June 30, 2026

The Honorable Robert F. Kennedy Jr.
U.S. Department of Health and Human Services
200 Independence Avenue S. W. Washington, D.C. 20201

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Secretary Kennedy:

On behalf of the residents of the State of Utah, I am pleased to submit the enclosed application to renew Utah's Medicaid Reform 1115 Demonstration. Utah's existing Demonstration project is currently approved through June 30, 2027. Our application is seeking a renewal period from July 1, 2027, through June 30, 2032.

Over the period of this Demonstration, Utah has provided high-quality, cost -effective health care services. Utah's Demonstration currently authorizes programs and benefits for approximately 225,000 Medicaid members.

Utah is requesting a renewal of its 1115 Demonstration to maintain current services and secure approval for six new amendments. These six amendments focus on:

1. Chronic Care: Expanding Medicaid services for fee-for-service enrollees with chronic health conditions.
2. Work/Community Requirement: Adding a community engagement component to the Adult Expansion Medicaid program
3. Dual Coverage for Disability: Offering "wraparound" Medicaid services to disabled individuals who have private insurance.
4. Integrated Care: Delivering integrated physical and behavioral health services through a local mental health authority.
5. Behavioral Health Support: Providing long-term services and support for people with complex behavioral health needs.

6. Tribal Services: Reimbursing traditional healing services for American Indian and Alaskan Native (AI/AN) members of Medicaid.

Utah is also requesting the authority to combine the four UPP Demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population, the authority to end the Targeted Adult Medicaid Demonstration on June 30, 2027, and the removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion population.

The continuation of this Demonstration is critical to Utah's ongoing efforts to provide cost effective care that improves the health and wellbeing of our citizens, and to continue the many successes we have already achieved under our 1115 Demonstration.

Thank you for your consideration of this proposal. We look forward to your approval which will ensure Utahns have access to cost effective, quality healthcare.

Sincerely,

Spencer J. Cox
Governor

Utah Department of Health & Human Services

Utah's Medicaid Reform 1115 Demonstration

Renewal Request
(2027-2032)

Demonstration project No: 11-W-00145/8
21-W-00054/8

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Utah's Medicaid Reform 1115 Demonstration Renewal

Section I. Summary

The Utah Department of Health and Human Services (DHHS) is requesting a five-year renewal of Utah's Medicaid Reform 1115 Demonstration ("1115 Demonstration") under Section 1115 of the Social Security Act. Utah's existing 1115 Demonstration is currently approved through June 30, 2027. With this application, Utah is seeking a renewal period from July 1, 2027, through June 30, 2032. This 1115 Demonstration renewal requests authority to continue to operate as currently approved, with minimal changes.

Utah's 1115 Demonstration currently authorizes programs and benefits for approximately 225,000 individuals per month. These programs and benefits are outlined below:

- **Adult Expansion** - Provides Medicaid benefits to adults age 19-64 who have household income up to 133 percent of the federal poverty level (FPL).
- **Demonstration Population III** - comprised of working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.
- **Demonstration Population V** - premium subsidies for adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).
- **Current Eligible CHIP Children** -premium subsidies for children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.
- **Demonstration Population VI** -premium subsidies for children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is

no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:

    - COBRA-Eligible Children: A child that meets the definition of a targeted low-income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.
    - COBRA Continuation Children: A child that meets the definition of a targeted low-income child except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium subsidies.

- **Dental Services**- All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental, Oral Maxillofacial, and Orthodontia Services.
- **Employer Sponsored Insurance**- Individuals in the Adult Expansion Population are required to enroll in employer sponsored insurance (ESI), if it is available to the eligible individual.
- **Extended Postpartum Coverage** - Provides coverage for individuals enrolled in Medicaid up to 12 months from the last day of an individual's pregnancy.
- **Family Planning Services** - Provides family planning services to a specific population.
- **Fertility Treatment for Individuals Diagnosed with Cancer** - Provides fertility preservation for eligible individuals diagnosed with cancer and requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility (i.e., infertility caused by treatment for cancer).
- **Former Foster Care Youth from Another State**- Provides State Plan Medicaid benefits to former foster care youth from other states until they reach age 26.
- **Health Related Social Needs (HRSN)**- Provides a defined set of HRSN services to individuals who meet qualifying criteria.
- **In Vitro Fertilization and Genetic Testing** - Provides genetic testing services to eligible individuals, ages 18 through 35, diagnosed by a physician with a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, spinal muscular atrophy, or myotonic dystrophy.
- **Reentry Pre-Release Services** - Provides limited coverage of targeted services for inmates in a state prison, county jail, or juvenile justice facility for up to 90 days prior to the expected release date.
- **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI)**- Provides access to services for individuals diagnosed with a serious mental illness residing in an Institution for Mental Diseases (IMD) treatment setting.
- **Substance Use Disorder (SUD) Residential Treatment**- Covers SUD Residential Treatment in an IMD for all Medicaid-eligible individuals.
- **Targeted Adult Medicaid (TAM)**- Provides State Plan Medicaid benefits to a targeted group

of adults without dependent children.

- **Utah Medicaid Integrated Care (UMIC**)- Allows the State to operate an integrated managed care pilot combining physical health and behavioral health services in five Utah counties for the Adult Expansion Population (not including the Targeted Adult Population).

In addition to the provisions currently approved, Utah is asking for approval of the following pending amendments as part of the renewal of this 1115 Demonstration:

- Chronic Conditions Support: This amendment seeks approval from CMS to provide additional Medicaid services to fee-for-service (FFS) enrolled individuals with qualified chronic health conditions.
- Community Engagement: This amendment requests the authority to implement a community engagement (CE) work requirement for the Adult Expansion Demonstration. This requirement would apply to Adult Expansion members who are able to participate in the requirement, are not already participating in other work or training activities, and do not meet an exemption or do not demonstrate good cause. The State will assist members in meeting the CE requirement through outreach. This outreach will reinforce the participation requirements and the member support available to complete them.
  Additional support from the State may include non-Medicaid assistance with transportation, childcare, language access services, sending text message reminders and other supports; and connect members with disabilities. Members can also utilize the DWS employment counselors to assist in understanding employment resources and helping to successfully meet CE requirements.
- Disability Wraparound Coverage: This amendment seeks approval to provide wraparound Medicaid services for qualified individuals who have private health insurance and have a disability. This would include services covered by Medicaid and not by private health insurance.
- Integrated Behavioral Health Services: This amendment seeks approval to allow individuals to receive existing State Plan covered physical and behavioral services in an integrated model through a contracted local mental health authority which will be selected through a request for proposal process.
- Long Term Services and Supports for Behaviorally Complex Individuals: This amendment seeks approval to allow individuals to provide Long Term Services and Supports to individuals with behaviorally complex conditions.
- Native American Health Amendments: Approval of this amendment will allow the State to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to Medicaid enrollees who are members of an American Indian or Alaskan Native (AI/AN) tribe.

In addition to the renewal of current 1115 Demonstration and expenditure authorities, the State is requesting the following changes:

- The new federal law, H.R.1 (passed on July 4, 2025), included two provisions that will

impact the TAM program. These provisions are the community engagement (CE) requirement and 6-month eligibility renewals, which will be effective on January 1, 2027. In addition, on July 17, 2025 the Centers for Medicare and Medicaid Services (CMS) issued a letter announcing that continuous eligibility provisions under the 1115 Demonstration will not be renewed. With these federal changes, the State is requesting to end TAM on June 30, 2027. If approved, TAM Members will transition to Adult Expansion. The objective of this change is to meet the provisions of the federal law while still providing coverage for this population.

- Combining the four UPP Demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population. The State is requesting this change to simplify reporting, because the overall group population has remained relatively small, and because the State considers these to be one population for administration purposes.
- The State is requesting the removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion Population. This is because these services were moved into the State Plan on November 7, 2024.

Section II. Historical Background

Utah's 1115 Demonstration is a statewide waiver that was originally approved in February 2002 and implemented July 1, 2002. Initially, the State received approval to provide State Plan eligibles (referred to as Current Eligibles), a reduced benefit package and increased cost-sharing. Savings from this State Plan population were used to fund the PCN program, which provided a limited package of preventive and primary care services to uninsured adults aged 19 to 64 with family incomes up to 150 percent of the Federal Poverty Level (FPL). In addition, it provided full Medicaid benefits to high-risk pregnant women, whose resources made them ineligible under the State Plan. The initial objectives of the 1115 Demonstration were to provide high-quality, cost-effective health care services by expanding the programs and benefits authorized under the demonstration. Over the past 24 years, the Section 1115 Demonstration approval has continued to support the State in achieving its core objectives. Evidence of this progress is presented in the ongoing evaluation of the demonstration, as detailed in Section III. As new amendments have been added, the goals of the demonstration have broadened accordingly. The primary objectives are outlined in Section III. Looking ahead, the demonstration aims to continue meeting these objectives while remaining open to new initiatives that further enhance services for our members. Below is the history of amendments to Utah's 1115 Demonstration.

- Utah's 1115 Demonstration was submitted on December 11, 2001, approved on February 8, 2002, implemented on July 1, 2002, and was originally scheduled to expire on June 30, 2007.
- Amendment #1 - This amendment made a technical correction needed to ensure that certain current Medicaid eligibles (i.e., those ages 19 and above who are eligible through sections 1925 and 1931) in the demonstration that become pregnant received the full Medicaid State Plan benefit package. It eliminated or reduced the benefit package for

Current Eligibles to conform with changes to the benefits available under the State Plan. Finally, it increased the co-payment for hospital admissions from $100 to $220, again to conform with changes to the State Plan. (Approved on August 20, 2002, effective on July 1, 2002)

- Amendment #2 - This amendment provided a premium assistance option called Covered at Work (CAW) for up to 6,000 of the 25,000 potential expansion enrollees. Specifically, the State subsidized the employee's portion of the premium for up to 5 years. The employer sponsored insurance must have provided coverage equal to or greater than the limited Medicaid package. The subsidy was phased down over 5 years, to provide a span of time over which employees' wages could increase to the point of unsubsidized participation in the employer sponsored plan. With this amendment, the State was also granted authority to reduce the enrollment fee for approximately 1,500 General Assistance individuals, who are either transitioning back to work or are awaiting a disability determination. These individuals were required to enroll in PCN, but the $50 fee was prohibitive as they earn less than $260 per month. For this population, the State reduced the enrollment fee to $15. (Approved on May 30, 2003, effective on May 30, 2003).
- Amendment #3 - This amendment reduced the enrollment fee for a second subset of the expansion population. Specifically, approximately 5,200 individuals with incomes under 50 percent of the FPL had their enrollment fee reduced from $50 to $25. (Approved on July 6, 2004, effective on July 6, 2004).
- Amendment #4 - This amendment changed the way that the maximum visits per year for Physical Therapy/Occupational Therapy/Chiropractic Services are broken out for the Current Eligibles ("non-traditional" Medicaid) population. Instead of limiting these visits to a maximum of 16 visits per policy year in any combination, the State provides 10 visits per policy year for Physical Therapy/Occupational Therapy and 6 visits per policy year for Chiropractic Services. (Approved on March 31, 2005, effective on March 31, 2005).
- Amendment #5 - This amendment implemented the adult dental benefit for the Current Eligibles population (section 1925/1931 and medically needy non-aged/blind/disabled adults). (Approved on August 31, 2005, effective on October 1, 2005).
- Amendment #6 - This amendment suspended the adult dental benefit coverage for Current Eligibles of Amendment #5 above. (Approved on October 25, 2006, effective on November 1, 2006).
- Amendment #7 - This amendment implemented an increase in the prescription copayments for the Current Eligibles population from $2.00 per prescription to $3.00 per prescription. (Approved on October 25, 2006, effective on November 1, 2006).
- Amendment #8 - This amendment implemented a Preferred Drug List (PDL) for Demonstration Population I adults in the PCN. (Approved on October 25, 2006, effective on November 1, 2006).
- Amendment #9 - This amendment implemented the State's Health Insurance Flexibility and Accountability (HIFA) application request, entitled State Expansion of Employer Sponsored Health Insurance (dated June 23, 2006, and change #1 dated September 5, 2006). Also, this

amendment suspended Amendment #2 - for the CAW program, which was absorbed by the new HIFA-ESI program. (Approved on October 25, 2006, effective on November 1, 2006). This amendment provides the option of ESI assistance to adults with countable household income up to and including 150 percent of the FPL, if the employee's cost to participate in the plan is at least five percent of the household's countable income. The State subsidizes premium assistance through a monthly subsidy of up to $150 per adult. The employer must pay at least half (50 percent) of the employee's health insurance premium, but no employer share of the premium is required for the spouse or children. Likewise, an ESI component for children provides CHIP eligible children with family incomes up to and including 200 percent of the FPL with the option of ESI premium assistance through their parent's employer or direct CHIP coverage. The per-child monthly premium subsidy depends on whether dental benefits are provided in the ESI plan. If provided, the premium subsidy is $140 per month; otherwise, it is $120 per month. If dental benefits are not provided by a child's ESI plan, the State offers dental coverage through direct CHIP coverage. Families and children are subject to the cost sharing of the employee's health plan, and the amounts are not limited to the Title XXI out-of-pocket cost sharing limit of five percent. Benefits vary by the commercial health care plan product provided by each employer. However, Utah ensures that all participating plans cover, at a minimum, well- baby/well childcare services, age appropriate immunizations, physician visits, hospital inpatient, and pharmacy. All children have the choice to opt back into direct CHIP coverage at any time.

- Amendment #10 – This amendment enables the State to provide premium assistance to children and adults for coverage obtained under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of employer-based group health coverage at group rates. COBRA coverage becomes available following the loss of ESI due to specified qualifying events, such as an end of employment (voluntary or involuntary); divorce or legal separation; death of employee; entitlement to Medicare; reduction in hours of employment; and loss of dependent-child status. Through this amendment, Utah is able to provide premium assistance to programmatically- eligible adults and children (as differentiated from individuals who are COBRA-eligible but not otherwise eligible for the Utah COBRA premium assistance program) toward the purchase of COBRA coverage, in a manner similar to the provision of premium assistance for the purchase ESI coverage. (Medicare-eligible individuals who are also COBRA-eligible would be ineligible for the Utah COBRA Premium Assistance Program (CPAP) based on age or the State's standard processes of cross-matching with SSI/SSDI eligibility files).

  During its initial period of operation, Utah's COBRA Premium Assistance Program (CPAP) worked in tandem with the subsidy provided under the American Recovery and Reinvestment Act (ARRA) for the purchase of COBRA coverage. Specifically, ARRA provided a federal subsidy of 65 percent of the cost of COBRA coverage, to individuals and families affected by involuntary job loss occurring September 1, 2008, through December 31, 2009,

and as extended by Congress. As long as the individual received the ARRA subsidy, the State would provide the family with premium assistance based on the number of programmatically-eligible individuals, but limited to the lower of 35 percent of the cost of COBRA that remains the individual's responsibility or the maximum amounts allowable by the State under these STCs.

The ARRA COBRA subsidy could last for up to nine months, whereby individuals qualifying on December 31, 2009 could receive a subsidy through September 30, 2010. Once the ARRA subsidy ended, or for those not eligible for the ARRA COBRA subsidy, the Utah CPAP continued to provide a monthly payment for up to 18 months to offset the cost of COBRA coverage.

The Utah CPAP program provided premium assistance to programmatically-eligible individuals and families with existing COBRA coverage, whether or not the individual qualified for the ARRA COBRA subsidy. Individuals and families who are COBRA-eligible but uninsured may also apply for enrollment in the Utah CPAP. CPAP assistance will be limited to the maximums set in the ESI program, will last for the period of COBRA coverage, and will not exceed the family's share of the cost of the premium or the maximum amounts allowable as set by the State under the STCs. The amendment was approved by CMS on December 18, 2009.

- Amendment #11 - This amendment raised the income eligibility for premium assistance for adults between the ages of 19 and 64 [Demonstration populations III (ESI) and V (COBRA)] from 150 percent of the FPL to 200 percent of the FPL. This amendment was approved by CMS on September 28, 2012.
- Amendment #12 – On June 29, 2017, CMS approved an amendment which allows the State to provide State Plan dental benefits to adults with disabilities or blindness, age 18 and older, removed the sub-caps for enrollment of Demonstration Population I, and removed Demonstration Population II (high risk pregnant women) since changes to federal law rendered this group obsolete and it has not had individuals covered under this population since 2014.
- Amendment #13 – On October 31, 2017 (effective on November 1, 2017), CMS approved an extension that creates a new demonstration population, Targeted Adults, under which eligible individuals receive State Plan services. This new population is made of adults without dependent children, aged 19 through 64 years of age, whose income is at zero percent of FPL. In addition, they must meet at least one of three criteria; chronically homeless, involved in the justice system and in need of substance use and mental health treatment, or those who are just in need of substance use or mental health treatment. In addition, under this approval, the State has expenditure authority to restore full mental health benefits for Current Eligibles and remove the exclusion of Norplant as a covered benefit.
- Amendment #14 – This amendment would have terminated the EPSDT waiver of Section 1902(a)(43) for individuals ages 19 and 20 for all Title XIX populations affected by this 1115 Demonstration. The State withdrew this amendment.

- Amendment #15 – In February 2019, the State received the authority to provide comprehensive dental benefits to Targeted Adults who are receiving SUD treatment. In addition, the State received approval to provide State Plan Medicaid coverage to Former Foster Care Youth who were ever enrolled in Medicaid in another state.
- Amendment #16 – In March 2019, the State received authority to provide full State Plan benefits to adults without children who have incomes up to 95 percent of the FPL and the Current Eligibles benefit package to adults with children who have incomes up to 95 percent of the FPL (together, these categories are known as the Adult Expansion Population) effective April 1, 2019. If the State determines that the State needs to close enrollment in this Medicaid eligibility group (MEG) due to budgetary restrictions, coverage will be closed and no applicants will be able to enroll in this MEG until enrollment re-opens. Individuals in this category who have access to ESI coverage are required to enroll in that coverage to maintain Medicaid eligibility, and receive wraparound coverage. In addition, non-exempt Adult Expansion Population individuals are required to complete community engagement requirements (or demonstrate good cause for failing to do so) each benefit year to be eligible for continued coverage. Lastly, this approval allowed the State to provide clinically managed residential withdrawal services to adult individuals who reside in Salt Lake County.
- Amendment #17 – In November 2019, the State received the authority to provide intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or those at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS includes State Plan and home community-based services, and are provided during the first eight -weeks of the intensive program on a fee-for-service (FFS) basis using a daily bundled rate. The State uses this authority to demonstrate that providing these services will reduce Emergency Room (ER) utilization, psychiatric hospitalizations, and residential treatment services and length of stay as well as positively impact the child/youth's physical health in terms of comprehensive care.
- Amendment #18 – In December 2019, the State received the authority to expand the Adult Expansion Population to include adults, ages 19 through 64, with incomes up to and including 133 percent of the FPL, subject to previously approved community engagement requirements. In addition, the approval provided the State authority to provide dental benefits to Medicaid eligible individuals age 65 and older, as well as porcelain or porcelain-to-metal crowns and to Targeted Adults who receive treatment for SUD. This approval also revised and expanded the definition for the Targeted Adults eligibility criteria. Lastly, with this approval, the State received the ability to enroll demonstration populations in managed care plans; create and operate an integrated managed care model, called Utah Medicaid Integrated Care (UMIC), to combine the delivery of physical health and behavioral health services in five Utah counties for the Adult Expansion Population on individuals. Adult Expansion individuals in eight additional counties are enrolled in an Accountable Care Organization (ACO) for their physical health services and in a Prepaid Mental Health Plan (PMHP) for their behavioral health services. Adult Expansion individuals in the remaining 16

counties receive their physical health services on a FFS basis and are enrolled in a PMHP for their behavioral health services. ACOs and PMHPs also deliver services to Current Eligibles.

- Amendment #19- In December 2020, the State received authority to maintain and enhance access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive treatment to Medicaid individuals with SMI and/or SUD. This demonstration will provide the State with authority to provide high quality, clinically appropriate treatment to individuals with SMI while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD. It will also support state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including withdrawal management services. With this approval, the State also received authority to change how dental benefits are provided to blind or disabled members and to add porcelain and porcelain-to-metal crowns as a benefit to this population.
- Amendment #20-In December 2020, the State received authority to receive FFP, once CMS approves the serious mental illness (SMI) Implementation Plan, for inpatient residential and other services to otherwise eligible Medicaid beneficiaries receiving treatment for a SMI while residing in facilities that meet the definition of an institution for mental diseases (IMD). In addition, this approval also authorized the State to provide porcelain or porcelain-to-metal crowns to Medicaid eligible blind or disabled adults, as well as to restrict the provider network for this population.
- Amendment #21-In July 2021, the State received authority to increase the maximum premium assistance reimbursement amount for adults (age 19 through 64), enrolled in Utah's Premium Partnership for Health Insurance (UPP) from $150 per enrollee per month, to a higher amount, through the state administrative rulemaking process, rather than by an amendment to the demonstration.
- Amendment #22- In March 2022, the State received authority to provide housing related services and supports (HRSS) for beneficiaries in the Targeted Adult population. This demonstration provides HRSS in the form of tenancy support, community transition and supportive living services to beneficiaries experiencing homelessness, food, transportation insecurity, or interpersonal violence and trauma. Beneficiaries must meet one needs-based criteria and one risk factor.
- Amendment #23- In May 2023, the State submitted an amendment requesting authority to provide twelve months of extended Medicaid coverage for certain postpartum women. In September 2023, CMS denied the amendment. The State subsequently submitted a state plan amendment that extended postpartum coverage for all women, effective January 1, 2024.
- Amendment #24- In February 2024, the State received authority to provide fertility preservation services to certain individuals diagnosed with cancer, as well as for in vitro fertilization (IVF) and genetic testing services for certain individuals. This amendment also

approved an increase in the premium subsidy amount for CHIP beneficiaries. Additionally, this amendment added four risk factors to the HRSS program to align program eligibility with eligibility for the TAM population.

- Amendment #25- In July 2024, the State received authority to provide a set of pre-release benefits for Medicaid individuals who are inmates residing in county jails, state prisons, or youth correctional facilities. To qualify for services, individuals residing in a county jail, state prison, or youth correctional facility must have been determined eligible for Medicaid pursuant to an application filed before or during incarceration and must have an expected release date no later than 90-days after initiation of demonstration-covered services. Covered services include, but are not limited to, intensive case management, Medication-Assisted Treatment (MAT) services for all types of Substance Use Disorders (SUD), a 30-day supply of prescription medication upon release, targeted outpatient services, lab and radiology services, diagnosis and treatment of physical and behavioral health conditions, and screening for housing related services.
- Amendment #26- In January 2025, the State received authority to provide dental services to Medicaid-eligible adults ages 21 and older who are not already eligible for dental services. This approval thereby phased out the dental benefit that was previously limited to individuals in the TAM population that were receiving SUD treatment, or who were in the aged, blind or disabled demonstrations. The State also received authority to provide Health Related Social Needs (HRSN) services for qualifying beneficiaries. Services include housing supports without room and board, home remediations, home/environmental accessibility modifications, episodic housing interventions with clinical services with room and board limited to a clinically appropriate amount of time, and room and board-only supports limited to a clinically appropriate amount of time. This approval also provides authority to provide non-medical transportation (NMT) to and from HRSN services. In addition, the State received authority to change the upper age limit for fertility preservation services for individuals diagnosed with cancer from 40 to 50 years old.
- Amendment #27-In November, 2025, the State received authority to provide family planning services and family planning related services to individuals age 18 or older with a household income at or below 185 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and are not in a public institution. This approval also moved the authority for extended postpartum coverage for individuals enrolled in Medicaid (up to 12 months from the last day of an individual's pregnancy) from the State Plan into this demonstration. CMS also approved an amendment request to move dental services for Medicaid-eligible children and pregnant or postpartum women into the demonstration and the FFS delivery system (from managed care plans) in partnership with the University of Utah School of Dentistry's (UUSOD) and their associated statewide provider network. Additionally, the ISS program provided through the demonstration ended. ISS-covered services will be addressed through the 1915(b) waiver authority. Lastly, CMS removed the HRSS program from the demonstration as coverage for those services has fully transitioned to the HRSN program.

Extensions

- Section 1115(e) Extension - On June 23, 2006, the State of Utah formally requested an extension of their 1115 PCN demonstration waiver under the authority of section 1115(e) of the Social Security Act. The demonstration, which would have expired on June 30, 2007, was approved for a 3-year extension from July 1, 2007, through June 30, 2010.
- Section 1115(f) Extension – On March 1, 2010, the State of Utah formally requested an extension of the PCN Demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration, which would have expired on June 30, 2010, was approved for a 3-year extension from July 1, 2010, through June 30, 2013. The demonstration was temporarily extended through December 31, 2013.
- Temporary Extension – The December 24, 2013, amendment and temporary extension, changed the STCs such that beginning on January 1, 2014, the cost-sharing for Current Eligibles and adults in the PCN program was required to align with Medicaid regulations and State Plan requirements. In addition, the income eligibility for the PCN program decreased from 150 percent FPL to 100 percent FPL.
- Temporary Extension – The December 19, 2014 approval amendment and temporary extension changed the STCs so the FPL for Demonstration Population I was decreased to 95 percent (effectively 100 percent of the FPL because of the 5 percent income disregard) in order to ensure that eligible individuals above 100 percent of the FPL would be able to receive APTC to help purchase insurance through the federally facilitated marketplace (FFM).
- Temporary Extension – On November 19, 2015, the demonstration was temporarily extended through December 31, 2016.
- Section 1115(f) Extension - On June 24, 2016, the State of Utah formally requested an extension of the PCN Demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration was scheduled to expire on December 31, 2016.
- Temporary Extension - On December 16, 2016, the demonstration was temporarily extended through December 31, 2017.
- Section 1115(a) Extension - On October 31, 2017, the demonstration was approved for a 5-year extension from November 1, 2017, through June 30, 2022. The STCs were changed to provide full State Plan benefits to TAM members who are adults without dependent children, ages 19-64, have incomes at zero percent of the federal poverty level (FPL) and are chronically homeless or involved in the criminal justice system, and in need of substance use or mental health treatment; or only in need of substance use or mental health treatment. Additionally, with this approval, the State was authorized to restore full mental health benefits for the Current Eligibles (that is, beneficiaries eligible under the State Plan) and cover former foster care youth who were covered by Medicaid in another state.
- Section 1115(f) Extension - On June 30, 2021, the State of Utah formally requested an extension of the PCN demonstration under the authority of Section 1115(f) of the Social Security Act. The demonstration was scheduled to expire on June 30, 2022. On July 16, 2021,

- Section 1115(f) Extension - On June 30, 2022, the demonstration was approved for a 5-year extension from July 1, 2022, through June 30, 2027. The STCs were changed to sunset the authority for "Current Eligibles" Medicaid eligibility group, providing this population instead with full State Plan benefits by December 31, 2023. The disparity between the benefits provided to childless adult beneficiaries in the Adult Expansion Population Medicaid *eligibility* group and adults with children in the same group were also eliminated, thereby aligning the benefit packages so that the entire Adult Expansion Population would have uniform, State Plan benefits. Finally, the renewal removed authority for and language addressing Demonstration Population I since this eligibility group is empty and any individuals who would qualify for this group are covered in the Adult Expansion Population.

Section III. Current Demonstration Goals, Objectives and Evaluation

Since the initial approval in 2002, Utah has received CMS authority to implement many additional programs and benefits through its 1115 Demonstration.
With these additions, Utah's primary objectives have expanded. Utah's demonstration strives to do the following:

- Provide health care coverage for low-income Utahns eligible under the demonstration who would not otherwise have access to, or be able to afford, health care coverage;
- Improve beneficiary health outcomes and quality of life;
- Lower the uninsured rate of low income Utahns;
- Provide continuity of coverage for individuals eligible under the demonstration;
- Increase access to primary care;
- Reduce uncompensated care provided by Utah hospitals;
- Reduce barriers to health care and housing, an important social determinant of health;
- Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
- Improve access to services across the continuum of care;
- Provide for better care coordination for individuals transitioning to community-based care;
- Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
- Reduce the overdose death rate; and
- Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders.

Future goals for the 1115 Demonstration:

- Enhancing care for vulnerable populations, including justice-involved individuals.
- Increasing access to medication-assisted treatment.
- Increase access to family planning services.

Demonstration Evaluation

To determine if Utah's 1115 Demonstration is meeting its intended goals and objectives, the State has contracted with an independent evaluator to conduct an evaluation of the demonstration. This evaluator is Public Consulting Group, Inc. (PCG). PCG is responsible for conducting an evaluation of the following demonstration populations:

- Adult Expansion, including the ESI component
- Demonstration Populations III, V, VI and Current Eligible CHIP children
- Dental Services
- Extended Postpartum Coverage
- Family Planning Services
- Former Foster Care Youth from Another State
- Fertility Preservation for Individuals Diagnosed with Cancer
- HRSN (includes HRSS)
- In Vitro Fertilization and Genetic Testing
- Reentry Pre-Release Services
- SMI
- SUD
- Targeted Adult Medicaid
- UMIC

PCG will also include the following demonstrations, no longer in the demonstration, in the Interim and Summative Reports:

- Intensive Stabilization Services
- Current Eligibles

The evaluations have been designed by the independent evaluator to meet the STCs of Utah's 1115 Demonstration. The evaluations will test the specific hypotheses and performance measures as identified by the evaluation designs for the demonstration populations.

Evidence of how demonstration goals and objectives were met:

PCG's 2024 Summative Evaluation Report[1] findings provide evidence that many of the demonstration goals were met. These include providing health care coverage for low-income Utahns eligible under the demonstration who would not otherwise have access to, or be able to afford, health care coverage; providing continuity of coverage for individuals eligible under the demonstration; increasing access to primary care; increasing the utilization of preventive dental services, while reducing emergency dental procedure costs; and reducing the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate. This is specific to the 2017-2022 demonstration period. Report findings include:

[1] Report can be found here: https://medicaid.utah.gov/evaluation-plan-documents/

- Multiple indicators showed improved access among low-income Utah residents. This includes having a personal doctor or usual source of care, a primary care appointment in the last year, and having preventative screening.
- Increase in utilization and engagement in treatment for SUD in the TAM population. The engagement of TAM members in treatment likely contributed to an observed reduction in ED visits for this population, and is a foundation for supporting members in stable recovery in the longer term. Moreover, the dental benefit provided to TAM members was utilized by approximately one-third of TAM members, an unusually high rate for individuals with SUD and housing instability or other social risk factors. This engagement in dental care probably avoided ED visits - no ED visits for dental conditions occurred among TAM members during the Demonstration.
- In comparison to other states, low-income UT residents reported improved access to both SUD and SMI services over the course of the Demonstration period. This improvement was most significant in the early years of the Demonstration. During the COVID-19 Public Health Emergency (PHE), these relative gains were maintained, but further progress was not observed. This timing suggests that the improvement can be attributed both to systemic improvement in BH care delivery, and the addition of SUD IMD services.

The addition of several demonstrations during this demonstration period has helped to lower the uninsured rate of low income Utahns. The addition of dental services to all Medicaid members further strengthens the goal of increasing the utilization of preventive dental services. In July, 2025, the State began providing HRSN to Adult Expansion members, which includes Housing Related Services and Supports. This helps to reduce barriers to health care and housing while improving health outcomes and quality of life. The addition of Extended Postpartum Coverage, Reentry Pre-Release Services and Family Planning Services will provide additional coverage to members who would not otherwise have access to, or be able to afford, health care coverage as well as provide continuity of coverage. In addition, the implementation of In Vitro Fertilization and Genetic Testing and Fertility Preservation for Individuals Diagnosed with Cancer has helped to meet the goal of improving access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders.

Given that many of the demonstration's objectives have been achieved, it is reasonable to conclude that beneficiaries' health outcomes and overall quality of life have improved. During the requested extension period, the State will focus on continuing to meet these goals while also enhancing care coordination for individuals transitioning to community-based care and implementing strategies to reduce the rate of overdose deaths.

Evaluation Designs and Interim Evaluation Reports

The State and PCG coordinated with CMS in the development and approval of the evaluation designs for the demonstration populations identified above. In July, 2024, PCG completed the required Summative Report for the demonstration period of November 2017 through June 2022. In June,

2025, PCG completed the required SUD and SMI/SED Mid-Point Assessment. PCG also completed the required interim evaluation report, which can be found in Attachment 1. A Reentry Pre-Release Services Midpoint Assessment will be submitted to CMS by February 2028. As required by the 1115 Demonstration STCs, the summative evaluation report for the demonstration period July 1, 2022, through June 30, 2027 will be submitted to CMS within 18 months of the end of the demonstration period (no later than December 2028).

External Quality Review

Part of the overall quality strategy mandated by Section 1932(c)(2) of the Social Security Act and 42 CFR §438.350-370 requires states to include annual independent external quality reviews (EQRs) in each managed care contract. This approach requires an independent External Quality Review Organization (EQRO) to validate performance measures, conduct compliance reviews and otherwise evaluate the performance of Medicaid managed care plans. Utah contracts with HSAG as its EQRO vendor. A summary of activities performed by the Utah EQRO along with their key findings are contained in Attachment 2.

Section IV. Current Program Features to Continue under Demonstration Renewal

With this renewal, the State is requesting to continue all currently approved demonstration populations and components, except for TAM. The State is requesting to end TAM on June 30, 2027, as outlined in section 1 above.

A description of the currently approved demonstration populations is detailed below.

1. **Adult Expansion** -comprised of adults, ages 19 through 64 who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the State.
2. **Demonstration Population III** - premium subsidies for working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.
3. **Demonstration Population V** - premium subsidies for adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are

not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).

4. **Current Eligible CHIP Children** -premium subsidies for children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.
5. **Demonstration Population VI** -premium subsidies for children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:
    a. COBRA-Eligible Children: A child that meets the definition of a targeted low-income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.
    b. COBRA Continuation Children: A child that meets the definition of a targeted low-income child except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium subsidies.
6. **Dental Services**- All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental, Oral Maxillofacial, and Orthodontia Services.
7. **Employer Sponsored Insurance (ESI)** - Individuals in the Adult Expansion Population are required to enroll in employer sponsored insurance, if it is available to the eligible individual.
8. **The Extended Postpartum Coverage population** -comprised of women who are eligible for Medicaid during their pregnancy. Includes coverage for individuals from the end of the State Plan 60-day postpartum period to the end of the 12th month following the end of the pregnancy.
9. **The Family Planning and Family Planning Related population** -provides family planning services and family planning related services to individuals age 18 or older with a household income at or below 185 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and are not in a public institution.
10. **Fertility Preservation for Individuals Diagnosed with Cancer** -Fertility preservation services are available for beneficiaries undergoing gonadotoxic cancer treatments, or other medically necessary treatment, that is expected to render them permanently infertile. Cost sharing requirements for this benefit will not differ from those under the State Plan.

Reimbursement for cryopreservation storage is covered as a single payment for five years. Additional 5-year storage increments may only be requested for members that retain eligibility.

11. **Former Foster Care Youth from Another State** -defined as individuals under age 26, who were in foster care under the responsibility of a state other than Utah or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid. Beginning January 1, 2023, the Former Foster Care Youth from Another State population will include individuals who otherwise meet the definition and turned age 18 on December 31, 2022, or earlier. Individuals who turn age 18 on January 1, 2023, or later, and who qualify as a Former Foster Care Youth, will be eligible under the State Plan.
12. **Health Related Social Needs** - Provides coverage for the following HRSN housing interventions: housing supports without room and board (i.e., pre-tenancy navigation services, one-time transition and moving costs other than rent, and tenancy and sustaining services), home remediations, home/environmental accessibility modifications, episodic housing interventions with clinical services with room and board (i.e., short-term recuperative care and short-term post-transition housing) limited to a clinically appropriate amount of time, and room and board-only supports (i.e., short term rental assistance) limited to a clinically appropriate amount of time.
13. **In Vitro Fertilization and Genetic Testing for Qualified Conditions** -Provides in vitro fertilization services and genetic testing services for eligible individuals between the ages of 18 and 35 and who have a familial medical history or be in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.
14. **Reentry Pre-Release Services** -Provides limited coverage of targeted services for inmates in a state prison, county jail, or juvenile justice facility for up to 90 days prior to the individual's expected release date. Covered services include, but are not limited to, intensive case management, Medication-Assisted Treatment (MAT) services for all types of Substance Use Disorders (SUD), a 30-day supply of prescription medication upon release, lab and radiology services, targeted outpatient services, diagnosis and treatment of physical and behavioral health conditions, and screening for housing related services.
15. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI)**- provides services to eligible individuals age 21 through 64 who receive treatment for a SMI and who are short-term residents in facilities that qualify as an IMD.
16. **Substance Use Disorder Services in an IMD**- provides eligible Medicaid recipients opioid use disorder (OUD)/substance use disorder (SUD) treatment services, primarily treatment and withdrawal management services, to individuals who are short-term residents in residential or inpatient settings that qualify as an IMD.

17. **Targeted Adult Medicaid** -comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:
    a. Be chronically homeless, defined as:
        i. An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, posttraumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
        ii. An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the State, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
        iii. An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter; or
        iv. An individual currently living in supportive housing who has previously met the definition of chronically homeless as specified in paragraphs (i)(1), (i)(2), or (i)(3), above.
    b. Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
        i. An individual who has complied with and substantially completed a substance use disorder treatment program while they were incarcerated in jail or prison, including Tribal jails (requirements regarding the type and length of qualifying programs will be established in the Utah Administrative Code);
        ii. An individual who is court ordered to receive substance abuse or mental health treatment by a district court or Tribal court;
        iii. An individual on probation or parole with serious mental illness and/or serious substance use disorder;
        iv. An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
        v. An individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.
    c. Needing substance use or mental health treatment, defined as:

i. An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or

ii. An individual recently discharged from the Utah State Hospital who was civilly committed, to be further specified in the Utah Administrative Code.

18. The State currently has approval to mandatorily enroll the Adult Expansion Population into UMIC managed care organizations (MCO) for delivery of their physical and behavioral health services in the five urban counties in the State (Davis, Salt Lake, Utah, Washington, and Weber). The State also mandatorily enrolls members of the Adult Expansion Population in an ACO and a PMHP or FFS, for beneficiaries residing in the remaining eight counties (Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, and Wasatch) in which beneficiaries are not enrolled into UMIC.

Benefits, Delivery System, Cost Sharing and Eligibility Requirements

The State intends to continue to provide benefits per the delivery systems outlined below.

Table 1: Demonstration Benefits, Delivery System and Eligibility Requirements

Demonstration Populations	Benefits	Delivery System	Eligibility Requirements
Adults and Adult Children in Demonstration Populations III and V	Individuals in this eligibility category are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	The sole benefit provided to persons eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	Demonstration Population III: Working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to

			participate in the plan is at least five percent of the household's countable income. Demonstration Population V: Adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, are U.S. citizens or qualified non-citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).
Children in Demonstration (Current Eligible CHIP Children	Individuals in this eligibility category are eligible to receive premium assistance (through ESI or COBRA) in paying the	The primary benefit provided to children eligible for premium subsidies (through ESI or COBRA coverage) is	Children up to age 19 with family income up to and including 200 percent of the FPL who would meet the

and Demonstration Populations VI)	employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	assistance in paying the child's share of the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	definition of a targeted low-income child.
Adult Expansion	• Expansion adults will receive State Plan benefits • Expansion adults also receive benefits that are the equivalent of (b)(3) services under the State's 1915(b) PMHP waiver, which include psychoeducational services, personal services, respite care	• Benefits are provided through UMIC in five counties. • Adult Expansion individuals in eight additional counties are enrolled in an Accountable Care Organization (ACO) for their physical health services and in a Prepaid Mental Health Plan (PMHP) for their behavioral health services. Adult Expansion individuals in the remaining 16 counties receive their physical health services on a FFS basis and are enrolled in a PMHP for their behavioral health services.	Adults age 19-64 who have household income up to 133 percent of the FPL.
Dental Benefits	Dental benefits that are defined in the Utah Medicaid Provider Manual, Dental, Oral Maxillofacial, and Orthodontia Services. Cost sharing requirements for this benefit will not differ from those under the State Plan.	Benefits are provided through a fee-for-service delivery system and are delivered through the University of Utah School of Dentistry and their associated statewide provider network.	All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women.
Employer Sponsored Insurance	Individuals in the Adult Expansion Population will be reimbursed for the full	• Individuals will receive services through the delivery systems	Individuals in the Adult Expansion Population

	amount of the individual's share of the monthly premium cost of the qualified ESI plan.	provided by their respective qualified plan. ● Wrap-around benefits will be provided through a fee-for-service delivery system.	
Extended Postpartum Coverage	Individuals enrolled in this eligibility category will receive full Medicaid State Plan benefits.	● Benefits are delivered through the individual's applicable delivery system (ACO, PMHP, UMIC, or FFS).	Pregnant individuals enrolled in Medicaid
Family Planning Services	● Comprehensive family planning preventive visits based on nationally recognized clinical guidelines that must have a primary focus and diagnosis of family planning which includes counseling, education, and initiation or management of contraceptive methods. ● FDA-approved methods of contraception. ● Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, Pap smears, and pelvic exams. ● Drugs, supplies, or devices related to family planning services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements, subject to the national drug rebate	Benefits are provided through a fee-for-service delivery system.	Women and men age 18 and older who have a household income at or below 185 of the FPL. Must be a U.S. Citizen or qualified non-citizen, a resident of Utah and not in a public institution, and be ineligible for coverage under any other Medicaid program.

	program requirements. ● Contraceptive management, patient education, and counseling. ● Sterilization procedures and devices, the office visits or physical exams related to and necessary for sterilization or long-acting reversible contraception, laboratory testing necessary to complete a sterilization or long-acting reversible contraception insertion, and approved prescription medication to treat anxiety and pain in relation to the sterilization procedure. ● Treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a screen pursuant to a routine or periodic family planning visit. A follow-up visit or encounter for the treatments, such as drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for Disease Control and Prevention guidelines, may be covered. ● STI/STD diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling. ● FDA-approved		

	vaccination for Human Papillomavirus (HPV).		
Fertility Treatment for Individuals Diagnosed with Cancer	Eligible beneficiaries can receive the following services once per lifetime: ● Collection and storage of eggs and sperm consistent with established medical practices or professional guidelines published by the American Society of Reproductive Medicine or the American Society of Clinical Oncology. ● Preimplantation genetic testing prior to cryopreservation storage, with coverage as described in Utah's coverage and reimbursement materials and policy manuals. ● Cryopreservation storage, which is covered as a single payment for a five-year period. If the individual remains eligible for Medicaid or demonstration coverage, the State will continue to provide cryopreservation storage in five-year increments. Cost sharing requirements for this benefit will not differ from those under the State Plan.	Benefits will be provided through a fee-for-service delivery system.	Medicaid eligible individuals diagnosed by a physician as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility.
Former Foster Care Youth from Another State	Individuals enrolled in this eligibility category will receive full Medicaid State Plan benefits.	Benefits are delivered through the individual's applicable delivery system (ACO, PMHP, UMIC, or FFS).	An individual aged 18-26 who were in foster care under state custody on or after their 18th birthday and received

			Medicaid at some point during the foster care period in which they turned age 18.
Health Related Social Needs	The following services may be covered: Housing Interventions, including: ● Housing supports without room and board, including: ○ Pre-tenancy navigation services (e.g., finding and securing housing). ○ One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), movers, relocation expenses, pest eradication, cooking supplies, and the	Benefits will be provided through a fee-for-service delivery system.	Individuals eligible for Adult Expansion or Targeted Adult Medicaid.

	purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. This does not include clothing. ○ Tenancy and sustaining services (e.g., eviction prevention, tenant rights education). ● Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections. ● Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, and grab bars. ● Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including: ○ Short-term recuperative care,		

	where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care. ○ Short-term post-transition housing (e.g., post-hospitalization) , where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required. ● Room and board-only supports (also referred to as “rent-only” supports or interventions), limited to a clinically appropriate amount of time, including: ○ Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment. Cost sharing requirements		

	for this benefit will not differ from those under the State Plan.		
In Vitro Fertilization and Genetic Testing	The following services may be covered: ● Genetic testing services. ● Preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus. In vitro fertilization services, up to three cycles per lifetime. Cost sharing requirements for this benefit will not differ from those under the State Plan.	Benefits will be provided through a fee-for-service delivery system.	An individual must be age 18 through 35, diagnosed by a physician as having a generic trait associated with a qualified condition including cystic fibrosis, spinal muscular atrophy, Morquio Syndrome, Myotonic dystrophy, or Sickle cell anemia and intends to get pregnant with a partner who has been diagnosed by a physician as having a generic trait associated with the same qualified condition as the individual.
Reentry Pre-Release Services	The following services may be covered: ● Case management to assess and address physical and behavioral health needs, and health-related social needs. ● MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies. ● A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual	Benefits will be provided through a fee-for-service delivery system.	An individual must be a qualified inmate which is defined as an individual who is incarcerated in a correctional facility with 90 days or fewer remaining before release and meets eligibility requirements for Medicaid.

	immediately upon release from the correctional facility, consistent with approved Medicaid State Plan coverage authority and policy. ● Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support prerelease case managers' development of a post-release treatment plan and discharge planning. ● Diagnostic services, including laboratory and radiology services, and treatment services. ● Prescribed drugs and medication administration. ● Family planning services and supplies. ● Services provided by community health workers. ● Peer support services. ● Treatment for Hepatitis C. ● Medical equipment and supplies and/or medical equipment provided upon release. Cost sharing requirements for this benefit will not differ from those under the State Plan.		
SMI IMD	Individuals will receive State Plan services,	Benefits are delivered through the	Individuals ages 21through 64 who

	including mental health treatment services. provided in residential and inpatient treatment settings that qualify as an IMD.	individual's applicable delivery system (PMHP, UMIC, or FFS).	receive treatment for a SMI, and who are short-term residents in facilities that meet the definition of an IMD.
SUD IMD	Individuals will receive State Plan services, including SUD treatment services provided in residential treatment settings that qualify as an IMD.	Benefits are delivered through the individual's applicable delivery system (PMHP, UMIC, or FFS).	Medicaid eligible individuals receiving SUD residential treatment in an IMD.

