACR Rate Demonstration: Case Mix Adjusted ACR for MCS and Provider Class

Outpatient Facility	State	UMIC	Composite	$1,101	$431	$291	0.676	$744	71,928	0.9946	71,542	$18,407,884	$256	$262	$18,719,644	$53,223,799

Notes:
1) Commercial benchmarks include commercial claims experience for inpatient and outpatient services provided by hospitals located in Utah to individuals residing in Utah from FY 2022 - CY 2023 in Milliman's Consolidated Health Cost Guidelines Sources Database. Because data cannot be shared at this level of detail if the underlying exposure is below a threshold, we are therefore unable to show full details for MSA 4100 (St. George, Utah). No adjustments have been made to this data, including for trend or inflation.
2) Both the Commercial and Medicaid data sets were repriced to Medicare levels for purposes of adjusting the mix of units to be comparable to the mix of services in the Medicaid population. The ratio of these two unit costs at Medicare levels represents the adjustment to the Commercial data to reflect a Medicaid mix of services by MSA.
3) Medicaid utilization (days for inpatient and cases for outpatient) is based on managed care claims with first dates of service in the months spanning July 2023 through June 2024. Claims for Medicare and Medicaid dual-eligible individuals and claims with any reported third-party liability are excluded.
4) Medicaid utilization adjustments are based on the utilization adjustments included in the SFY 2026 capitation rate development as included in the rate certification.
5) The SFY24 Medicaid Paid Amount are the base managed care plan paid amounts.

PREPRINT SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS
ADDENDUM TABLE 2.A. PROVIDER PAYMENT ANALYSES

Directions

2. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22 of the State Directed Payment preprint file), please use the rows in Table 2.A below to add provider classes to Table 2 and an analysis showing the impact of the SDP on payment levels for each additional provider class. States may also use Table 2.A in lieu of completing Table 2 in the preprint. Input data only in beige cells in columns B - G.

States should only submit the tables they populate to CMS; please do not submit the entire workbook unless the State inputs data into Tables 1.A - 8.A. For example, if the state only needs extra rows to complete Table 2. in the preprint, please delete Tabs 1.A and 3.A - 8.A. CMS requests States submit the addendum tables with the preprint in this Excel format; please do not merge and re-PDF the preprint.

TABLE 2.A: Provider Payment Analyses

Column1	Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of SDP	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs)
Data Format	**Free text**	**Percent (#.##%)**	**Percent (#.##%)**	**Percent (#.##%) or N/A**	**Percent (#.##%) or N/A**	**Percent (#.##%)**
Example:	*Rural Inpatient Hospital Services*	*80.0%*	*20.0%*	*N/A*	*N/A*	*100.0%*
a.	Private Inpatient Services - ACO Legacy	64.5%	35.5%	N/A	N/A	100.0%
b.	Private Inpatient Services - ACO Expansion	71.8%	28.2%	N/A	N/A	100.0%
c.	Private Inpatient Services - UMIC (Utah Medicaid Integrated Care)	68.8%	31.2%	N/A	N/A	100.0%
d.	Private Outpatient Services - ACO Legacy	37.6%	62.4%	N/A	N/A	100.0%
e.	Private Outpatient Services - ACO Expansion	33.0%	67.0%	N/A	N/A	100.0%
f.	Private Outpatient Services - UMIC (Utah Medicaid Integrated Care)	34.6%	65.4%	N/A	N/A	100.0%
g.	State Inpatient Services - ACO Legacy	45.2%	54.8%	N/A	N/A	100.0%
h.	State Inpatient Services - ACO Expansion	49.3%	50.7%	N/A	N/A	100.0%
i.	State Inpatient Services - UMIC (Utah Medicaid Integrated Care)	46.3%	53.7%	N/A	N/A	100.0%
j.	State Outpatient Services - ACO Legacy	35.0%	65.0%	N/A	N/A	100.0%
k.	State Outpatient Services - ACO Expansion	34.9%	65.1%	N/A	N/A	100.0%
l.	State Outpatient Services - UMIC (Utah Medicaid Integrated Care)	35.2%	64.8%	N/A	N/A	100.0%

Appendix 1
Utah Department of Health and Human Services
Managed Care Capitation Rate Setting
SFY 2026 Directed Payments
Providers receiving Directed Payments