Cost Sharing

Cost sharing requirements for individuals under this demonstration are as defined in the Medicaid State Plan, with two exceptions:

- Individuals receiving premium assistance under the UPP program (Demonstration populations III, V, VI and current eligible CHIP children) will have cost sharing requirements set by their qualified ESI or COBRA plan.
- American Indian/Alaska Natives enrolled in the demonstration are exempt from cost sharing requirements under section 5006 of the American Recovery Reinvestment Act of 2009.

Section V. Proposed Changes to Current Demonstration

The State requests the following changes to the current demonstration for the identified demonstration populations or components:

Targeted Adult Medicaid

The State is requesting to end TAM on June 30, 2027. If approved, TAM Members will transition to Adult Expansion.

- Objective: To transition current TAM members to the Adult Expansion group to comply with the removal of the authority to provide continuous eligibility to the TAM population.
- Desired Outcome: A seamless transition of coverage for TAM members into the Adult Expansion group, ensuring no loss of benefits or gaps in care during the administrative shift.
- Impact on Demonstration Goals: This change will simplify reporting requirements and reduce administrative burden while maintaining coverage for individuals transitioning from TAM to Adult Expansion

Utah's Premium Partnership for Health Insurance (UPP)- Demonstration Populations III, V, VI, and Current Eligible CHIP Children

The State is requesting the consolidation of the four UPP demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population.

- Objective: To combine these four relatively small, historically distinct UPP groups into a single population for simplified administration and reporting.
- Desired Outcome: Streamlined program administration, consolidated tracking for budget neutrality, and the elimination of redundant reporting requirements for small sub-populations.
- Impact on Demonstration Goals: This change will simplify reporting requirements and reduce administrative burden while making no adverse coverage change to members.

Removal of Supportive Living Services (mental health services in residential treatment settings) from Behavioral Health Benefits

The State is requesting the removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion Population, as these services were moved into the Medicaid State Plan on November 7, 2024.

- Objective: To remove duplicative waiver authority for Supportive Living Services now that they are an approved, standardized benefit under the Medicaid State Plan.
- Desired Outcome: Streamline authority for Supportive Living Services into a single source to prevent duplication and provider confusion.
- Impact on Demonstration Goals: This change will simplify Medicaid's authority for coverage of this service without reducing coverage.

Pending 1115 Demonstration Amendments

At this time, the State has several 1115 Demonstration amendment requests pending a decision from CMS. These amendments can be found in Attachment 3, and on the State's 1115 Demonstration website at https://medicaid.utah.gov/1115-waiver. The State requests that these amendments be considered in addition to the 1115 Demonstration renewal, with the hope of gaining approval for these amendments prior to the approval of the full 1115 Demonstration renewal. A brief overview of the amendments is contained below.

Chronic Conditions Support

On July 27, 2023, the State submitted an amendment as a result of Senate Bill 269, "Chronic Conditions Support Amendments" which passed during the 2023 General Session of the Utah State Legislature. This amendment requests the authority to provide additional Medicaid services to fee for service enrolled individuals with qualified chronic health conditions.

Community Engagement

On July 3, 2025, the State submitted a Community Engagement Amendment. This amendment requests the authority to implement a community engagement work requirement for the Adult Expansion Population. This requirement would apply to Adult Expansion members who are able to participate in the requirement, are not already participating in other work or training activities, and do not meet an exemption or do not demonstrate good cause.

Disability Wraparound Coverage

On June 30, 2025, the State submitted an amendment as a result of House Bill 310, "Disability Coverage Amendments" which passed during the 2025 General Session of the Utah State Legislature. This amendment requests authority to provide wraparound Medicaid services for qualified individuals who have private health insurance and have a disability. This would include services covered by Medicaid and not by private health insurance.

Integrated Behavioral Health Services

On December 30, 2022, the State submitted an amendment as a result of Senate Bill 41, "Behavioral Health Services Amendments" which passed during the 2022 General Session of the Utah State Legislature. This amendment requests authority to allow individuals to receive existing StatePlan covered physical and behavioral services in an integrated model through a contracted local mental health authority.

Long Term Services and Supports for Behaviorally Complex Individuals

On December 30, 2022, the State submitted an amendment seeking approval to provide Long Term Services and Supports (LTSS) to individuals with behaviorally complex conditions through a contracted LTSS provider.

Native American Health Amendments

On November 25, 2024, the State submitted an amendment seeking approval to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to Medicaid enrollees who are members of an American Indian or Alaskan Native (AI/AN) tribe.

Other Amendments

At this time the State is not requesting action on the following 1115 Demonstration amendments as part of the renewal. However, the State is not withdrawing these amendment requests at this time.

- Fallback Plan
- Per Capita Cap

Section VI. Goals, Objectives, and Evaluation of Proposed Demonstration Renewal

Utah proposes the following research hypotheses and design approach for Utah's demonstration renewal. The hypotheses below are consistent with those already approved in the evaluation designs. The State is not requesting any changes at this time.

Table 3: Demonstration Objectives and Proposed Hypotheses		
Objectives	**Proposed Hypotheses**	**Potential Approaches/Data Sources**
Low-income UT residents		
Provide health care coverage for low-income Utahns eligible who would not otherwise have access to or be able to afford healthcare coverage.	The demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.	Behavioral Risk Factor Surveillance System (BRFSS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Custom Member Survey Claims Data
Adult Expansion/UMIC/Dental		
Improve healthcare access and engagement for the AEM population.	The demonstration will improve healthcare access and engagement for the Adult Expansion Population.	Claims Data Pre-Dental Expansion Baseline Custom Member Survey
Targeted Adults/TAM Dental		
Improve healthcare access and engagement for the TAM population.	By providing coverage through the Targeted Adult Medicaid demonstration, healthcare access and engagement will improve for this population.	Claims Data
Health Related Social Needs		
The HRSN demonstration will mitigate housing and transportation needs, increase continuity of behavioral health treatment, and improve health outcomes for eligible members.	The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.	Administrative Data American Community Survey Area Health Resources File Case Records Claims Data Participant Interviews Administrative: Maintenance of Effort section of Annual Monitoring Reports

		Key Informant Interviews
SUD and SMI		
Behavioral Health coverage for residential and inpatient services provided to members in IMDs will lead to a reduction in inpatient stays, ED utilization, and rate of unplanned readmission among recipients, resulting in cost decrease or stabilization. Coverage will also lessen unmet need and increase engagement in treatment to reduce overdose deaths in the long-term.	The SMI and SUD demonstrations increased access to appropriate treatment.	Claims Data National Survey on Drug Use and Health (NSDUH) Administrative Data
Greater utilization of non-hospital, non-residential services will lead to greater reductions in inpatient stays, ED utilization, and overdose deaths in the long-term.	The SMI and SUD demonstrations stabilized or reduced cost of care for these populations.	Claims
UPP/ESI, Former Foster Care Youth from Another State, Fertility and Genetic Testing Services		
Utilization of the services provided to these populations will increase and total cost of care will decrease.	The demonstration delivered coverage/ services appropriately to individuals in the smaller demonstration populations.	Claims Monitoring Reports
Reentry Pre-Release Services		
The demonstration will enhance cross-system collaboration between the correctional and community-based services systems, that enrollment and redetermination support will improve continuity of coverage, and that coverage of pre-release and reentry	The Reentry Pre-Release Services Benefit will enhance cross-system communication and coordination between correctional and community services.	Beneficiary Interviews Case Manager Interviews Correctional System Staff Interviews Community-based Providers Interviews
	The ReentryPre-Release Services Benefit will improve pre-release service provision	Claims/administrative Carceral Facility Readiness Assessment and Key Informant

pre-release services will improve engagement in high quality care, reduce unnecessary acute care utilization, and ultimately improve health outcomes for the Reentry population.	during the covered period and continuity of coverage for the reentry population.	Interviews Beneficiary Interviews Carceral Facility Administrative Data Medicaid Administrative Data: Eligibility and Enrollment
	The Reentry Pre-Release Services Benefit's 90-day pre-release coverage period ("the coverage timeline") will support effective program implementation.	Carceral Facility Administrative Data Beneficiary Interviews State and Correctional System Staff Interviews
	The Reentry Pre-Release Services Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the reentry population post-release.	Claims Beneficiary Interviews Case Manager Interviews Vital Statistics
Family Planning Services		
Effectively implement a fiscally sustainable family planning demonstration.	Hypothesis 1: The family planning demonstration will be effectively implemented.	Qualitative Analysis ● Interviews with State Medicaid agency staff ● Interviews with health plan staff or providers Quantitative Analysis ● State-administered beneficiary survey ● Medicaid administrative data ● Monitoring reports
	Hypothesis 2: The family planning demonstration will improve the fiscal sustainability of the Utah Medicaid program.	Qualitative Analysis ● Interviews with State Medicaid agency staff Quantitative Analysis ● State-administered data
Enhance awareness of family planning demonstrations and improve participation in	Hypothesis 3: The family planning demonstration will maintain or increase	Quantitative Analysis ● State-administered beneficiary survey

programs and access to family planning and other family planning demonstration-covered services among demonstration beneficiaries.	beneficiary participation in family planning programs, including awareness of and access to family planning services.	• Medicaid administrative data
Increase the effective use of family planning services or other family planning demonstration-covered services among demonstration beneficiaries.	Hypothesis 4: The ongoing access to family planning services through the demonstration will maintain or increase the use of these services among beneficiaries.	Quantitative Analysis • Medicaid administrative data
Extended Postpartum		
Improve maternal and infant health outcomes, particularly focusing on reducing unintended pregnancies.	Hypothesis 5: The ongoing provision of family planning services, family planning-related services, and other demonstration-covered services will lead to improvements in maternal and infant health outcomes.	Quantitative Analysis • State-administered beneficiary survey • Medicaid administrative data • Vital statistics data
Dental Services for Medicaid-Eligible Children and Pregnant or Postpartum Women		
Increase the utilization of dental services.	Hypothesis 6: The provision of dental services will increase utilization among Medicaid-eligible children and pregnant or postpartum women.	Quantitative Analysis • State-administered beneficiary survey • Medicaid administrative data

Note: The demonstration objectives, hypotheses, and proposed evaluation approaches are aligned with the STCs and CMS' Section 1115 Family Planning and Assessing Demonstration Costs Technical Assistance Guides. Modifications were made to reflect the November 2025 amendment's focus on family planning, extended postpartum coverage, and dental services for Medicaid-eligible children and pregnant or postpartum individuals.

Section VII. Requested Waiver Authorities, Expenditure Authorities, and Non-Applicables

The following table summarizes the current demonstration waiver and expenditure authorities, and whether Utah is requesting to continue these authorities with this renewal request.

Table 4: Requested Waiver Authorities			
Waiver Authority	**Reason and Use of Waiver**	**Demonstration Populations Applicable To**	**Status under Renewal**
Section 1902(a)(84)(D)-Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release	To enable the State not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a State Plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the State instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The State will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the State Plan.	Reentry Pre-Release Services Demonstration	Continue

Table 5: Requested Non-Applicables			
Waiver Authority	**Reason and Use of Waiver**	**Demonstration Populations Applicable To**	**Status under Renewal**

Section 1902(a)(10)(B) and Section 1902(a)(17)-Comparability; Amount, Duration and Scope of Services and Comparability	To enable the State to vary the amount, duration, and scope of services offered to individuals by demonstration group. To enable the State to include additional benefits, such as behavioral health, case management, and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system. To enable the State to provide benefit packages to the Demonstration population that differs from the State Plan benefit package. To enable the State to provide additional benefits to AEM members compared to the benefits available to members eligible under the State Plan that are not affected by the Demonstration.	-Individuals affected by this demonstration with the exception of Former Foster Care Youth from Another State -Adult Expansion -Populations III and V -Fertility Preservation for Beneficiaries Diagnosed with Cancer -In Vitro Fertilization and Genetic Testing -Reentry Pre-Release Services Demonstration -HRSN -Family Planning Services -Chronic Conditions -Community Engagement -Disability Wraparound Coverage -Long Term Services and Supports for Behaviorally Complex Individuals	Continue and Approval Requested
Section 1902(a)(34)-Retroactive Eligibility	To permit the State to not provide retroactive eligibility for individuals under this demonstration.	-Demonstration Populations III and V -Family Planning Services	Continue
Section 1902(a)(1)-Statewideness/ Uniformity	To enable the State to provide differing types of managed care plans in certain geographical areas of the State for Title XIX populations affected by this demonstration. To enable the State to provide pre-release services	-Title XIX Populations affected by this demonstration -Reentry Pre-Release Services Demonstration -HRSN -Integrated Behavioral Health Services	Continue and Approval Requested

	to qualifying individuals on a geographically limited basis. To enable the State to provide housing and home environment interventions without room and board, short-term recuperative care, and short-term rental assistance services on a less-than statewide basis. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.		
Section 1902(a)(23)(A)-Freedom of Choice	To enable the State to restrict freedom of choice of providers for individuals under this demonstration. To enable the State to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers. To enable the State to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration	-Title XIX Populations affected by this demonstration -Reentry Pre-Release Services Demonstration -Chronic Conditions Support -Long Term Services and Supports for Behaviorally Complex Individuals	Continue and Approval Requested
Section 1902(a)(43)-Early Periodic Screening, Diagnosis and Treatment (EPSDT)	To enable the State to not furnish or arrange for EPSDT services to the demonstration population receiving family planning services and family planning related services.	Family Planning Services	Continue

Section 1902(a)(8), (a)(10) and (a)(10)(A) -Eligibility and Provision of Medical Assistance and Eligibility Requirements	To the extent necessary to enable the State to suspend eligibility for, and not make medical assistance available to members subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the member is exempted, or demonstrates good cause, as described in the STCs. To the extent necessary to enable the State to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs. To permit the State to cap enrollment for individuals eligible under the Disability Wraparound Coverage demonstration group.	-Community Engagement -Chronic Conditions Support	Approval requested
Section 1902(a)(10)(A)(i)(VIII) and 1902(a)(17) Comparability of Eligibility Requirements	To the extent necessary to enable Utah to require work, training, and/or engagement as a condition to qualify for and maintain eligibility for the eligibility category defined in 1902(a)(10)(A)(i)(VIII).	Community Engagement	Approval Requested
Section 1902(a)(14) Cost Sharing Requirements	To permit individuals affected by this demonstration, whose benefits are limited to wraparound coverage, to have cost sharing requirements.	Disability Wraparound Coverage	Approval Requested

Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)	To the extent necessary to enable the State to reimburse for traditional healing services for AI/AN members provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program.	-Native American Health Amendments	Approval Requested
Expenditure authority for services not covered under Section 1905 of the Social Security Act	To the extent necessary to enable the State to claim FFP for the cost of traditional healing services provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program and receive 100 percent FMAP.	-Native American Health Amendments	Approval Requested

Expenditure Authorities

Table 6: Requested Expenditure Authorities

Demonstration Population	Reason and Use of Expenditure Authority	Status Under Renewal
Demonstration Population III	Expenditures for premium subsidies related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the health insurance premium for employer sponsored insurance (ESI) to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the federal poverty level (FPL), but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid, as described in the Special Terms and Condition (STCs).	Continue

Demonstration Population V	Expenditures for premium subsidies related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the FPL, but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs.	Continue
Former Foster Care Youth from Another State	Expenditures to extend eligibility for full Medicaid State Plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the State has elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.	Continue
Targeted Adults	Expenditures to provide State Plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs. Expenditures for State Plan coverage for individuals who have been determined eligible as a Targeted Adult for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination (continuous eligibility).	Discontinue beginning June 30, 2027, and transition these individuals into the Adult Expansion group.
Substance Use Disorder	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).	Continue
Adult Expansion	Expenditures to provide coverage to adults, age 19 through 64 and have household income at or below 133 percent of the FPL.	Continue
Mandatory Employer Sponsored Insurance	Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population beneficiaries who are enrolled in ESI plans.	Continue
Residential and Inpatient Treatment for Individuals with Serious Mental Illness	Expenditures for services furnished to eligible individuals age 21 through 64 who receive treatment for a serious mental illness (SMI) and who are short-term residents in facilities that meet the definition of an IMD.	Continue

Expenditures Related to Fertility Preservation for Beneficiaries Diagnosed with Cancer	Expenditures for fertility preservation provided to eligible individuals with an active diagnosis of cancer which puts them at risk for sterility or iatrogenic infertility.	Continue
Expenditures Related to In Vitro Fertilization and Genetic Testing Services	Expenditures for in vitro fertilization and genetic testing services for qualifying individuals.	Continue
Expenditures for Pre-Release Services	Expenditures for pre-release services furnished to individuals who meet qualifying criteria for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Pre-Release Services Demonstration Initiative under this demonstration.	Continue
Expenditures for Pre-Release Administrative Costs	Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Pre-Release Services Demonstration Initiative.	Continue
Dental Services	Expenditures for dental services provided to all Medicaid-eligible adults and children as well as Medicaid-eligible pregnant and postpartum women.	Continue
Health-Related Social Needs (HRSN) Services	Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria.	Continue
Health-Related Social Needs Services Infrastructure	Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act.	Continue
Expenditures for Non-Medical Transportation (NMT)	Expenditures for NMT.	Continue
Expenditures for Continuous Eligibility for State Plan Benefits for the Full Pregnancy and 12-Month Period	Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12- month extended postpartum eligibility period.	Continue
Family Planning Services and Family Planning Related Services	Expenditures for providing Medicaid eligibility for family planning services and family planning related services, limited to: Women and men age 18 and older with family income at or below 185 percent of the FPL (using MAGI methodology which includes a 5 percent FPL income disregard) who are not in a public institution and are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP).	Continue

COBRA Children (Demonstration Population VI)	Expenditures to provide premium assistance and benefits to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.	Continue
Current Eligible CHIP Children	Expenditures to provide premium assistance to children up to age 19 with family income up to and including 200 percent of the FPL who meet the definition of a targeted low-income child, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving direct coverage under the CHIP State Plan. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.	Continue

Table 7 Title XXI Requirements Not Applicable to Children's Health Insurance Program (CHIP) Expenditure Authorities for Demonstration Population VI and Current Eligible CHIP Children

Demonstration Population	Reason and Use of Expenditure Authority	Status Under Renewal
Section 2102-General Requirements, and Eligibility Screening Requirements	The State child health plan does not have to reflect the demonstration population. Eligibility screening is not required to exclude eligibility for individuals enrolled in continuation coverage pursuant to COBRA.	Continue
Section 2103 and 2110-Restrictions on Coverage and Eligibility to Targeted Low-Income Children	Coverage and eligibility are not restricted to targeted low-income children, to the extent that it includes individuals enrolled under continuation coverage pursuant to COBRA.	Continue
Section 2105(c)(10)-Qualified Employer Sponsored Coverage	To permit the State to offer a premium assistance subsidy that does not meet the requirements of section 2105(c).	Continue

Table 8: Title XXI Requirements Not Applicable to Current Eligible CHIP Children

Demonstration Population	Reason and Use of Expenditure Authority	Status Under Renewal
Section 2102-Cost Sharing Exemption for	To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration,	Continue

American Indian/Alaskan Native (AI/AN) Children	and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.	
Section 2103-Benefit Package Requirements	To permit the State to offer a benefit package for all CHIP populations affected by this demonstration that is limited to premium assistance.	Continue
Section 2103(e)-Cost Sharing	To the extent necessary to permit all CHIP populations affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing imposed by employer-sponsored insurance plans.	Continue
Section 2102-Cost Sharing Exemption for American Indian/Alaskan Native (AI/AN) Children	To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.	Continue

Section VIII. Budget Neutrality

Utah's 1115 Demonstration must be "budget neutral" to the Federal government, which means that during the course of the demonstration, Federal Medicaid expenditures will not be more than Federal spending without the demonstration. Information regarding budget neutrality for this demonstration can be found in Attachment 4. The budget neutrality figures in Attachment 4 include the unduplicated member months for the total number of individuals that are expected to be enrolled in the demonstration.

For the budget neutrality calculations in Attachment 4, historical per-member-per month (PMPM) amounts from the prior demonstration period were used. When current costs exceeded those figures, the PMPM amounts were instead determined in accordance with CMS guidance issued in September 2022. Under this guidance, PMPM amounts were calculated as a weighted average consisting of 80 percent of the State's recent actual PMPM costs from the most recent demonstration period and 20 percent of the historical WOW PMPM baseline.

The weighted average method described above was used for the Adult Expansion, Male Fertility Treatment for Individuals Diagnosed with Cancer and the Substance Use Disorder demonstrations.

Section IX. Compliance with Public Notice and Tribal Consultation

Public Notice Process

The State certifies that public notice of the State's request for this demonstration renewal and notice of public hearing were advertised in the newspaper of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public notice was posted to the State's Medicaid website at https://medicaid.utah.gov/1115-waiver.

The State certifies that three public hearings to take public comment on this renewal request were held. The first public hearing was held via video and teleconferencing on April 23, 2026, from 10:00

a.m. to 12:00 p.m., during the Medicaid Advisory Committee (MAC) meeting. The second public hearing was held in-person on May 7, 2026, from 2:30 p.m. to 3:30 p.m. at the Martha Hughes Cannon Building, 288 North 1460 West, Salt Lake City, UT 84116, Room 125. The third public hearing was held via video and teleconferencing on May 7, 2026, from 4:00 p.m. to 5:00 p.m.

Public Comment

The State accepted public comment during a 30-day public comment period, which was held April 21, 2026, through May 21, 2026. The State received public comment from 81 individuals, advocacy groups, and other community partners. This includes comments provided during the three public hearings, email and online comments, and mailed comments. The State reviewed and considered all public comments received during the public comment period. Summarized comments and the State's responses can be found in Attachment 6.

Annual Public Forum

As required by the demonstration Special Terms and Conditions, the State held several annual public forums during the currently approved demonstration period. The forums were held during the Medicaid Advisory Committee (MAC) meetings on the following dates, and include all comments provided. The date, time and location of the forums were published on the State's 1115 Demonstration website 30 days prior to the date of the forum:

- January 20, 2022
    - One commenter asked about the status of the State's pending 1115 Demonstration renewal. No other comments were received.
- January 19, 2023
    - No comments received.
- January 18, 2024
    - One commenter asked about the delayed reporting of data counts for certain demonstrations. The State responded that we do not have control over this as we are unable to obtain enrollment data until all claims are submitted by providers and loaded into our PRISM system. No additional comments were received.
- January 6, 2025
    - One commenter expressed concern about the State's AEM enrollment and that the number seems to drop each month and is not stable. The commenter indicated she did not expect a response but just wanted to provide the comment. No additional comments were received.
- March 26, 2026
    - One commenter asked for clarity on pregnant women moving to the 1115 Demonstration. The State responded with additional information on the demonstration. No additional comments were received.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the DHHS Intergovernmental Policy 01.19 Formal DHHS Tribal Consultation and Urban Indian Organization Conferment Process Policy, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. DIH has notified the DHHS Tribal Health Liaison of the 1115 Demonstration renewal. As a result of this notification, DIH began to engage in the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meetings on April 10, 2026, and May 8, 2026 to present this demonstration renewal request. During the April 10, 2026 meeting, an attendee asked for the approval date of the Native American Health Amendment. The State responded that the amendment is pending a decision with CMS, and the approval date remains unknown. The State also addressed two commenters who requested clarification on the amendment's name, confirming it is the same as the Traditional Healing Amendment and that the name is based on state statute language. No additional comments were received during the May 8, 2026 UIHAB meeting. The UIHAB meeting agenda can be found in Attachment 7.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section X. Demonstration Administration

Name and Title: Julie Ewing, State Medicaid Director, Utah Department of Health and Human Services
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2027-2032 Renewal

Attachment 1

Interim Evaluation Report

Utah 1115 Medicaid Reform Demonstration Preliminary Interim Evaluation Report

Report prepared by the Public Consulting Group

Preliminary Interim Report Delivered to UT DHHS: 3/30/26

Draft Interim Report Submittal Date to CMS: 6/30/26

Project Nos. 11-W-00145/8 and 21-W-00054/8

PUBLIC CONSULTING GROUP

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A. Executive Summary

1. Demonstration

On June 30, 2022, the Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Utah's section 1115 waiver, formerly known as the "Primary Care Network (PCN) Demonstration" (hereafter, "the Demonstration" or "the 1115 Demonstration"). The current extension is entitled "Medicaid Reform 1115 Demonstration" and is approved for the five-year period from July 1, 2022, through June 30, 2027. Through the Demonstration, CMS has granted the state expenditure authorities to expand service offerings for vulnerable populations, move some members into integrated managed care plans, and to provide coverage to populations not otherwise eligible for Medicaid. The Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) administers the Utah Medicaid program and is responsible for the implementation of the Demonstration.

2. Findings

Member Experience of Care: Strengths and Opportunities for Improvement
The state hypothesized that the Demonstration would expand coverage for low-income Utah residents, thereby increasing engagement in health care and improving member satisfaction (Hypothesis 1). Findings from the member satisfaction survey show high rates of access to primary care providers and substance use treatment, as well as generally positive perceptions of provider communication and shared decision-making. However, the results also highlight several persistent challenges. Survey respondents reported barriers to accessing timely urgent, routine, and mental health care; difficulties obtaining needed medical care, tests or treatment; and concerns related to care coordination and providers' screening for health-related social needs. Together, these findings indicate that, while member satisfaction persists across several measures, additional targeted efforts are necessary to strengthen access, coordination, and responsiveness within the health care system.

Variation in Acute Care Utilization, Ambulatory Care, and Behavioral Health Care Results Across Demonstration Populations
The state anticipated that the Demonstration would enhance access to and engagement in health care for the Adult Expansion (AE) and Targeted Adult Medicaid (TAM) populations, thereby reducing reliance on inpatient and emergency department services (Hypotheses 2 and 3). Findings from the first three years of the Demonstration present a mixed picture. While emergency department utilization (EDU) decreased significantly for both populations, the expected reductions in acute hospital utilization (AHU) and emergency department utilization for behavioral health conditions (EDU-BH) were not observed. Several ambulatory and behavioral health measures demonstrated positive movement: adult access to ambulatory/preventive care (AAP) and initiation and engagement in substance use disorder treatment (IET) increased relative to baseline for both populations, and 7-day follow-up after hospitalization for mental illness (FUH) improved for the TAM population. However, anticipated improvements in 7-day FUH for the AE population, 30-day FUH for both groups, and reductions in 30-day all-cause unplanned readmission following hospitalization in an inpatient psychiatric facility (IPF) were not observed. Overall, these results indicate meaningful progress in certain areas of access and engagement, while highlighting ongoing challenges that warrant continued attention and targeted intervention.

Progress and Challenges for the Serious Mental Illness (SMI)/Substance Use Disorder (SUD) Demonstration Populations
The state posited that the SMI and SUD Demonstrations would expand access to appropriate treatment (Hypothesis 5), reflected in expected increases in IET and decreases in IPF. Findings indicate that while the SUD population experienced a significant increase in IET relative to baseline, the anticipated reduction in IPF among individuals with SMI diagnoses was not observed. These results suggest progress in some aspects of treatment access, while highlighting continued challenges in reducing psychiatric readmissions for the SMI population.

3. RECOMMENDATIONS

Based on these preliminary analyses, the IE offers these recommendations to the state:

(1) *Anticipate gradual improvement in measurement outcomes*
Evidence from prior studies demonstrates that while insurance coverage is a necessary foundation, meaningful increases in engagement and improvements in health outcomes are often not immediately realized.[1,2] Although the findings indicate progress across several measures, these gains should be interpreted within the broader context of adjustment periods associated with gaining coverage, establishing care relationships, and navigating the health care system.

The results underscore the importance of robust, targeted outreach efforts and comprehensive population health strategies to accelerate engagement and sustain progress over time. Medicaid members who were recently uninsured or underinsured may face persistent barriers—including limited health system familiarity, unmet social needs, and delayed care-seeking behaviors—that are not fully addressed through coverage alone. As such, proactive strategies that support care navigation, connection to primary and preventive services, and culturally responsive engagement are critical. Accordingly, the state should continue to invest in and refine outreach and population health initiatives that complement coverage expansion. Sustained monitoring of trends across program years will be essential to assess the effectiveness of these strategies and to distinguish short-term enrollment effects from longer-term improvements in engagement and health status.

(2) *Engage with members to streamline health care access*
The state should deepen collaboration with Medicaid members to more comprehensively assess and address areas in need of improvement. Feedback from survey respondents highlighted a broad range of concerns, emphasizing the need for targeted action to improve member experience and access to care. To mitigate these concerns, the state should prioritize strategies to streamline administrative processes, enhance support for identifying in-network providers, expand access to telehealth services, and increase awareness of existing essential supports that facilitate access to care such as non-emergency medical transportation.

The state's existing Beneficiary Advisory Council (BAC), composed of current and former Medicaid members and individuals who support Medicaid populations, provides an important forum for capturing member perspectives and informing program improvements. Continued engagement through the BAC alongside the development of additional feedback and outreach mechanisms such as community-based partnerships, public forums, and targeted communication campaigns would further strengthen the state's ability to incorporate member input into program design and implementation. Collectively, these efforts can support more responsive, member-centered strategies and help ensure that improvements are aligned with the needs and experiences of the populations served.

(3) *Strengthen care coordination and address members' health-related social needs (HRSN)*
The member satisfaction survey highlights persistent gaps in provider coordination of care and attention to health-related social needs. Fragmentation within the health care system—particularly limited access to comprehensive medical histories, such as prior tests, results, prescribed medications, and specialist care—impedes providers' ability to deliver timely, informed care. These inefficiencies disproportionately affect individuals with chronic or complex health needs, leading to reduced care quality, poorer health outcomes, and increased patient dissatisfaction. Furthermore, screening for health-related social needs is essential to advancing a more holistic approach to care, ensuring the providers can meet the full range of members'

[1] Miller, S., Wherry, L., 2017. *Health and Access to Care during the First 2 Years of the ACA Medicaid Expansion.* The New England Journal of Medicine. Health and Access to Care during the First 2 Years of the ACA Medicaid Expansion

[2] Courtemanche, C., Marton, J., Ukert, B., et al., 2017. *Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health.* National Bureau of Economic Research. Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health

physical, behavioral, and social needs. Improved information sharing, integrated care approaches, and provider engagement in assessing and addressing health-related social needs are therefore critical to improving member experience and overall health outcomes.

Enhancing care coordination and more effectively addressing members' health-related social needs may also help achieve the anticipated improvements in the evaluated acute, ambulatory, and behavioral health care measures that were not observed during the evaluation period. The state has taken meaningful steps to address health-related social needs through the Housing Related Services and Supports (HRSS) amendment implemented in 2022, which enabled the provision of housing support services, and the HRSN amendment in 2025, which expanded HRSS and additional services for eligible individuals. These initiatives represent an important component of the state's broader strategy to support member health and well-being and should be acknowledged as part of ongoing program development.

(4) *Promote continued integration of behavioral health care*

Evaluation findings indicate substantial unmet behavioral health needs, as the anticipated reductions in EDU-BH and 30-day all-cause unplanned readmission following hospitalization in an inpatient psychiatric facility were not realized. Similarly, expected improvements in FUH were not observed. These patterns underscore the need for comprehensive behavioral health care to more effectively meet members' needs.

The state's planned initiatives to expand access to behavioral health services and strengthen integration across the care continuum (e.g., increasing provider capacity, enhancing the availability of treatment options, and improving access to crisis stabilization services) represent important opportunities to advance more coordinated, effective care for Medicaid members.

B. General Background Information

1. Demonstration Name and Timing

On June 30, 2022, the Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Utah's section 1115 waiver, formerly known as the "Primary Care Network (PCN) Demonstration" (hereafter, "the Demonstration" or "the 1115 Demonstration"). The current extension is entitled "Medicaid Reform 1115 Demonstration" and is approved for the five-year period from July 1, 2022, through June 30, 2027. Through the Demonstration, CMS has granted the state expenditure authorities to expand service offerings for vulnerable populations, move some members into integrated managed care plans, and to provide coverage to populations not otherwise eligible for Medicaid. The Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) administers the Utah Medicaid program and is responsible for the implementation of the Demonstration.

2. Demonstration Goals

The Utah DHHS, Division of Integrated Healthcare administers the Utah Medicaid program and is responsible for the implementation of adult Medicaid expansion.

The Demonstration goals, as outlined in the Special Terms and Conditions[3], are:

1. Provide health care coverage for low-income Utahns eligible under the Demonstration who would not otherwise have access to, or be able to afford, health care coverage
2. Improve beneficiary health outcomes and quality of life
3. Lower the uninsured rate of low income Utahns
4. Provide continuity of coverage for individuals eligible under the Demonstration
5. Increase access to primary care
6. Reduce uncompensated care provided by Utah hospitals
7. Reduce barriers to health care and housing, an important social determinant of health
8. Increase the utilization of preventive dental services, while reducing emergency dental procedure costs
9. Improve access to services across the continuum of care
10. Provide for better care coordination for individuals transitioning to community-based care
11. Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate
12. Reduce the overdose death rate
13. Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders

With the addition of the SUD and SMI Institution for Mental Diseases (IMD) amendment approvals, the state has expanded its objectives to include the following for individuals with SUD and/or SMI:

1. Improve access to services across the continuum of care
2. Provide for better care coordination for individuals transitioning to community-based care
3. Reduce the utilization of emergency departments and inpatient hospital settings for treatment, where utilization is preventable or medically inappropriate
4. Reduce the overdose death rate
5. Improve access to care for physical health conditions for these individuals

With the addition of the Pre-Release Services under Reentry Demonstration Initiative amendment approval, the state has further expanded its objectives to include the following for eligible individuals:

[3] Centers for Medicare & Medicaid Services, 2025. *Demonstration Approval.* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-medicaid-reform-appvl-11132025.pdf

1. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release
2. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry
3. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable) and community-based providers
4. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release
5. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs
6. Reduce all-cause deaths in the near-term post-release
7. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care
8. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release

The Demonstration goals and/or objectives may be updated upon integration of the November 2025 amendment in the evaluation design for the summative evaluation report.

3. Description

Utah's 1115 Demonstration was first approved in 2002 and has transformed over the last twenty-four years through extensions and amendments that have added new authorities and Demonstration populations.

The original PCN Demonstration provided a limited package of preventive and primary care benefits (the PCN benefit) to adults ages 19-64 with household incomes up to 150 percent of the Federal Poverty Level (FPL) and a slightly reduced benefit package to Parent/Caretaker Relatives (PCR) who comprised the Current Eligibles population. With Medicaid expansion in April 2019, PCN program participants became eligible for full state plan benefits, and the PCN benefit was phased out. The Current Eligible population was phased out by December 31, 2023, eliminating disparities in benefit packages by parental status. An assessment of the phase-out process is included in the evaluation design.

The 1115 Demonstration has historically served as a vehicle to provide premium assistance to adults with household incomes above Medicaid eligibility requirements. In 2006, the Utah DHHS amended the 1115 Demonstration to establish the Health Insurance Flexibility and Accountability Employer Sponsored Insurance (ESI) program, which provides premium assistance to adults with household incomes up to and including 150 percent of the FPL and CHIP-eligible children with family incomes up to 200 percent of the FPL. This was later amended to include adults with incomes up to 200 percent of the FPL and programmatically eligible adults and children obtaining coverage through COBRA[4]. Under the current 1115 Demonstration, premium assistance helps pay the individual's or family's share of monthly premium costs of ESI or COBRA and is aggregated under Utah's Premium Partnership for Health Insurance Program (UPP). Individuals in the AE population with access to employer-sponsored insurance are required to enroll, with few exceptions. The state also increased the maximum assistance reimbursement amount in July 2021 making this program more substantial and potentially increasing the number of individuals covered by UPP. In February 2024, CMS approved an increase in the premium subsidy for children that would otherwise receive CHIP services under the state plan from $120 to $180. If a plan offers dental coverage, the premium subsidy amount will increase from $140 to $200.

[4] Consolidated Omnibus Reconciliation Act of 1986

For nearly a decade, Utah's Demonstration has emphasized improving the behavioral health (BH) continuum of care. In November 2017 the state received approval to establish the TAM eligibility group. The TAM population consists of vulnerable adults ages 19-64, whose incomes are at 5 percent of the FPL, and who meet detailed eligibility criteria in one of three targeted categories: chronically homeless, involved in the justice system and in need of substance use or mental health treatment, or are in need of substance use or mental health treatment.

In December 2019, Utah received authority to enroll Demonstration populations in managed care plans and to create an integrated managed care model, known as the Utah Medicaid Integrated Care (UMIC) plan. The four UMIC plans manage both physical and behavioral health benefits for the AE population in Utah's five most populous counties: Davis, Salt Lake, Utah, Washington, and Weber. The AE population in the rest of the state are enrolled in Accountable Care Organizations (ACOs) for their physical health service delivery system and in Prepaid Mental Health Plans (PMHPs) for their behavioral health service delivery system. The integrated care model is intended to provide more holistic and coordinated care than previously.

In March 2022, CMS approved the HRSS amendment, allowing Utah to provide housing support services, such as tenancy supports, community transition services, and supportive living services to TAM individuals who meet additional eligibility criteria and exhibit one of seven risk factors. In an amendment approved in February 2024, an additional four risk factors were added to the HRSS program eligibility criteria to align eligibility with the sub-groups of the Targeted Adult group. The HRSS are paid on a fee-for-service basis. Providers are required to enroll and are evaluated to ensure they meet HRSS qualifications which includes being a certified case management provider. Once care plans have been approved, providers can submit claims for HRSS and receive reimbursement. As the program ramps up in the current waiver period, the state anticipates that HRSS will serve approximately 5,000 TAM individuals each year. By addressing crucial health-related social needs in a high-needs population, the state anticipates that the HRSS program will improve participant health outcomes or quality of life and reduce non-housing related Medicaid costs.

In January 2025, CMS approved coverage of HRSN services. The amendment:

- Expands the HRSS benefit to the AE population and to recently incarcerated individuals
- Adds short-term rental assistance and short-term recuperative care for AE and TAM populations
- Authorizes HRSN infrastructure investments
- Authorizes the state to provide non-medical transportation (NMT) to and from HRSN services for eligible individuals

Eligibility for HRSN services includes social and clinical risk factors and medical necessity criteria.

The 1115 Demonstration also includes components that focus on individuals with SUD and/or SMI, and youth with significant emotional disorder (SED) and/or behavioral challenges. Utah received approval of the SUD Implementation plan in November 2017. The Opioid Use Disorder (OUD) and SUD Program provides state plan behavioral health benefits to Demonstration participants. The state also received authority to provide residential and inpatient OUD/SUD treatment services to all Medicaid beneficiaries while they are short-term residents in treatment settings that qualify as IMDs.

The SMI/SED implementation plan was approved in December 2020 and is similar in expenditure authority to the OUD/SUD program. The state is taking action to meet key milestones of the SMI/SED program including, ensuring quality of care in psychiatric hospitals and residential settings, improving care coordination and transitions to community-based care, increasing access to the continuum of care including crisis stabilization services, and earlier identification and engagement in treatment and increased integration. Together, the SUD and SMI components expand access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services. The 1115 Demonstration supports state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and

improve access to a continuum of SMI evidence-based services at varied levels of intensity, including crisis stabilization services.

In February 2019, Utah received CMS approval to provide state plan Medicaid coverage to Former Foster Care Youth from another state (FFCYAS) who were ever enrolled in Medicaid in another state and are not otherwise Medicaid eligible in Utah. State plan coverage is provided to this population until 26 years of age.

In November 2019, Utah received CMS approval for the provision of intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS program provides both state plan BH services and home and community-based services (HCBS) that are not currently authorized through the state plan.

The Demonstration also authorized the Clinically Managed Residential Withdrawal Pilot from May 1, 2019, to April 1, 2021; this benefit became available statewide as of April 1, 2021 to all eligible Medicaid members. As a result, the state received approval on July 23, 2021, to remove this pilot project from the 1115 Demonstration and CMS is not requiring the state to evaluate this population.

The current 1115 Demonstration includes dental coverage for vulnerable populations. The PCN Demonstration first provided an adult dental benefit to the Current Eligibles population in November 2006. CMS approved dental benefits for adults with disabilities or blindness in 2017. In 2019, the state chose to provide comprehensive dental benefits to TAM adults receiving SUD treatment because research showed that dental coverage could increase initiation and engagement in treatment for individuals living with SUD. In 2020, dental benefits were extended to Medicaid eligible individuals aged 65 and older and to TAM adults in need of porcelain or porcelain-to-metal crowns. In January 2025, CMS approved an expansion of dental benefits to all Medicaid-eligible adults.