NPI	MedicareID	Name	Type
1962412486	460044	Alta View Hospital	Private
1912014358	460023	American Fork Hospital	Private
1447296249	460030	Ashley Regional Med Cntr	Private
1679582944	460039	Bear River Valley Hospital	Private
1558513812	461310	Blue Mountain Hospital	Private
1245282227	460017	Brigham City Comm Hosp	Private
1952703472	460054	Cache Valley Hospital	Private
1417064205	460011	Castleview Hospital LLC	Private
1538178801	460007	Cedar City Hospital	Private
1790551794	462005	Central Utah Rehabilitation	Private
1881658110	461304	Central Valley Medical Ctr	Private
1851416838	461304	Central Valley Medical Ctr	Private
1477876902	460041	Davis Hosp Med Cntr Psych	Private
1548205818	460041	Davis Hospital And Med Cntr	Private
1962504068	461300	Delta Community Hospital	Private
1366452880	460021	Dixie Medical Center	Private
1154438596	461301	Fillmore Community Hospital	Private
1467425173	463025	Healthsouth Rehab Hosp	Private
1316055205	464015	Heber Valley Medical Ctr	Private
1346945839	460041	Holy Cross Davis	Private
1194420695	460041	Holy Cross Davis - Psych	Private
1801591391	460051	Holy Cross Jordan Valley	Private
1366440620	460051	Holy Cross Jordan Valley	Private
1144490160	460051	Holy Cross Jordan Valley	Private
1720470974	460051	Holy Cross Jordan Valley	Private
1518662014	460051	Holy Cross Jordan Valley - Psych	Private
1508561010	460051	Holy Cross Jordan Valley - Rehab	Private
1053016550	460003	Holy Cross Salt Lake - Psych	Private
1013612514	460003	Holy Cross Salt Lake - Rehab	Private
1043915523	460003	Holy Cross-Salt Lake	Private
1154551919	460058	IHC Riverton Hospital	Private
1043220650	460010	Intermountain Medical Center	Private
1033159603	460051	Jordan Valley Hosp Lp	Private
1396036695	460051	Jordan Valley Med Psych	Private
1154985695	462004	KPC Promise Hospital of Salt Lake	Private
1528010451	460042	Lakeview Hospital	Private
1497709471	460042	Lakeview Hospital Psych	Private
1689913451	462006	Landmark Hosp Salt Lake	Private
1417460205	460061	Layton Hospital	Private
1528078581	460006	LDS Hospital	Private
1831108497	460015	Logan Regional Med Center	Private
1770821571	460060	Lone Peak Hospital	Private
1194749580	460004	Mckay Dee Hospital	Private
1770513236	461302	Moab Regional Hospital	Private
1487607669	460013	Mountain View Hospital	Private
1124090659	460014	Mountain West Medical Cntr	Private
1851364947	460014	Mountain West Medical Cntr	Private
1053732024	463027	Northern Utah Rehab Hosp	Private
1720031636	460005	Ogden Regional Medical Ctr	Private
1023603214	460005	Ogden Regional Medical Ctr Rehab	Private
1801903240	460043	Orem Community Hospital	Private
1609886126	460049	Orthopedic Specialty Hosp (Tosh)	Private
1851530984	460057	Park City Hospital	Private
1235148594	463301	Primary Childrens Hosp	Private
1609838911	462004	Promise Hosp of Salt Lake	Private
1598056053	999104	Provo Canyon Behavioral (Aspen Grove)	Private
1417988833	460003	Salt Lake Reg Med Cntr	Private
1568619963	460003	Salt Lake Reg Med Psych	Private
1386728665	460003	Salt Lake Reg Med Rehab	Private
1295066116	464013	Salt Lake Behavioral	Private
1407964398	461303	Sanpete Valley Hospital	Private
1336256775	460026	Sevier Valley Hospital	Private
1255461075	463302	Shriners Hosp For Children	Private
1124661384	460062	Spanish Fork Hospital(3)	Private
1164469243	460047	St Marks Hospital	Private
1457794323	460047	St Marks Hospital Psych	Private
1972879609	460047	St Marks Rehab Hosp	Private
1497702195	460052	Timpanogos Regional Hosp	Private
1871556217	460019	Uintah Basin Medical Cntr	Private
1699889576	460009	University Hospital Psych	State
1881708766	460009	University Hospital Rehab	State
1588656870	460009	University of Utah Hosp	State
1487734976	460009	University of Utah Huntsman	State
1740749415	460009	University of Utah Huntsman	State
1114025491	460001	Utah Valley Hospital	Private
1760412530	462005	Utah Valley Specialty Hosp	Private
1982647103	462003	WESTERN PEAKS SPECIALTY HOSPITAL	Private