In February 2024, CMS approved an amendment to the current 1115 Demonstration enabling the state to receive expenditure authority for fertility preservation services provided to certain individuals diagnosed with cancer, as well as for IVF and genetic testing services for certain individuals. Under the IVF and genetic testing amendment, the state may provide genetic testing services to eligible individuals, preimplantation genetic testing of embryos, and IVF services to eligible individuals, ages 18 through 35, diagnosed by a physician with a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, spinal muscular atrophy, or myotonic dystrophy. Under the fertility treatment for individuals diagnosed with cancer amendment, the state is now enabled to provide fertility preservation for eligible individuals diagnosed with cancer and requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility (i.e., infertility caused by treatment for cancer). Services covered under this once per lifetime benefit include the collection and storage of eggs or sperm and coverage for cryopreservation storage. Coverage for cryopreservation storage is covered as a single payment in five-year increments. In January 2025, CMS authorized an increase in the upper age limit for fertility preservation services for individuals diagnosed with cancer from 40 to 50 years of age.

In July 2024, CMS approved an additional amendment to the 1115 Demonstration called the “Pre-Release Services under Reentry Demonstration Initiative” that allows the state to provide limited coverage for a targeted set of services to certain eligible incarcerated individuals for 90 days prior to the individuals’ expected release. This amendment closely aligns with CMS’s “Reentry Demonstration Opportunity”, described in the State Medicaid Director Letter released in April 2023.

Individuals residing in a county jail, state prison, or youth correctional facility who have been determined eligible for Medicaid based on an application filed before or during incarceration are eligible to receive a limited set of pre-release benefits for up to 90 days before their expected release date. These benefits include, but are not limited to, case management, medication-assisted treatment for SUD, and physical and

behavioral health clinical consultation services. A full description of the pre-release services can be found in Exhibit 2.

In November 2025, CMS approved an amendment to the 1115 Demonstration that authorized the following changes:

- Authority for the state to provide extended postpartum coverage to individuals enrolled in Medicaid for up to 12 months from the last day of an individual's pregnancy (effective January 1, 2026).
- Coverage for dental services for children and pregnant or postpartum women enrolled in Medicaid (services to be received through FFS in partnership with the University of Utah School of Dentistry and associated statewide provider network effective July 1, 2026)
- Removal of ISS from the 1115 waiver (CMS and the state do not anticipate a disruption in care as the same service is authorized through a 1915(b) waiver authority)
- Removal of the HRSS program from the 1115 waiver where coverage for those services has fully transitioned to the HRSN program
- Coverage for family planning and family planning related services for adults (effective in 2027).

4. POPULATIONS

Exhibit 1 provides a summary of the Demonstration populations during the Demonstration period. AE is the largest population, consisting of approximately 116,000 adults ages 19-64 with incomes up to 133 percent of the FPL. Additional Demonstration benefits, programs, and services are summarized in Exhibit 2.

4.1 Scope of Interim Evaluation Report

The interim evaluation report will address health care access and engagement among the AE and TAM populations, as well as BH services among the SMI and SUD Demonstration populations. This report does not evaluate the goals of the HRSN amendment, small populations, and certain programs or services (e.g., FFYCAS, UPP/ESI, ISS, and Fertility and Genetic Testing Services) due to data feasibility. ISS has been removed from this 1115 waiver as of the November 2025 amendment, but the population receiving these services will be assessed in the Summative Evaluation Report for the duration of their participation in the demonstration. Additionally, the implementation of the Justice-Involved Reentry Benefit did not begin until February 2026, limiting sufficient data collection to adequately address the benefit within this report. Lastly, the November 2025 CMS approved amendment is undergoing evaluation design and will not be included in this report. Aspects of the Demonstration not discussed within this report will be assessed and shared upon in the summative evaluation report.

EXHIBIT 1: DEMONSTRATION ELIGIBLE POPULATIONS

Demonstration Eligible Populations	Eligibility[5]	Benefits[2]	Estimated Number of Annual Enrollees[6]
Current Eligibles (CE)	Adults aged 19-64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum.	Individuals enrolled in this eligibility category receive most of the benefits covered under Utah's state plan according to limitations specified in the state plan. Current Eligibles also receive benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include psychoeducational services, personal services, respite care and supportive living services (mental health services in residential treatment settings)	The CE population was phased out entirely on December 31, 2023
Adult Expansion (AE)	Adults, age 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include psychoeducational services, personal services, respite care and supportive living services.	115,584
Utah Medicaid Integrated Care (UMIC) – a subgroup of the AE population	Adult Expansion members enrolled in the Utah Medicaid Integrated Care program, which operates in Utah's most populous counties: Davis, Salt Lake, Utah, Washington, and Weber.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include psychoeducational services, personal services, respite care and supportive living services.	49,963
Demonstration Populations III, V, VI, and Current	Demonstration Population III - working adults, aged 19-64, their spouses, and their children ages 19-26, with gross family incomes above 133 percent of the FPL and up to and including 200 percent of the FPL, are not	Individuals in these eligibility categories are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans. Together, the ESI and COBRA benefits are the	1,288

[5] Centers for Medicare & Medicaid Services, 2024. *Demonstration Approval.* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-cms-amndmnt-aprvl.pdf

[6] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments, and estimates for HRSN Services, are taken from the state's amendment applications to CMS. Estimates for the Justice-Involved populations are taken from state-generated updates to the state's amendment application to CMS.

Demonstration Eligible Populations	Eligibility[5]	Benefits[2]	Estimated Number of Annual Enrollees[6]
Eligible CHIP Children	otherwise eligible for Medicaid and participate in an approved ESI plan. Demonstration Population V - same as Demonstration population III, except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage. Current Eligible CHIP Children - these children are eligible for the CHIP, but the children's parents have elected to receive premium assistance for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. Demonstration Population VI - children up to age 19 with family income up to 200 percent of the FPL who would meet the definition of a low-income child. The population is divided into 2 groups: COBRA-Eligible Children and COBRA-Continuation Children.	"Utah Premium Partnership Program" (UPP). Premium assistance is the sole Medicaid benefit provided to these members.	
Targeted Adult Medicaid (TAM)	Includes adults, ages 19 through 64, with incomes below five percent of the FPL and no dependent children, who meet detailed criteria in one of three major categories: • Chronic homelessness • Involved in the criminal justice system and in need of substance use or mental health treatment. • In need of substance use or mental health treatment	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	9,384

Demonstration Eligible Populations	Eligibility[5]	Benefits[2]	Estimated Number of Annual Enrollees[6]
Intensive Stabilization Services (ISS)	Medicaid eligible children and youth under age 21, who are in state custody, or at risk of state custody, and experiencing significant emotional and/or behavioral challenges.	Individuals eligible for this category will receive state plan and home community-based crisis stabilization services during the first eight-weeks of the intensive program on a FFS basis using a daily bundled rate.	Anticipate 20
Former Foster Care Youth from Another State (FFCYAS)	Individuals under age 26, who were in foster care under the responsibility of a state other than Utah, or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	17

EXHIBIT 2: ADDITIONAL DEMONSTRATION BENEFITS, PROGRAMS, AND SERVICES

Additional Demonstration Benefits, Programs, and Services	Eligibility[7]	Benefits[2]	Estimated Number of Annual Enrollees[8]
Dental Benefit	As of the amendment approved in January 2025, all individuals enrolled in Medicaid and are the age of 21 or older. Previously, dental benefits were available only to the aged, blind, or disabled groups, and to TAM members receiving SUD treatment. As of the amendment approved in November 2025, children and pregnant or postpartum women enrolled in Medicaid will have coverage for dental services.	Individuals that are enrolled in this eligibility category will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services and porcelain or porcelain-to-metal crowns, if needed. Following the November 2025 amendment, dental services for children and pregnant or postpartum women will be offered through a FFS delivery system in partnership with the University of Utah School of Dentistry and their associated statewide provider network rather than through managed care plans.	Entire Adult Expansion population 115,584 Number of children to receive November 2025 dental benefit TBD
Health-Related Social Needs (HRSN) Services	As of the amendment approved in January 2025: the following covered populations will be eligible to receive HRSN services if they also satisfy the applicable clinical and social risk criteria and the HRSN services are determined to be medically appropriate: Recently Incarcerated Individuals are eligible for HRSS. Adult Expansion and TAM Demonstration populations are eligible for HRSS, Short-Term Rental Assistance, Short-Term Recuperative Care, and Short-Term Post Transition Housing	Housing-Related Services and Supports (HRSS): includes pre-tenancy navigation services, tenancy sustaining services, one-time transition and moving costs other than rent, home accessibility modifications and remediations that are medically necessary. Short-Term Rental Assistance: payment for rent and/or short-term temporary stays for up to six months in a 5-year period. Short-Term Recuperative Care (a/k/a Medical Respite): clinically oriented recuperative or rehabilitative services and supports for individuals	5,000

[7] Centers for Medicare & Medicaid Services, 2024. *Demonstration Approval.* https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-cms-amndmnt-aprvl.pdf

[8] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments, and estimates for HRSN Services are taken from the state's amendment applications to CMS. Estimates for the Justice-Involved populations are taken from state-generated updates to the state's amendment application to CMS.

Additional Demonstration Benefits, Programs, and Services	Eligibility[7]	Benefits[2]	Estimated Number of Annual Enrollees[8]
		who require ongoing monitoring and continuous access to medical care. Short-Term Post Transition Housing: clinically oriented rehabilitative services and supports for individuals who do not require ongoing monitoring and continuous access to medical care.	
Serious Mental Illness (SMI) IMD Benefit	Medicaid recipients, age 21 through 64 receiving SMI services in IMD treatment settings.	The Demonstration grants Utah expenditure authority for services provided to beneficiaries during short term stays in an IMD to receive acute care for a primary diagnosis of SMI or SED for stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services in an IMD.	8
Opioid Use Disorder/ Substance Use Disorder Program	SUD benefits are available to all Medicaid members through state plan authority.	The Demonstration grants Utah expenditure authority to provide the following services in IMDs: residential treatment, withdrawal management, medication-assisted treatment (MAT), peer support, residential crisis stabilization.	767
In Vitro Fertilization and Genetic Testing Services	In Vitro Fertilization (IVF): Medicaid recipients ages 18-35 diagnosed by a physician or qualified health professional as having a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, or spinal muscular atrophy, and has a reproductive partner who has been diagnosed with the same condition. Has been diagnosed by a physician or qualified health professional as having a genetic trait associated with myotonic dystrophy.	In vitro fertilization services, genetic testing services, and preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus. These services require prior authorization, and qualifying beneficiaries may receive up to three cycles of IVF per lifetime.	50

Additional Demonstration Benefits, Programs, and Services	Eligibility[7]	Benefits[2]	Estimated Number of Annual Enrollees[8]
	Genetic testing: Medicaid recipients who have a familial medical history or are in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.		
Fertility Preservation Benefit for Individuals Diagnosed with Cancer	Medicaid recipients diagnosed by a physician or qualified health professional as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility. Individuals must be post pubertal and younger than age 50.	Individuals can receive egg and sperm collection and storage, preimplantation genetic testing prior to cryopreservation storage, and cryopreservation storage. These benefits require prior authorization and are available once per lifetime.	226
Justice-Involved Reentry Benefit	Individuals who are inmates residing in county jails, state prisons, or youth correctional facilities and have been determined eligible for Medicaid pursuant to an application filed before or during incarceration.	Eligible individuals can receive the following pre-release services starting 90 days before their release from incarceration: • Case management to assess and address physical and behavioral health needs • Medication-assisted treatment services for all types of SUD as clinically appropriate, with accompanying counseling • A 30-day supply of all prescription medications that have been prescribed for the individuals at the time of release provided to the individual immediately upon release from the correctional facility • Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-	Adults: 3,600 Youth:15

Additional Demonstration Benefits, Programs, and Services	Eligibility[7]	Benefits[2]	Estimated Number of Annual Enrollees[8]
		release treatment plan and discharge planning • Diagnostic services, including laboratory and radiology services, and treatment services in addition to coverage for MAT described above • Prescribed drugs, in addition to MAT and the 30-day supply of prescription medication, and medication administration • Family planning services and supplies • Services provided by community health workers • Peer support services • Treatment for Hepatitis C • Medical equipment and supplies and/or medical equipment provided upon release Youth eligible for CHIP will receive pre-release screening, diagnostic, and case management services starting 30 days before their release.[9]	
Family Planning Services and Family Planning Related Services	Individuals ages 18 and older with family income at or below 185 percent of the FPL (5% income disregard) who are not in a public institution and are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP)	The demonstration provides a set of family planning services and family planning related services delivered through a FFS delivery system: • Comprehensive family planning visits, which include counseling, education or management of contraceptive methods • FDA approved methods of contraception • FDA-approved vaccination for Human Papillomavirus (HPV)	TBD

[9] Authority for pre-release services for CHIP eligible youth is covered under the SPA, and not held under the Utah Medicaid Reform 1115 Demonstration waiver; this evaluation will not include this population.

Additional Demonstration Benefits, Programs, and Services	Eligibility[7]	Benefits[2]	Estimated Number of Annual Enrollees[8]
		• Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, pap smears, and pelvic exams • Drug, supplies, or devices related to family planning services as prescribed by a health care provider • Treatment for STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a screen pursuant to a routine or periodic family planning visit • STI/STD diagnosis and treatment pursuant to a family planning visit • Sterilization procedures and devices, the office visits or physical exams related to and necessary for sterilization or long-acting reversible contraception, and insertion of contraception and/or approved prescription of anxiety and pain medication in relation to the sterilization procedure (covered procedures include vasectomies, salpingectomy, tubal occlusions, and tubal ligations)	
Extended Postpartum Coverage	Individuals enrolled in any Medicaid eligibility group while pregnant (including during a period of retroactive eligibility)	Eligible individuals will remain enrolled continuously within their eligibility group regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination, or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period	13,805 – 13,992

5. CONTEXT

The Utah Medicaid 1115 Demonstration also coincided with the unwinding of the Medicaid Continuous Enrollment requirement associated with the Covid-19 pandemic beginning in 2020. Enrollment in Medicaid remained high during the continuous enrollment period as states were required to keep current Medicaid beneficiaries enrolled. The unwinding of continuous eligibility for Medicaid began on March 1, 2023.[10] Under Utah's unwinding plan[11],every member's case was slated for a full review, with cases spread over a 12-month period. Cases most likely to change programs or coverage were prioritized for review, and those most likely to remain Medicaid eligible were deferred to later in the year. DHHS communicated with providers and beneficiaries about the redetermination process. Members were urged to update their contact information and check the unwinding website[12] to learn their anticipated review date. During the redetermination process, between April 2023 to March 2024, there was a 36% decrease in Medicaid enrollment.[13]

[10] Tolbert, J. and Ammula, M., 2023. *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision.* KFF. 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision | KFF

[11] Utah Department of Health & Human Services. *Unwinding Continuous Medicaid Eligibility*. https://medicaid.utah.gov/unwinding/

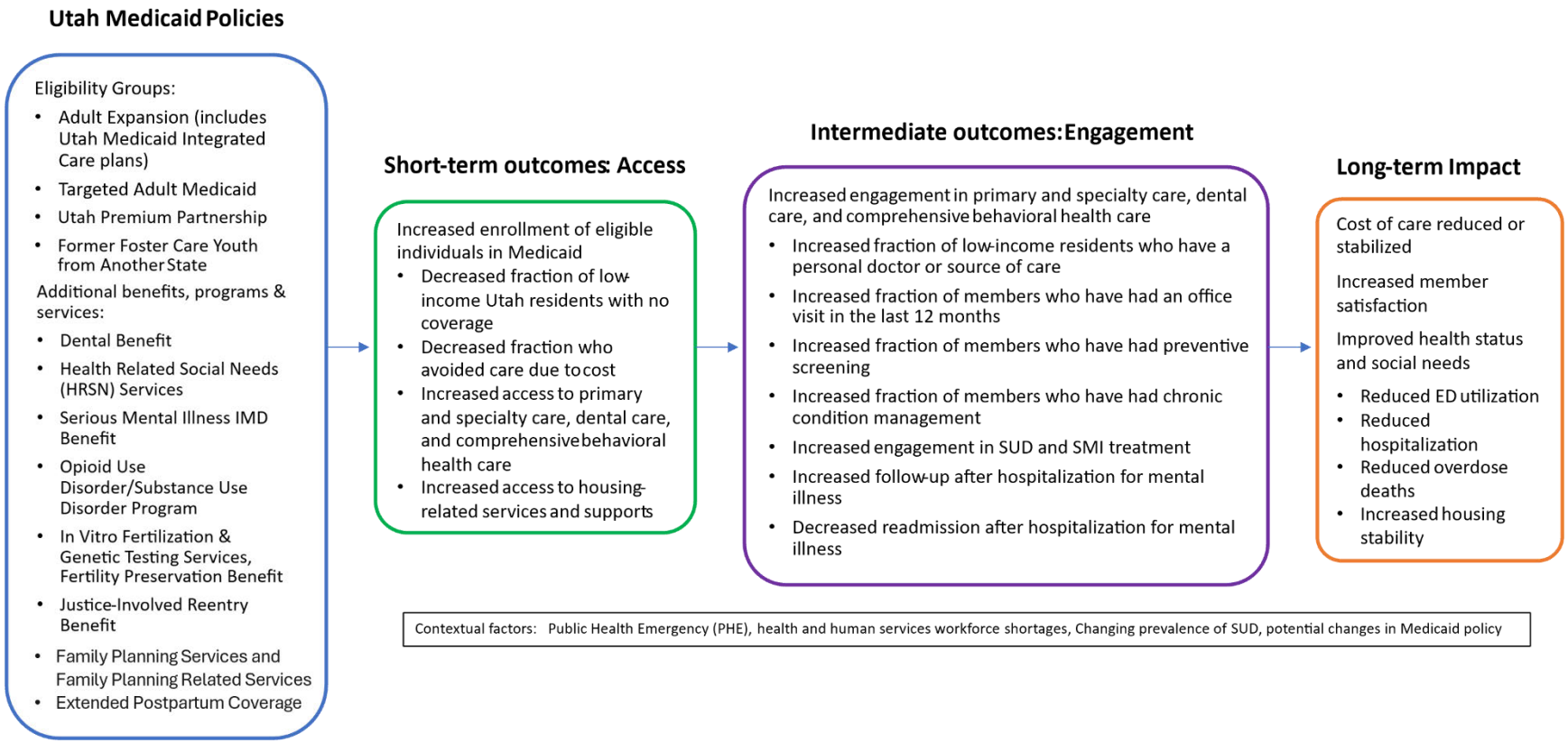
[12] Utah Department of Workforce Services. *MyCase.* https://jobs.utah.gov/mycase/

[13] Strohecker, J. and Burt, K., 2024. *Utah Medicaid Unwinding Closeout.* Utah Department of Health & Human Services. https://le.utah.gov/interim/2024/pdf/00002275.pdf

C. Evaluation Questions and Hypotheses

1. Logic Model

Exhibit 3: Logic Model[14]



[14] The logic model will include the November 2025 amendment once measures are determined.

2. Hypotheses and Research Questions

The logic model above illustrates how the Demonstration objectives are expected to be achieved by program activities, following a natural progression from proximate to distal outcomes as the Demonstration goes on. Each outcome is represented by a testable hypothesis, listed below, about the impact of the Demonstration activities, and a corresponding research question. Tables 15-25 specify the measures that will be used to assess each hypothesis.

The hypotheses are organized by population or program/benefit and are focused on the broad themes of increasing health care coverage, increasing access to primary care and appropriate utilization, reducing high-cost acute care utilization, including potentially preventable utilization, and reducing the cost of uncompensated care.

The first objective of the 1115 Demonstration, providing health care coverage for low-income Utahns eligible who would not otherwise have access to or be able to afford health care coverage, is achieved through enrollment in a number of the Demonstration populations, including the AE, TAM, UPP, and ISS. Individuals in these populations would not otherwise be eligible for Medicaid without the presence of the Demonstration in Utah.[15] The first hypothesis is thus focused on the impact of the 1115 Demonstration overall on the population of low-income UT residents. A large fraction of low-income UT residents is expected to report having access to coverage and engaging in health care relative to reported access and engagement in other states. Engagement in care is expected to improve member satisfaction and lead to reductions in inappropriate care utilizations, also known as “Low Value Care”.

The second hypothesis is similar to the first hypothesis and focuses specifically on the AE population’s improved health care access and engagement. The state hypothesizes that by providing coverage through Medicaid expansion, members will engage in primary and preventive care, which will lead to reductions in acute care utilization. The UMIC population, a subpopulation of the AE population, consists of members in Utah’s five-most populous counties who are enrolled in plans that integrate care for physical and behavioral health needs. Thus, the UMIC research questions are specific to the outcomes produced when members gain access to behavioral health care that is managed by the same managed care organization that manages their physical health care. It is anticipated that the UMIC population will experience improved engagement in BH services and reduced ED utilization.

The third hypothesis examines access and engagement in health care, for the TAM population. The state hypothesizes that the Demonstration will continue to improve health care access and engagement for this population.

The fourth hypothesis addresses the HRSN Demonstration, which expands the HRSS benefit previously available only to TAM members, to the entire AE population who meet the needs-based eligibility criteria. The state is authorized to provide HRSS, short-term rental assistance, short-term recuperative care, short-term post-transition housing, and NMT. The evaluation design focuses on HRSS and NMT. The other authorized services had not been implemented at the time of writing this report. The other services may, or may not, be implemented later in the Demonstration period. If they are implemented, they should contribute to the same outcomes theorized for HRSS. It is anticipated that the HRSN Demonstration will reduce the prevalence and severity of housing and transportation needs, increase continuity of BH treatment, and improve health outcomes for eligible members. Research questions include whether HRSN services were provided and utilized as planned, care manager perspectives on incorporating this new benefit, whether there is unmet need, and whether HRSS improves perceived health status. Other research questions about the HRSN Demonstration focus on how HRSN affects high-cost acute care utilization.

[15] Individuals in the Current Eligibles population received expanded benefits through the waiver, although they would have received coverage regardless of the presence of the waiver.

The fifth and sixth hypotheses speak to BH services provided to Demonstration participants and Medicaid beneficiaries with SMI and SUD treated in IMD. The state anticipates that BH coverage for residential and inpatient services provided to members in IMDs will lead to a reduction in inpatient stays, ED utilization, and rate of unplanned readmission among recipients, resulting in cost decrease or stabilization. The state also anticipates this will lessen unmet needs and increase engagement in treatment to reduce overdose deaths in the long-term. The IE will monitor the impact of the state's efforts to increase access to crisis stabilization services. Greater utilization of non-hospital, non-residential services is anticipated to lead to greater reductions in inpatient stays, ED utilization, and overdose deaths in the long-term.

The seventh hypothesis addresses smaller Demonstration populations, which include UPP/ESI, ISS, TAM Dental, and FFCYAS. The state anticipates that utilization of the services provided to these populations will increase and total cost of care will decrease, as these members engage in acute and preventive care. Although the number of AE members enrolled in Employer Sponsored Insurance will grow due to the new provision present in this waiver requiring enrollment in ESI for all AE members who have access to insurance through their employers, the number of members enrolled in ESI is not projected to exceed 1,385 members during this Demonstration period. As a result, the ESI policy by itself is unlikely to lead to population-level reductions in uncompensated care and inappropriate care utilization. In addition, the number of individuals in the FFCYAS population, and the number receiving ISS, were both very small in the prior Demonstration period. Therefore, the evaluation will include counts and a qualitative summary of program implementation.

Hypotheses eight through eleven focus on the justice-involved (JI) population and the newly covered pre-release and reentry services. The state anticipates that the Demonstration will enhance cross-system collaboration between the correctional and community-based services systems, that enrollment and redetermination support will improve continuity of coverage, and that coverage of pre-release and reentry services will improve engagement in high quality care, reduce unnecessary acute care utilization, and ultimately improve health outcomes for the JI population.

In addition, the state will conduct a Demonstration cost assessment including administrative costs of Demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The evaluation design is being revised to reflect the November 2025 waiver amendment, including family planning services, at the time of the drafting of this report. New hypotheses and research questions will be included in the summative evaluation report, following CMS approval of the revised evaluation design document.

Hypothesis 1: The Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.

- Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?
- Primary research question 1.2: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?
- Primary research question 1.3: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?
- Primary research question 1.4: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?
- Primary research question 1.5: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?
- Primary research question 1.6: What is the member experience of care in terms of access, timeliness, and patient-centeredness?
- Primary research question 1.7: Did Low Value Care decrease among Demonstration participants, relative to baseline?

Hypothesis 2: The Demonstration will improve health care access and engagement for the AE population.

- Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the AE population?
- Primary research question 2.2: Did ED visits decrease, relative to baseline, for the AE population?
  - Subsidiary research question 2.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the AE population?
  - Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for AE population, relative to FFS or physical health-only ACO plans?
- Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the AE population?
- Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the AE population?
  - Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for the AE population, relative to FFS or physical health-only ACO plans?
- Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the AE population?
- Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the AE population?
- Primary research question 2.7: Did dental service provision increase relative to baseline for the AE population?
- Primary research question 2.8: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the AE population?
- Primary research question 2.9: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the AE population?
- Primary research question 2.10: To what extent are beneficiaries aware of the dental care benefit?

Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.

- Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?
- Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?
  - Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?
- Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?
- Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?
- Primary research question 3.5: Did dental service provision increase relative to baseline for the TAM population?
- Primary research question 3.6: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the TAM population?
- Primary research question 3.7: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the TAM population?

Hypothesis 4: The HRSN Services Demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.

- Primary research question 4.1: What is the prevalence and severity of beneficiaries' social needs?
- Primary research question 4.2: Were HRSN services provided and utilized as planned?
- Primary research question 4.3: Did the HRSN Demonstration effectively mitigate beneficiaries' housing and transportation needs?

- Primary research question 4.4: Did high-cost acute utilization decrease, relative to baseline, for HRSN recipients?
- Primary research question 4.5: Did engagement in primary and ambulatory care increase, relative to baseline, for HRSN recipients?
- Primary research question 4.6: Did engagement in behavioral health care increase, relative to baseline, for HRSN recipients?
- Primary research question 4.7: From the beneficiaries' perspective, did the HRSN services meet their housing-related needs, support their engagement in behavioral health care, and overall positively impact their physical and mental health?
- Primary research question 4.8: Did state and local investments in housing supports change over time during the HRSN Demonstration?
- Primary research question 4.9: Were there any improvements in the quality and effectiveness of downstream housing-related services and supports?

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.

- Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?
- Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?
- Primary research question 5.3: Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?
- Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?
- Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?
- Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?
- Primary research question 5.7: Did the number of individuals needing but not receiving SUD treatment decrease among low-income residents, relative to comparison states?
- Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?
- Primary research question 5.9: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services[16]?

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.

- Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?
  - Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?
  - Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?
- Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?
  - Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?
  - Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?

[16] This includes services made available through crisis call centers, mobile crisis units, and coordinated community response services as defined in STC 12.4 SMI/SED Financing Plan.

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations and programs.

UPP/ESI

- Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?
- Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?
- Primary research question 7.3: Did the pmpm cost for enrollees change over time?

ISS

- Primary research question 7.4: Did the number of individuals receiving ISS increase relative to baseline?

FFCYAS

- Primary research question 7.5: How many FFCYAS received coverage?

Fertility and Genetic Testing Services

- Primary research question 7.6: Did the number of individuals receiving fertility preservation services increase relative to baseline?
- Primary research question 7.7 Did the number of individuals receiving genetic testing services increase relative to baseline?

Hypothesis 8: The JI Reentry Benefit will enhance cross-system communication and coordination between correctional and community services.

- Primary research question 8.1: Did the Demonstration's services facilitate beneficiaries' post-release transitions to care?
- Primary research question 8.2: Was communication and coordination between the correctional system and community-based health services enhanced?

Hypothesis 9: The JI Reentry Benefit will improve pre-release service provision during the covered period and continuity of coverage for the justice-involved population.

- Primary research question 9.1: What Demonstration services did JI individuals receive in the pre-release period?
- Primary research question 9.2: What was beneficiaries' experience of pre-release service provision?
- Primary research question 9.3: Were beneficiaries potentially in need of behavioral health services identified in the pre-release period?
- Primary research question 9.4: What fraction of JI individuals received navigation support for accessing Medicaid coverage pre-release?
- Primary research question: 9.5: Did reentry continuity of coverage improve for incarcerated individuals compared to the pre-Demonstration comparison population?

Hypothesis 10: The JI Reentry Benefit's 90-day pre-release coverage period ("the coverage timeline") will support effective program implementation.

- Primary research question 10.1: Did the coverage timeline facilitate providing more coordinated, efficient, and effective reentry planning?
    - Subsidiary research question 10.1.a: Were assessments and care plans completed in a timely manner?
    - Subsidiary research question 10.1.b: Did beneficiaries receive a 30-day supply of all prescribed medications immediately upon release from the carceral setting?
- Primary research question 10.2: Did the coverage timeline enable pre-release management and stabilization of clinical, physical, and behavioral health conditions?

- Primary research question 10.3: Did the coverage timeline help mitigate potential operational challenges the state might have encountered in a more compressed timeline?

Hypothesis 11: The JI Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.

- Primary research question 11.1: Did engagement in appropriate health care services post-release increase relative to a pre-Demonstration comparison population?
- Primary research question 11.2: Did inpatient hospital utilization post-release decrease relative to the pre-Demonstration comparison population?
- Primary research question 11.3: Did ED visits post-release decrease, relative to the pre-Demonstration comparison population?
- Primary research question 11.4: Did the rate of deaths post-release decrease relative to the pre-Demonstration population?
- Primary research question 11.5: Was the timing or provision of specific pre-release services associated with better post-release outcomes?

D. Methodology

1. Evaluation Design

The Independent Evaluator (IE) used a mixed-methods evaluation approach for the interim evaluation report that combined survey and Medicaid claims data to address the goals and hypotheses presented in the Demonstration. The evaluation design for the entirety of the Demonstration, including the HRSS participant interview methodology undergoing qualitative data collection for the summative evaluation report, can be found in the Attachments (Sections J.1 and J.3, respectively). For a brief summary of what is included in the interim evaluation report and planned for the summative evaluation report, see Exhibit 4 below.

Exhibit 4: Interim and Summative Report Analysis Details

	Interim Evaluation Report	Summative Evaluation Report
Time period	July 1, 2017 – June 30, 2022 (Baseline) July 1, 2022 – June 30, 2025 (Intervention Period)	July 1, 2017 – June 30, 2022 (Baseline) July 1, 2022 – June 30, 2027 (Intervention Period)
Data sources	✓ Medicaid Claims (MMIS) ✓ Custom Member Survey Data	✓ National Survey Data ✓ Medicaid Claims (MMIS) ✓ Administrative Data ✓ Beneficiary Interviews
Approach	Quasi-experimental	Quasi-experimental Qualitative Interviews
Findings	Trends within the first three years of the Demonstration	Impact of full five years of Demonstration

2. Target Populations

As described in Exhibit 1, the Demonstration provided coverage and services for multiple populations. The Demonstration populations (the target groups) for the interim evaluation report are shown below in Exhibit 5. For each population, the comparison was to pre-Demonstration baseline trends.

Exhibit 5: Demonstration Populations and Comparisons

Demonstration Population	Program Implementation Start	Baseline Years	Comparison[1]	Analytic Approach
Adult Expansion Population (AE)	April 1, 2019 (partial expansion, up to 100% of the FPL) January 1, 2020 (full expansion)	July 1, 2018-June 30, 2022	Pre-Demonstration baseline	Trend Over Time Regression Modeling
Targeted Adult Medicaid (TAM)	November 1, 2017	November 1, 2017 - June 30, 2022	Pre-Demonstration baseline	Trend Over Time Regression Modeling

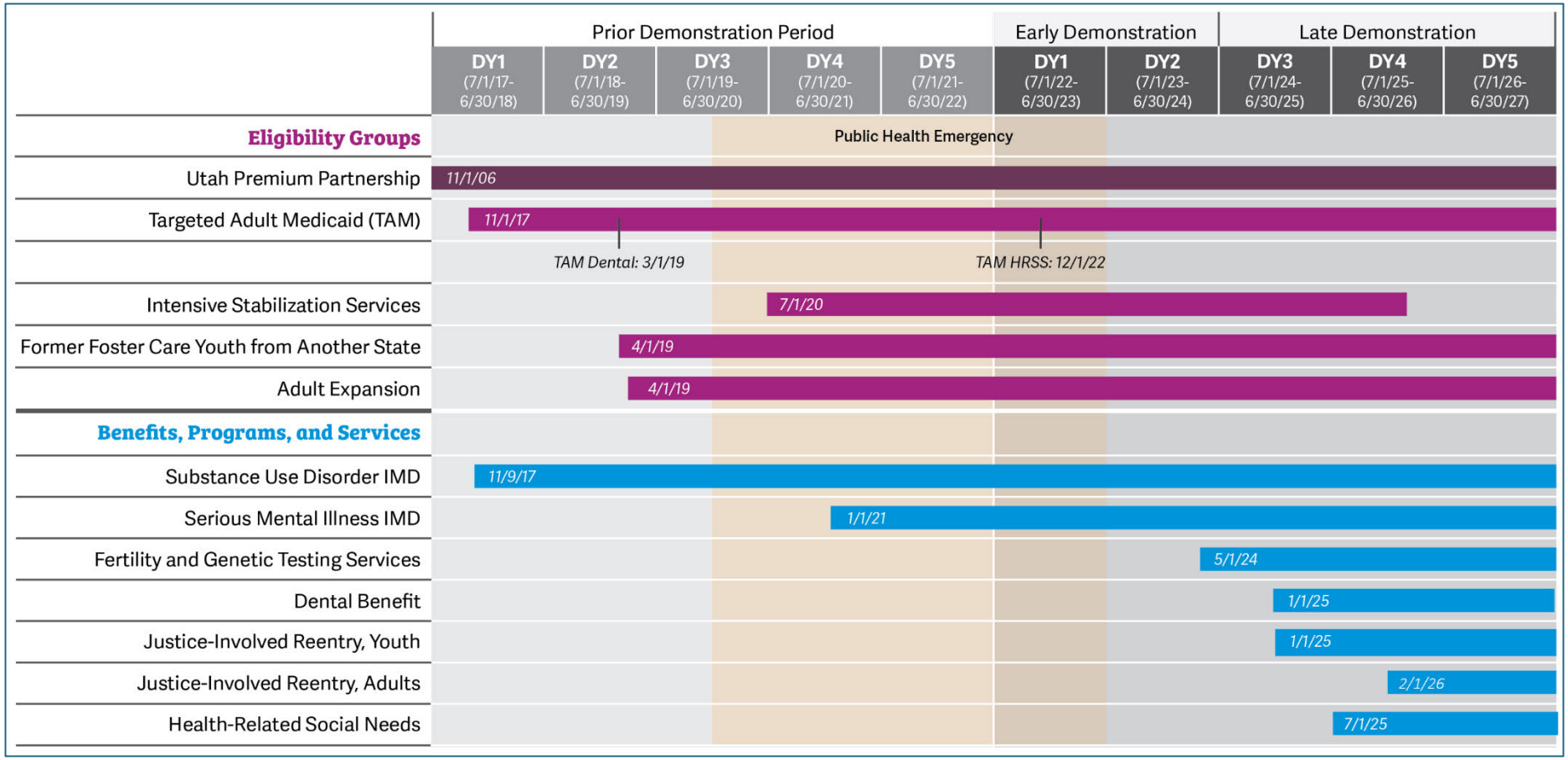
Serious Mental Illness (SMI) IMD	December 1, 2020	December 1, 2020 - June 30, 2022	Pre-Demonstration baseline	Trend Over Time Regression Modeling
Substance Use Disorder (SUD) IMD	November 9, 2017	November 1, 2017 - June 30, 2022	Pre-Demonstration baseline	Trend Over Time Regression Modeling

[1]The term "pre-Demonstration baseline" refers to the period before the start of the current Demonstration period; before July 1, 2022.

3. Evaluation Period

This summative evaluation report will cover the five-year Demonstration period from July 1, 2022, through June 30, 2027. The interim evaluation report covers the first three years of the Demonstration: July 1, 2022, through June 30, 2025. The summative evaluation report will extend these findings and incorporate additional analyses through the end of the Demonstration period, June 30, 2027. See Exhibit 6 for the breakdown of eligibility groups and services across the Demonstration timeline.

EXHIBIT 6: ELIGIBILITY GROUPS AND SERVICES TIMELINE[17]



[17] New eligibility groups and services authorized under the November 2025 amendment will be included once implementation start dates are determined.

4. Evaluation Measures

The Medicaid claims data were used to calculate Healthcare Effectiveness Data and Information Set (HEDIS) measures explored in the interim evaluation report. The standardized HEDIS measures are described below in Exhibit 7.

Exhibit 7: Claims-Based HEDIS Measures

Measure	Description
Acute Care Measures	
Acute Hospital Utilization (AHU)	The rate per member per year of inpatient admissions among members 19–64 years of age.
Emergency Department Utilization (EDU)	The rate per 1,000 of members 19–64 years of age who had emergency department visits during the measurement year.
Emergency Department Utilization for Behavioral Health Conditions (EDU-BH)	The rate per 1,000 of members 19-64 years of age who had emergency department visits for behavioral health conditions during the measurement year.
Ambulatory and Behavioral Health Care Measures	
Adults' Access to Ambulatory/Preventive Care (AAP)	The percentage of members 19–64 years of age and older who had an ambulatory or preventive care visit during the measurement year.
Initiation and Engagement of Substance Use Disorder Treatment (IET)	The percentage of members 19–64 years of age with a substance use disorder (SUD) episode that results in treatment initiation and engagement. Two rates are reported: 1. *Initiation of SUD Treatment* – The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. 2. *Engagement of SUD Treatment* – The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Follow-Up After Hospitalization for Mental Illness (FUH)	The percentage of discharges for members 19-64 years of age who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported: 1. *7-Day Follow-Up* – The percentage of discharges for which the member received follow-up within 7 days after discharge. 2. *30-Day Follow-Up* – The percentage of discharges for which the member received follow-up within 30 days after discharge.
30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30-day readmission for members 19-64 years of age discharged from an inpatient psychiatric facility (IPF) with a principal discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. A readmission is any admission, for any reason, to an IPF or short-stay acute care hospital (including Critical Access Hospitals) that occurs within 30 days after the discharge date from an eligible index admission to an IPF, except those considered planned.

5. Data Sources

The evaluation utilized the following quantitative data sources for the interim evaluation report:

- Medicaid Claims (MMIS)
- Custom Member Survey

5.1 Medicaid Claims Data

The IE received claims data from the state on an annual basis. Administrative data was of high quality, in terms of completeness and accuracy, with the exception of race/ethnicity data. The demographic summary provided in Results (Section F.2) indicates that race/ethnicity was "other" or missing for a large portion of each population (35.7% for AE and 31.1% for TAM).

5.2 Custom Member Survey Data

The IE developed a custom member survey with subcontracted commissioned ForHealth Consulting at UMass Chan Medical School to design and conduct a custom member survey evaluating the impact of the Demonstration on Utah Medicaid members' access to an engagement in health care. The full report is provided in the Attachments (Section J.4). The member satisfaction survey consisted of custom survey questions and select questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The survey was administered from July 2, 2025, to September 17, 2025, in English and Spanish. Members had the opportunity to complete the survey via mail, online, or by phone. Among the 23,011 Utah AE Medicaid members in the sampling frame, 6,000 members were selected for the survey, and 1,865 completed the survey, yielding a response rate of 32%.

6. Analytic Methods

6.1 Quantitative Methods

The evaluation design includes multiple analytic strategies to answer the research questions and provide robust conclusions. The approach includes quasi-experimental analyses, employing descriptive statistics and mixed effects regression. Quasi-experimental analyses were conducted where data was available. Multivariate regression was used to model outcomes over time, following individuals longitudinally. This approach allows for the trend over time to be adjusted for changes in the Demonstration populations as members enter and leave the Populations. The specific analytic method for each research question and measure is provided in Attachments (Section J.2).

Descriptive Statistics

The IE used descriptive statistical methods to generate summary tables of population size and characteristics for the AE and TAM Demonstration participants. Data were presented as counts and percentages. These tables were used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling.

Trend Over Time

The outcomes of interest were plotted over time, illustrating changes between the baseline and Demonstration years. The trend over time figures can be found in Attachments (Sections J.5 and J.6).

Regression Modeling

All measures underwent an event study analysis to determine whether there was a significant trend in the outcome of interest prior to the Demonstration. If the pre-Demonstration trend was significant, an interrupted time series analysis was conducted. If the pre-Demonstration trend was insignificant, a logistic (binary outcome) or negative binomial (count outcome) regression model was conducted.

Logistic regression models accommodate both fixed and random effects. In this case, it allows for the fact that members can appear multiple times in the datasets and that they can appear different numbers of times resulting in unbalanced data. The models included the 'client id' variable as a random effect. The

outcome variable is the binary or count outcome. To assess changes over time for each population, a fixed effect for measurement year and population was included in addition to an interaction term between them. Measurement year was included as a continuous variable after plotting raw trends to assess linearity. Adjusted models included the covariates age (continuous), gender, ethnicity, and race. Models are described in the following formulas.

Interrupted Time Series Model

$$Y = \beta_0 + \beta_1 T + \beta_2 X + \beta_3 XT + \varepsilon$$

Where Y represents the outcome of interest, β_0 the y-intercept, β_1 the baseline trend, β_2 the post-level change, and β_3 the post-Demonstration trend change.

Logistic Regression Model

$$logit(Y = 1_{ij}) = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i}$$

Negative Binomial Regression Model

$$log\ log\ (Y)_{ij} = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i} + ln\ (offset)$$

Where Y corresponds to outcome of interest with a different expression depending on its distribution, β_0 to the overall intercept of the model, $\beta_1 Pop_i$ to the effect of belonging to the post-Demonstration, $\beta_2 MY_{ij}$ to the effect of measurement year as a continuous variable, $\beta_3 MY_{ij} * Pop_i$ is the interaction effect between population and measurement year which allows us to estimate change over time between populations, $\beta_x X_i$ corresponds to individual level adjustment covariates, and γ_{0i} corresponds to the random intercept of each client to account for the clustering effect of appearing in more than one measurement year. In the case of negative binomial models, the model includes an offset, for EDU corresponding the total number of clients and for IPU to the total member-months.

Tables were produced that contain the respective adjusted coefficients, standard errors, 95% confidence intervals, and p-value distinctions at $p < 0.05$, $p < 0.01$ and $p < 0.001$.

E. METHODOLOGICAL LIMITATIONS

1. **Lack of a true comparison group.** The Demonstration is implemented statewide, making a perfect comparison group impossible. For the analysis, the IE compared the Demonstration to the pre-Demonstration baseline.
2. **Historic effects.** The impacts of the Covid-19 PHE were profound in 2020 and 2021, and lingering effects continued into 2022. Medicaid unwinding took place during the Demonstration period under evaluation, with eligibility redeterminations beginning in April 2023. Ongoing direct and indirect impacts of the PHE such as staffing shortages should be considered in interpreting findings. The continuous enrollment policy and concomitant increase in Medicaid enrollment created a limitation in interpreting evaluation findings. PHE policy prevented states from removing individuals from the rolls when their income rose above eligibility thresholds, which in effect expanded Medicaid eligibility nationally. Sensitivity analyses excluding the years of the Covid-19 PHE will be included in the summative evaluation report.
3. **Missing race/ethnicity data**. In the claims data set used for measures of engagement in care, the race/ethnicity field was missing for a substantial number of individuals. Given this, the IE was unable to draw meaningful conclusions about racial disparities in Demonstration outcomes. For regression analysis, the field was included as a covariate using three categories: White, Non-white (Black, Hispanic, Pacific Islander, AIAN) and Missing/Other.

F. Results

Results are organized by hypothesis. Exhibit 8 summarizes the hypotheses and corresponding research questions addressed in this interim evaluation report due to data availability and analytic feasibility; the remaining hypotheses and research questions for the Demonstration will be examined in the summative evaluation report.

Exhibit 8. Interim Evaluation Report Hypotheses and Research Questions Overview

Research Question (RQ)	Description
Hypothesis 1: The Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.	
Primary RQ 1.6	What is the member experience of care in terms of access, timeliness, and patient-centeredness?
Hypothesis 2: The Demonstration will improve health care access and engagement for the Adult Expansion population.	
Primary RQ 2.1	Did inpatient hospital utilization decrease over time, for the AE population?
Primary RQ 2.2	Did ED visits decrease, relative to baseline, for the AE population?
Subsidiary RQ 2.2a	Did ED visits for BH conditions decrease over time, for the AE population?
Primary RQ 2.3	Did engagement in primary and ambulatory care increase over time for the AE population?
Primary RQ 2.4	Did engagement in behavioral health care increase over time for the AE population?
Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.	
Primary RQ 3.1	Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?
Primary RQ 3.2	Did ED visits decrease, relative to baseline, for the TAM population?
Subsidiary RQ 3.2a	Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?
Primary RQ 3.3	Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?
Primary RQ 3.4	Did engagement in behavioral health care increase, relative to baseline, for the TAM population?
Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.	
Primary RQ 5.4	Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?
Primary RQ 5.5	Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?

1. Overview of Claims-based Measures Results

The analytic approach for the claims-based measures include trend over time and regression models. Trend over time figures and full regression result tables are provided in the Attachments (Sections J.5 - J.9). Abbreviated regression result tables and corresponding figures are found within the report. Regression models adjusted for age, gender, ethnicity, and race.

Baseline and Demonstration Years

The baseline and Demonstration years begin on July 1 and end on June 30 of the following year. The claims-based measures were calculated annually and included in the appropriate regression models. Select measures required two years of continuous enrollment data for inclusion; therefore, the first baseline year was excluded from analysis for these measures. To avoid excessively lengthy labels in charts and graphs, throughout this report, the baseline and Demonstration years are referenced as shown below in Exhibit 9.

EXHIBIT 9: SUMMARY OF BASELINE AND DEMONSTRATION POPULATIONS UNDER EVALUATION

Baseline/Demonstration Year	Time Period	References in Text or Tables*
Baseline Year 1 (BY1)	July 1, 2017 to June 30, 2018	BY1 (2017-2018)
Baseline Year 2 (BY2)	July 1, 2018 to June 30, 2019	BY2 (2018-2019)
Baseline Year 3 (BY3)	July 1, 2019 to June 30, 2020	BY3 (2019-2020)
Baseline Year 4 (BY4)	July 1, 2020 to June 30, 2021	BY4 (2020-2021)
Baseline Year 5 (BY5)	July 1, 2021 to June 30, 2022	BY5 (2021-2022)
Demonstration Year 1 (DY1)	July 1, 2022 to June 30, 2023	DY1 (2022-2023)
Demonstration Year 2 (DY2)	July 1, 2023 to June 30, 2024	DY2 (2023-2024)
Demonstration Year 3 (DY3)	July 1, 2024 to June 30, 2025	DY3 (2024-2025)

*In instances where an axis is labeled with the year only (2018), it represents the end of the BY or DY. "2018" indicates BY1, which ended June 2018.

Regression Table Interpretation

Below is an example illustrating how the coefficients are interpreted (Exhibit 10). In this example, EDU is modeled for the TAM population over time using logistic regression.

- The coefficient for Measure Year (a time indicator illustrating year irrespective of the baseline or Demonstration period) represents the change in the odds of EDU for a one-year increase during the baseline period, adjusting for covariates.
- The coefficient for Post-Demonstration*Measure Year represents the change in the odds of EDU for a one-year increase during the Demonstration, adjusting for covariates.

EXHIBIT 10: REGRESSION TABLE INTERPRETATION EXAMPLE: EMERGENCY DEPARTMENT UTILIZATION, TAM

	Adjusted	SE	CI
Measure Year	0.982	0.013	[0.957,1.007]
Post-Demonstration*Measure Year	0.913***	0.023	[0.869,0.960]
Age	1.004***	0.001	[1.003,1.005]
Gender			
Male	1	-	[1,1]
Female	1.102***	0.027	[1.050,1.157]
Ethnicity			
Non-Hispanic	1	-	[1,1]
Hispanic	1.011	0.042	[0.932,1.098]
Race			
White	1	-	[1,1]
Non-White	1.056*	0.027	[1.004,1.111]
Other or Missing	0.864**	0.043	[0.783,0.953]
N	36,719		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Following the Demonstration, the odds of EDU significantly decreased by 8.7% annually (p< 0.001) among the TAM population.

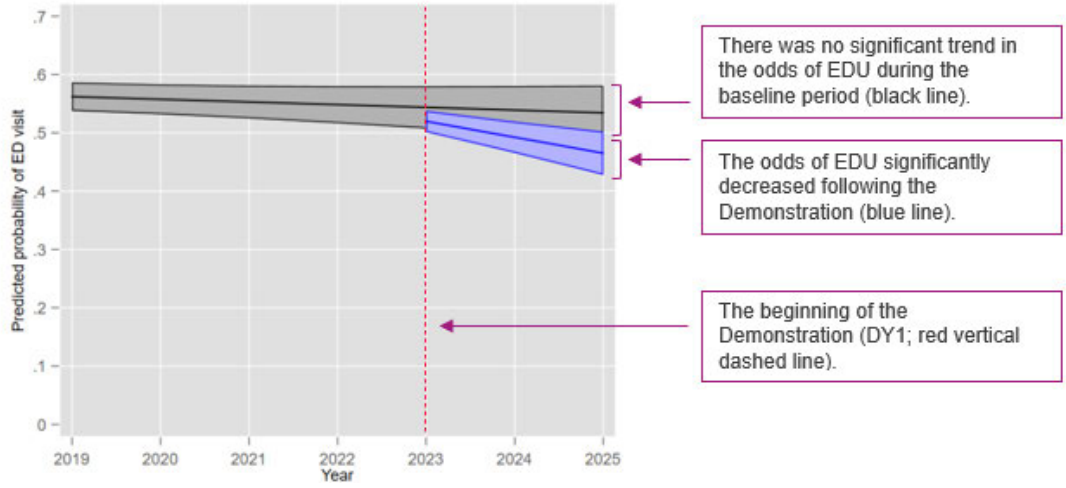
Higher odds of ED visits were associated with older age, female gender, and non-White race. Lower odds of ED visits were associated with other or missing race.

Regression Figure Interpretation

Below is an example indicating how to interpret the figures in conjunction with the result tables. In this example, EDU is modeled for the TAM population over time using logistic regression. (Exhibit 11)

- The red vertical dashed line indicates the beginning of the DY1.
- The black line represents predicted values without the Demonstration.
- The blue line represents predicted values with the Demonstration.
- The width of the black and blue lines is indicative of the corresponding 95% CI.

EXHIBIT 11: REGRESSION FIGURE INTERPRETATION EXAMPLE: EMERGENCY DEPARTMENT UTILIZATION, TAM

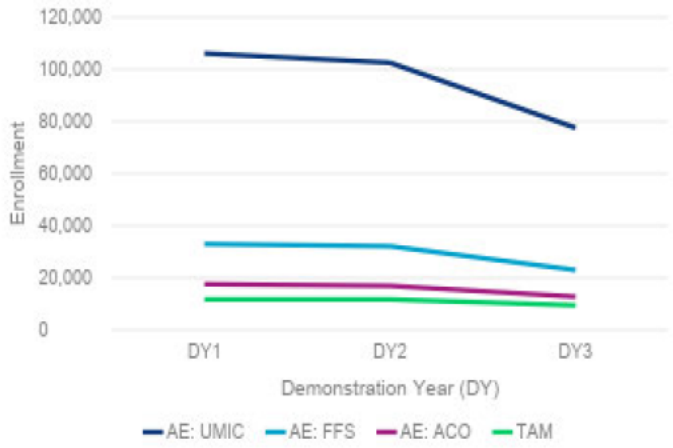


2. Enrollment

Exhibit 12: Enrollment Over Demonstration Years

		DY1 (2022-2023)	DY2 (2023-2024)	DY3 (2024-2025)
Adult Expansion	UMIC	106,042	102,599	77,568
	FFS	33,047	32,223	22,982
	ACO	17,691	17,071	12,745
	Total	156,780	151,893	113,295
Targeted Adult Medicaid		11,696	11,678	9,448

Exhibit 13: Enrollment Trends Over Time – Comparison Among AE Population



Enrollment in AE plans and TAM trended downward across the Demonstration (Exhibit 13). There was a small decline between DY1 and DY2 across all plans (UMIC: -3.25%, FFS: -2.49%, ACO: -3.50%, TAM: -0.15%) with a greater rate of decline between DY2 and DY3 (UMIC: -24.40%, FFS: -28.68%, ACO: -25.34%, TAM: -19.10%).

Exhibit 14: AE and TAM Demographic Information

Demographic Characteristics		Adult Expansion N (%)	Targeted Adult Medicaid N (%)
Gender	Male	118,837 (46.0%)	13,064 (77.3%)
	Female	139,722 (54.0%)	3,847 (22.7%)
Age	19-44	194,871 (70.0%)	13,351 (70.5%)
	45-54	47,233 (17.0%)	3,994 (21.1%)
	55-64	36,120 (13.0%)	1,589 (8.4%)
Ethnicity	Hispanic	24,704 (9.3%)	1,683 (9.4%)
	Non-Hispanic	241,423 (90.7%)	16,188 (90.6%)
Race	White	94,272 (28.0%)	7,076 (28.7%)

	Non-White	121,781 (36.2%)	9,926 (40.2%)
	Other/Missing	120,046 (35.7%)	7,672 (31.1%)
SMI/SUD Diagnosis	None	216,619 (76.2%)	8,524 (36.3%)
	SMI Only	17,637 (6.2%)	944 (4.0%)
	SUD Only	33,816 (11.9%)	9,830 (41.9%)
	Both SMI/SUD	16,171 (5.7%)	4,175 (17.8%)

Note: The characteristics shown above represent every person enrolled across baseline and Demonstration years (7/1/2017-6/30/2025). Individuals may be represented in more than one year.

The AE population was relatively evenly split between males and females (46.0% vs. 54.0%), but the TAM population had a substantially larger male population than female (77.3% vs 22.7%). The majority of the AE and TAM populations were between the ages of 19 and 44 years old (70.0% and 70.5%), non-Hispanic (90.7% and 90.6%), and non-White (36.2% and 40.2%). Demographic factors were adjusted in the measure analyses. (Exhibit 14)

Most individuals in the AE population did not have SMI/SUD diagnoses (76.2%). In the TAM population, however, more individuals had SUD only diagnoses than any other category (41.9%).

3. Access and Engagement

3.1 Member Satisfaction Survey; Hypothesis 1

Hypothesis 1: The Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.

Member Satisfaction Survey Results

Research question 1.6 assesses access to care, experiences with health care, and health status among low-income residents in Utah.

- Primary research question 1.6: What is the member experience of care in terms of access, timeliness, and patient-centeredness?

Participant Demographic Characteristics

The demographic characteristics of members who completed the survey are depicted in Exhibit 15. Survey respondents averaged 41 years of age, and identified as mostly female (60%), non-Hispanic White (39%), and as having English as their primary language (93%).

Exhibit 15: Demographic characteristics of member satisfaction survey respondents

Demographic Characteristics		Percent (%)
Age	19-25	14%
	26-35	25%
	36-45	24%
	46-55	19%
	56-64	19%
Gender	Male	40%

	Female	60%
Race/Ethnicity	White (non-Hispanic)	39%
	Hispanic or Latino	9%
	Black (non-Hispanic)	1%
	Asian (non-Hispanic)*	1%
	Another race or multi-race	4%
	Missing	46%
Primary Language	English	93%
	Spanish	4%
	Another Language	3%
Completed Surveys: 1,865		

*In the Utah Medicaid member database, Asian includes "Asian or Pacific Islander"

Survey respondents had the highest enrollment in UMIC (74%), followed by FFS (14%), then ACO (13%). Furthermore, the average length of enrollment in a Medicaid plan was 14 months, with 37% reporting enrollment for less than 6 months, 37% reporting enrollment for 6 to 12 months, 22% reporting enrollment for 13 to 24 months, and 14% reporting enrollment for 25 months or more.

Respondents were asked to rate their overall health and overall mental or emotional health. Less than one third of respondents rated their overall health (27%) or mental or emotional health (30%) as very good or excellent.

Access to Care

The majority of respondents (86%) reported having a personal doctor (e.g., primary care provider). Of them, 83% reported having had a visit with their personal doctor in the last six months.

Similarly, respondents were asked about their experience of accessing mental health care. 42% of respondents reported needing mental health counseling in the last 6 months. Among them, 78% received mental health counseling.

Respondents that received mental health counseling were asked how difficult it was to find a mental health counselor, and nearly half (49%) reported experiencing no difficulty at all, while 27% reported it was somewhat or very difficult to find a mental health counselor. The 27% of respondents who found it somewhat or very difficult to find a mental health counselor were asked to select all the applicable reasons why it was difficult. Respondents were also allowed to write in "other reasons" as applicable. The top three reasons include not finding a counselor in the network (60%), not finding a counselor they felt comfortable with (57%), and not finding a counselor who was taking new patients (52%).

Despite these initial barriers to accessing mental health care, 85% of those that were able to receive mental health counseling did not report experiencing much difficulty in making appointments with their counselor.

A majority of respondents who need substance use treatment reported being able to access it. Six percent of respondents reported needing any health care services in the last 6 months to help with alcohol or drug use. Among them, 82% reported receiving substance use treatment.

Timeliness of Care

Respondents were asked about their experience obtaining timely care. Nearly half (49%) reported having an illness, injury, or condition that needed care right away. Among them, 56% reported always getting care

as soon as it was needed, indicating a gap in respondent access to urgent care. Respondents who reported sometimes or never getting urgent care as soon as it was needed (15%) were asked to select all the reasons they could not get timely care. Respondents were also allowed to write in “other reasons” as applicable. The top three reasons include long wait times to get an appointment (61%), not getting an appointment at a time that was good for them (35%), and other reasons (e.g., complex steps to care, delayed care due to work commitment, the doctor/ER not treating the health problem as urgent, and Medicaid coverage having been cancelled; 33%)

Roughly three-quarters of respondents (76%) reported making appointments for routine care in the past six months. Among them, 48% reported always getting an appointment as soon as it was needed, highlighting a gap in access to routine care.

The survey findings illustrated gaps in respondents’ ease of accessing needed medical care, tests, or treatment. Overall, 53% of respondents reported it was always easy to get the care, tests, or treatment they needed in the past six months, indicating a gap of 47%.

Patient-Centered Care

Respondents that reported visiting their personal doctor in the last 6 months were asked about their perceptions of communication with their personal doctor. Respondent perceptions were relatively positive, as 85% reported their personal doctor always shows respect for what they have to say, 79% reported their personal doctor always explains things in a way that is easy to understand, and 77% reported their personal doctor always listens carefully to them. Respondent perceptions of their personal doctor’s time spent with them, however, showed a wider gap for improvement with only 70% of respondents reporting that their personal doctor always spends enough time with them.

Respondents’ perceptions of how well their mental health counselor communicates with them were mostly positive, as 84% reported their mental health counselor always shows respect for what they have to say, and 77% reported their mental health counselor always listens carefully to them. Respondent perceptions of their mental health counselor spending enough time with them showed a slightly wider gap for improvement, with only 74% of respondents reporting their mental health counselor always spends enough time with them.

Respondents who had a visit with a personal doctor in the last 6 months were asked about their personal doctors’ use of information to coordinate care, and several gaps were identified. When asked if their personal doctor knew important information about their medical history, 65% of respondents reported their personal doctor always knew. Among respondents who reported taking prescription medicine in the last 6 months (96%), 70% reported their personal doctor always discussed all prescription medications they were taking. Additionally, for those who had a specialist visit in the last 6 months (62%), 56% reported their personal doctor always seemed informed and up to date about their care from the specialists, and 59% reported their personal doctor always knew about any tests or results from specialists.

Nearly 90% of respondents who had a personal doctor visit in the last 6 months reported needing medical treatment. Among them, 73% reported that their personal doctor always involved them when developing their treatment plan.

89% of respondents who received mental health counseling in the last 6 months reported needing a treatment plan. Among them, 72% reported that their mental health counselor always involved them when developing their treatment plan.

Provider follow-up for medication management was limited. 83% of respondents reported they currently need to take prescription medication, mostly for a condition that has lasted for at least three months (96%); however, only 36% reported that their provider’s office contacted them to ensure they were taking the medication as directed.

Respondents were asked about their experience with HRSN screenings at their personal doctor's office. Among respondents who had a personal doctor visit in the last 6 months, 49% reported that someone from their personal doctor's office asked if there were things that made it hard for them to take care of their health, and only 44% reported being asked if they are facing any difficulties with food, housing, transportation, or childcare. Screening for HRSN remains an area for improvement.

Key Findings

Access to care

- Many respondents report having primary care providers, but experience difficulty accessing mental health counseling.
- Majority of respondents who need substance use treatment can access it.

Timeliness of Care

- There are gaps in respondent experience obtaining timely urgent and routine care.
- There is a gap in respondents' ease of accessing medical care, tests, or treatment.

Patient Centered Care

- Perception of how well primary care providers and mental health counselors communicate are largely positive.
- There is room for improvement on care coordination.
- Perceptions of shared decision-making are relatively positive.
- Providers' screening for HRSN appears to be limited.

3.2 Adult Expansion Population; Hypothesis 2

Hypothesis 2: The Demonstration will improve health care access and engagement for the AE population.

Changes in access and engagement measures for the AE population were modeled over time. Regression models adjusted for gender, age, race, and ethnicity.

Acute Care Utilization Summary

Research questions 2.1 and 2.2 assess health outcomes among the AE population by measuring acute care utilization. Decreases are hypothesized.

- Primary research question 2.1: Did inpatient hospital utilization decrease over time, for the AE population?
- Primary research question 2.2: Did ED visits decrease, relative to baseline, for the AE population?
    - Subsidiary research question 2.2a: Did ED visits for BH conditions decrease over time, for the AE population?

EXHIBIT 16: REGRESSION MODELS: ACUTE CARE MEASURES, AE

	Adjusted	SE	CI
Acute Hospital Utilization (AHU) Negative Binomial Regression (N=314,247)			
Measure Year	0.028	0.023	[-0.018, 0.074]
Post-Demonstration*Measure Year	0.159***	0.033	[0.094, 0.224]
Emergency Department Utilization (EDU) Interrupted Time Series (N=8,170)			
Measure Year	43.555***	3.104	[37.471 ,49.639]
Post-Demonstration*Measure Year	-67.164***	7.094	[-81.071, -53.257]
Emergency Department Utilization, Behavioral Health Condition (EDU-BH) Interrupted Time Series (N=2,983)			
Measure Year	19.437***	4.890	[9.850, 29.025]
Post-Demonstration*Measure Year	2.603	13.132	[23.146, 28.352]

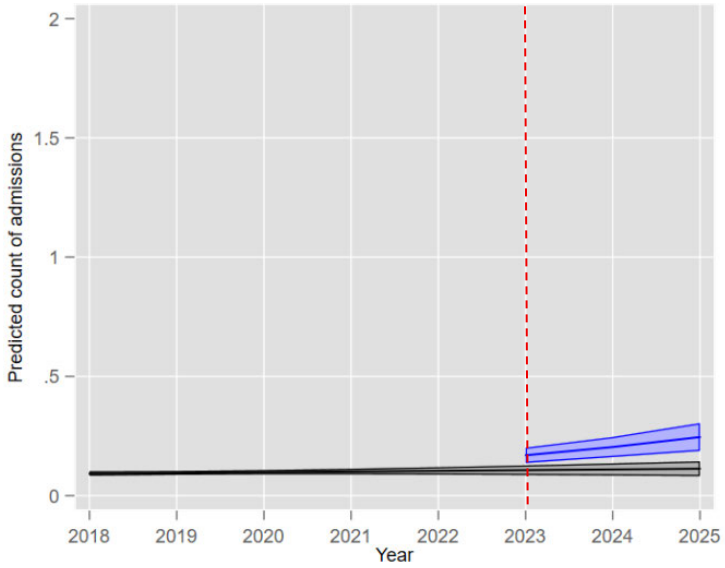
95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Among the acute care utilization measures for the AE population, EDU decreased over time as hypothesized. AHU significantly increased over time, and emergency department utilization for EDU-BH had no significant difference over time. (Exhibit 16)

Acute Care Utilization Details

Acute Hospital Utilization

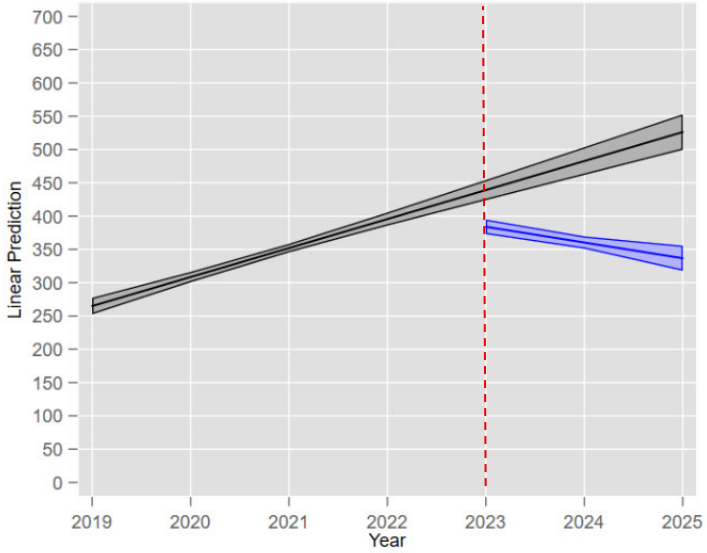
EXHIBIT 17: NEGATIVE BINOMIAL REGRESSION MODEL: ACUTE HOSPITAL UTILIZATION , AE



A negative binomial regression model was used to estimate the change in AHU among the AE population. There was no significant trend in the rate ratio of AHU during the baseline period; however, the rate ratio of AHU significantly increased by a factor of 1.17 for each additional year in the Demonstration ($p < 0.001$). Higher rates of AHU were associated with older age. Lower rates of AHU were associated with female gender. (Exhibit 17)

Emergency Department Utilization

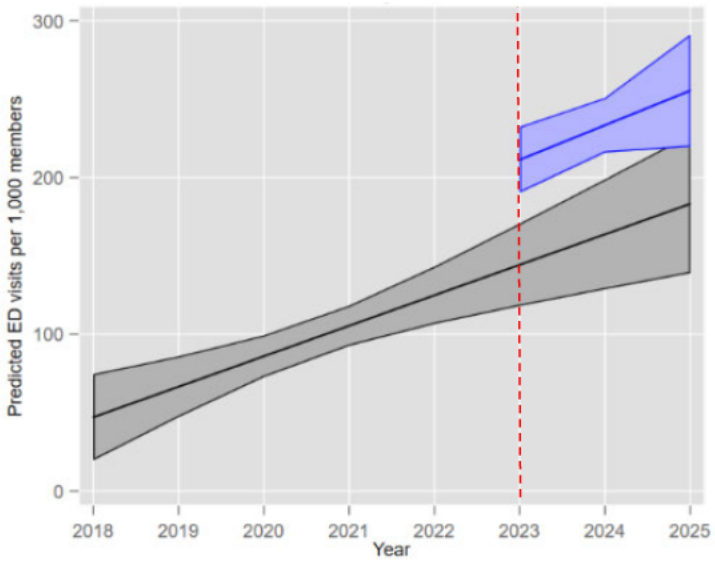
EXHIBIT 18: INTERRUPTED TIME SERIES MODEL: EMERGENCY DEPARTMENT UTILIZATION, AE



An interrupted time series model was used to estimate the change in EDU per 1,000 members among the AE population. Prior to the Demonstration, EDU significantly increased by an average of 43.56 visits per 1,000 members annually ($p < 0.001$). However, following the Demonstration, EDU significantly decreased by an average of 67.16 visits per 1,000 members annually ($p < 0.001$). Higher rates of EDU were associated with Hispanic ethnicity and non-White race. Lower rates of EDU were associated with older age, female gender, and other or missing race. (Exhibit 18)

Emergency Department Utilization, Behavioral Health Condition

EXHIBIT 19: INTERRUPTED TIME SERIES MODEL: EMERGENCY DEPARTMENT UTILIZATION, BEHAVIORAL HEALTH CONDITION , AE



An interrupted time series model was used to estimate the change in EDU-BH per 1,000 members among the AE population. EDU-BH significantly increased by an average of 19.44 visits per 1,000 members annually during the baseline period ($p < 0.01$). There was no significant trend in EDU-BH following the Demonstration. Lower rates of EDU-BH were associated with female gender and other or missing races. (Exhibit 19)

Ambulatory and Behavioral Health Care Summary

Research questions 2.3 and 2.4 assess engagement in primary and ambulatory care, and in behavioral health treatment through utilization measures for the AE population. Increases are hypothesized for all measures except IPF.

- Primary research question 2.3: Did engagement in primary and ambulatory care increase over time for the AE population?
- Primary research question 2.4: Did engagement in behavioral health care increase over time for the AE population?

EXHIBIT 20: REGRESSION MODELS: AMBULATORY AND BEHAVIORAL HEALTH CARE MEASURES, AE

	Adjusted	SE	CI
Adult Access to Ambulatory/Preventive Care (AAP) Interrupted Time Series (N=2,875)			
Measure Year	-0.843***	0.204	[-1.243, -0.444]
Post-Demonstration*Measure Year	2.790***	0.485	[1.840, 3.741]

Initiation and Engagement in SUD Treatment (IET), Initiation Logistic Regression (N=45,241)			
Measure Year	0.982	0.026	[0.932, 1.035]
Post-Demonstration*Measure Year	1.387***	0.119	[1.171, 1.642]
Initiation and Engagement in SUD Treatment (IET), Engagement Interrupted Time Series (N=2,785)			
Measure Year	0.820	0.444	[-0.050, 1.690]
Post-Demonstration*Measure Year	3.546**	1.350	[0.900, 6.192]
Follow-Up After Hospitalization for Mental Illness (FUH), 7 Day Logistic Regression (N=16,003)			
Measure Year	1.100***	0.029	[1.045, 1.158]
Post-Demonstration*Measure Year	1.021	0.041	[0.944, 1.105]
Follow-Up After Hospitalization for Mental Illness (FUH), 30 Day Logistic Regression (N=16,003)			
Measure Year	1.099***	0.017	[1.066, 1.132]
Post-Demonstration*Measure Year	0.977	0.031	[0.918, 1.040]
30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF) Logistic Regression (N=21,197)			
Measure Year	1.037	0.051	[0.942, 1.142]
Post-Demonstration*Measure Year	1.287***	0.068	[1.160, 1.427]

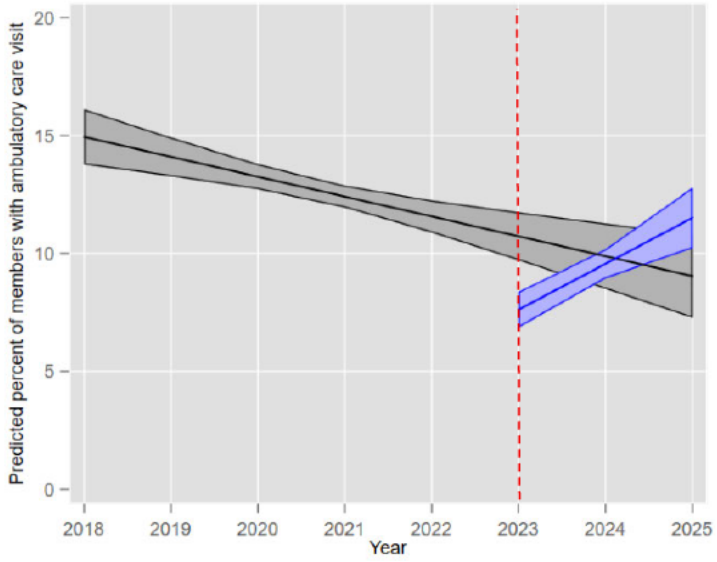
95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

AAP and IET significantly increased following the Demonstration for the AE population, as hypothesized. There was no significant change during the Demonstration for either 7-day or 30-day FUH. It was hypothesized that 30-day all-cause IPF would decrease; however, it significantly increased following the Demonstration. (Exhibit 20)

Ambulatory and Behavioral Health Care Details

Adult Access to Ambulatory/Preventive Care

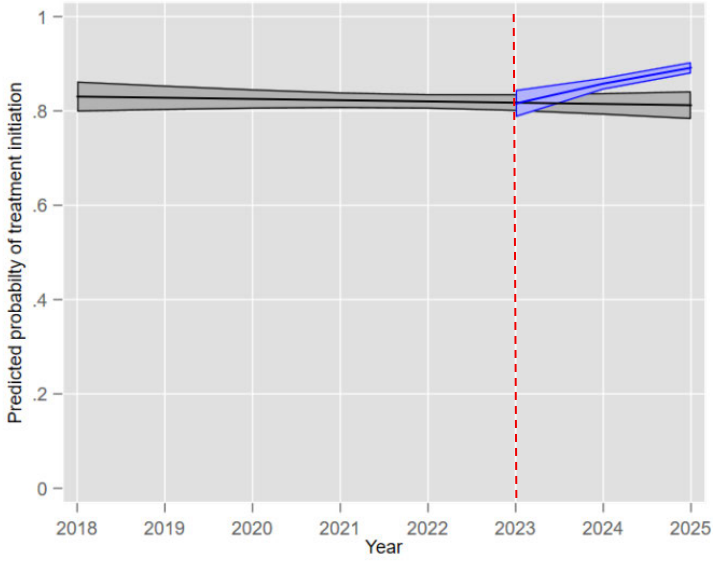
EXHIBIT 21: INTERRUPTED TIME SERIES MODEL: ADULT ACCESS TO AMBULATORY/PREVENTIVE CARE, AE



An interrupted time series model was used to estimate the change in the percentage of members with an AAP among the AE population. During the baseline period, the rate of AAP significantly decreased by an average of 0.84% annually. Following the Demonstration, the rate of AAP significantly increased by an average of 2.79% annually. Higher rates of AAP were associated with older age and female gender. Lower rates of AAP were associated with Hispanic ethnicity and non-White race. (Exhibit 21)

Initiation and Engagement in SUD Treatment, Initiation

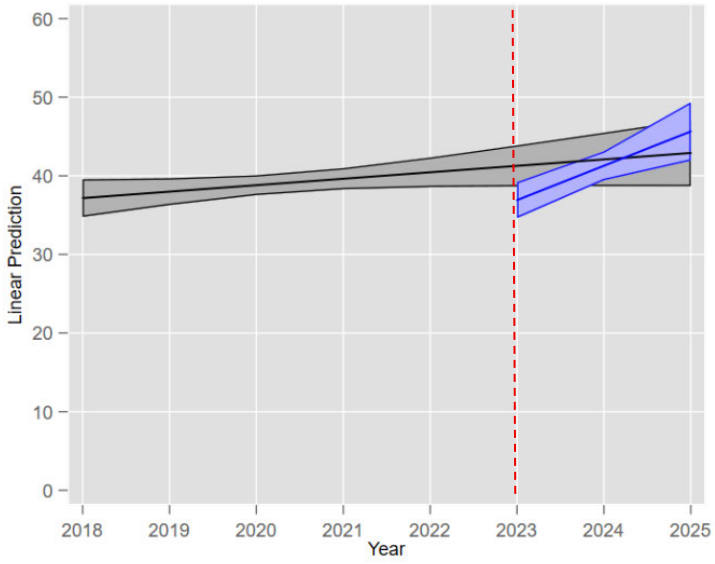
EXHIBIT 22: LOGISTIC REGRESSION MODEL: INITIATION AND ENGAGEMENT IN SUD TREATMENT, INITIATION, AE



A logistic regression model was used to estimate the change in initiation of SUD treatment (IET initiation) among the AE population. There was no significant trend in IET initiation during the baseline period. Following the Demonstration, the odds of IET initiation significantly increased by 38.7% annually ($p < 0.001$). Higher odds of IET initiation were associated with older age and female gender. Lower odds of IET initiation were associated with Hispanic ethnicity. (Exhibit 22)

Initiation and Engagement in SUD Treatment, Engagement

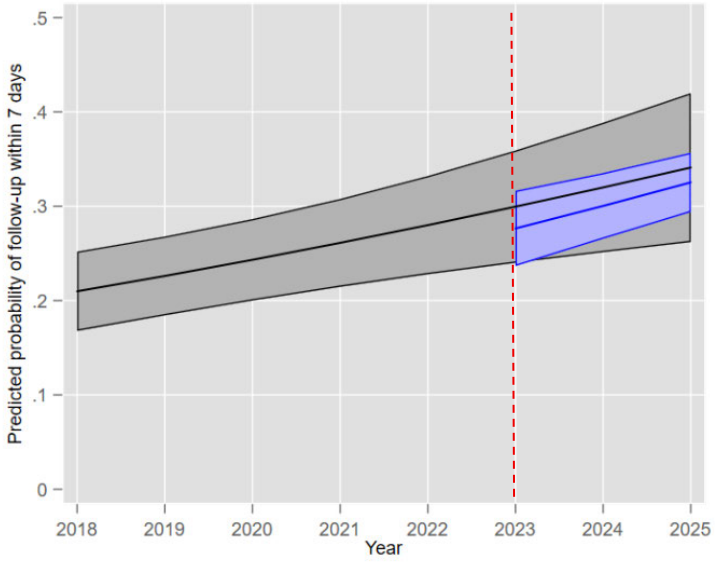
EXHIBIT 23: INTERRUPTED TIME SERIES MODEL: INITIATION AND ENGAGEMENT IN SUD TREATMENT, ENGAGEMENT, AE



An interrupted time series model was used to estimate the change in engagement in SUD treatment (IET engagement) among the AE population. There was no significant trend in IET engagement during the baseline period. However, IET engagement significantly increased by an average of 3.55% annually following the Demonstration ($p < 0.01$). Higher rates of IET engagement were associated with female gender. Lower rates of IET engagement were associated with Hispanic ethnicity and non-White race. (Exhibit 23)

Follow-Up After Hospitalization for Mental Illness, 7 Day

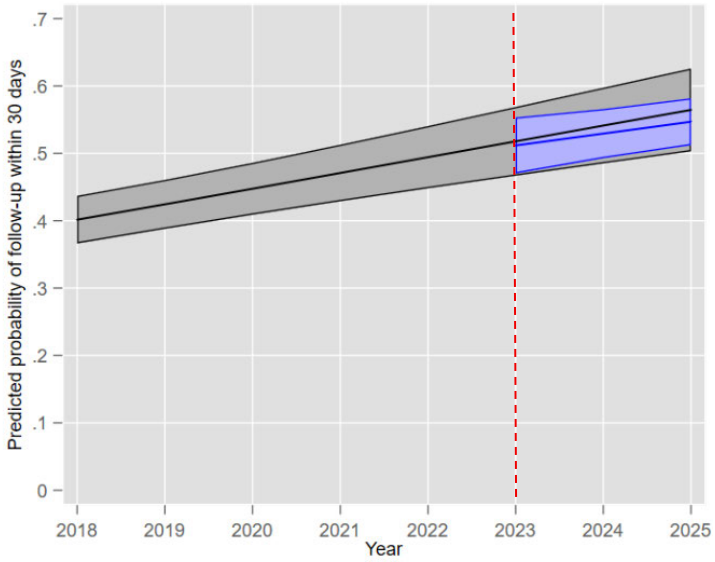
EXHIBIT 24: LOGISTIC REGRESSION MODEL: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS, 7 DAY, AE



A logistic regression model was used to estimate the change in follow-up after hospitalization for mental illness within 7 days of discharge (7-day FUH) among the AE population. The odds of 7-day FUH increased by 10% annually during the baseline period ($p < 0.001$). There was no significant trend in the odds of 7-day FUH during the Demonstration period. Higher odds of 7-day FUH were associated with female gender. Lower odds of 7-day FUH were associated with older age, Hispanic ethnicity, non-White race, and other or missing race. (Exhibit 24)

Follow-Up After Hospitalization for Mental Illness, 30 Day

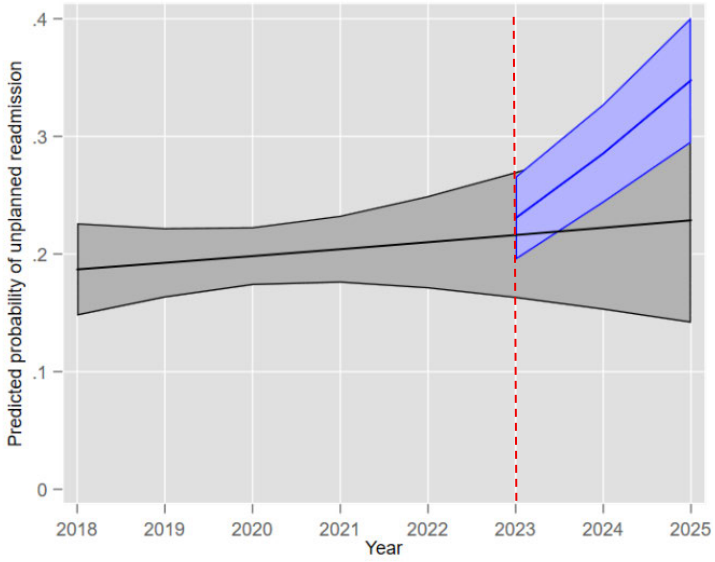
EXHIBIT 25: LOGISTIC REGRESSION MODEL: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS, 30 DAY, AE



A logistic regression model was used to estimate the change in follow-up after hospitalization for mental illness within 30 days of discharge (30-day FUH) among the AE population. The odds of 30-day FUH increased by 9.9% annually during the baseline period ($p < 0.001$). There was no significant trend in the odds of 30-day FUH during the Demonstration period. Higher odds of 30-day FUH were associated with female gender. Lower odds of 30-day FUH were associated with Hispanic ethnicity, non-White race, and other or missing race. (Exhibit 25)

30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility

EXHIBIT 26: LOGISTIC REGRESSION MODEL: 30-DAY ALL-CAUSE UNPLANNED READMISSION FOLLOWING HOSPITALIZATION IN AN INPATIENT PSYCHIATRIC FACILITY, AE



A logistic regression model was used to estimate the change in IPF among the AE population. There was no significant trend in IPF during the baseline period. The odds of IPF significantly increased by 28.7% annually following the Demonstration ($p < 0.001$). Higher odds of IPF were associated with older age. Lower odds of IPF were associated with female gender. (Exhibit 26)

Key Findings

Trends in acute care utilization were mixed among the AE population.

- EDU decreased over time and relative to baseline, as hypothesized.
- AHU increased over time and relative to baseline.
- EDU-BH had no significant change over time.

Trends in ambulatory and behavioral health care were mixed among the AE population.

- AAP and IET increased over time and relative to baseline, as hypothesized.
- FUH had no significant change over time.
- IPF increased over time and relative to baseline.

3.3 Targeted Adult Medicaid Population; Hypothesis 3

Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.

Changes in access and engagement measures for the TAM population were modeled over time. Regression models were adjusted for gender, age, race, and ethnicity.

Acute Care Utilization Summary

Research questions 3.1 and 3.2 assess health outcomes among the TAM population by measuring acute care utilization. Decreases are hypothesized.

- Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?
- Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?
    - Subsidiary research question 3.2a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?

EXHIBIT 27: REGRESSION MODELS: ACUTE CARE MEASURES, TAM

	Adjusted	SE	CI
Acute Hospital Utilization (AHU) Negative Binomial Regression (N=28,147)			
Measure Year	0.010	0.037	[-0.062, 0.082]
Post-Demonstration*Measure Year	-0.087	0.054	[-0.193, 0.019]
Emergency Department Utilization (EDU) Logistic Regression (N=36,719)			
Measure Year	0.982	0.013	[0.957,1.007]
Post-Demonstration*Measure Year	0.913***	0.023	[0.869,0.960]
Emergency Department Utilization, Behavioral Health Condition (EDU-BH) Interrupted Time Series (N=2,172)			
Measure Year	46.577**	17.366	[15.521, 83.633]
Post-Demonstration*Measure Year	-45.816	38.642	[-121.594, 29.963]

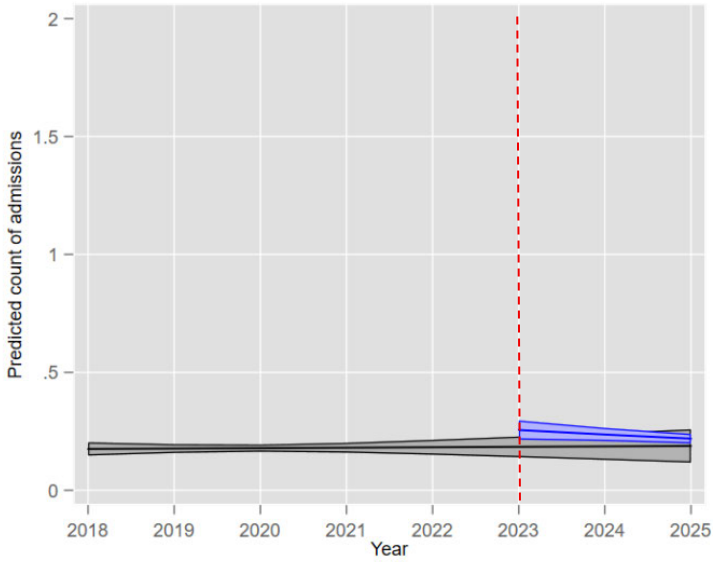
95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Across the acute care utilization measures for the TAM population, EDU decreased over time as hypothesized. There was no significant difference in AHU or EDU-BH over time. (Exhibit 27)

Acute Care Utilization Details

Acute Hospital Utilization

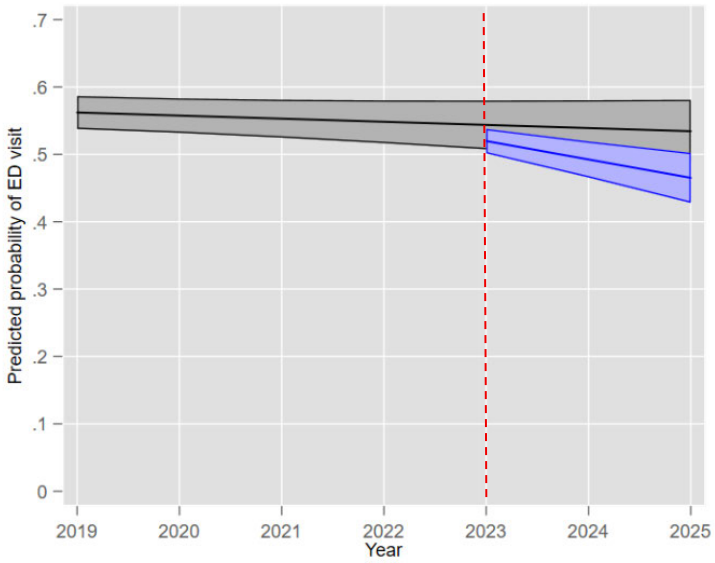
EXHIBIT 28: NEGATIVE BINOMIAL REGRESSION MODEL: ACUTE HOSPITAL UTILIZATION, TAM



A negative binomial regression model was used to estimate the change in AHU among the TAM population. There was no significant trend in the rate ratio of AHU during the baseline or Demonstration periods. Higher rates of AHU were associated with older age. Lower rates of AHU were associated with non-White race. (Exhibit 28)

Emergency Department Utilization

EXHIBIT 29: LOGISTIC REGRESSION MODEL: EMERGENCY DEPARTMENT UTILIZATION, TAM

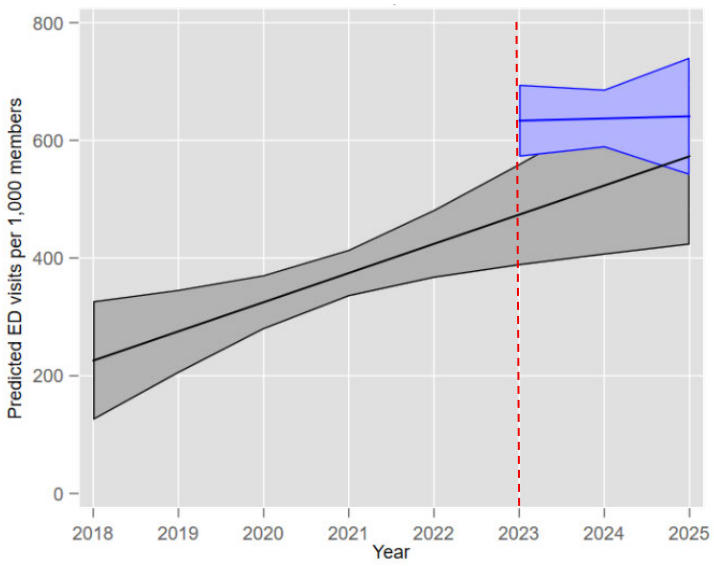


A logistic regression model was used to estimate the change in EDU among the TAM population. There was no significant trend in the odds of EDU during the baseline period. Following the Demonstration, the

odds of EDU significantly decreased by 8.7% annually ($p < 0.001$). Higher odds of EDU were associated with older age, female gender, and non-White race. Lower odds of EDU were associated with other or missing race. (Exhibit 29)

Emergency Department Utilization, Behavioral Health Condition

EXHIBIT 30: INTERRUPTED TIME SERIES MODEL: EMERGENCY DEPARTMENT UTILIZATION, BEHAVIORAL HEALTH CONDITION, TAM



An interrupted time series model was used to estimate the change in EDU-BH among the TAM population. EDU-BH significantly increased by an average of 46.58 visits per 1,000 members annually during the baseline period ($p < 0.01$). There was no significant trend in EDU-BH following the Demonstration. Lower rates of EDU-BH were associated with older age and other or missing race. (Exhibit 30)

Ambulatory and Behavioral Health Care Summary

Research questions 3.3 and 3.4 assess engagement in primary and ambulatory care, and in behavioral health treatment through utilization measures for the TAM population. Increases are hypothesized for all measures except IPF.

- Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?
- Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?

EXHIBIT 31: REGRESSION MODELS: AMBULATORY AND BEHAVIORAL HEALTH CARE MEASURES, TAM

	Adjusted	SE	CI
Adult Access to Ambulatory/Preventive Care (AAP) Logistic Regression (N=89,355)			
Measure Year	1.041**	0.014	[1.013, 1.069]
Post-Demonstration*Measure Year	1.314***	0.026	[1.265, 1.366]
Initiation and Engagement in SUD Treatment (IET), Initiation Interrupted Time Series (N=1,993)			
Measure Year	1.571**	0.526	[0.539, 2.603]
Post-Demonstration*Measure Year	3.611*	1.434	[0.799, 6.422]
Initiation and Engagement in SUD Treatment (IET), Engagement Logistic Regression (N=14,378)			
Measure Year	0.993	0.019	[0.956, 1.031]
Post-Demonstration*Measure Year	1.483***	0.032	[1.421, 1.548]
Follow-Up After Hospitalization for Mental Illness (FUH), 7 Day Logistic Regression (N=2,879)			
Measure Year	1.030	0.019	[0.993, 1.069]
Post-Demonstration*Measure Year	1.141*	0.064	[1.022, 1.273]
Follow-Up After Hospitalization for Mental Illness (FUH), 30 Day Logistic Regression (N=2,879)			
Measure Year	1.026	0.023	[0.981, 1.073]
Post-Demonstration*Measure Year	1.044	0.062	[0.929, 1.173]
30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF) Logistic Regression (N=4,383)			
Measure Year	0.995	0.080	[0.849, 1.165]
Post-Demonstration*Measure Year	0.978	0.065	[0.859, 1.113]

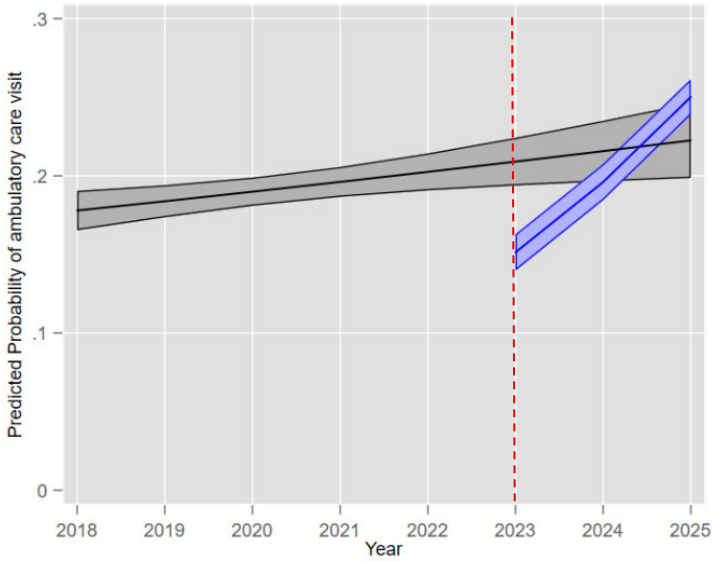
95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

AAP, IET, and 7-day FUH significantly increased following the Demonstration for the TAM population, as hypothesized. There was no significant change during the Demonstration for either 30-day FUH or IPF. (Exhibit 31)

Ambulatory and Behavioral Health Care Details

Adult Access to Ambulatory/Preventive Care

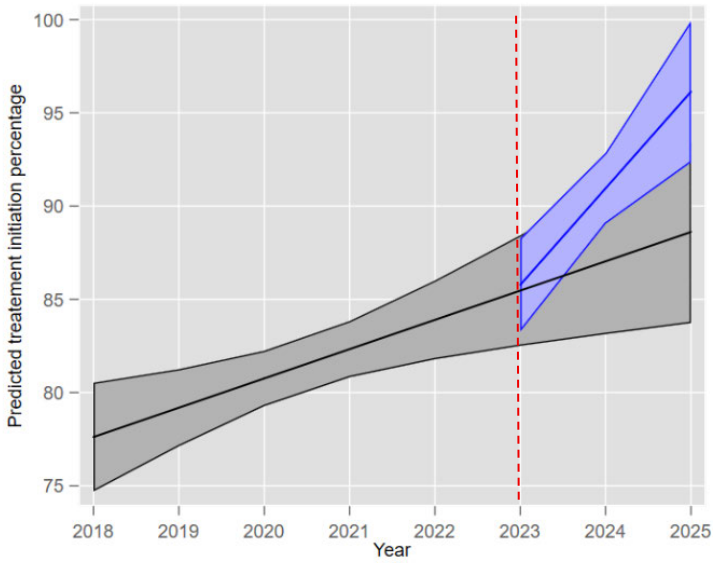
EXHIBIT 32: LOGISTIC REGRESSION MODEL: ADULT ACCESS TO AMBULATORY/PREVENTIVE CARE, TAM



A logistic regression model was used to estimate the change in adult access to AAP among the TAM population. The odds of AAP significantly increased by 4.1% annually ($p < 0.01$) during the baseline period. Following the Demonstration, the odds of AAP significantly increased by 31.4% annually ($p < 0.001$). Higher odds of AAP were associated with older age and female gender. Lower odds of AAP were associated with Hispanic ethnicity, non-White race, and other or missing race. (Exhibit 32)

Initiation and Engagement in SUD Treatment, Initiation

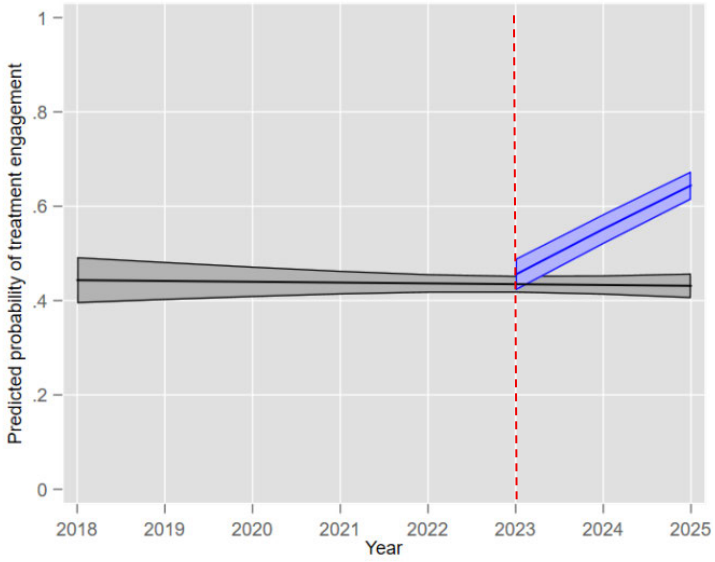
EXHIBIT 33: INTERRUPTED TIME SERIES MODEL: INITIATION AND ENGAGEMENT IN SUD TREATMENT, INITIATION, TAM



An interrupted time series model was used to estimate the change in initiation of SUD treatment (IET initiation) among the TAM population. IET initiation significantly increased by an average of 1.57% annually during the baseline period ($p < 0.01$). Following the Demonstration, IET initiation increased by an average of 3.61% annually ($p < 0.05$). Lower rates of IET initiation were associated with non-White race. (Exhibit 33)

Initiation and Engagement in SUD Treatment, Engagement

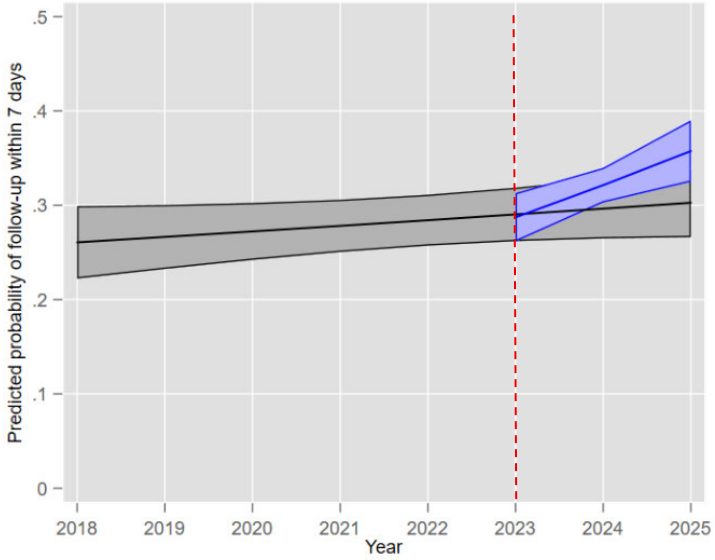
EXHIBIT 34: LOGISTIC REGRESSION MODEL: INITIATION AND ENGAGEMENT IN SUD TREATMENT, ENGAGEMENT, TAM



A logistic regression model was used to estimate the change in engagement in SUD treatment (IET engagement) among the TAM population. There was no significant trend in IET engagement during the baseline period. However, the odds of IET engagement significantly increased by 48.3% annually ($p < 0.001$) following the Demonstration. Higher odds of IET engagement were associated with older age. Lower odds of IET engagement were associated with non-White race. (Exhibit 34)

Follow-Up After Hospitalization for Mental Illness, 7 Day

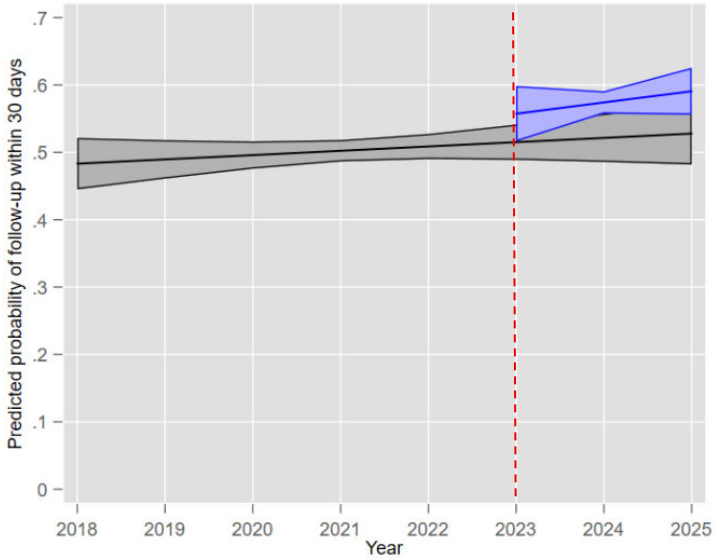
EXHIBIT 35: LOGISTIC REGRESSION MODEL: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS, 7 DAY, TAM



A logistic regression model was used to estimate the change in 7-day FUH among the TAM population. There was no significant trend in the odds of 7-day FUH during the baseline period. Following the Demonstration, the odds of 7-day FUH significantly increased by 14.1% annually ($p < 0.05$). (Exhibit 35)

Follow-Up After Hospitalization for Mental Illness, 30 Day

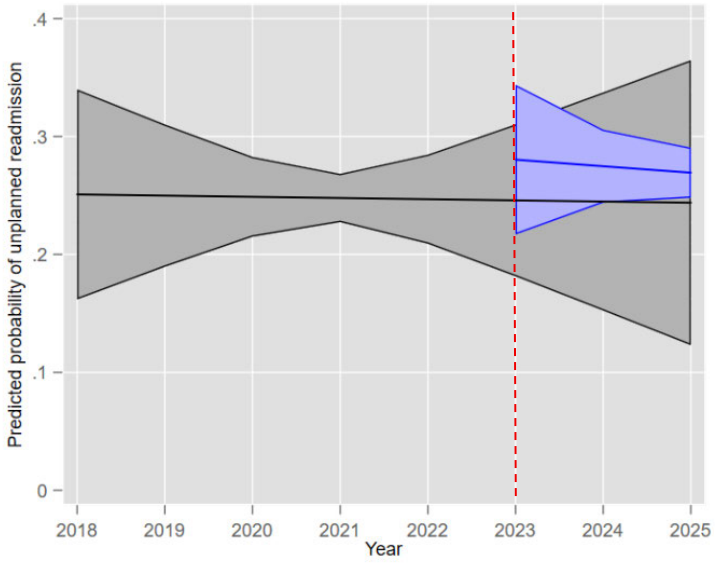
EXHIBIT 36: LOGISTIC REGRESSION MODEL: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS, 30 DAY, TAM



A logistic regression model was used to estimate the change in 30-day FUH among the TAM population. There was no significant trend in the odds of 30-day FUH during the baseline or Demonstration periods. Higher odds of 30-day FUH were associated with female gender. (Exhibit 36)

30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility

EXHIBIT 37: LOGISTIC REGRESSION MODEL: 30-DAY ALL-CAUSE UNPLANNED READMISSION FOLLOWING HOSPITALIZATION IN AN INPATIENT PSYCHIATRIC FACILITY, TAM



A logistic regression model was used to estimate the change in IPF among the TAM population. There was no significant trend in IPF during the baseline or Demonstration periods. Higher odds of IPF were associated with older age. Lower odds of IPF were associated with female gender. (Exhibit 37)

Key Findings

Trends in acute care utilization improved or experienced no change among the TAM population.

- EDU decreased over time and relative to baseline, as hypothesized.
- AHU and EDU-BH had no significant change over time.

Trends in ambulatory and behavioral health care improved or experienced no change among the TAM population.

- AAP, IET, and FUH (7-day) increased over time and relative to baseline, as hypothesized.
- FUH (30-day) and IPF had no significant change over time.

4. SMI AND SUD DEMONSTRATIONS

4.1 SMI and SUD Demonstrations; Hypothesis 5

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.

Changes in access and engagement measures for individuals diagnosed with SMI or SUD were modeled over time. Regression models adjusted for gender, age, race, and ethnicity.

Behavioral Health Care Summary

Research questions 5.4 and 5.5 assess engagement in behavioral health treatment through utilization measures for individuals diagnosed with SMI or SUD. Increases are hypothesized for IET, and decreases are hypothesized for 30 Day All Cause Unplanned Readmission Following Hospitalization in IPF.

- Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?
- Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?

EXHIBIT 38: REGRESSION MODELS: BEHAVIORAL HEALTH CARE MEASURES, SMI/SUD

	Adjusted	SE	CI
Initiation and Engagement in SUD Treatment (IET), Initiation Logistic Regression (N=75,605)			
Measure Year	0.990	0.019	[0.954, 1.028]
Post-Demonstration*Measure Year	1.406***	0.060	[1.294, 1.528]
Initiation and Engagement in SUD Treatment (IET), Engagement Logistic Regression (N=75,605)			
Measure Year	0.987	0.012	[0.964, 1.010]
Post-Demonstration*Measure Year	1.270***	0.040	[1.193, 1.351]
30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF) Interrupted Time Series (N=3,687)			
Measure Year	3.020***	0.383	[2.269, 3.771]
Post-Demonstration*Measure Year	4.815***	1.177	[2.507, 7.122]

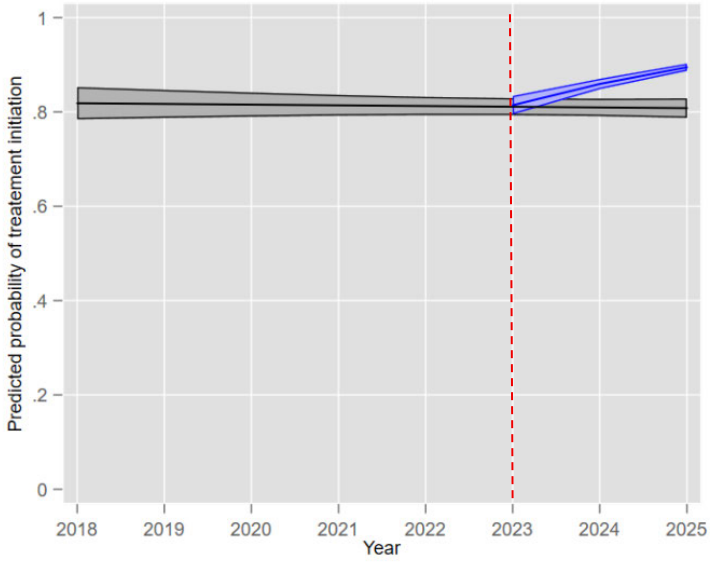
95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

IET among individuals with SUD diagnoses significantly increased following the Demonstration, as hypothesized. Contrary to the hypothesis, 30-day all-cause unplanned readmission following hospitalization in an IPF also significantly increased among individuals with SMI diagnoses. (Exhibit 38)

Behavioral Health Care Details

Initiation and Engagement in SUD Treatment, Initiation

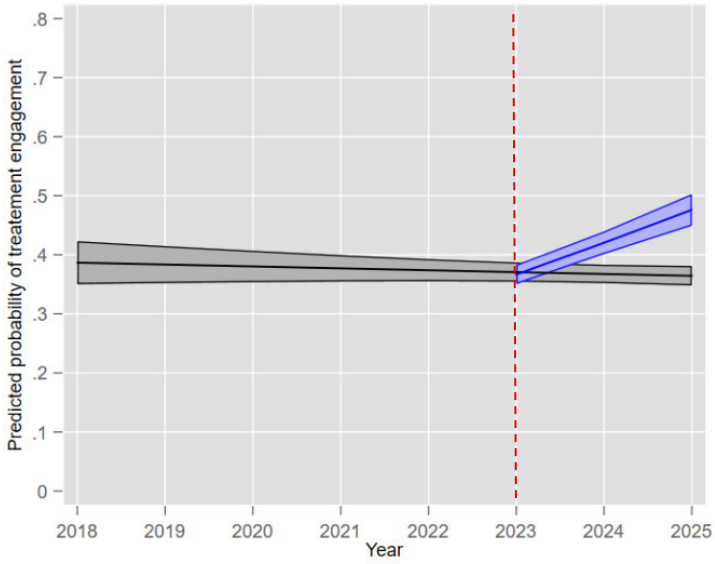
EXHIBIT 39: LOGISTIC REGRESSION MODEL: INITIATION AND ENGAGEMENT IN SUD TREATMENT, INITIATION, SUD



A logistic regression model was used to estimate the change in initiation of SUD treatment (IET initiation) among individuals with SUD diagnoses. There was no significant trend in IET initiation during the baseline period. The odds of IET initiation significantly increased by 40.6% annually following the Demonstration ($p < 0.001$). Higher odds of IET initiation were associated with older age and female gender. Lower odds of IET initiation were associated with Hispanic ethnicity and non-White race. (Exhibit 39)

Initiation and Engagement in SUD Treatment, Engagement

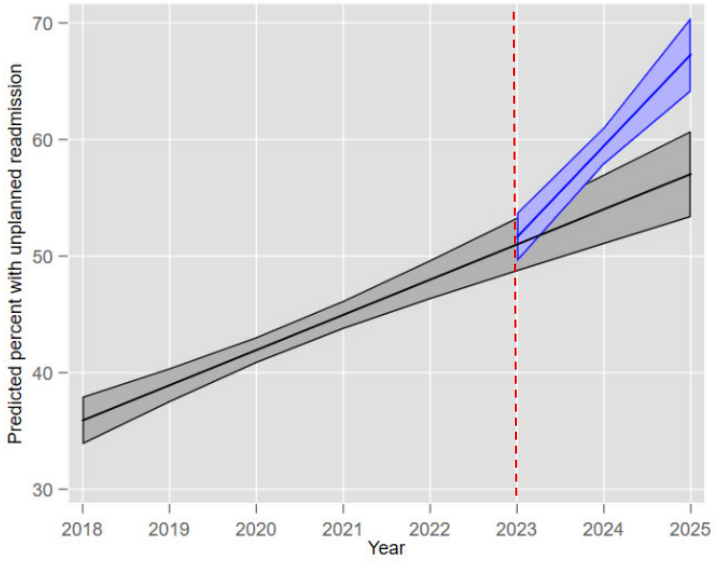
EXHIBIT 40: LOGISTIC REGRESSION MODEL: INITIATION AND ENGAGEMENT IN SUD TREATMENT, ENGAGEMENT, SUD



A logistic regression model was used to estimate the change in engagement in SUD treatment (IET engagement) among individuals with SUD diagnoses. There was no significant trend in IET engagement during the baseline period. The odds of IET engagement significantly increased by 27.0% annually following the Demonstration ($p < 0.001$). Lower odds of IET engagement were associated with older age, Hispanic ethnicity, and non-White race. (Exhibit 40)

30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility

EXHIBIT 41: INTERRUPTED TIME SERIES MODEL: 30-DAY ALL-CAUSE UNPLANNED READMISSION FOLLOWING HOSPITALIZATION IN AN INPATIENT PSYCHIATRIC FACILITY, SMI



An interrupted time series model was used to estimate the change in IPF among individuals with SMI diagnoses. Prior to the Demonstration, IPF significantly increased by an average of 3.02% annually ($p < 0.001$). Following the Demonstration, IPF increased by an average of 4.82% annually ($p < 0.001$). Higher rates of IPF were associated with older age. Lower rates of IPF were associated with female gender, Hispanic ethnicity, and non-White race. (Exhibit 41)

Key Findings

Trends in behavioral health care were mixed among the SMI/SUD Demonstrations

- IET increased over time and relative to baseline, as hypothesized.
- IPF increased over time and relative to baseline.

G. Conclusions

1. Member Experience of Care: Strengths and Opportunities for Improvement

The state hypothesized that the Demonstration would expand coverage for low-income Utah residents, thereby increasing engagement in health care and improving member satisfaction (Hypothesis 1). Findings from the member satisfaction survey show high rates of access to primary care providers and substance use treatment, as well as generally positive perceptions of provider communication and shared decision-making. However, the results also highlight several persistent challenges. Survey respondents reported barriers to accessing timely urgent, routine, and mental health care; difficulties obtaining needed medical care, tests or treatment; and concerns related to care coordination and providers' screening for health-related social needs. Together, these findings indicate that, while member satisfaction persists across several measures, additional targeted efforts are necessary to strengthen access, coordination, and responsiveness within the health care system.

2. Variation in Acute Care Utilization, Ambulatory Care, and Behavioral Health Care Results Across Demonstration Populations

The state anticipated that the Demonstration would enhance access to and engagement in health care for the AE and TAM populations, thereby reducing reliance on inpatient and emergency department services (Hypotheses 2 and 3). Findings from the first three years of the Demonstration present a mixed picture. While EDU decreased significantly for both populations, the expected reductions in AHU and EDU-BH were not observed. Several ambulatory and behavioral health measures demonstrated positive movement: AAP and IET increased relative to baseline for both populations, and 7-day FUH improved for the TAM population. However, anticipated improvements in 7-day FUH for the AE population, 30-day FUH for both groups, and reductions in 30-day all-cause unplanned readmission following hospitalization in an inpatient psychiatric facility were not observed. Overall, these results indicate meaningful progress in certain areas of access and engagement, while highlighting ongoing challenges that warrant continued attention and targeted intervention.

3. Progress and Challenges for the Serious Mental Illness (SMI)/Substance Use Disorder (SUD) Demonstration Populations

The state posited that the SMI and SUD Demonstrations would expand access to appropriate treatment (Hypothesis 5), reflected in expected increases in IET and decreases in IPF. Findings indicate that while the SUD population experienced a significant increase in IET relative to baseline, the anticipated reduction in IPF among individuals with SMI diagnoses was not observed. These results suggest progress in some aspects of treatment access, while highlighting continued challenges in reducing psychiatric readmissions for the SMI population.

H. Interpretations, Policy Implications, and Interactions with Other State Initiatives

1. Utah's Medicaid Strategy

The Medicaid Reform Demonstration is being implemented in the context of Utah's long-term strategy of using managed care to increase access and quality while containing cost. The transition to managed care plans for beneficiaries began in 1982 under Utah's 1915(b) waiver program. Utah's Primary Care Network section 1115 Demonstration waiver was first approved in 2002 and included a pre-ACA coverage expansion (called the Primary Care Network) to certain non-disabled adults. Since 2013, four full-risk ACOs have managed physical health care for all residents of designated counties and for other beneficiaries who opt in to ACO plans. Utah has also operated a 1915(b)-waiver program called the Prepaid Mental Health Plan (PMHP) since July 1, 1991. The PMHP was designed to maximize the contractors' flexibility to effectively and responsibly use Medicaid funds to ensure Medicaid beneficiaries have access to BH services and to improve BH outcomes for Medicaid beneficiaries. Under the PMHP, Medicaid beneficiaries have access to a spectrum of inpatient and outpatient mental health care and outpatient substance use disorder care.

2. Impact of COVID-19 Pandemic

The COVID-19 public health emergency impacted Utah Medicaid profoundly during this Demonstration period through multiple mechanisms. In 2020 at the onset of the pandemic, many facilities cancelled non-emergency services, and many individuals avoided going to health care facilities. Health plans altered or paused their planned care delivery initiatives, including outreach to individuals newly eligible under AE, and rollouts of care coordination programs. As the PHE progressed, telehealth expanded from a small fraction of care delivery into a critical tool in routine use for primary care, behavioral health, chronic disease management, and urgent care. Vaccines became available, and vaccinating the patient population became a priority for all providers, health plans, and state agencies. By the end of the Demonstration period in 2022, approximately two-thirds of adult Utah residents had been fully vaccinated, and health plans were resurrecting their plans for population health programs.

The continuous enrollment policy also impacted the Medicaid system. Nationally, Medicaid enrollment increased by roughly 30%, reflecting both new enrollments and paused redeterminations of enrolled members. Continuous enrollment nearly eliminated the churn typically seen as individuals on the edge of income eligibility cycle in and out of eligibility. At that stage, key goals were using existing data to identify individuals at risk of losing coverage and reaching out to members to obtain accurate contact information. When unwinding officially began in March of 2023, CMS urged states to improve call center assistance for renewing members, and Utah reviewed and streamlined processes in order to reduce call wait times and improve messaging to members. Utah Medicaid worked with DWS to leverage existing data and partnered with health plans to provide more assistance to members. Before the PHE, Utah had discussed automating the process of ex-parte renewal to reduce administrative burden and avoidable loss of coverage; in 2022 this initiative gained urgency. Utah developed a custom tool for renewals, including a smartphone app that went live in January 2023. Among individuals whose coverage was renewed during the unwinding process by October 2023, 54% experienced successful ex-parte renewals, similar to national rates.[18]

National trends show that health care utilization remained lower through 2021, and did rebound in 2022, though not fully to pre-PHE levels.[19] ED utilization remained about 4% below historical levels. For BH services, in-person services remain about 20% below pre-PHE levels, but telehealth BH appointments in

[18] Corallo, B. and Tolbert, J., 2023. *Understanding Medicaid Ex Parte Renewals During the Unwinding*. KFF Accessed 02/15/2024. Understanding Medicaid Ex Parte Renewals During the Unwinding | KFF

[19] McGough, M. et al., 2023. *How has healthcare utilization changed since the pandemic?* KFF Accessed 02/15/2024 How has healthcare utilization changed since the pandemic? - Peterson-KFF Health System Tracker

the post-acute stage of the PHE were at more than 10 times the pre-PHE rate.[20] The observation that overall mental health utilization stayed 10% higher than pre-PHE rates[21] suggests that replacement of some in-person BH services with telehealth is a permanent change in care delivery. Telehealth utilization is highest among Medicaid members, with 28% of Medicaid members nationally reporting that they received a telehealth service in the 2021-22 survey period.[22] This adds urgency to the development of evidence-based policies and guidelines for telehealth use, which in turn depends on ongoing research and collective sharing of emerging practices.

3. Potential Implications of the One Big Beautiful Bill Act (H.R. 1)

On July 4, 2025, the One Big Beautiful Bill Act (H.R. 1) was signed into law by President Trump, introducing substantial changes to Medicaid including eligibility and financing. The Congressional Budget Office estimates that the H.R. 1 Medicaid provisions will significantly reduce federal Medicaid spending, decrease enrollment, and increase the number of uninsured individuals nationwide, with far reaching implications for health care access and outcomes.[23-24] Although the analyses presented in this interim evaluation report predate the enactment of H.R. 1, it provides important baseline context for interpreting potential impacts that will be examined in the forthcoming summative evaluation report.

[20] Cantor, J., McBain, R., Ho, P., 2023. *Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022.* Jama Health Forum Accessed 02/29/2024. Telehealth and In-Person Mental Health Service Utilization and Spending, 2019 to 2022

[21] 2023. *COVID-19 Pandemic Impacted Behavioral Health in D.C. and Drove Significant Growth in Telehealth Care*. Georgetown University Medical Center Accessed 02/29/2024. COVID-19 Pandemic Impacted Behavioral Health in D.C. and Drove Significant Growth in Telehealth Care

[22] Lee, E., Grigorescu, V., Enogieru, I., et al., 2023. *Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)*. HHS ASPE Office of Health Policy Accessed 02/29/2024. Updated National Survey Trends in Telehealth Utilization and Modality (2021-2022)

[23] Ortaliza, J., McGough, M., Cox, C., et al., 2025. *How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?* KFF. How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?

[24] Baumrucker, E., Fernandez, B., Forsberg, V., et al., 2025. *Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1) as Passed by the House with Comparison of Senate Draft Language.* Congressional Research Service. Health Coverage Provisions in One Big Beautiful Bill Act (H.R. 1) as Passed by the House with Comparison of Senate Draft Language

I. Lessons Learned and Recommendations

Based on these preliminary analyses, the IE offers these recommendations to the state:

(1) *Anticipate gradual improvement in measurement outcomes*

Evidence from prior studies demonstrates that while insurance coverage is a necessary foundation, meaningful increases in engagement and improvements in health outcomes are often not immediately realized.[25-26] Although the findings indicate progress across several measures, these gains should be interpreted within the broader context of adjustment periods associated with gaining coverage, establishing care relationships, and navigating the health care system.

The results underscore the importance of robust, targeted outreach efforts and comprehensive population health strategies to accelerate engagement and sustain progress over time. Medicaid members who were recently uninsured or underinsured may face persistent barriers—including limited health system familiarity, unmet social needs, and delayed care-seeking behaviors—that are not fully addressed through coverage alone. As such, proactive strategies that support care navigation, connection to primary and preventive services, and culturally responsive engagement are critical. Accordingly, the state should continue to invest in and refine outreach and population health initiatives that complement coverage expansion. Sustained monitoring of trends across program years will be essential to assess the effectiveness of these strategies and to distinguish short-term enrollment effects from longer-term improvements in engagement and health status.

(2) *Engage with members to streamline health care access*

The state should deepen collaboration with Medicaid members to more comprehensively assess and address areas in need of improvement. Feedback from survey respondents highlighted a broad range of concerns, emphasizing the need for targeted action to improve member experience and access to care. To mitigate these concerns, the state should prioritize strategies to streamline administrative processes, enhance support for identifying in-network providers, expand access to telehealth services, and increase awareness of existing essential supports that facilitate access to care such as non-emergency medical transportation.

The state's existing BAC, composed of current and former Medicaid members and individuals who support Medicaid populations, provides an important forum for capturing member perspectives and informing program improvements. Continued engagement through the BAC alongside the development of additional feedback and outreach mechanisms such as community-based partnerships, public forums, and targeted communication campaigns would further strengthen the state's ability to incorporate member input into program design and implementation. Collectively, these efforts can support more responsive, member-centered strategies and help ensure that improvements are aligned with the needs and experiences of the populations served.

(3) *Strengthen care coordination and address members' health-related social needs*

The member satisfaction survey highlights persistent gaps in provider coordination of care and attention to health-related social needs. Fragmentation within the health care system—particularly limited access to comprehensive medical histories, such as prior tests, results, prescribed medications, and specialist care—impedes providers' ability to deliver timely, informed care. These inefficiencies disproportionately affect individuals with chronic or complex health needs, leading to reduced care quality, poorer health outcomes, and increased patient dissatisfaction. Furthermore, screening for health-related social needs is essential to advancing a more holistic approach to care, ensuring the providers can meet the full range of members' physical, behavioral, and social needs. Improved information sharing, integrated care

[25] Miller, S., Wherry, L., 2017. *Health and Access to Care during the First 2 Years of the ACA Medicaid Expansion.* The New England Journal of Medicine. Health and Access to Care during the First 2 Years of the ACA Medicaid Expansion

[26] Courtemanche, C., Marton, J., Ukert, B., et al., 2017. *Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health.* National Bureau of Economic Research. Early Effects of the Affordable Care Act on Health Care Access, Risky Health Behaviors, and Self-Assessed Health

approaches, and provider engagement in assessing and addressing health-related social needs are therefore critical to improving member experience and overall health outcomes.

Enhancing care coordination and more effectively addressing members' health-related social needs may also help achieve the anticipated improvements in the evaluated acute, ambulatory, and behavioral health care measures that were not observed during the evaluation period. The state has taken meaningful steps to address health-related social needs through the HRSS amendment implemented in 2022, which enabled the provision of housing support services, and the HRSN amendment in 2025, which expanded HRSS and additional services for eligible individuals. These initiatives represent an important component of the state's broader strategy to support member health and well-being and should be acknowledged as part of ongoing program development.

(4) Promote continued integration of behavioral health care
Evaluation findings indicate substantial unmet behavioral health needs, as the anticipated reductions in EDU-BH and 30-day all-cause unplanned readmission following hospitalization in an inpatient psychiatric facility were not realized. Similarly, expected improvements in FUH were not observed. These patterns underscore the need for comprehensive behavioral health care to more effectively meet members' needs.

The state's planned initiatives to expand access to behavioral health services and strengthen integration across the care continuum (e.g., increasing provider capacity, enhancing the availability of treatment options, and improving access to crisis stabilization services) represent important opportunities to advance more coordinated, effective care for Medicaid members.

J. ATTACHMENTS

1. EVALUATION DESIGN DOCUMENT

Utah Medicaid Reform 1115 Demonstration: Evaluation Design Document

Report prepared by the Public Consulting Group

Draft EDD Submittal Date: March 15, 2023

Final EDD Submittal Date: July 31, 2023

Revised Final EDD Submittal Date: December 20, 2023

Second Revised Final EDD Submittal Date: February 9, 2024

Third Revised Final EDD Submittal Date: May 30, 2024

Fourth Revised Final EDD Submittal Date: December 30, 2024

Fifth Revised Final EDD Submittal Date: May 30, 2025

Sixth Revised Final EDD Submittal Date: November 19, 2025

PUBLIC CONSULTING GROUP

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A. General Background Information

1. Demonstration Name and Timing

On June 30, 2022, the Centers for Medicare & Medicaid Services (CMS) approved a five-year extension of Utah's section 1115 waiver, formerly known as the "Primary Care Network (PCN) Demonstration" (hereafter, "the Demonstration" or "the 1115 Demonstration"). The current extension is entitled "Medicaid Reform 1115 Demonstration" and is approved for the five-year period from July 1, 2022, through June 30, 2027. Through the Demonstration, CMS has granted the state expenditure authorities to expand service offerings for vulnerable populations, move some members into integrated managed care plans, and to provide coverage to populations not otherwise eligible for Medicaid. The Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) administers the Utah Medicaid program and is responsible for the implementation of the Demonstration.

2. Demonstration Goals

The Medicaid Reform 1115 Demonstration expands coverage for populations not traditionally eligible for Medicaid through direct coverage or premium subsidies. By providing access to preventive care and enhanced services to vulnerable populations, the Demonstration aims to improve health outcomes and to reduce cost of care.

The Demonstration goals, as outlined in the Special Terms and Conditions[27], are:

Provide health care coverage for low-income Utahns eligible under the Demonstration who would not otherwise have access to, or be able to afford, health care coverage;

Improve beneficiary health outcomes and quality of life;

Lower the uninsured rate of low income Utahns;

Provide continuity of coverage for individuals eligible under the Demonstration;

Increase access to primary care;

Reduce uncompensated care provided by Utah hospitals;

Reduce barriers to health care and housing, an important social determinant of health;

Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;

Improve access to services across the continuum of care;

Provide for better care coordination for individuals transitioning to community-based care;

Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;

Reduce the overdose death rate; and

Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders

With the addition of the Substance Use Disorder (SUD) and Serious Mental Illness (SMI) Institution for Mental Diseases (IMD) amendment approvals, the state expanded its objectives to

[27] Source: medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-primary-care-network-protocol-apprvl-ltr-01082025.pdf

include the following for individuals with SUD and/or SMI:

Improve access to services across the continuum of care;

Provide for better care coordination for individuals transitioning to community-based care;

Reduce the utilization of emergency departments and inpatient hospital settings for treatment, where utilization is preventable or medically inappropriate;

Reduce the overdose death rate; and

Improve access to care for physical health conditions for these individuals.

With the addition of the Pre-Release Services under Reentry Demonstration Initiative amendment approval, the state has further expanded its objectives to include the following for eligible individuals:

Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable) and community-based providers

Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs;

Reduce all-cause deaths in the near-term post-release;

Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care; and

Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release

3. Description

Utah’s 1115 Demonstration was first approved in 2002 and has transformed over the last twenty years through extensions and amendments that have added new authorities and Demonstration populations.

The original PCN Demonstration provided a limited package of preventive and primary care benefits (the PCN benefit) to adults ages 19-64 with household incomes up to 150 percent of the Federal Poverty Level (FPL) and a slightly reduced benefit package to Parent/Caretaker Relatives (PCR) who comprised the Current Eligibles population. With Medicaid expansion in April 2019, PCN program participants became eligible for full state plan benefits, and the PCN benefit was phased out. The Current Eligible population was phased out by December 31, 2023, eliminating disparities in benefit packages by parental status. An assessment of the phase-out process is included in the evaluation design.

The 1115 Demonstration has historically served as a vehicle to provide premium assistance to adults with household incomes above Medicaid eligibility requirements. In 2006, the Utah Department of Health and Human Services (DHHS) amended the 1115 Demonstration to establish the Health Insurance Flexibility

and Accountability Employer Sponsored Insurance (ESI) program, which provides premium assistance to adults with household incomes up to and including 150 percent of the FPL and CHIP-eligible children with family incomes up to 200 percent of the FPL. This was later amended to include adults with incomes up to 200 percent of the FPL and programmatically eligible adults and children obtaining coverage through COBRA[28]. Under the current 1115 Demonstration, premium assistance helps pay the individual's or family's share of monthly premium costs of ESI or COBRA and is aggregated under Utah's Premium Partnership for Health Insurance Program (UPP). Individuals in the AE population with access to employer-sponsored insurance are required to enroll, with few exceptions. The state also increased the maximum assistance reimbursement amount in July 2021 making this program more substantial and potentially increasing the number of individuals covered by UPP. In February 2024, CMS approved an increase in the premium subsidy for children that would otherwise receive CHIP services under the state plan from $120 to $180. If a plan offers dental coverage, the premium subsidy amount will increase from $140 to $200.

For nearly a decade, Utah's Demonstration has emphasized improving the behavioral health (BH) continuum of care. In November 2017 the state received approval to establish the Targeted Adult Medicaid (TAM) eligibility group. The TAM population consists of vulnerable adults ages 19-64, whose incomes are at or 0 percent of the FPL (effectively 5 percent of the FPL with the 5 percent disregard), and who meet detailed eligibility criteria in one of three targeted categories: chronically homeless, involved in the justice system and in need of substance use or mental health treatment, or are in need of substance use or mental health treatment. As of June 2022, enrollment in TAM was 9,384 individuals.

In December 2019, Utah received authority to enroll demonstration populations in managed care plans and to create an integrated managed care model, known as the Utah Medicaid Integrated Care (UMIC) plan. The four UMIC plans manage both physical and behavioral health benefits for the AE population in Utah's five most populous counties: Davis, Salt Lake, Utah, Washington, and Weber. The AE population in the rest of the state are enrolled in Accountable Care Organizations (ACOs) for their physical health service delivery system and in Prepaid Mental Health Plans (PMHPs) for their behavioral health service delivery system. The integrated care model is intended to provide more holistic and coordinated care than previously.

In March 2022, CMS approved the Housing Related Services and Supports (HRSS) amendment, allowing Utah to provide housing support services, such as tenancy supports, community transition services, and supportive living services to TAM individuals who meet additional eligibility criteria and exhibit one of seven risk factors. In an amendment approved in February 2024, an additional four risk factors were added to the HRSS program eligibility criteria to align eligibility with the sub-groups of the Targeted Adult group. The HRSS are paid on a fee-for-service basis. Providers are required to enroll and are evaluated to ensure they meet HRSS qualifications which includes being a certified case management provider. Once care plans have been approved, providers can submit claims for HRSS and receive reimbursement. As the program ramps up in the current waiver period, the state anticipates that HRSS will serve approximately 5,000 TAM individuals each year. By addressing crucial health-related social needs in a high-needs population, the state anticipates that the HRSS program will improve participant health outcomes or quality of life and reduce non-housing related Medicaid costs.

In January 2025, CMS approved coverage of Health-Related Social Needs (HRSN) services. The amendment:

expands the HRSS benefit to the AE population and to recently incarcerated individuals;

adds short-term rental assistance and short-term recuperative care for Adult Expansion and TAM populations;

authorizes HRSN infrastructure investments; and

[28] Consolidated Omnibus Reconciliation Act of 1986

authorizes the state to provide non-medical transportation (NMT) to and from HRSN services for eligible individuals.

Eligibility for HRSN services includes social and clinical risk factors and medical necessity criteria.

The 1115 Demonstration also includes components that focus on individuals with SUD and/or SMI, and youth with significant emotional disorder (SED) and/or behavioral challenges. Utah received approval of the SUD Implementation plan in November 2017. The Opioid Use Disorder (OUD) and SUD Program provides state plan behavioral health benefits to Demonstration participants. The state also received authority to provide residential and inpatient OUD/SUD treatment services to all Medicaid beneficiaries while they are short term residents in treatment settings that qualify as IMDs.

The SMI/SED Implementation plan was approved in December 2020 and is similar in expenditure authority to the OUD/SUD program. The state is taking action to meet key milestones of the SMI/SED program including, ensuring quality of care in psychiatric hospitals and residential settings, improving care coordination and transitions to community-based care, increasing access to the continuum of care including crisis stabilization services, and earlier identification and engagement in treatment and increased integration. Together, the SUD and SMI components expand access to mental health services, opioid use disorder (OUD) and other substance use disorder (SUD) services. The 1115 Demonstration supports state efforts to enhance provider capacity, improve the availability of Medication Assisted Treatment (MAT) and improve access to a continuum of SMI evidence-based services at varied levels of intensity, including crisis stabilization services.

In February 2019, Utah received CMS approval to provide state plan Medicaid coverage to Former Foster Care Youth from another state (FFCYAS) who were ever enrolled in Medicaid in another state and are not otherwise Medicaid eligible in Utah. State plan coverage is provided to this population until 26 years of age.

In November 2019, Utah received CMS approval for the provision of intensive stabilization services (ISS) to Medicaid eligible children and youth under age 21 in state custody or at risk of being placed in state custody who are experiencing significant emotional and/or behavioral challenges. The ISS program provides both state plan BH services and home and community-based services (HCBS) that are not currently authorized through the state plan.

The Demonstration also authorized the Clinically Managed Residential Withdrawal Pilot from May 1, 2019, to April 1, 2021; this benefit became available statewide as of April 1, 2021 to all eligible Medicaid members. As a result, the State received approval on July 23, 2021, to remove this pilot project from the 1115 Demonstration and CMS is not requiring the State to evaluate this population.

The current 1115 Demonstration includes dental coverage for vulnerable populations. The PCN Demonstration first provided an adult dental benefit to the Current Eligibles population in November 2006. CMS approved dental benefits for adults with disabilities or blindness in 2017. In 2019, the state chose to provide comprehensive dental benefits to TAM adults receiving SUD treatment because research showed that dental coverage could increase initiation and engagement in treatment for individuals living with SUD. In 2020 dental benefits were extended to Medicaid eligible individuals aged 65 and older and to TAM adults in need of porcelain or porcelain-to-metal crowns. In January 2025, CMS approved an expansion of dental benefits to all Medicaid-eligible adults.

In February 2024, CMS approved an amendment to the current 1115 Demonstration enabling the state to receive expenditure authority for fertility preservation services provided to certain individuals diagnosed with cancer, as well as for in vitro fertilization (IVF) and genetic testing services for certain individuals. Under the IVF and genetic testing amendment, the state may provide genetic testing services to eligible individuals, preimplantation genetic testing of embryos, and IVF services to eligible individuals, ages 18 through 35, diagnosed by a physician with a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, spinal muscular atrophy, or myotonic dystrophy. Under the fertility treatment for individuals diagnosed with cancer amendment, the state is now enabled to provide fertility

preservation for eligible individuals diagnosed with cancer and requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility (i.e., infertility caused by treatment for cancer). Services covered under this once per lifetime benefit include the collection and storage of eggs or sperm and coverage for cryopreservation storage. Coverage for cryopreservation storage is covered as a single payment in five-year increments. In January 2025, CMS authorized an increase in the upper age limit for fertility preservation services for individuals diagnosed with cancer from 40 to 50 years of age.

In July 2024, CMS approved an additional amendment to the 1115 Demonstration called the “Pre-Release Services under Reentry Demonstration Initiative” that allows the state to provide limited coverage for a targeted set of services to certain eligible incarcerated individuals for 90 days prior to the individuals’ expected release. This amendment closely aligns with CMS’s “Reentry Demonstration Opportunity,” described in the State Medicaid Director Letter released in April 2023.

Individuals residing in a county jail, state prison, or youth correctional facility who have been determined eligible for Medicaid based on an application filed before or during incarceration are eligible to receive a limited set of pre-release benefits for up to 90-days before their expected release date. These benefits include, but are not limited to, case management, medication-assisted treatment for SUD, and physical and behavioral health clinical consultation services. A full description of the pre-release services can be found in Table 2: Additional Demonstration Benefits, Programs and Services

4. Populations

Table 1 provides a summary of the demonstration populations during the Demonstration period. Adult Expansion (AE) is the largest population, consisting of approximately 116,000 adults ages 19-64 with incomes up to 133 percent of the FPL. Additional demonstration benefits, programs, and services are summarized in Table 2. The evaluation design includes hypotheses and research questions for all key policies and programs of the demonstration.

Table 1: Demonstration Eligible Populations

Demonstration Eligible Populations	Eligibility[29]	Benefits[2]	Estimated Number of Annual Enrollees[30]
Current Eligibles (CE)	Adults aged 19-64 who are medically needy and not aged, blind, or disabled. Individuals who are pregnant are excluded, through the 60th day postpartum.	Individuals enrolled in this eligibility category receive most of the benefits covered under Utah's state plan according to limitations specified in the state plan. Current Eligibles also receive benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services (mental health services in residential treatment settings)	The CE population will be phased out entirely no later than December 31, 2023
Adult Expansion (AE)	Adults, age 19 through 64, who are not Current Eligibles, who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services.	115,584
Utah Medicaid Integrated Care (UMIC) – a subgroup of the AE population	Adult Expansion members enrolled in the Utah Medicaid Integrated Care program, which operates in Utah's most populous counties: Davis, Salt Lake, Utah, Washington, and Weber.	Expansion adults will receive state plan benefits and benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include; psychoeducational services, personal services, respite care and supportive living services.	49,963
Demonstration Populations III, V, VI, and Current	Demonstration Population III - working adults, aged 19-64, their spouses, and their children ages 19-26, with gross family incomes above 133 percent of the FPL and up to and including 200 percent of the FPL, are not	Individuals in these eligibility categories are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying	1,288

[29] ut-cms-amndmnt-aprvl.pdf (medicaid.gov)

[30] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments, and estimates for HRSN Services, are taken from the state's amendment applications to CMS. Estimates for the Justice-Involved populations are taken from state-generated updates to the state's amendment application to CMS.

Demonstration Eligible Populations	Eligibility[29]	Benefits[2]	Estimated Number of Annual Enrollees[30]
Eligible CHIP Children	otherwise eligible for Medicaid and participate in an approved ESI plan. Demonstration Population V - same as Demonstration population III, except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage. Current Eligible CHIP Children - these children are eligible for the CHIP, but the children's parents have elected to receive premium assistance for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. Demonstration Population VI - children up to age 19 with family income up to 200 percent of the FPL who would meet the definition of a low-income child. Population is divided into 2 groups: COBRA-Eligible Children and COBRA-Continuation Children.	insurance plans. Together, the ESI and COBRA benefits are the "Utah Premium Partnership Program" (UPP). Premium assistance is the sole Medicaid benefit provided to these members.	
Targeted Adult Medicaid (TAM)	Includes adults, ages 19 through 64, with incomes below five percent of the FPL and no dependent children, who meet detailed criteria in one of three major categories: Chronic homelessness Involved in the criminal justice system and in need of substance use or mental health treatment. In need of substance use or mental health treatment	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	9,384
Intensive Stabilization Services (ISS)	Medicaid eligible children and youth under age 21, who are in state custody, or at risk of state custody, and	Individuals eligible for this category will receive state plan and home community-based crisis stabilization	Anticipate 20

Demonstration Eligible Populations	Eligibility[29]	Benefits[2]	Estimated Number of Annual Enrollees[30]
	experiencing significant emotional and/or behavioral challenges.	services during the first eight-weeks of the intensive program on a FFS basis using a daily bundled rate.	
Former Foster Care Youth from Another State (FFCYAS)	Individuals under age 26, who were in foster care under the responsibility of a state other than Utah, or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid.	Individuals enrolled in this eligibility category receive full Medicaid state plan benefits.	17

In addition to the benefits associated with each eligibility pathway outlined above, the Demonstration includes several benefits, programs, and services that have expanded over time to broaden access to care and to meet the needs of vulnerable populations (see Table 2).

Table 2: Additional Demonstration Benefits, Programs, and Services

Additional Demonstration Benefits, Programs, and Services	Eligibility[31]	Benefits[2]	Estimated Number of Annual Enrollees[32]
Dental Benefit	As of the amendment approved in January 2025: all individuals enrolled in Medicaid and are the age of 21 or older. Previously, dental benefits were available only to the aged, blind, or disabled groups, and to TAM members receiving SUD treatment.	Individuals that are enrolled in this eligibility category will receive state plan dental benefits that are defined in the Utah Medicaid Provider Manual, Dental Services and porcelain or porcelain-to-metal crowns, if needed.	Entire Adult Expansion population 115,584
Health-Related Social Needs (HRSN) Services	As of the amendment approved in January 2025: the following covered populations will be eligible to receive HRSN services if they also satisfy the applicable clinical and social risk criteria and the HRSN services is determined to be medically appropriate: Recently Incarcerated Individuals are eligible for HRSS. Adult Expansion and TAM demonstration populations are eligible for HRSS, Short-Term Rental Assistance, Short-Term Recuperative Care, and Short-Term Post Transition Housing	Housing-Related Services and Supports (HRSS): includes pre-tenancy navigation services, tenancy sustaining services, one-time transition and moving costs other than rent, home accessibility modifications and remediations that are medical necessary. Short-Term Rental Assistance: payment for rent and/or short-term temporary stays for up to six months in a 5-year period. Short-Term Recuperative Care (a/k/a Medical Respite): clinically oriented recuperative or rehabilitative services and supports for individuals	5,000

[31] ut-cms-amndmnt-aprvl.pdf (medicaid.gov)

[32] The annual estimates reflect the enrollment numbers reported in the Annual Monitoring Report for the period July 2021 – June 2022 for populations that are continuing from the prior waiver period. Estimates for TAM HRSS, a new population, are taken from the approved Waiver renewal. Estimates for IVF and genetic testing and fertility preservation treatments, and estimates for HRSN Services are taken from the state's amendment applications to CMS. Estimates for the Justice-Involved populations are taken from state-generated updates to the state's amendment application to CMS.

Additional Demonstration Benefits, Programs, and Services	Eligibility[31]	Benefits[2]	Estimated Number of Annual Enrollees[32]
		who require ongoing monitoring and continuous access to medical care. Short-Term Post Transition Housing: clinically oriented rehabilitative services and supports for individuals who do not require ongoing monitoring and continuous access to medical care.	
Serious Mental Illness (SMI) IMD Benefit	Medicaid recipients, age 21 through 64 receiving SMI services in IMD treatment settings.	The Demonstration grants Utah expenditure authority for services provided to beneficiaries during short term stays in an IMD to receive acute care for a primary diagnosis of SMI or SED for stays of up to 60 days, as long as the state shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services in an IMD.	8
Opioid Use Disorder/ Substance Use Disorder Program	SUD benefits are available to all Medicaid members through state plan authority.	The Demonstration grants Utah expenditure authority to provide the following services in IMDs: residential treatment, withdrawal management, medication-assisted treatment (MAT), peer support, residential crisis stabilization.	767
In Vitro Fertilization and Genetic Testing Services	In Vitro Fertilization (IVF): Medicaid recipients ages 18-35 diagnosed by a physician or qualified health professional as having a genetic trait associated with cystic fibrosis, morquio syndrome, sickle cell anemia, or spinal muscular atrophy, and has a reproductive partner who has been diagnosed with the same condition. Has been diagnosed by a physician or qualified health	In vitro fertilization services, genetic testing services, and preimplantation genetic testing to test embryos for genetic disorders prior to transfer to the uterus. These services require prior authorization, and qualifying beneficiaries may receive up to three cycles of IVF per lifetime.	50

Additional Demonstration Benefits, Programs, and Services	Eligibility[31]	Benefits[2]	Estimated Number of Annual Enrollees[32]
	professional as having a genetic trait associated with myotonic dystrophy. Genetic testing: Medicaid recipients who have a familial medical history or are in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.		
Fertility Preservation Benefit for Individuals Diagnosed with Cancer	Medicaid recipients diagnosed by a physician or qualified health professional as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility. Post pubertal and up to age 50.	Individuals can receive egg and sperm collection and storage, preimplantation genetic testing prior to cryopreservation storage, cryopreservation storage. These benefits require prior authorization and are available once per lifetime.	226
Justice-Involved Reentry Benefit	Individuals who are inmates residing in county jails, state prisons, or youth correctional facilities and have been determined eligible for Medicaid pursuant to an application filed before or during incarceration.	Eligible individuals can receive the following pre-release services starting 90 days before their release from incarceration: Case management to assess and address physical and behavioral health needs; Medication-assisted treatment services for all types of SUD as clinically appropriate, with accompanying counseling; A 30-day supply of all prescription medications that have been prescribed for the individuals at the time of release; provided to the individual immediately upon release from the correctional facility;	Adults: 3,600 Youth:15

Additional Demonstration Benefits, Programs, and Services	Eligibility[31]	Benefits[2]	Estimated Number of Annual Enrollees[32]
		Physical and behavioral health clinical consultation services, as clinically appropriate, to diagnose health conditions, provide treatment, and support pre-release case managers' development of a post-release treatment plan and discharge planning; Diagnostic services, including laboratory and radiology services, and treatment services in addition to coverage for MAT described above; Prescribed drugs, in addition to MAT and the 30-day supply of prescription medication, and medication administration; Family planning services and supplies; Services provided by community health workers; Peer support services; Treatment for Hepatitis C; and Medical equipment and supplies and/or medical equipment provided upon release Youth eligible for CHIP will receive pre-release screening, diagnostic, and case management services starting 30 days before their release.[33]	

[33] Authority for pre-release services for CHIP eligible youth is covered under the SPA, and not held under the Utah Medicaid Reform 1115 Demonstration waiver; this evaluation will not include this population.

5. Context

The Utah Medicaid 1115 Demonstration also coincided with the unwinding of the Medicaid Continuous Enrollment requirement associated with the Covid-19 pandemic beginning in 2020. Enrollment in Medicaid remained high during the continuous enrollment period as states were required to keep current Medicaid beneficiaries enrolled. The unwinding of continuous eligibility for Medicaid began on March 1, 2023.[34] Under Utah's unwinding plan[35], every member's case was slated for a full review, with cases spread over a 12-month period. Cases most likely to change programs or coverage were prioritized for review, and those most likely to remain Medicaid eligible were deferred to later in the year. DHHS communicated with providers and beneficiaries about the redetermination process. Members are urged to update their contact information and check the unwinding website[36] to learn their anticipated review date. Redetermination will likely affect enrollment numbers in the Demonstration, as some individuals moved from one eligibility category to another, and individuals above income limits transitioned off Medicaid coverage. This evaluation design includes qualitative interviews and process metrics on implementation as it will be a moderating factor that may affect Demonstration outcomes.

[34] 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision | KFF
[35] https://medicaid.utah.gov/unwinding/
[36] https://jobs.utah.gov/mycase/

B. Evaluation Questions and Hypotheses

1. Logic Model

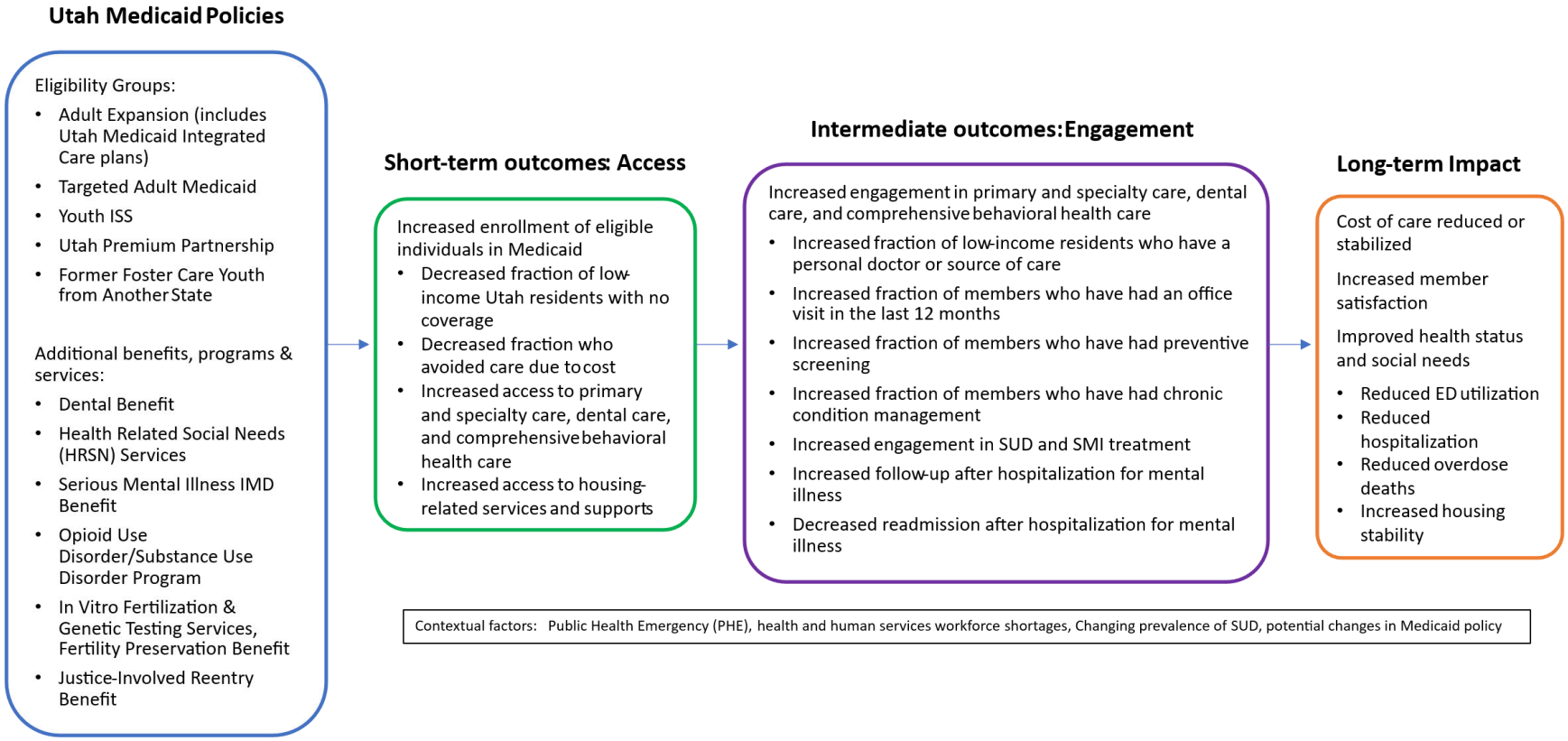


FIGURE 1: MEDICAID REFORM DEMONSTRATION OVERALL LOGIC MODEL

2. Hypotheses and Research Questions

The logic model above illustrates how the Demonstration objectives are expected to be achieved by program activities, following a natural progression from proximate to distal outcomes as the Demonstration goes on. Each outcome is represented by a testable hypothesis, listed below, about the impact of the Demonstration activities, and a corresponding research question. Tables 15-25 specify the measures that will be used to assess each hypothesis.

The hypotheses are organized by population or program/benefit, and are focused on the broad themes of increasing health care coverage, increasing access to primary care and appropriate utilization, reducing high-cost acute care utilization, including potentially preventable utilization, and reducing the cost of uncompensated care.

The first objective of the 1115 Demonstration, providing health care coverage for low-income Utahns eligible who would not otherwise have access to or be able to afford health care coverage, is achieved through enrollment in a number of the Demonstration populations, including the Adult Expansion, TAM, UPP, and ISS. Individuals in these populations would not otherwise be eligible for Medicaid without the presence of the Demonstration in Utah.[37] The first hypothesis is thus focused on the impact of the 1115 Demonstration overall on the population of low-income UT residents. A larger fraction of low-income UT residents is expected to report having access to coverage and engaging in health care relative to reported access and engagement in other states. Engagement in care is expected to improve member satisfaction and lead to reductions in inappropriate care utilizations, also known as “Low Value Care”.

The second hypothesis is similar to the first hypothesis, and focuses specifically on the Adult Expansion population. The second hypothesis is that the Demonstration will improve health care access and engagement for the Adult Expansion population. The state hypothesizes that by providing coverage through Medicaid expansion, members will engage in primary and preventive care, which will lead to reductions in acute care utilization. The Utah Medicaid Integrated Care (UMIC) population, a subpopulation of the Adult Expansion population, consists of members in Utah’s five-most populous counties who are enrolled in plans that integrate care for physical and behavioral health needs. Thus, the UMIC research questions are specific to the outcomes produced when members gain access to behavioral health care that is managed by the same managed care organization that manages their physical health care. It is anticipated that UMIC will improve engagement in BH services and reduce ED utilization.

The third hypothesis again focuses on access and engagement in health care, this time focusing on the TAM population. The state hypothesizes that the Demonstration will continue to improve health care access and engagement for this population.

The fourth hypothesis addresses the HRSN demonstration, which essentially expands the housing-related services and supports (HRSS) benefit previously available only to TAM members, to the entire Adult Expansion population who meet the needs-based eligibility criteria. The state is authorized to provide HRSS, short-term rental assistance, short-term recuperative care, short-term post-transition housing, and non-medical transportation (NMT). The evaluation design focuses on HRSS and NMT, with a planned implementation date of July 1, 2025. The other authorized services may, or may not, be implemented during the current demonstration period. If they are implemented, they should contribute to the same outcomes theorized for HRSS. It is anticipated that the HRSN demonstration will reduce the prevalence and severity of housing and transportation needs, increase continuity of BH treatment, and improve health outcomes for eligible members. Research questions include whether HRSN services were provided and utilized as planned, care manager perspectives on incorporating this new benefit, whether there is unmet need, and whether HRSS improves perceived health status. Other research questions about the HRSN demonstration focus on how HRSN affects high-cost acute care utilization.

[37] Individuals in the Current Eligibles population received expanded benefits through the waiver, although they would have received coverage regardless of the presence of the waiver.

The fifth and sixth hypotheses speak to BH services provided to Demonstration participants and Medicaid beneficiaries with SMI and SUD treated in Institutions of Mental Disease (IMD). The state anticipates that BH coverage for residential and inpatient services provided to members in IMDs will lead to a reduction in inpatient stays, ED utilization, and rate of unplanned readmission among recipients, resulting in cost decrease or stabilization. The state also anticipates this will lessen unmet need and increase engagement in treatment to reduce overdose deaths in the long-term. The IE will monitor the impact of the state's efforts to increase access to crisis stabilization services. Greater utilization of non-hospital, non-residential services should lead to greater reductions in inpatient stays, ED utilization, and overdose deaths in the long-term.

The seventh hypothesis addresses smaller Demonstration populations, which include UPP/ESI, ISS, , TAM Dental, and FFCYAS. The state anticipates that utilization for the services provided to these populations will increase and total cost of care will decrease, as these members engage in acute and preventive care. Although the number of Adult Expansion members enrolled in Employer Sponsored Insurance will grow due to the new provision present in this waiver requiring enrollment in ESI for all Adult Expansion members who have access to insurance through their employers, the number of members enrolled in ESI is not projected to exceed 1,385 members during this Demonstration period. As a result, the ESI population by itself is unlikely to lead to reductions in uncompensated care and inappropriate care utilization. In addition, the number of individuals in the FFCYAS population, and the number receiving ISS, were both very small in the prior Demonstration period. Therefore, the evaluation will include counts and a qualitative summary of program implementation.

Finally, hypotheses eight through eleven focus on the justice-involved (JI) population and the pre-release and reentry services newly covered. The state anticipates that the demonstration will enhance cross-system collaboration between the correctional and community-based services systems, that enrollment and redetermination support will improve continuity of coverage, and that coverage of pre-release and reentry services will improve engagement in high quality care, reduce unnecessary acute care utilization, and ultimately improve health outcomes for the JI population. In addition, the State will conduct a demonstration cost assessment including administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. The results of the cost assessment will be included in the Interim and Summative Evaluation Reports.

Hypothesis 1: The Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.

Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?

Primary research question 1.2: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?

Primary research question 1.3: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?

Primary research question 1.4: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?

Primary research question 1.5: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?

Primary research question 1.6: What is the member experience of care in terms of access, timeliness, and patient-centeredness?

Primary research question 1.7: Did Low Value Care decrease among Demonstration participants, relative to baseline?

Hypothesis 2: The Demonstration will improve health care access and engagement for the Adult Expansion population.

Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the Adult Expansion population?

Primary research question 2.2: Did ED visits decrease, relative to baseline, for the Adult Expansion population?

Subsidiary research question 2.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the Adult Expansion population?

Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for Adult Expansion population, relative to FFS or physical health-only ACO plans?

Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the Adult Expansion population?

Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the Adult Expansion population?

Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for the Adult Expansion population, relative to FFS or physical health-only ACO plans?

Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the Adult Expansion population?

Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the Adult Expansion population?

Primary research question 2.7: Did dental service provision increase relative to baseline for the Adult Expansion population?

Primary research question 2.8: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the Adult Expansion population?

Primary research question 2.9: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the Adult Expansion population?

Primary research question 2.10: To what extent are beneficiaries aware of the dental care benefit?

Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.

Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?

Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?

Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?

Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?

Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?

Primary research question 3.5: Did dental service provision increase relative to baseline for the TAM population?

Primary research question 3.6: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the TAM population?

Primary research question 3.7: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the TAM population?

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.

Primary research question 4.1: What is the prevalence and severity of beneficiaries' social needs?

Primary research question 4.2: Were HRSN services provided and utilized as planned?

Primary research question 4.3: Did the HRSN demonstration effectively mitigate beneficiaries' housing and transportation needs?

Primary research question 4.4: Did high-cost acute utilization decrease, relative to baseline, for HRSN recipients?

Primary research question 4.5: Did engagement in primary and ambulatory care increase, relative to baseline, for HRSN recipients?

Primary research question 4.6: Did engagement in behavioral health care increase, relative to baseline, for HRSN recipients?

Primary research question 4.7: From the beneficiaries' perspective, did the HRSN services meet their housing-related needs, support their engagement in behavioral health care, and overall positively impact their physical and mental health?

Primary research question 4.8: Did state and local investments in housing supports change over time during the HRSN demonstration?

Primary research question 4.9: Were there any improvements in the quality and effectiveness of downstream housing-related services and supports?

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.

Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?

Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?

Primary research question 5.3: Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?

Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?

Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?

Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?

Primary research question 5.7: Did the number of individuals needing but not receiving SUD treatment decrease among low-income residents, relative to comparison states?

Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?

Primary research question 5.9: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services[38]?

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.

Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?

Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?

Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?

Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?

Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?

Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations and programs.

<u>UPP/ESI</u>

Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?

Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?

Primary research question 7.3: Did the pmpm cost for enrollees change over time?

<u>ISS</u>

Primary research question 7.4: Did the number of individuals receiving ISS increase relative to baseline?

<u>Former Foster Care Youth from Another State (FFCYAS)</u>

Primary research question 7.5: How many FFCYAS received coverage?

[38] This includes services made available through crisis call centers, mobile crisis units, and coordinated community response services as defined in STC 12.4 SMI/SED Financing Plan.

Fertility and Genetic Testing Services

Primary research question 7.6: Did the number of individuals receiving fertility preservation services increase relative to baseline?

Primary research question 7.7 Did the number of individuals receiving genetic testing services increase relative to baseline?

Hypothesis 8: The Justice-Involved Reentry Benefit will enhance cross-system communication and coordination between correctional and community services.

Primary research question 8.1: Did the Demonstration's services facilitate beneficiaries' post-release transitions to care?

Primary research question 8.2: Was communication and coordination between the correctional system and community-based health services enhanced?

Hypothesis 9: The Justice-Involved Reentry Benefit will improve pre-release service provision during the covered period and continuity of coverage for the justice-involved population.

Primary research question 9.1: What Demonstration services did justice-involved individuals receive in the pre-release period?

Primary research question 9.2: What was beneficiaries' experience of pre-release service provision?

Primary research question 9.3: Were beneficiaries potentially in need of behavioral health services identified in the pre-release period?

Primary research question 9.4: What fraction of justice-involved individuals received navigation support for accessing Medicaid coverage pre-release?

Primary research question: 9.5: Did reentry continuity of coverage improve for incarcerated individuals compared to the pre-demonstration comparison population?

Hypothesis 10: The Justice-Involved Reentry Benefit's 90-day pre-release coverage period ("the coverage timeline") will support effective program implementation.

Primary research question 10.1: Did the coverage timeline facilitate providing more coordinated, efficient, and effective reentry planning?

Subsidiary research question 10.1.a: Were assessments and care plans completed in a timely manner?

Subsidiary research question 10.1.b: Did beneficiaries receive a 30-day supply of all prescribed medications immediately upon release from the carceral setting?

Primary research question 10.2: Did the coverage timeline enable pre-release management and stabilization of clinical, physical, and behavioral health conditions?

Primary research question 10.3: Did the coverage timeline help mitigate potential operational challenges the state might have encountered in a more compressed timeline?

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care services and social, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.

Primary research question 11.1: Did engagement in appropriate health care services post-release increase relative to a pre-demonstration comparison population?

Primary research question 11.2: Did inpatient hospital utilization post-release decrease relative to the pre-demonstration comparison population?

Primary research question 11.3: Did ED visits post-release decrease, relative to the pre-demonstration comparison population?

Primary research question 11.4: Did the rate of deaths post-release decrease relative to the pre-demonstration population?

Primary research question 11.5: Was the timing or provision of specific pre-release services associated with better post-release outcomes?

3. Independent Assessments

In addition to evaluating the hypotheses and research questions outlined in the previous section, several independent assessments will be conducted. The purpose and methods for each of these assessments are described here.

Wind-down of Current Eligibles

An assessment of the wind-down of the Current Eligibles (CE) demonstration population will be conducted. The original PCN Demonstration provided a limited package of preventive and primary care benefits (the PCN benefit) to adults ages 19-64 with household incomes up to 150 percent of the Federal Poverty Level (FPL) and a slightly reduced benefit package to Parent/Caretaker Relatives (PCR) who comprised the Current Eligibles population. With Medicaid expansion in April 2019, PCN program participants became eligible for full state plan benefits, and the PCN benefit was phased out. The Current Eligible population was phased out entirely on December 31, 2023, eliminating disparities in benefit packages by parental status.

The research question is: Was the wind-down process implemented efficiently and effectively? The assessment data sources are:

Key Informant Interviews (KIIs) with 2-3 State agency staff

MRT Demonstration Quarterly Monitoring Reports

High-level topics for the KIIs include operational challenges and successes, strategies implemented to overcome barriers, and overall lessons learned throughout the wind-down process.

Cost Assessments

A Demonstration cost assessment will be conducted. The IE will use the cost analyses in concert with findings from hypothesis tests to assess the demonstration’s effects on the fiscal sustainability of the State’s Medicaid program.

The IE will conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

For the HRSN Demonstration, the IE will conduct a cost analysis to support developing comprehensive and accurate cost estimates of providing such services.

Table 3: Description of Cost Assessments

Cost Assessment	Description
Medicaid Reform Demonstration	Administrative costs, health service expenditures, uncompensated care Exclude JIR costs, exclude HRSN costs
Justice-Involved Reentry	Administrative costs, health service expenditures Estimates of cost saved through reduced ED visits & hospital admissions
Health-Related Social Needs	Costs associated with potentially preventable high-acuity health care Administrative costs, health service expenditures Infrastructure investments

The cost assessments will rely on administrative data, the specific measures and data sources are provided in Table 4.

Table 4: Cost Assessment Measures & Data Sources

Measure	Data Source
Administrative Costs of the Demonstration Report for JIR, HRSN, all other Total and per beneficiary per month PMPM growth rate	Form CMS-64
Medicaid Health Service Expenditures Report for JIR, HRSN, all other Total and per beneficiary per month PMPM growth rate Report by type of service, identify cost drivers, where possible	Form CMS-64, Medicaid claims data
Demonstration Costs: sum of administrative & services Report for JIR, HRSN, all other	Form CMS-64, Medicaid claims data

Total and per beneficiary per month PMPM growth rate	
HRSN Infrastructure Costs	Form CMS-64, Annual Monitoring Reports
Provider Uncompensated Care Costs	CMS-HCRIS, NASHP HCT

C. Methodology

1. Evaluation Approach

The Independent Evaluator (IE) will use a mixed-methods evaluation approach that will combine administrative and survey data as well as qualitative data to address the goals and hypotheses presented in the Demonstration application and answer all research questions listed above.

The evaluation will employ multiple comparison strategies, both in-state and out-of-state. Interrupted Time Series (ITS) is the preferred approach to analyze the impact of the Demonstration by comparing trends during the pre-demonstration period to the Demonstration period. ITS will be the approach in all instances for which there is sufficient pre-demonstration data available. When pre-demonstration data is not available the evaluation will rely on descriptive statistics and trends over time To assess the impact of UMIC plans, regression analysis will compare members in three plan types – fee for service, physical health-only ACO, and UMIC.

Results will be stratified by demographic characteristics SMI/SUD status, and plan type, when sufficient numbers are available to permit comparisons. A summary of the characteristics of the Demonstration populations as of the end of the previous waiver period (June 30, 2022) is provided in Table 13 in the Subgroup Analyses section.

Comparisons to Medicaid beneficiaries in other states also provide valuable context. A difference-in-difference (DiD) comparison, and a synthetic control method (SCM), will be used to compare the impact of the Demonstration as a whole on the aggregate Medicaid population to Medicaid beneficiaries in other states. Out-of-state comparisons will address the research question “Did the Demonstration as a whole improve health care access and quality for the Medicaid beneficiary population?”

Member perspectives will be collected through a customized member survey, and through interviews of members receiving HRSS and pre-release and reentry services. Where a survey provides a broader and more representative sample, individual interviews allow for in-depth understanding of member experiences. Additional qualitative data will be collected through key informant interviews with stakeholders. Together, these complementary methods will enable a comprehensive evaluation of the Demonstration.

2. Target and Comparison Populations

As summarized in Table 1, the Demonstration provides coverage and services for multiple populations. Out-of-state comparison using national survey data and other publicly available data sources will be used for investigating the impact of the Demonstration as a whole on the full Medicaid eligible population. For specific populations, the comparison will be to pre-Demonstration trends. For UMIC plans, the comparison will be to other plan types without integrated BH services. The Demonstration populations (the target groups) and the approach to comparisons are shown below in Table 5.

Table 5: Demonstration Populations, Benefits, and Comparisons

Demonstration (target) Population	Program Implementation Start	Baseline Years	Comparison[1]	Analytic Approach
Substance Use Disorder (SUD) IMD	November 9, 2017	November 1, 2017 - June 30, 2022	Pre-SUD demonstration baseline	Trend over time, Interrupted Time Series
Targeted Adult Medicaid (TAM)	November 1, 2017	November 1, 2017 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Adult Expansion Population	April 1, 2019 (partial expansion, up to 100% of the FPL) January 1, 2020 full expansion	July 1, 2018-June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Utah Medicaid Integrated Care (UMIC- subset of the Adult Expansion Population)	January 1, 2020	N/A	Three plan types: FFS, ACO, UMIC	Multiple Linear Regression
Serious Mental Illness (SMI) IMD	December 1, 2020	December 1, 2020 - June 30, 2022	Pre-demonstration baseline	Trend over time, Interrupted Time Series
Expanded Dental Benefit	January 13, 2025	January 1 2020 – December 31, 2024	Pre-Dental demonstration baseline	Interrupted Time Series
Health-related Social Needs Services	July 1, 2025	July 1, 2020—June 30, 2025	Pre-HRSN demonstration baseline	Longitudinal cohort design with pre-HRSN demonstration baseline, if available
Justice-Involved Adults	February 1, 2026	February 1, 2022-January 31, 2026	Pre-demonstration comparison baseline	Trend over time, Interrupted Time Series

[1] The term "pre-demonstration baseline" refers to the time period before the start of the current Demonstration period; before July 1, 2022. The term "pre-demonstration comparison baseline" refers to individuals who were incarcerated in Utah county jails or state prisons whose Medicaid status was paused due to incarceration.

Justice-Involved Reentry Comparison Group

To analyze outcomes for the Justice-Involved Adults, the IE plans to construct a historical, pre-demonstration comparison group comprised of individuals who were incarcerated in Utah county jails or state prisons before the implementation of the Justice-Involved Reentry benefit. Utah DHHS will provide Medicaid claims data for the pre-demonstration comparison group through the standardized claims-data transfer process. Utah DHHS can identify individuals for this population who have a suspension status due to incarceration for their Medicaid eligibility, and were assigned the “incarcerated benefit” during their incarceration, but are unable to identify specific carceral facilities. The accurate identification of this group relies on the historical assignment of the “incarcerated benefit”. All adults released from incarceration in Utah during the pre-demonstration baseline period, identified by a lift of Medicaid suspension status due to incarceration, will be included in the comparison group. There are no other criteria for inclusion in the comparison group. The IE has established a data use agreement between the IE, Utah DHHS, and the Utah Office of Vital Records and Statistics (OVRS) to provide vital statistics data. Appropriate identifiers will be used, including name, date of birth, social security number, and a unique client identifier to link vital statistics data with Medicaid data for the pre-demonstration comparison group.

Several demonstration populations are too small to feasibly conduct a comparison to a baseline period. The analytic approaches for these demonstration populations are primarily trend over time and descriptive statistics.

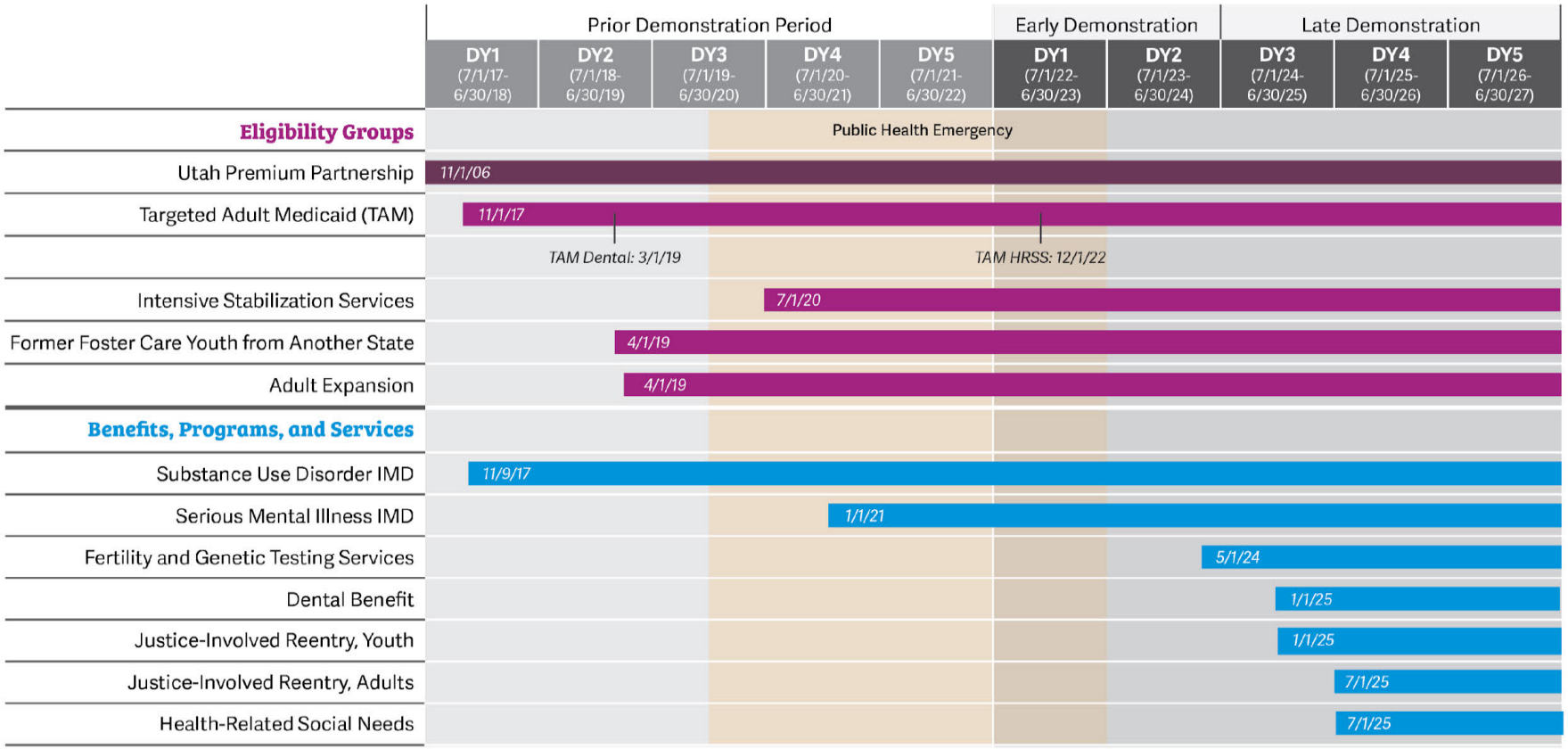
Table 6: Small Demonstration Populations

Demonstration (target) Population	Program Implementation Start	Analytic Approach
Utah Premium Partnership Program (UPP)	November 1, 2006	Trend over time, descriptive statistics
TAM Dental	March 1, 2019	Trend over time, descriptive statistics
Former Foster Care Youth from Another State (FFCYAS)	March 1, 2019	Counts (small population size)
Intensive Stabilization Services (ISS)	July 1, 2020	Counts (small population size)
TAM members receiving Housing Related Services and Supports (HRSS)	December 1, 2022	Trend over time, descriptive statistics, qualitative interviews and analysis
Fertility and Genetic Testing Services	May 1, 2024	Counts (small population size)
Justice-Involved Youth	January 1, 2025	Counts (small population size)

3. Evaluation Period

This evaluation will cover the five-year Demonstration period from July 1, 2022, through June 30, 2027. The pre-Demonstration baseline will be the previous waiver period from July 1, 2017- June 30, 2022. The IE acknowledges that many policies authorized under this waiver are continuations of policies implemented in previous waiver periods. The goal of this evaluation is to quantify any gains realized in the current waiver period. As a result, the baseline period for each analysis will be specific to program start dates listed in Table 5. Please see Figure 2 below for more information. Sensitivity analysis will be conducted to determine whether excluding part of 2020 due to the Covid-19 PHE is appropriate.

FIGURE 2: ELIGIBILITY GROUPS AND SERVICES TIMELINE



*The planned implementation start date for the Justice-Involved Reentry benefit for adults has been extended from July 1, 2025 to February 1, 2026. This image will be updated when the JIR benefit for adults has launched.

4. Evaluation Measures

Evaluation hypotheses and corresponding measures are listed in Section F.4., Evaluation Tables.

5. Data Sources

The evaluation will use the following quantitative and qualitative data sources:

National Surveys and Other Publicly Available Data Sources:

Behavioral Risk Factor Surveillance System (BRFSS)

National Survey of Drug Use and Health (NSDUH)

National Academy for State Health Policy's (NASHP) Hospital Cost Tool (HCT)

Utah Specific Data Sources:

Medicaid Administrative Data

Eligibility & enrollment

Claims

Cost (Form CMS-64)

Carceral Facility Administrative Data

Justice-Involved Correctional Facility Readiness Assessment

Vital Statistics

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey

Custom member survey

Participant interviews with TAM members receiving HRSS, JIR beneficiaries, and HRSN service recipients

Key Informant Interviews (KIIs)

National Surveys and Other Publicly Available Data Sources

Measures employing national survey data and other publicly available data sources for an out-of-state comparison will use a three-year pre-Demonstration baseline.

BRFSS

The BRFSS is a large, high-quality federal survey that may be used to measure outcomes of interest for out-of-state comparison groups. Importantly, the BRFSS contains respondents' state identifiers and demographic variables needed for comparison purposes. The IE will use the BRFSS data to address research questions related to coverage and access to care among low-income residents (Table 8).

The BRFSS insurance coverage question outcome does not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance) for years prior to 2022. In order to approximate which respondents are Medicaid eligible and who fall below 138 percent of the FPL, a continuous value for household income will be imputed using the midpoint of BRFSS income category. Using imputed

income with household size allows the ability to link to annual thresholds for 138 percent FPL in each state. This method will be employed for the years prior to 2022 only.

The IE has also conducted power analysis for using the BRFSS. Our analyses will have high statistical power due to the large sample sizes involved. We estimated the minimum detectable effect sizes for each of our outcomes using Hu & Hoover's (2018) power equation for non-randomized longitudinal difference-in-difference studies:

$$MDES = \frac{T(1-\rho)\sigma}{bkn} \times \left(z_{1-\frac{\alpha}{2}} + z_{1-\beta}\right)^2$$

Where:

MDES = the minimum detectable effect size, defined as a percentage point change in outcome

T = the total number of time periods

b = the number of pre-intervention periods

k = the number of post-intervention periods

n = sample size

σ = standard deviation

ρ = serial correlation

$z_{1-\frac{\alpha}{2}}$ = The critical z-value for statistical significance

$z_{1-\beta}$ = desired statistical power

The final analysis will include 5 pre-intervention years and three post-intervention years. We used BRFSS data to identify serial correlations, standard deviations, and sample sizes for each study outcome. Serial correlation is the relationship between state-level means in consecutive years. We then calculated minimum detectable effect sizes (MDES) at 80% power and α=0.05. The MDES ranges from 0.41% to 0.58% for our access outcomes. For preventive service outcomes, the MDES ranges from 0.54% (receipt of annual checkup) to 2.29% (receipt of HPV test in the past 12 months). The sexual and reproductive health questions are only asked of female respondents in even years, which limits our ability to detect smaller effects.

Table 7: Minimum Detectable Effect Sizes

Outcome	Serial correlation	Standard deviation	Sample size	MDES
Insurance Coverage	0.891	0.478	116,482	0.41
Having a personal doctor	0.840	0.488	116,893	0.48
Avoided care due to cost	0.796	0.460	117,000	0.58
Receipt of annual checkup	0.809	0.482	115,376	0.54
Receipt of mammogram in past 12 months	0.758	0.430	26,814	1.41

Notes: SD = Standard deviation. MDES = Minimum detectable effect size (percentage point change) at 80% for a difference-in-differences analysis with α=0.05.

NSDUH

To investigate the SUD and SMI waiver impact, the IE will use the NSDUH public use dataset. NSDUH collects data annually on incidence and treatment of mental health and substance use conditions. Key NSDUH questions address whether individuals have experienced BH conditions, and whether they have

received treatment. The NSDUH public use dataset does not contain enough information to conduct a power analysis.

NASHP HCT

To investigate the Demonstration's impact on uncompensated care costs, the IIE will use the NASHP HCT. The HCT provides a range of measures for hospital revenue, costs, profitability, and break-even points across over 4,600 hospitals nationwide. The underlying dataset includes variables extracted and calculated from the national Healthcare Cost Report Information System (HCRIS).

Table 8: National Surveys and Other Publicly Available Data

Survey	Topic	Survey Questions
BRFSS	Health Risk Factors	Insurance Coverage Having a personal doctor Avoided care due to cost Receipt of annual checkup Receipt of mammogram in past 12 months
NSDUH	BH Needs and Services	Received treatment for SUD in the last 12 months Received treatment for mental health condition in the last 12 months Needed, but did not receive, treatment for BH condition
NASHP Hospital Cost Tool	Uncompensated Care Cost	Uncompensated care/bad debt as a percentage of net patient revenue, and as a percentage of operating expenditures

Medicaid Administrative Data

The IE anticipates receiving claims and other Medicaid administrative data, such as eligibility files, from the state on an annual basis. Administrative data is expected to be of high quality, in terms of completeness and accuracy.

The IE anticipates having access to aggregate CAHPS data collected by the health plans and reported to DHHS. Health plans are able to distinguish between ACO and UMIC plan enrollment in CAHPS data and report this information to the state. This data will allow for comparisons of plan types.

CAHPS data will also be used to analyze differences in access to care coordination and patient satisfaction between subgroups. Because CAHPS data will be available only in aggregate, subgroup analysis will be limited to the available demographic stratifications: age, race (White and Other), ethnicity (Hispanic/ Not Hispanic), and gender.

Correctional Facility Readiness Assessment and Carceral Facility Administrative Data

The state developed a Correctional Facility Readiness Assessment tool that is administered to each participating carceral facility prior to their implementation of the JIR benefit. The Readiness Assessment is a 37 item REDCap survey completed by an appropriate representative of each carceral facility. It captures information about facilities' existing operations and procedures (including screening for Medicaid enrollment, use of data sharing agreements, use of case management services, and provision of specific health services covered under the JIR benefit) and their plans for standing up the needed systems to support the JIR benefit.

The IE anticipates utilizing the results of the Correctional Facility Readiness Assessment to assess the pre-release services and operational capabilities of participating facilities prior to implementation of the Demonstration. This is important context for understanding the successes and challenges of Demonstration implementation.

Carceral facility administrative data refers to data elements that are pertinent to the evaluation of the Demonstration that are not captured in Medicaid administrative data. These data elements will be collected by the carceral facilities, and will be included in a Data Use Agreement developed between the carceral facilities, DHHS, and the IE. These data elements include information on date of incarceration, Medicaid eligibility screening and application support, care planning, 30 day supply of Rx Medication upon release, and provision of health or social service referrals pre-release.

The JIR evaluation design is being prepared in parallel with the JIR implementation planning process, which includes establishing an electronic interface between carceral facilities and Medicaid systems to enable more "real-time" eligibility and enrollment data to be exchanged. In addition, Medicaid is working closely with the participating carceral facilities to establish data collection tools, processes, and workflows. The data needs for the evaluation were shared with the implementation team.

Custom member survey

The member survey will be administered once during the Demonstration period to a sample of approximately 6,000 adult Medicaid members who received a mental health diagnosis or service in the past 6 months. The mental health selection criteria is needed because a section of the survey is about access to mental health care. Examples of survey topics are summarized below in Table 9.

Table 9: Member Survey Topics

Focus Area	Example topics
Access to Care	Able to obtain care in a timely manner Ease of obtaining BH services Barriers to accessing care
Patient-centered care	Satisfaction with amount of time doctor spent Doctor explains in a way you can understand
Coordination of care	Primary care doctor has information needed about specialty care received

Survey Design

The IE will design the survey to assess the impact of the Demonstration on members' access to and engagement in health care. The survey will cover key topic areas related to members' recent history of health care coverage, access to health care (whether they have a primary care provider, if they have seen a specialist when needed, the regularity with which they obtain preventive care, etc.), and experience with care coordination. Being mindful of respondent burden, the IE aims for the survey length to not exceed 12 minutes when administered by phone.

Sample Frame Development and Sampling

The IE will work with DHHS to obtain the necessary member data, from which the IE will select a sample of members to survey. The sample will be comprised of 4,000 members. Assuming an approximately 35% response rate, we expect n=1,400 completed surveys (expected confidence interval of +/-2.54 at the 95% confidence level). To ensure that the sample accurately reflects the member population, the IE will conduct implicit random sampling using the appropriate variables available in the Pathways member database, such as gender, age, race/ethnicity, income, and length of enrollment in the program.

Assuming equal propensity for non-response between subgroups, we expect that this sample size will allow for reliable estimates for some subgroups of interest within a margin of error of +/- 5 percentage points, including by age group (individuals aged 19-26 years, aged 27-44 years, and aged 45-64 years), sex, and some racial and ethnic groups (Asian, White, Hispanic, Black, American Indian/Alaska Native and individuals of multiple races).

The ability to detect a significant difference between two groups is in part dependent on the measured prevalence of an outcome, and it will vary for each variable captured in the survey. Generally, if the prevalence of an outcome is around 50% in one group, this study is powered to detect a difference of 6.7 to 15.7 percentage points between respondents of different age groups, genders and racial and ethnic groups, with probability (power) of 80% at the 95% confidence level. If the prevalence of an outcome is very rare or very common (e.g., prevalence of 5% or 95%), this study is powered to detect smaller differences of 2.5 to 9.4 percentage points.

Survey Preparation

To maximize response rates, the IE will prepare the survey for three modes of data collection – mail, online (via smartphone/tablet device/PC), and phone. Each version will be thoroughly tested for quality control. The survey will also be translated into Spanish for interviewing respondents whose preferred language may be Spanish. Additional languages may be added if a need is identified.

Survey Administration

The IE will send the survey by mail to all members in the selected sample together with a cover letter (which will include an online link to the survey), and postage paid business reply envelope. For beneficiaries for whom email addresses are available, we will also send an email invitation with a link to the survey, followed by weekly reminder emails. After 21 days from the mailing, the IE will begin phone follow-up to non-respondents to administer the survey over the phone. To maximize response rates, the IE will make up to five phone attempts to each non-respondent at different times of day and during different days of the week including weekdays and weekends.

Data Analysis and Reporting

The IE will apply weights to the survey data to ensure that the weighted distribution of survey respondents accurately reflects the distribution of the member population on key population metrics, including gender, age, race/ethnicity, income, and length of enrollment in the program. Analysis of the survey data will focus on understanding members' access to health care, availability of employer-sponsored health insurance, and plans to transition to commercial health insurance. The IE will include analysis by key subgroups of interest, such as gender, age, and race/ethnicity.

Participant interviews with members receiving HRSS and/or pre-release and reentry services

Participant interviews will provide a necessary understanding of the experience of members receiving HRSS as well as pre-release and reentry services, including facilitators and barriers impacting the key outcome measures. The IE anticipates that the HRSS and JI populations will overlap, and interviews will be tailored to the experience and services received by members. The IE will conduct phone interviews to directly capture the input of participants, with privacy protections in accordance with CMS guidelines. Two waves of interviews will be conducted, with approximately 75-80 individuals in each wave (based on projected enrollment of approximately 56000 individuals) or until thematic saturation is reached for each subgroup. For this component of the evaluation, the IE is partnering with Dr. Palmira Santos, a doctoral-level social worker and researcher with expertise in interviewing individuals experiencing housing insecurity, BH conditions, and justice-involvement. Dr. Santos will lead the development of the interview guides, conduct interviews, and analyze results.

Potential interviewees will be invited to participate by their case managers, who will explain that the purpose of the evaluation is to improve the program and ask for permission to release their phone number. If an individual chooses to participate, the interviewer will receive only a first name (or chosen alias) and phone number for each participant. When a participant is reached by phone the interviewer will explain the evaluation and seek informed consent before beginning the interview.

Interviewees will be given a gift card as a thank-you, in a small amount for a store that does not sell alcohol or cigarettes.

Table 10: Participant Interview Topics

Interview Question	Example topics
How do participants' interaction with care managers happen? In what ways is it helpful, or not helpful?	Outreach approach, engagement, and follow through. Understanding of participant needs and perspective – whether care manager took steps to assist or explained limitations of service
What role did the HRSS case manager have in participants' housing situation?	Addressing specific patient needs, timeliness, role of other housing liaisons
What factors enhance or inhibit participants' engagement in behavioral health care?	Factors (barriers/facilitators) to access, coordination, continuity, and outcome
Are participants experiencing unmet needs for health care, including SUD and SMI treatment?	Participation in behavioral and physical health services and support. Use of the ED and hospitalizations (avoidable and/or BH related) – perspective on alternatives. Participation in preventive, acute and chronic condition services
Do participants perceive their life circumstances have changed since receiving HRSS services?	Previous and current life (SDOH, family, work etc.) situation
Did participants receive services in the pre-release period that met their needs? Was there enough time to get the screening and services you needed prior to release? And did such services result in stable physical and behavioral health upon release?	Access to and quality of pre-release services (case management, behavioral health care, diagnostic services, family planning services). Perceptions of stigma associated with care.
Were participants' post-release transitions to care needs adequately met by the pre-release services?	Access to care and medications, continuity of coverage, care, medication, and providers.

NOTE: Participants interviewed include TAM members receiving HRSS, JIR beneficiaries, and HRSN service recipients

Key Informant Interviews

Qualitative data on program implementation will be gathered through key informant interviews (KIIs) with providers and state administrators. A total of 30-35 -30 KIIs are planned; three at each of the four health plans, five state employees participating in implementation, at least three community-based providers, case managers supporting HRSS and JIR, and carceral-setting administrators.

In addition to the administrative contacts from the ACOs and MCOs, the IE will interview at least three community-based providers, such as primary care providers and behavioral health clinicians, who directly serve Medicaid patients at sites such as community health centers, in order to capture the perspective of

front-line clinicians working through the UMIC Demonstration. These providers will be asked about topics including integration of behavioral health care, barriers to access, and their perceptions of patients' engagement in care.

Because HRSS and JIR are new components of the Demonstration, interviews with case managers will provide essential insights into the challenges and successes during implementation. Case managers will be asked about topics including their observations regarding communication with members and providers, ways in which HRSS and JIR services are effective or not, and promising practices in care coordination for a population with housing instability and/or justice-involvement.

Semi-structured key informant interviews lasting 30-45 minutes per contact will be conducted by phone or videoconference, with privacy protections in accordance with CMS guidelines. Interviews will be recorded and transcribed. The IE will develop Interview guides in collaboration with DHHS for providers, health plans, and for state administrators involved in implementation of the Demonstration. The interview guide and questions will be tailored to the interviewee role. For example, state administrators will be invited to discuss the program rollout and feedback received from plans, health plan representatives will be asked about the plan's approach to integrating BH services, and questions regarding telehealth experiences will be directed towards clinicians.

As appropriate, interviews will explore successes and challenges with regard to program implementation, and other topics drawn from the logic model; examples are shown in Table7.[39] Interview guides will include questions that address disparities and health equity as appropriate for the interviewee's role. This may include population health analysis strategies, language services, and targeted outreach programs.

Table 11: Topics for Key Informant Interviews

Interview Question	Example topics
Was the Demonstration implemented effectively? Could the pre-release services provided under the JIR benefit have been effectively implemented in a shorter time period? Why or why not?	Perceived successes and challenges in implementation Care integration with behavioral health Perceived steps towards integrating behavioral health with physical health services, e.g., screening and referrals Perceptions about the role of telehealth in achieving Demonstration goals
Was cross-system coordination effective?	Experiences with communication and data sharing between the carceral settings, Medicaid, and community-based services/health care
To what extent are BH services integrated with physical health services?	Screening and referrals Care coordination for members with BH conditions Sharing of patient data across practices Access to MAT pre-release and post-release
Did enrollment or outcomes differ by demographic factors?	Perceptions of barriers to access and participation in care

[39] KIIs will cover topics relevant to the evaluation of the Adult Expansion and ESI components of the Demonstration as well; these are covered in separate evaluation designs.

	Steps health plans/providers are taking to identify, understand, and address disparities in access and engagement
Was continuity of coverage and care improved by the Demonstration?	Medicaid enrollment or redetermination navigation support for justice-involved population Access to care pre-release in the carceral setting

6. Analytic Methods

Quantitative Analyses

The evaluation design includes multiple analytic strategies to answer the research questions and provide robust conclusions. The proposed approach is to use quasi-experimental analyses, employing descriptive statistics, trends over time, interrupted time-series analysis (ITS), regression, difference-in-differences (DiD), and synthetic control methods (SCM) Quasi-experimental analyses will be conducted where data is available. Multivariate regression will be used to model outcomes over time, following individuals longitudinally. This approach allows for the trend over time to be adjusted for changes in the Demonstration populations as members enter and leave the Populations. For example, for Hypotheses 4, 5, and 6, interrupted time series will be used where data is available over the time period of interest.

For smaller Demonstration populations and small subgroups where regression analysis is not feasible, the evaluation will focus on trends over time. For example, Hypothesis 6 focuses on the smaller demonstration populations; most research questions for this hypothesis will be addressed with descriptive statistics, such as service counts and cost over time.

The specific analytic method for each research question is provided in section F.4 Evaluation Tables.

Table 12: Summary of Analytic Tactics to be Used for Evaluation

Method	Comparison	Data sources
Subgroup comparison	Demonstration participants stratified by demographic and health factors	Encounter data, Administrative data
Event study/ time series	Trend during Demonstration vs baseline	Encounter data, Administrative data
Difference in difference; Synthetic Control Methods	Pre/Post change in Utah vs Pre/Post change in other states; predicted outcomes for 'synthetic UT'	National surveys and other public data sources

Descriptive statistics

The evaluation will provide summary tables of population size and characteristics, and outcomes for the three groups of Demonstration participants. Data will be analyzed using standard tests as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode). These tables will be used to develop a quantitative picture of the population, to describe raw trends, and to identify characteristics that will be included as covariates in regression modeling.

Prior to performing regression analysis of the plan types within AE, the composition of the beneficiary population in the three groups (FFS, ACO, and UMIC) will be compared to identify differences in demographic or clinical characteristics. ANOVA/MANOVA tests will be used as a first pass comparison of mean outcomes for the three groups. For metrics derived from BRFSS survey data, results for Utah will be compared to national averages for each year.

Trend over time and linear regression modeling

Outcomes of interest will be plotted over time for the duration of the Demonstration. The trend for each evaluation group will be modeled using multivariate linear regression and compared. The null hypothesis will be that the groups have identical trends. In order to account for demographic characteristics such as age and gender that may differ among groups, the IE will use inverse probability of treatment weighting. Individuals in intervention groups will be assigned weights based on the composition of the reference group, producing groups that are equivalent for measurable characteristics and allowing any difference in outcomes to be attributed to the intervention.[40]

For the measures with binary outcomes the models will be logistic; Poisson models will be used for count-based outcomes. The mixed effects logistic regression model accommodates for both fixed and random effects. In this case, it allows for the fact that members can appear multiple times in the datasets and that they can appear different numbers of times resulting in unbalanced data. The models will include the 'client id' variable as a random effect. The outcome variable will be the binary or count outcome. To assess changes over time for each population, a fixed effect for measurement year and population will be included in addition to an interaction term between them. Measurement year will be included as a continuous variable after plotting raw trends to assess linearity. Adjusted models will include the covariates gender, race/ethnicity, age as a continuous variable, region, and SMI/SUD diagnosis group, as appropriate. Additional covariates will be considered for analyses specific to the JIR benefit, such as facility type. The post-release address of the JIR beneficiary may impact access to care outcomes and will be considered as a covariate. When adjustment variables besides age, gender and race are not statistically significantly associated (p <0.05) the IE will proceed with a stepwise selection to reduce the number of covariates in the model. The IE will also run stratified mixed models by gender, age group and race/ethnicity with the same adjustment procedures, if subgroup size is adequate. Models are described in the following formulas.

Mixed logistic regression model

$$logit(Y = 1_{ij}) = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i}$$

Mixed Poisson regression model

$$log\ log\ (Y)_{ij} = \beta_0 + \beta_1 Pop_i + \beta_2 MY_{ij} + \beta_3 MY_{ij} * Pop_i + \beta_x X_i + \gamma_{0i} + ln\ (offset)$$

Where Y corresponds to outcome of interest with a different expression depending on its distribution, β_0 to the overall intercept of the model, $\beta_1 Pop_i$ to the effect of belonging to a certain population group compared to a reference group, $\beta_2 MY_{ij}$ to the effect of measurement year as a continuous variable, $\beta_3 MY_{ij} * Pop_i$ is the interaction effect between population and measurement year which allows us to estimate change over time between populations, $\beta_x X_i$ corresponds to individual level adjustment covariates, and γ_{0i} corresponds to the random intercept of each client to account for the clustering effect of appearing in more than one measurement year. In the case of Poisson models, the model includes an offset, for EDU corresponding the total number of clients and for IPU to the total member-months.

[40] Austin PC, Stuart EA. Moving towards best practice when using inverse probability of treatment weighting (IPTW) using the propensity score to estimate causal treatment effects in observational studies. Stat Med. 2015; 34(28):3661–79. Epub 2015/08/05. https://doi.org/10.1002/sim.6607 PMID: 26238958; PubMed Central PMCID: PMC4626409.

Difference-in-difference

To examine the impact of the demonstration on its overarching aim of improved access, PCG will conduct a difference-in-difference (DiD) analysis to model the effect of the demonstration in Utah relative to comparison states. The comparison states are those states not exposed to the treatment of interest – in this case, all other states that either (1) have not expanded Medicaid, or (2) expanded Medicaid before the pre-intervention period (July 1st 2017 – June 30th 2022) The parallel trends assumption will be tested over the five years before the demonstration period. Sensitivity analysis will be conducted to determine whether the PHE influences the baseline or the parallel trends assumption.

The DiD model equation is:

$$Y_{its} = \alpha_s + \beta_t + \beta_2 Expansion_s + \beta_3 Post_t + \beta_4 Intervention_s \times Post_t + \delta X_{it} + \varepsilon_{ist}$$

Where:

Y_{its} = Our outcome(s) of interest
α_s = A vector of state fixed effects
β_t = A vector month and year fixed effects
$Intervention_s$ = A binary indicator for residence in our treated state (Utah)
$Post_t$ = A binary indicator for whether the outcome occurred during the demonstration period
δX_{it} = A vector of observed individual-level characteristics

Covariates will include respondent age, education, employment status, household size, veteran status, sex, household income, homeownership status, presence of children in the household, survey month, and whether the survey was conducted via landline or cell phone. The regression coefficient β_4 thus represents our regression-adjusted estimates of changes in outcomes associated with Utah's Medicaid expansion, after controlling for state, month, year, and observed covariates.

Synthetic control method

In addition to the DiD approach, the IE will use synthetic control methods (SCM) to estimate the association between implementation of the Demonstration and study outcomes. SCM have been employed to evaluate state-level policy impacts because they are particularly useful when estimating the impact of a policy change that affects a small number of treatment groups (i.e., a state).[41,42,43,44] These methods are a quasi-experimental approach similar to traditional difference-in-difference (DID) estimation but require fewer assumptions to obtain estimates of association. DID assumes that any differential changes in outcomes between treated and control groups are attributable to the policy change. Yet treated and control groups are often nonequivalent in terms of pre-treatment outcome levels, trends in outcomes, and other important covariates. To mitigate this limitation, researchers typically attempt to control for observed variables that may be associated with both treatment likelihood and the outcome of interest. However, treatment and control groups may still differ in terms of outcome pre-trends and levels due to unobserved factors. This introduces potential selection issues, which may bias any estimates of association.

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[41] Abadie, A., 2012. *Synthetic control methods for comparative case studies: estimating the effect of California's tobacco control program. J Am Stat Assoc* 105(490):493-505. https://www.tandfonline.com/doi/abs/10.1198/jasa.2009.ap08746

[42] Rudolph, K.E., *et al.*, 2015. *Association between Connecticut's Permit-ti-Purchase handgun law and homicides. Am J Public Health* 105(8):e49-e54. https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302703

[43] Santella-Tenorio, J. *et al*., 2020. *Association of recreational cannabis laws in Colorado and Washington state with changes in traffic fatalities. JAMA* 180 (8):1061-1068. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2767647

[44] Bhatt, A. *et al.* 2020. *Association of changes in Missouri firearm laws with adolescent and young adult suicides by firearms. JAMA Netw Open* 3(11). https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772526

In contrast, SCM constructs a synthetic control. The synthetic control is constructed using a weighted average of the states included, with weights determined through a fully empirical process; weights for individual control units may range from 0 to 1 and are assigned so the synthetic control is as similar as possible to the treated group in terms of outcome pre-trends. Unlike traditional regression, inclusion of covariates is not required to achieve equivalence between treated and control groups.

Public Health Emergency; Sensitivity Analysis

The pre-Demonstration baseline period to be used for all quasi-experimental methods includes the period where the Covid-19 pandemic had a profound impact on health care utilization. First, trends for UT and controls will be modeled with and without the most affected months in 2020 and 2021. This sensitivity analysis will help to identify whether the groups have been impacted differentially. If the pattern changes observed in the first quarter of the Public Health Emergency are similar for all evaluation groups, then confounding of the results by pandemic impacts is less likely. The most affected quarters may be omitted from the baseline depending on the results.

Subgroup Analyses

The evaluation will seek to understand how different subgroups of participants are impacted by the Demonstration. Analyses will partition participants by gender, race/ethnicity, age, and SMI/ SUD diagnosis status. Where possible, race will include White, Black, Asian, Latinx, and Native American populations and Ethnicity will be characterized as Hispanic/Not Hispanic. Due to the low prevalence of some subgroups, it may be necessary to combine racial and ethnic groups for purposes of stratification. As seen in Table 13 below, 45% of race/ethnicity data gathered during the previous waiver period was missing. It is unlikely the evaluation will be able to identify racial/ethnic disparities in outcomes due to the high amount of missing data unless there is substantial improvement in the availability of this data. While data on region is available (urban, rural, frontier), the state does not plan to conduct subgroup analyses by geographic location because the geography variable is confounded with Plan Type. Specifically, Adult Expansion members in 5 counties *must* enroll in the UMIC plans with integrated physical and behavioral health benefits. In 8 other counties, Adult Expansion *must* enroll in an ACO and a Prepaid Mental Health Plan. In the remaining counties of the state, members may enroll in an ACO or stay with FFS.

Analyses of the JIR benefit will be stratified by adult versus juvenile facility and by facility type (prison vs jail), as feasible. In Utah, there are 26 jails, two prisons, and nine juvenile detention centers. The IE's ability to stratify analyses by facility type will depend on facility-level participation in implementing the JIR benefit during the course of the demonstration period. Analyses will also be stratified by beneficiary demographic characteristics such as gender, age, SMI/SUD diagnosis, and length of incarceration as feasible.

Table 13: Previous Waiver Demonstration Period; Population Characteristics

Demographic / Health Characteristic		Adult Expansion (N= 92,026)	Targeted Adult Medicaid (N=9,582)
Gender	Male	44,703 (48.6%)	7,223 (75.4%)
	Female	47,323 (51.4%)	2,359 (24.6%)
Age	19-44	62,781 (68.2%)	6,948 (72.5%)
	45-54	15,821 (17.2%)	1,791 (18.7%)
	55-64	13,424 (14.6%)	843 (8.8%)
Race/ethnicity	Other/Missing	41,772 (45.4%)	3,840 (40.1%)

	White (non-Hispanic)	14,963 (16.3%)	1,634 (17.1%)
	Hispanic, Black, AIAN, Pacific Islander	35,291 (38.3%)	4,108 (42.9%)
SMI/SUD Diagnosis	None	66,539 (72.3%)	1,781 (18.6%)
	SMI Only	3,155 (3.4%)	171 (1.8%)
	SUD Only	16,658 (18.1%)	5,652 (59.0%)
	Both SMI/SUD	5,674 (6.2%)	1,978 (20.6%)

NOTE: The characteristics shown above represent every person ever enrolled during the previous waiver demonstration period (7/1/2017--6/30/2022), as of their last appearance in the claims data.

Cost Analyses for SUD and SMI Demonstrations

The analytic methods for the SUD Demonstration cost analysis are detailed below. *The same approach will be taken for the SMI Demonstration.* The only difference is the target group and the dates of the pre-demonstration baseline periods (outlined in Table 5).

SUD demonstration target group beneficiaries will be identified based on claims and encounters with an SUD diagnosis and/or procedure code. Pharmacy claims and encounters with a dispensed drug for Medication Assisted Treatment (MAT) will also be used to identify the population of interest. Once a beneficiary has been identified, they will remain in the population of interest until 11 months pass without another qualifying SUD claim or encounter.

There will be three levels of cost analyses:

Total Cost of Care = Total Medicaid Costs (claims and managed care capitation payments) + federal costs (Total Medicaid Costs * the Utah specific Federal Financial Participation rate)

Costs related to the diagnosis and treatment of SUD = SUD-IMD costs + other SUD costs + non-SUD costs

Source of care cost drivers = inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care

The Total Cost of Care will not include administrative costs, as the State does not currently track administrative costs specific to these demonstrations. Given the large number of waivers and amendments in Utah, it is not possible to estimate administrative costs separately.

Within each of the three levels, the results will be stratified by: SUD diagnosis only; SMI/SUD dual diagnosis. Given the lack of a comparison group, an interrupted time series model will be used to estimate the linear effects of the SUD demonstration. The IE will conduct both a logit model for estimating zero-cost months and a generalized linear model [GLM] for estimating non-zero cost months. The GLM model will use log costs to account for costs that are not normally distributed.

Qualitative analysis

Qualitative analysis will be used for participant and key informant interview transcripts. The research questions to be addressed, with corresponding example topics, are listed in Tables 18, 22, 23, 24, and 25 (Attachment 4). Interviews will address these questions by probing for perspectives from providers and from administrators involved in implementing the Demonstration. Thematic analysis using a coding tree derived from the Demonstration logic model will be used to excerpt transcripts. Additional themes that arise during coding will be added to the analysis. Results of provider interviews will be used to add context to the quantitative findings regarding experience of care, beneficiary engagement, and barriers to engagement. Results of provider and administrator interviews will address implementation and will inform the Evaluation Report chapter on Lessons Learned and Recommendations.

D. Methodological Limitations

Lack of a true comparison group. The Demonstration is implemented statewide, making a perfect comparison group impossible. To mitigate this limitation, the IE plans to use both in-state comparison among benefit groups, and out-of-state comparisons using national survey data sources. The JIR amendment to the Demonstration specifically also lacks a true comparison group as the state is unable to collect data from carceral settings who have not yet implemented the pre-release and reentry services. While the IE considered the use of leveraging the phased implementation of the JIR benefit by facility to create a comparison group and allow for a more rigorous analysis, data collection from non-participating facilities is not feasible due to limitations in data collection and data sharing infrastructure and processes at this time. To address this limitation, the IE plans to use a historical pre-demonstration comparison group, comprised of individuals who were incarcerated and released from state carceral facilities during the two years prior to the demonstration.

Lack of pre-demonstration data on health care service provision in carceral settings. Interrupted time-series is the preferred statistical method for analyzing the impact of the JIR demonstration by comparing pre-demonstration trends to post-intervention trends. The lack of pre-demonstration data on health care service provision in carceral settings prohibits using ITS to determine the impact of JIR on access to health care services pre-release.

Sample size. Population sample sizes may not support quasi-experimental analyses or stratification. Full UMIC participation is projected to be around 60,000 individuals. The data set for specific outcomes may not have sufficient size statistical analysis on all subgroups of interest. The IE will explore disparities in outcomes by race/ethnicity within the groups where numbers are sufficient. To further investigate health equity, KII interview guides will include questions about health plan efforts to identify and remediate disparities in access, such as population health analyses and targeted outreach. TAM and other populations are smaller. For the smallest populations, regression analysis is unlikely to be feasible, so descriptive and trend over time analyses will be used and stratification will be limited. For the ISS FFCYAS, and youth JI populations, the number of individuals may be too small to support significance testing, in which case descriptive results will be provided.

Health Plan Reporting. The independent evaluator will receive aggregate CAHPS data reported in aggregate by the health plans, stratified by gender, age, and race/ethnicity. Patient-level data is not available for privacy reasons. Data aggregation will limit the available subgroup analyses that can be performed. The current age and race/ethnicity reporting buckets for CAHPS data are limited and are not standardized across health plans. In order to aggregate data across the population, the IE will combine categories as needed, creating wider age bands, and characterizing race as White/Other.

Lack of data on source of insurance coverage in national survey data. The use of national survey data allows for out of state comparison groups but limits the ability to specifically identify individuals enrolled in the Demonstration. As noted in Section C.5, prior to 2022 the BRFSS insurance coverage outcome did not allow determination of the source of coverage (e.g., Medicaid, Medicare, or private insurance) As a result, it was not possible to identify individuals enrolled in Medicaid and thus not possible to determine if respondents fell into the Demonstration group or were enrolled in Medicaid in comparison states. While an approximation will be achieved by using income and household size to define a sample representing Demonstration participants as closely as possible, the inclusion of respondents who may not be part of the Demonstration group or be Medicaid enrolled in comparison states is expected to attenuate the effect estimates during the pre-demonstration period. While differences in BRFSS responses between Utah and the comparison states are of interest, the evaluation's results should be interpreted as associations and may not necessarily be directly attributed to the Demonstration.

Historic effects. The impacts of the Covid-19 pandemic/PHE were profound in 2020 and 2021 and are likely to continue to influence health care delivery well into the current Demonstration period. Analytic techniques described above will be used to minimize confounding by PHE effects during the baseline period. The PHE unwinding will take place during the Demonstration period, with eligibility

redeterminations beginning in April 2023, and may lead to unusual levels of disenrollment and enrollment category changes. Ongoing direct and indirect impacts of the PHE such as staffing shortages will be considered in interpreting findings.

Data availability for national surveys, publicly available data sources, and carceral setting data. The evaluation design includes national surveys and other publicly available data sources for some research questions that involve comparisons between states and over time. The design plan is contingent on the continued administration of these surveys, data release schedules, the elements included in public use files, the timing and process for accessing restricted data, and the comparability of the surveys to previous years. The NASHP HCT utilizes cost reports submitted by hospitals; as such, hospital reporting errors may be introduced. Should barriers be encountered, the IE will explore other options. Additionally, the JIR amendment introduces data from the carceral setting (prisons, jails, and youth correctional facilities). The IE anticipates that there may be early availability or quality challenges with this new data source, as carceral facilities become familiarized with Medicaid billing and claims systems.

Implementation dates and data sources for amendments newly approved during the Demonstration period. The evaluation design includes evaluation plans for amendments newly approved during the Demonstration period (JIR and HRSN) that have not been implemented at the time of writing this evaluation design document. The evaluation of these amendments relies on administrative data sources that are currently being designed or built. The IE works closely with the state to align on data sources and availability. In addition, the JIR and HRSN implementations may take place too late in the Demonstration to generate sufficient claims data for claims-based measures, or for year-over-year comparisons to be feasible.

F. Attachments

1. Independent Evaluator

As required by the Centers for Medicare & Medicaid Services (CMS) and the Section 1115 Demonstration's Special Terms and Conditions (STCs), DHHS conducted an open solicitation process to secure a third-party evaluator to conduct an evaluation of the State of Utah's Section 1115 Demonstration.

The State issued one contract for all evaluation activities and the production of required CMS reports.[45] As the successful bidder, Public Consulting Group (PCG) demonstrated the following qualifications:

Experience conducting program evaluations for programs administered by the federal department of Health and Human Services.

Ability to provide at least two examples of program evaluations conducted meeting the above criterion.

Experience with Medicaid claims data.

Experience complying with human subjects' protection and data confidentiality laws (state and federal)

Experience with quantitative and qualitative evaluation design, implementation, analysis, and reporting, and impact evaluations in public health and social services settings.

Consistent with the requirements of the State of Utah Division of Purchasing, DHHS selected and retained PCG as an independent evaluator to complete the independent evaluation of the Demonstration. DHHS contracted with the evaluator, PCG, to promote an independent evaluation, following the general requirements for each state contractor as well as project-specific standards.

The third-party evaluator, PCG, will conduct an evaluation following guidelines set forth by DHHS and CMS. The Department retains responsibility for monitoring the Demonstration activities and providing oversight of the evaluation design and overall approach for the contractor. To ensure a fair and impartial evaluation and mitigate any potential conflict of interest, the independent evaluator, PCG, will:

Conduct an evaluation of the 1115 Demonstration hypotheses for the Adult Expansion, Current Eligible, Targeted Adult Medicaid (TAM), Targeted Adult Dental (TAM-Dental), Blind and Disabled Dental (BDD), Aged Dental, Employer-Sponsored Insurance (ESI), Utah Premium Partnership (UPP), Intensive Stabilization Services (ISS), and Former Foster Care Youth from Another State (FFCYAS) populations of the 1115 waiver, as well as for the Serious Mental Illness (SMI) and Substance Use Disorder (SUD) components[46], IVF and Genetic Testing, Fertility Treatment for Individuals Diagnosed with Cancer, Housing Related Services and Supports and Justice-Involved Reentry Services to determine if the goals and objectives of the Demonstration have been achieved.

Meet the evaluation requirements of the 1115 Demonstration STCs.

Follow the CMS approved evaluation design.

Provide DHHS with the required annual interim evaluation report and summative evaluation report at the end of the 1115 Demonstration approval period, by the due dates outlined in the contract.

Provide future evaluations as required by the contract, at the option of DHHS, and develop the evaluation design and implement the design upon CMS approval.

[45] This procurement sought an Independent Evaluator for all the components of the current waiver period which runs from July 1, 2022, through June 30, 2027. PCG was awarded a five-year contract covering these components.
[46] The Utah Department of Health requested that PCG develop a single comprehensive Evaluation Design for the Utah Medicaid Reform 1115 Demonstration encompassing all evaluation populations and waiver components.

Complete any required IRB applications, data sharing agreements, or other documents needed to protect human subjects and data confidentiality.

Appropriately safeguard evaluation data in compliance with HIPAA requirements, protection of human subjects, data sharing agreements, state or federal laws, and other applicable regulations.

The 1115 Demonstration evaluation conducted by PCG will determine if the goals and objectives of the 1115 Demonstration have been achieved. The evaluation will meet the requirement of the 1115 Demonstration STCs, follow the CMS approved evaluation design, and provide required deliverables.

DHHS staff worked with the evaluator to identify and address concerns that might arise during the administration of the contract. By requiring initial satisfaction of these standards by the contracting party in order to be awarded the contract, as well as ongoing maintenance of the requirements during the term of service, DHHS is in a position to receive an objective evaluation report that is the product of a fair, impartial, and conflict-free evaluation.

2. Evaluation Budget

Table 14: Estimated Evaluation Budget

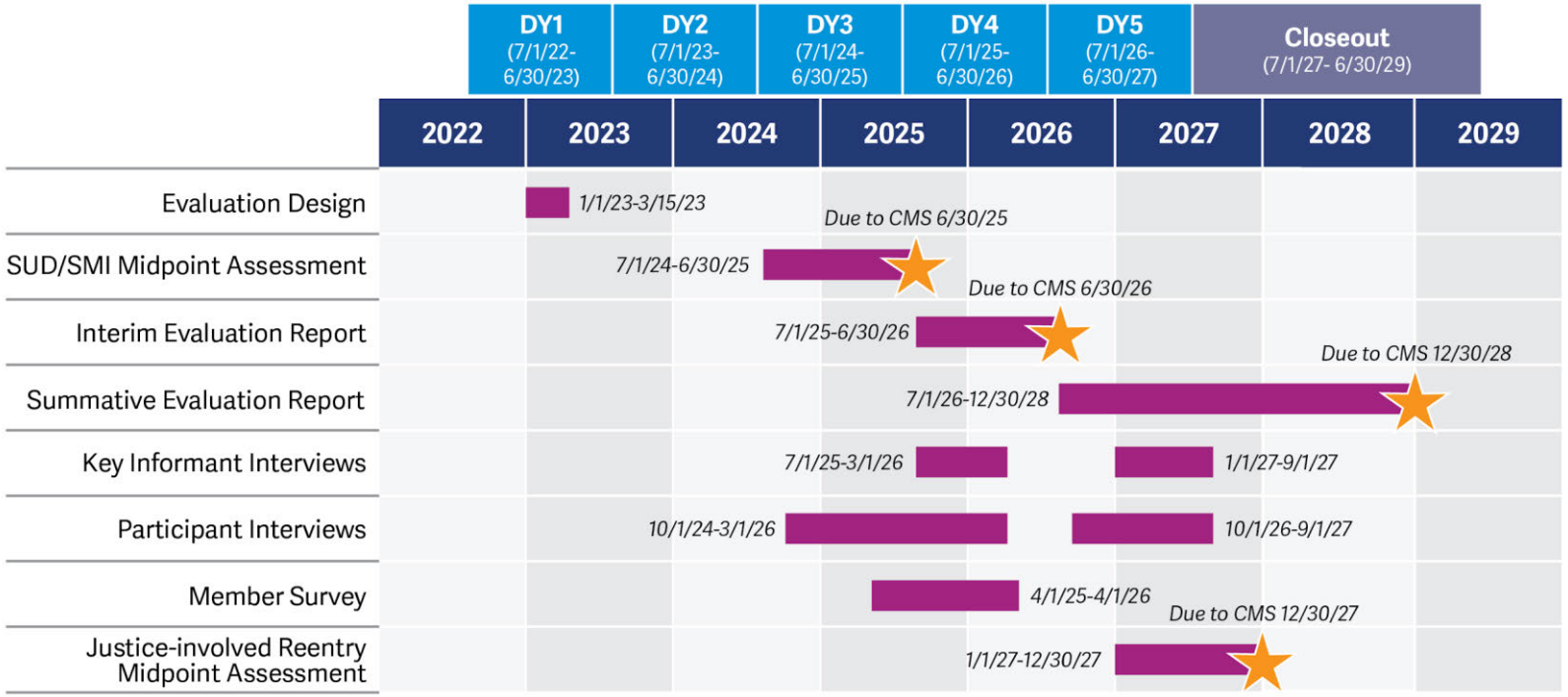
Evaluation Activity	Current Demonstration Period							
	DY1	DY2	DY3	DY4	DY5	Post Yr1	Post Yr2	TOTAL
	7/1/2022 – 6/30/2023	7/1/2023 – 6/30/2024	7/1/2024 – 6/30/2025	7/1/2025 – 6/30/2026	7/1/2026 – 6/30/2027	7/1/2027 – 6/30/2028	7/1/2028 – 6/30/2029	
Project Management	$49,500	$49,500	$153,082	$204,110	$102,055	$82,920	$76,541	$717,708
Evaluation Design		$16,875	$255,137	$68,037				$340,049
Quantitative Data	$289,980	$48,973	$102,055	$204,110	$204,110	$160,311	$163,288	$1,172,827
Summative Report Prior Demo Period	$143,820	$157,790						$301,610
Key Informant Interviews			$81,644	$136,073	$68,037	$27,640	$25,514	$338,908
Participant Interviews Wave 1		$50,000	$91,849	$149,680				$291,529
Custom Member Survey		$180,000	$10,205	$244,932	$68,037			$503,174
Participant Interviews Wave 2					$163,288	$22,112	$15,308	$200,708
Midpoint Assessment: SUD/SMI		$71,100	$204,110					$275,210

Interim Report			$122,466	$353,790	$40,822			$517,078
Midpoint Assessment: JIR						$116,087		$116,087
Summative Report					$34,018	$143,727	$229,623	$407,368
TOTAL	$483,300	$574,238	$1,020,548	$1,360,731	$680,366	$552,797	$510,274	$5,182,256

Note: Line items for new primary data collection activities (interviews and surveys) include costs for developing the tools, gathering the data, and performing data analytics.

3. Timeline and Major Milestones

FIGURE 3: EVALUATION TIMELINE



2. Evaluation Design Tables

Table 15: Evaluation Summary, Hypothesis 1, Low-income UT residents

Hypothesis 1: The 1115 Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 1.1: Did the fraction of low-income residents with no coverage decrease, relative to comparison states?				
Comparison states	Any coverage	Fraction with any health insurance coverage	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.2: Did the fraction of low-income residents who avoided care due to cost decrease, relative to comparison states?				
Comparison states	Avoided care due to cost	Fraction who delayed or avoided needed care because of cost	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.3: Did the fraction of low-income residents who have a personal doctor or usual source of care increase, relative to comparison states?				
Comparison states	Has a personal doctor	Fraction who says they have one person they think of as their person doctor or provider	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.4: Did the fraction of low-income residents who had a primary or specialty care appointment in the last year increase, relative to comparison states?				
Comparison states	Had a primary or specialty appointment	Had a checkup or visit with a specialist in the last 12 months	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.5: Did the fraction of low-income residents who had a preventive screening in the last year increase, relative to comparison states?				
Comparison states	Had a preventative screening	Fraction who reported having a mammogram in the last 12 months	BRFSS	Difference-in-difference Synthetic control model
Primary research question 1.6: What is the member experience of care in terms of access, timeliness, and patient-centeredness?				
Pre-Demonstration baseline	Member satisfaction	Getting needed care Getting needed care quickly How well doctors communicate	CAHPS	Descriptive statistics; Trend over time
Single point in time survey	Member satisfaction	Access to care Access to BH care Barriers to accessing physical care Barriers to accessing behavioral health care	Custom Member/Beneficiary Survey	Descriptive statistics

Hypothesis 1: The 1115 Demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
		Patient centered care Coordination of care		
Primary research question 1.7: Did Low Value Care decrease among Demonstration participants, relative to baseline?				
Pre-Demonstration baseline	Low Value Care	List of low value care scenarios appropriate for the Demonstration will be developed	Claims	Trend over time Interrupted Time Series

Table 16: Evaluation Summary, Hypothesis 2, Adult Expansion / UMIC

Hypothesis 2: The Demonstration will improve health care access and engagement for the Adult Expansion population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 2.1: Did inpatient hospital utilization decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Inpatient Utilization (IPU)	Inpatient admissions per member per year	Claims	Trend over time Interrupted Time Series
Primary research question 2.2: Did ED visits decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	ED visits (EDU)	ED visits per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	ED-BH visits (EDU-BH)	ED visits for BH condition per member per year	Claims	Trend over time Interrupted Time Series
Subsidiary research question 2.2.b: Did UMIC plans reduce ED visits for BH conditions for Adult Expansion population, relative to FFS or physical health-only ACO plans?				
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	ED-BH visits (EDU-BH)	ED visits for BH condition per member per year	Claims	Multiple linear regression; ANOVA
Primary research question 2.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the Adult Expansion population?				

Hypothesis 2: The Demonstration will improve health care access and engagement for the Adult Expansion population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Pre-Demonstration baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Interrupted Time Series
Primary research question 2.4: Did engagement in behavioral health care increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Antidepressant Medication Management (AMM)	Adults with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.	Claims	Interrupted Time Series
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Interrupted Time Series
Pre-Demonstration baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Interrupted Time Series
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Interrupted Time Series
Subsidiary research question 2.4.a: Did UMIC plans improve engagement in behavioral health care for Adult Expansion population, relative to FFS or physical health-only ACO plans?				
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Antidepressant Medication Management (AMM)	Adults with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medications.	Claims	Multiple linear regression; ANOVA

Hypothesis 2: The Demonstration will improve health care access and engagement for the Adult Expansion population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Multiple linear regression; ANOVA
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Multiple linear regression; ANOVA
Plan Type Comparison: UMIC, FFS/PMHP, ACO/PMHP	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Multiple linear regression; ANOVA
Primary research question 2.5: Did engagement in treatment for chronic conditions increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Monitoring for persistent medications (MPM)	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Interrupted Time Series
Pre-Demonstration baseline	Engagement in Diabetes Care (EDC)	Adults with type 1 or type 2 diabetes who had at least two A1C tests in the year	Claims	Interrupted Time Series
Primary research question 2.6: Did preventive cancer screening increase, relative to baseline, for the Adult Expansion population?				
Pre-Demonstration baseline	Breast Cancer Screening (BCS)	Women 50 years and over who had at least one mammogram to screen	Claims	Interrupted Time Series

Hypothesis 2: The Demonstration will improve health care access and engagement for the Adult Expansion population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
		for breast cancer in the past two years		
Primary research question 2.7: Did dental service provision increase relative to baseline for the Adult Expansion population?				
N/A	Dental Service Recipients	Number of unique individuals who received dental services	Claims	Descriptive statistics
N/A	Dental Services	Number of dental services provided	Claims	Descriptive statistics
Primary research question 2.8: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the Adult Expansion population?				
Pre-Dental Expansion baseline	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance measure EDV-A-A)	Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 member months for adults	Pre-Dental Expansion baseline	Interrupted Time Series
Primary research question 2.9: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the Adult Expansion population?				
Pre-Dental Expansion baseline	Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance EDF-A-A)	The percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit	Claims	Interrupted Time Series
Primary research question 2.10: To what extent are beneficiaries aware of the dental care benefit?				
N/A	Dental Benefit Awareness	Percentage of survey respondents who answer “yes” to: Does your health insurance cover any dental services, such as routine cleanings?	Custom Member Survey	Descriptive statistics

Table 17: Evaluation Summary, Hypothesis 3, TAM

Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 3.1: Did inpatient hospital utilization decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Inpatient Utilization (IPU)	Inpatient admissions per member per year	Claims	Interrupted Time Series
Primary research question 3.2: Did ED visits decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	ED visits (EDU)	ED visits per member per year	Claims	Interrupted Time Series
Subsidiary research question 3.2.a: Did ED visits for BH conditions decrease, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	ED-BH visits	ED visits for BH condition per member per year	Claims	Interrupted Time Series
Primary research question 3.3: Did engagement in primary and ambulatory care increase, relative to baseline, for the TAM population?				
Pre-Demonstration baseline	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Interrupted Time Series
Baseline	Monitoring for persistent medications (MPM)	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Interrupted Time Series
Primary research question 3.4: Did engagement in behavioral health care increase, relative to baseline, for the TAM population?				

Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Pre-Demonstration baseline	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Interrupted Time Series
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Interrupted Time Series
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Interrupted Time Series
Primary research question 3.5: Did dental service provision increase relative to baseline for the TAM population?				
N/A	Dental Service Recipients	Number of unique individuals who received dental services	Claims	Descriptive statistics
N/A	Dental Services	Number of dental services provided	Claims	Descriptive statistics
Primary research question 3.6: Did ED visits for non-traumatic dental conditions decrease relative to baseline for the TAM population?				
Pre-TAM Dental Benefit baseline	Ambulatory Care Sensitive ED Visits for Non-Traumatic Dental	Number of emergency department (ED) visits for ambulatory care sensitive	Claims	Interrupted Time Series

Hypothesis 3: The Demonstration will improve health care access and engagement for the TAM population.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
	Conditions in Adults (Dental Quality Alliance measure EDV-A-A)	non-traumatic dental conditions per 100,000 member months for adults		
Primary research question 3.7: Did follow-up after ED visits for non-traumatic dental conditions increase relative to baseline for the TAM population?				
Pre-TAM Dental Benefit baseline	Follow-Up after Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (Dental Quality Alliance EDF-A-A)	The percentage of ambulatory care sensitive non-traumatic dental condition emergency department visits among adults aged 18 years and older in the reporting period for which the member visited a dentist within (a) 7 days and (b) 30 days of the ED visit	Claims	Interrupted Time Series

Table 18: Evaluation Summary, Hypothesis 4, HRSN Demonstration

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 4.1: What is the prevalence and severity of beneficiaries' social needs?				
N/A	Prevalence of housing-related needs; individual level	Number and percent of beneficiaries eligible for HRSS	Administrative Data	Descriptive statistics
N/A	Extent of housing-related needs; Community level	Housing affordability (<=30% of income) at the county level	American Community Survey, Area	Trend over time

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
			Health Resources File	
Primary research question 4.2: Were HRSN services provided and utilized as planned?				
N/A	HRSN Provider Availability	Number of HRSN providers and description of service offerings	Administrative	Descriptive statistics
N/A	HRSN Service Utilization	HRSN service counts by type of service	Claims	Descriptive statistics Trend over time
N/A	NMT Utilization	NMT service counts	Administrative	Descriptive statistics Trend over time
Primary research question 4.3: Did the HRSN demonstration effectively mitigate beneficiaries' housing and transportation needs?				
N/A	Found housing	Fraction of previously unhoused HRSS participants who moved into housing while receiving HRSS.	Administrative	Descriptive statistics
N/A	Housing stability	Fraction of HRSS participants who maintained stable housing for a defined time period.	Case records	Descriptive statistics
Primary research question 4.4: Did high-cost acute utilization decrease, relative to baseline, for HRSN recipients?				
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	ED visits	ED visits condition per member per year	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	ED-BH visits	ED visits for BH condition per member per year	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Potentially preventable ED visits	ED visits for ambulatory sensitive conditions, such as asthma, urinary tract infections, and complications from diabetes (AHRQ measure)	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Inpatient utilization	Inpatient stays per member year	Claims	Trend over time or Interrupted time series

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Potentially preventable inpatient utilization	Inpatient stays for ambulatory sensitive conditions, such as asthma, urinary tract infections, and complications from diabetes (AHRQ measure)	Claims	Trend over time or Interrupted time series
Primary research question 4.5 Did engagement in primary and ambulatory care increase, relative to baseline, for HRSN recipients?				
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of beneficiaries who had an ambulatory or preventive care visit during the measurement year	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Monitoring for persistent medications	Assesses adults who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year:	Claims	Trend over time or Interrupted time series
Primary research question 4.6: Did engagement in behavioral health care increase, relative to baseline, for HRSN recipients?				
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Trend over time or Interrupted time series
Longitudinal cohort design with pre-HRSN demonstration baseline, if available	Follow-Up After Hospitalization for Mental Illness (FUH)	Following discharge for mental illness or intentional self-harm, fraction with outpatient follow-up in 7 days, and within 30 days.	Claims	Trend over time or Interrupted time series
Primary research question 4.7: From the beneficiaries' perspective, did the HRSN services meet their housing-related needs, support their engagement in behavioral health care, and overall positively impact their physical and mental health?				

Hypothesis 4: The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
N/A	Quality of HRSS, participant perspective	How satisfied are participants with the HRSS they received? What was helpful, not helpful? How easy or difficult is it to find appropriate housing without, and with, HRSS assistance? Are participants satisfied with their housing arrangements?	Participant Interviews	Qualitative analysis
N/A	Engagement in care, participant perspective	What factors enhance or inhibit participants' engagement in physical health care? in behavioral health care?	Participant Interviews	Qualitative analysis
N/A	Overall physical and mental health, participant perspective	How do participants think their physical and mental health has changed since receiving HRSS services?	Participant Interviews	Qualitative analysis
Primary research question 4.8: Did state and local investments in housing supports change over time during the HRSN demonstration?				
Baseline year	Local availability of HRSS	Percent change in number of HRSS type programs for the duration of the amendment	Administrative: Maintenance of Effort section of Annual Monitoring Reports	Percent change in each year compared to the baseline year
Primary research question 4.9: Were there any improvements in the quality and effectiveness of downstream housing-related services and supports?				
N/A	HRSN Provider Self-Assessment	Provider perceptions of the impact of infrastructure investments and related supports on the quality and effectiveness of their housing-related services and supports.	Key Informant Interviews	Qualitative

Table 19: Evaluation Summary, Hypothesis 5, SMI/SUD

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 5.1: Did the number of individuals receiving services for SMI and/or SUD increase, relative to baseline?				
Baseline year (DY1)	Service Counts: SUD	Number of members receiving SUD treatment	Claims	Descriptive statistics; Trend over time
Baseline year (DY1)	Service Counts: SMI	Number of members receiving SUD treatment	Claims	Descriptive statistics; Trend over time
Primary research question 5.2: Did ED visits for BH conditions decrease among individuals with SMI and/or SUD diagnoses, relative to baseline?				
Pre-Demonstration baseline Stratify by: SMI only, SUD only, SMI/SUD dually diagnosed	ED-BH visits	ED visits for BH condition per member per year	Claims	Interrupted Time Series
Primary research question 5.3: Did inpatient days (outside of IMDs) decrease, relative to baseline, for individuals with SMI and/or SUD?				
Pre-Demonstration baseline Stratify by: SMI only, SUD only, SMI/SUD dually diagnosed	Inpatient days	Inpatient days PMPY, exclusive of IMD stays	Claims	Interrupted Time Series
Primary research question 5.4: Did engagement in SUD treatment increase among individuals with SUD diagnoses relative to baseline?				
Pre-Demonstration baseline	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Fraction with a new episode of alcohol or other drug dependence who: 1) initiated treatment within 14 days of diagnosis. 2) engaged in continued treatment within 34 days of the initiation visit.	Claims	Interrupted Time Series
Primary research question 5.5: Did unplanned readmission following hospitalization for psychiatric treatment decrease among individuals with SMI relative to baseline?				
Pre-Demonstration baseline	30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (REA)	The rate of unplanned, 30-day, readmission for Demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease.	Claims	Interrupted Time Series

Hypothesis 5: The SMI and SUD Demonstrations increased access to appropriate treatment.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 5.6: Did utilization of any mental health service increase among low-income residents, relative to comparison states?				
Comparison states	Mental health treatment	Percentage who reported receiving mental health (non-SUD) treatment in the last 12 months	NSDUH	Difference-in-difference; Synthetic control model
Primary research question 5.7: Did the number of individuals needing but not receiving SUD service decrease among low-income residents, relative to comparison states?				
Comparison states	SUD treatment	Percentage who reported receiving SUD treatment in the last 12 months	NSDUH	Difference-in-difference; Synthetic control model
Primary research question 5.8: Did the rate of overdose deaths decrease, relative to baseline?				
Pre-Demonstration baseline	Overdose deaths	State rate of overdose deaths	Administrative	Interrupted Time Series
Primary research question 5.9: Did the number of individuals receiving crisis stabilization services increase (with an emphasis on non-hospital, non-residential services)?				
Pre-Demonstration baseline	Crisis stabilization services	Crisis Stabilization service count	Claims	Interrupted Time Series

Table 20: Evaluation Summary, Hypothesis 6, SMI/SUD Cost of Care

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 6.1: Did the total cost of care for individuals with SMI diagnoses change, relative to baseline?				
Pre-Demonstration baseline	Total Cost of Care	Total costs per beneficiary per month is the sum of the state's Medicaid costs (inpatient, outpatient, pharmacy, long-term care, IMD, and MCO capitated payments) and the federal cost (total Medicaid * FMAP for Utah).	Claims	Interrupted time series

Hypothesis 6: The SMI and SUD Demonstrations stabilized or reduced cost of care for these populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Subsidiary research question 6.1.a: Did costs related to the diagnosis and treatment of SMI change, relative to baseline? (SMI-IMD costs + other SMI costs + non-SMI costs)?				
Pre-Demonstration baseline	Costs related to the diagnosis and treatment of SMI	These costs include *SMI-IMD costs + other SMI costs + non-SMI costs*	Claims	Interrupted time series
Subsidiary research question 6.1.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SMI population?				
Pre-Demonstration baseline	Source of treatment cost drivers	These costs include inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care	Claims	Interrupted time series
Primary research question 6.2: Did the total cost of care for individuals with SUD diagnoses change, relative to baseline?				
Pre-Demonstration baseline	Total Cost of Care	Total costs per beneficiary per month is the sum of the state's Medicaid costs (inpatient, outpatient, pharmacy, long-term care, IMD, and MCO capitated payments) and the federal cost (total Medicaid * FMAP for Utah).	Claims	Interrupted time series
Subsidiary research question 6.2.a: Did costs related to the diagnosis and treatment of SUD change, relative to baseline? (SUD-IMD costs + other SUD costs + non-SUD costs)?				
Pre-Demonstration baseline	Costs related to the diagnosis and treatment of SMI	These costs include *SMI-IMD costs + other SMI costs + non-SMI costs*	Claims	Interrupted time series
Subsidiary research question 6.2.b: What types of care (inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care) are the primary drivers of the cost of care for the SUD population?				
Pre-Demonstration baseline	Source of treatment cost drivers	These costs include *inpatient + non-ED outpatient, + ED outpatient + pharmacy, + long-term care*	Claims	Interrupted time series

Table 21: Evaluation Summary, Hypothesis 7, Small Demonstration Populations: UPP/ESI, ISS, FFCYAS, Fertility and Genetic Testing Services

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
UPP/ESI				
Primary research question 7.1: Did the number of individuals receiving coverage increase relative to baseline?				
Baseline year (DY1)	Enrollment	Number of unique individuals enrolled in each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
Primary research question 7.2: What was the average total Medicaid cost of care for enrollees?				
Baseline year (DY1)	Total cost of care	Total cost of care (paid claims plus premium payments) for each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
Primary research question 7.3: Did the pmpm cost for enrollees change over time?				
Baseline year (DY1)	Average pmpm expenditure	Total per member per month cost of care (paid claims plus premium payments) for each plan (UPP/ESI)	Claims	Descriptive statistics Trend over time
ISS				
Primary research question 7.4 Did the number of individuals receiving ISS increase relative to baseline?				
Baseline year (DY1)	ISS Service Recipients	Number of unique individuals who received ISS	Claims	Counts
FFCYAS				
Primary research question 7.5: How many FFCYAS received coverage?				
Baseline year (DY1)	Number of FFCYAS	Number of unique individuals in FFCYAS coverage group	Required Monitoring Reports	Counts
Fertility and Genetic Testing Services				
Primary research question 7.6: Did the number of individuals receiving fertility preservation services increase relative to baseline?				
Baseline year (DY1)	Fertility services	Number of unique individuals receiving fertility preservation services	Claims	Counts
Primary research question 7.7: Did the number of individuals receiving genetic testing services increase relative to baseline?				

Hypothesis 7: The Demonstration delivered coverage/ services appropriately to individuals in the smaller Demonstration populations.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Baseline year (DY1)	Genetic testing services	Number of unique individuals receiving genetic testing services	Claims	Counts

Table 22: Evaluation Summary, Hypothesis 8, Justice-Involved Populations

Hypothesis 8: The Justice-Involved Reentry Benefit will enhance cross-system communication and coordination between correctional and community services.				
Comparison Strategy	**Measure Name**	**Measure Description**	**Data source**	**Analytic Approach**
Primary research question 8.1: Did the Demonstration's services facilitate beneficiaries' post-release transitions to care?				
N/A	Were beneficiaries able to access and engage in continuous care post-release that met their needs?	Beneficiaries' Perceptions	Beneficiary Interviews	Qualitative Analysis
N/A	Were beneficiaries able to access and engage in continuous care post-release that met their needs?	Case Managers' Perceptions	Case Manager Interviews	Qualitative Analysis
Primary research question 8.2: Was communication and coordination between the correctional system and community-based health services enhanced?				
N/A	What changes were made to communication systems between institutions?	Correctional system staff Perceptions	Correctional system staff interviews	Qualitative Analysis
N/A	What changes were made to communication systems between institutions?	Community-based providers' Perceptions	Community-based providers interviews	Qualitative Analysis

Table 23: Evaluation Summary, Hypothesis 9, Justice-Involved Populations

Hypothesis 9: The Justice-Involved Reentry Benefit will improve pre-release service provision during the covered period and continuity of coverage for the justice-involved population.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 9.1: What Demonstration services did justice-involved individuals receive in the pre-release period?						
N/A	Pre-release service distribution	Distribution of services rendered by service type and date. Service types include: clinical consultation (non-BH), diagnostic (radiology and lab), treatment (non-MAT), family planning and supplies, CHW, hepatitis C, medical equipment and supplies, hepatitis C screening, hepatitis C treatment if indicated, SUD services, MAT, MAT counseling, peer support	N/A	N/A	Claims/administrative	Descriptive statistics
N/A	Pre-demonstration carceral setting service offerings	Description of services offered by participating carceral settings in their institution's pre-demonstration	N/A	N/A	Carceral Facility Readiness Assessment and Key Informant Interviews	Document Review Descriptive statistics Qualitative Analysis
N/A	What services (case management or care provision) did beneficiaries receive in the 90 days before release? What services	Beneficiaries' Perceptions	N/A	N/A	Beneficiary Interviews	Qualitative Analysis

	that beneficiaries needed did they not receive in the 90 days before your release?					
Primary research question 9.2: What was beneficiaries' experience of pre-release service provision?						
N/A	Beneficiary experience of pre-release services	Beneficiary self-reported experience of quality of care	N/A	N/A	Beneficiary interviews	Qualitative Analysis
N/A	Provider availability	Ratio of facility Medicaid-enrolled providers to JIR beneficiaries	Medicaid-enrolled providers	JIR beneficiaries	TBD[47]	Descriptive statistics stratified by provider type
N/A	Pre-release service wait time	Time from JIR benefit start date to first Medicaid reimbursed service	N/A	N/A	Claims	Descriptive statistics stratified by service type (where feasible)

Primary research question 9.3: Were beneficiaries potentially in need of behavioral health services identified during the pre-release period?						
N/A	Diagnosed Mental Health Disorders (DMH)	The percentage of JIR beneficiaries who were diagnosed with a mental health disorder	Of the denominator, number diagnosed with a mental health disorder	JIR beneficiaries	Claims	Descriptive statistics
N/A	Diagnosed Substance Use Disorders (DSU)	The percentage of JIR beneficiaries who were diagnosed with a substance use disorder • Alcohol disorder	Of the denominator, number diagnosed with	JIR beneficiaries	Claims	Descriptive statistics

[47] The data source for facility Medicaid-enrolled providers has not yet been fully determined. It will likely be a combination of Medicaid provider enrollment data and carceral facility administrative data, such lists of providers that have entered into contracts or agreements with the facility.

		• Opioid disorder • Other or unspecified drugs • Any SUD	a substance use disorder			
Primary research question 9.4: What fraction of justice-involved individuals received navigation support for accessing Medicaid coverage pre-release?						
N/A	Intake coverage screening	Percentage of individuals newly incarcerated in participating institutions who were screened for coverage status[48]	Newly incarcerated individuals screened for Medicaid coverage	All newly incarcerated individuals in participating facilities	Carceral Facility Administrative Data	Descriptive statistics (stratified by time from intake to screening)
N/A	Medicaid renewal applications for justice-involved population	Percentage of incarcerated individuals who responded completely to Medicaid redetermination request	Incarcerated individuals who responded completely to Medicaid redetermination requests	Incarcerated individuals who received Medicaid redetermination requests	Medicaid Administrative Data: Eligibility and Enrollment	Descriptive statistics
N/A	New Medicaid applications for justice-involved population	Number of incarcerated individuals who submitted applications for Medicaid coverage	N/A/	N/A	Medicaid Administrative Data: Eligibility and Enrollment	Descriptive statistics
Primary research question 9.5: Did JIR beneficiaries experience gaps in coverage at the time of release?						
N/A[49]	Reentry continuity of coverage	Average number of days from release to Medicaid coverage reinstatement for incarcerated individuals with suspended status	N/A	N/A	Medicaid Administrative Data: Eligibility and Enrollment	Descriptive statistics

[48] In addition to coverage screening of newly incarcerated individuals, the carceral facilities will also screen individuals who were incarcerated prior to the demonstration. The process and timeline for such screenings is not yet in place. The IE may add a measure for screening of previously incarcerated individuals to the design once the planning process is complete.

[49] The preferred design it to compare JIR beneficiaries to a pre-demonstration group, or a non-participating comparison group, on continuity of coverage. The design will include the comparison approach if release dates are available for a potential comparison group.

TABLE 24: EVALUATION SUMMARY, HYPOTHESIS 10, JUSTICE-INVOLVED POPULATIONS

Hypothesis 10: The Justice-Involved Reentry Benefit's 90-day pre- release coverage period ("the coverage timeline") will support effective program implementation.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 10.1: Did the coverage timeline facilitate providing coordinated, efficient, and effective reentry planning?						
Subsidiary research question 10.1.a: Were assessments and care plans completed in a timely manner?						
N/A	Timely case management assessment	Time from JIR benefit start to first case management meeting/assessment	N/A	N/A	Carceral Facility Administrative Data	Descriptive statistics
N/A	Timely care planning	Time from JIR benefit start date to development of a care plan	N/A	N/A	Carceral Facility Administrative Data	Descriptive statistics
Subsidiary research question 10.1.b: Did beneficiaries receive a 30-day supply of all prescribed medications immediately upon release from the carceral setting?						
N/A	Prescription Medication Supply	Percentage of JIR beneficiaries who received a 30-day supply of all prescription medications that have been prescribed for the individual at the time of release immediately upon release from the correctional facility	JIR beneficiaries who received a 30-day supply of all prescription medications at release	JIR beneficiaries with prescription medication needs	Carceral Facility Administrative Data	Descriptive statistics
Primary research question 10.2: Did the coverage timeline enable pre-release management and stabilization of clinical, physical, and behavioral health conditions?						
N/A	Did the coverage timeline enable pre-release management and stabilization of	Beneficiary Perceptions	N/A	N/A	Beneficiary Interviews	Qualitative Analysis

Hypothesis 10: The Justice-Involved Reentry Benefit's 90-day pre- release coverage period ("the coverage timeline") will support effective program implementation.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
	clinical, physical, and behavioral health conditions?					
Primary research question 10.3: Did the coverage timeline help mitigate potential operational challenges the state might have encountered in a more compressed timeline?						
N/A	Did the coverage timeline help mitigate operational challenges?	State and Correctional System Perceptions	N/A	N/A	State and Correctional system staff interviews	Qualitative Analysis

Table 25: Evaluation Summary, Hypothesis 11, Justice-Involved Populations

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 11.1: Did engagement in appropriate health care services post-release increase relative to a pre-demonstration comparison population?						
Pre-demonstration comparison population	Controlling High Blood Pressure (CBP)	The percentage of JIR beneficiaries who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled	JIR beneficiaries with a diagnosis of hypertension with blood pressure adequately controlled	JIR beneficiaries with a diagnosis of hypertension	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Monitoring for Persistent Medications (MPM)	JIR beneficiaries who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent (for hypertension or heart	JIR beneficiaries who received at least 180 treatment days of ambulatory medication for a	JIR beneficiaries prescribed an ambulatory medication therapy	Claims	Trend over time Interrupted Time Series

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
		disease) during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year	select therapeutic agent and received at least one therapeutic monitoring event for the therapeutic agent			
Pre-demonstration comparison population	Adults' Access to Preventative/Ambulatory Health Services (AAP)	Fraction of JIR beneficiaries who had an ambulatory or preventive care visit during the measurement year	Number of JIR beneficiaries who had an ambulatory or preventive care visit	JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Pharmacotherapy for Opioid Use Disorder (POD)	The percentage of OUD pharmacotherapy events that lasted at least 180 days among JIR beneficiaries with a diagnosis of OUD and a new OUD pharmacotherapy event	OUD pharmacotherapy events that lasted at least 180 days	JIR beneficiaries with a diagnosis of OUD and a new OUD pharmacotherapy event	Claims	Trend over time Interrupted Time Series
N/A	Access to social services post-release	Beneficiary and case manager perceptions of beneficiary engagement in social services in the post-release period	N/A	N/A	Beneficiary and case manager interviews	Qualitative Analysis
Primary research question 11.2: Did inpatient hospital utilization post-release decrease relative to the pre-demonstration comparison population?						
Pre-demonstration comparison population	Inpatient Utilization (IPU)	Inpatient admissions per JIR beneficiary per year	Total inpatient admissions	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series

Hypothesis 11: The Justice-Involved Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the justice-involved population post-release.						
Comparison Strategy	**Measure Name**	**Measure Description**	**Numerator**	**Denominator**	**Data source**	**Analytic Approach**
Primary research question 11.3: Did ED visits post-release decrease, relative to the pre-demonstration comparison population?						
Pre-demonstration comparison population	ED visits (EDU)	ED visits per JIR beneficiary per year	Total ED visits	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	ED-BH visits (EDU-BH)	ED visits for BH condition per JIR beneficiary per year	Total ED visits for BH conditions	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Potentially Preventable ED visits	Non-Emergent ED visits per JIR beneficiary per year	Total non-emergent ED visits	Total JIR beneficiaries	Claims	Trend over time Interrupted Time Series
Primary research question 11.4: Did the rate of deaths post-release decrease relative to the pre-demonstration comparison population?						
Pre-demonstration comparison population	All-cause deaths	All-cause deaths among JIR beneficiaries	All cause deaths among JIR beneficiaries	JIR beneficiaries	Vital statistics	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Suicide deaths	Suicide deaths among JIR beneficiaries	Suicide deaths among JIR beneficiaries	JIR beneficiaries	Vital statistics	Trend over time Interrupted Time Series
Pre-demonstration comparison population	Overdose deaths	Overdose deaths among JIR beneficiaries	Overdose deaths among JIR beneficiaries	JIR beneficiaries	Vital statistics	Trend over time Interrupted Time Series
Primary research question 11.5: Was the timing or provision of specific pre-release services associated with better post-release outcomes?						
Associations between the pre-release service distribution data and post-release outcomes (utilization, engagement, deaths) will be explored. There are no new measures needed for this analysis.						Exploratory Regression

3. HRSS Participant Interview Methodology

Interim Evaluation: Participant Experience, Housing-Related Services and Supports

Overview

In January 2025, Utah received approval from the federal government to update its Housing-Related Services and Supports (HRSS) program and extend it to more people enrolled in Medicaid. These expanded services are being rolled out over time. Currently, HRSS covers costs associated with moving for eligible individuals, such as paying a security deposit, buying essential household items, paying application fees, or hiring movers. Once fully implemented, HRSS will also include services to help people stay in their homes, avoid eviction, make medically necessary home modifications (such as removing mold or installing air filters), and make accessibility modifications (such as installing ramps or grab bars). The State hypothesizes that HRSS will make housing needs less common and less severe, increase continuity of behavioral health treatment, and improve health outcomes for the eligible population. To examine the HRSS program's impact, the independent evaluation examines and analyzes the utilization of services included in the 1115 waiver, as well as associated outcomes. It also examines and analyzes the perspectives, experiences, and insights of HRSS participants. This midpoint evaluation covers the methodology being used, the specific individuals included in this portion of the midpoint evaluation, and the status of data gathering.

Eligibility

There are three Medicaid populations, outlined in Table 1, that currently are or eventually will be eligible for HRSS. This midpoint independent evaluation report focuses on the first eligible group, Targeted Adult Medicaid (TAM) individuals. The final report will include all groups presented in Table 1.

Table 1. Medicaid Covered Populations Eligible for HRSS

Covered Groups	Membership Criteria

Targeted Adult Medicaid Population
Current version: 1/2025
	• Age 19-64
	• No dependent children
	• Income below 5% of the federal poverty line
	• At least one of the following:
	  ○ Chronically homeless
	  ○ Involved in the justice system and need substance use or mental health treatment
	  ○ Need substance use or mental health treatment

Adult Expansion Population *Began: 1/2025*	• Age 19-64 • US citizen or qualified non-citizen • Utah resident • Household income at or below 133% of the federal poverty line
Recently Incarcerated Individuals *Future date*	• Age 18 or older • Released from incarceration within the last 12 months • Received the Medicaid Justice Benefit Plan while incarcerated

Evaluation Methodology

To gather HRSS participant perspectives, experiences, and insights, the independent evaluator collaborates with providers to identify HRSS-eligible individuals who would be interested in sharing their experience. Once identified by the provider, these volunteers are contacted by the evaluator, who is an established expert in reaching out to and interviewing individuals with substance use disorders (SUDs), behavioral health concerns, chronic homelessness, and recent incarceration.

Volunteers are contacted to arrange the best time for them to participate in an interview. They are informed that the interview is confidential and given information about its purpose and how the information will be used. Volunteers can decline to move forward with the interview or end an interview at any time. Their decisions about interview participation do not affect their services. Interviews use a semi-structured format, are conducted via telephone, and last between 40-60 minutes. Participants receive a grocery store gift card to thank them for their time. With the interview participant's permission, the evaluator will contact them in three to four months to gather their experience and perspective after utilization of the HRSS benefit. The interview question areas and related topics covered in the interviews are listed in Table 2.

Table 2. Interview Questions and Potential Related Topics

Interview Questions	Potential Related Topics
How do participants' interactions with care managers happen? In what ways are these interactions helpful or not helpful?	• Outreach approach, engagement, and follow-through • Understanding of participant needs and perspective – whether care manager took steps to assist or explained limitations of service
What role did the HRSS case manager have in participants' housing situation?	• Addressing specific patient needs, timeliness, role of other housing liaisons
What factors enhance or inhibit participants' engagement in behavioral health care?	• Factors (barriers/facilitators) to access, coordination, continuity, and outcome
Are participants experiencing unmet needs for health care, including SUD and serious mental illness treatment?	• Participation in behavioral and physical health services and support • Use of the emergency department and hospitalizations (avoidable and/or behavioral health related) – perspective on alternatives • Participation in preventive, acute, and chronic condition services
Do participants perceive their life circumstances have changed since receiving HRSS services?	• Previous and current life (social determinants of health, family, work, etc.) situation
Did participants receive services in the pre-release period that met their needs? Was there enough time to get the screening and services needed prior to release? Did such services result in stable physical and behavioral health upon release?	• Access to and quality of pre-release services (case management, behavioral health care, diagnostic services, family planning services) • Perceptions of stigma associated with care
Were participants' post-release transitions to care needs adequately met by the pre-release services?	• Access to care and medications, continuity of coverage, care, medication, and providers

For the HRRS population, the evaluator expects to conduct approximately 75-80 interviews, or until thematic saturation is reached. Thematic saturation occurs when new interviews do not add additional insight – themes have consistently been shared. Saturation will be assessed separately for three HRSS-eligible categories: individuals planning to utilize HRSS, those who have used HRSS, and those who were unable to access HRSS. Ensuring input from individuals with this range of HRSS experience will provide depth to this portion of the evaluation.

Data Collection and Analysis

A matrix template is used to code interview data and enable the identification of themes. Data is analyzed in the aggregate to ensure participant confidentiality. Interview data analysis will occur once interviews are completed and will utilize an inductive and deductive framework. The deductive approach will provide structure and organization to the non-open-ended questions, while the inductive approach enables the identification and explanation of findings. The analysis occurs through an iterative

process, with steps including sorting data into organizational categories; organizing data into categories aligned with the research questions; developing codes, themes, and findings using the conceptual framework; identifying representative data to support findings; and explaining findings, including connecting and comparing them with existing literature.

Addressing Limitations. There are limitations in every evaluation. The HRSS participant evaluation uses mitigation strategies throughout the process to achieve the highest level of validity. This includes incorporating peer review and inter-rater reliability prior to the inductive stage of the analysis, creating tested interview guides, conducting triangulation (comparing findings from three sources) and member checking (participant review of their data and findings), and assessing saturation separately for different groups. These strategies help to mitigate any bias or subjectivity.

Interim Evaluation Status

On December 2, 2024, the evaluator provided an orientation to 13 qualified organizations. Another orientation was conducted in January 2025 with case managers from 6 of these organizations. In addition, the evaluator met individually with case managers to discuss specific processes that would work for their organization and safeguards required for confidentiality. Several providers have just begun adding case managers to their organizations, delaying their inclusion in the evaluation. Currently, 7 of the 13 initial HRSS qualified providers are engaged in identifying HRSS-eligible individuals who wish to participate in evaluation interviews. Additional providers are aiming to begin identifying evaluation participants in the next few months.

Across the currently engaged providers, 64 individuals have been referred for interviews and 48 were able to participate. Once all providers are ready to identify evaluation participants, the data collection will be representative of individuals eligible for HRSS. In addition, a portion of the interview participants will be contacted again several months after utilizing HRSS to gain a deeper insight into its impact. Once data collection is completed, the analysis will be conducted.

4. Member Satisfaction Survey Report

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Survey Objectives & Methodology

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Background and Objectives

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To assess the impact of the Utah Medicaid Reform 1115 Demonstration on members' access to and engagement in health care, Public Consulting Group (PCG) commissioned ForHealth Consulting at UMass Chan Medical School to conduct a survey of Utah Medicaid members.

Specific objectives of the survey were to understand the following:

- Members' access to health care, including urgent care, routine care, mental health care, and substance use treatment.
- Members' perceived barriers to primary care and mental health care.
- Member perceptions of care coordination and shared decision making with providers.
- Members' self-reported health status, including physical and mental health.

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Methodological Overview

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Who?

6,000 Utah Adult Expansion Medicaid members who met the following criteria:

- Continuously enrolled in Medicaid (any Accountable Care Organization (ACO), Fee for Service (FFS), or Utah Medicaid Integrated Care (UMIC) program) for a period of six months prior to the start of the survey period.
- Had at least one primary care or preventive service over a period of six months prior to the start of the survey period.

When?

The survey was administered from July 2, 2025 to September 17, 2025.

How?

ForHealth Consulting's Office of Survey Research (OSR) conducted the survey in English and Spanish using three modes of data collection:

- **Mail**: All members in the survey sample were mailed a survey packet, containing a cover letter, questionnaire, and a postage-paid reply envelope. The cover letter included OSR's toll-free number that members could call if they preferred to complete the survey over the phone as well as a QR code/online link to the survey along with a username and password.
- **Online**: OSR sent survey invitations to members for whom an email address was available, with a unique web link for each member, followed by reminder emails to non-respondents.
- **Phone**: OSR made five attempts to reach non-respondents and conduct the survey over the phone.

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Survey Response Rate

From the 23,011 Utah Adult Expansion Medicaid members included in the sampling frame, a total of 6,000 members were selected for the survey, of which 1,865 responded for a response rate of 32%.

- OSR applied implicit random sampling to ensure that the survey sample was representative of the population by using the following variables: age, gender, race and ethnicity, and member type.
- To produce representative estimates of population parameters, survey respondents were subsequently weighted using the sampling variables.

	Sampling Frame	Sample Size	Completed Surveys	Response Rate*
Total	**23,011**	**6,000**	**1,865**	**32%**

**See the Appendix for the full disposition report.*

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Survey Content

OSR designed the survey in consultation with PCG to understand member access to health care, experiences with health care, and health status.

- Select questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys were included in addition to custom questions.

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Survey Findings

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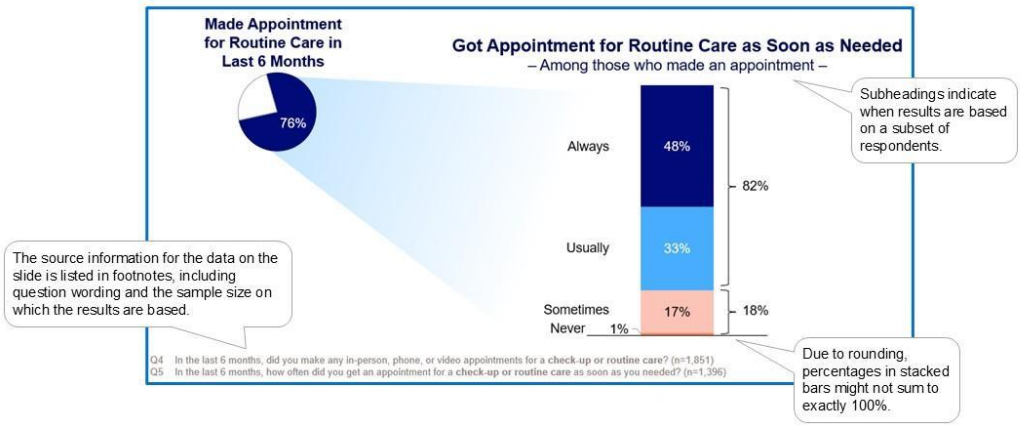
How to Read the Data in This Report

The illustrated example below serves as a guide on how to read the survey data.



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Member Profile

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Member Demographics

Adult Medicaid Expansion members are an average age of 41 years, skew female, are primarily white (non-Hispanic), and the majority have English as their primary language.

		%
Age	19 to 25	14
	26 to 35	25
	36 to 45	24
	46 to 55	19
	56 to 64	19
	Mean Age	*41*
Gender	Male	40
	Female	60

		%
Race/ Ethnicity	White (non-Hispanic)	39
	Hispanic or Latino	9
	Black (non-Hispanic)	1
	Asian (non-Hispanic)*	1
	Another race or multi-race	4
	Missing	*46*
Primary Language	English	93
	Spanish	4
	Another language	3

**In the Utah Medicaid member database, Asian includes "Asian or Pacific Islander"*

Age, Gender, Race/Ethnicity, and Primary Language from Utah Medicaid member data (n=1,865)

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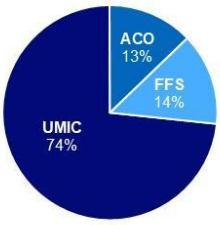
Member Type and Length of Enrollment

Members have been enrolled in their Medicaid plan for 14 months on average, with Utah Medicaid Integrated Care (UMIC) having the most enrollment.

Member Type



Length of Enrollment in Medicaid

Member Type and Length of Enrollment in Medicaid from Utah Medicaid member data (n=1,865)

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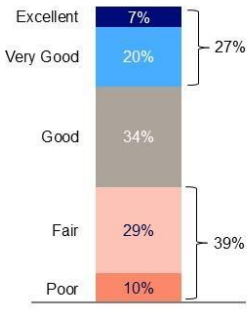
Member Health

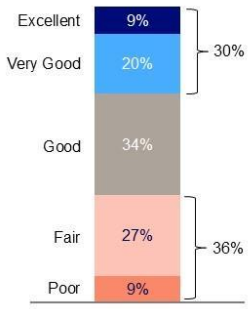
Members' ratings of their overall health or specifically, mental health, range mostly from good to poor.

- Less than a third of members rate their overall health or mental health as very good or excellent.

Overall Health



Overall Mental or Emotional Health



Q33 In general, how would you rate your overall health? (n=1,845)
Q34 In general, how would you rate your overall **mental or emotional** health? (n=1,851)

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Health Care Access

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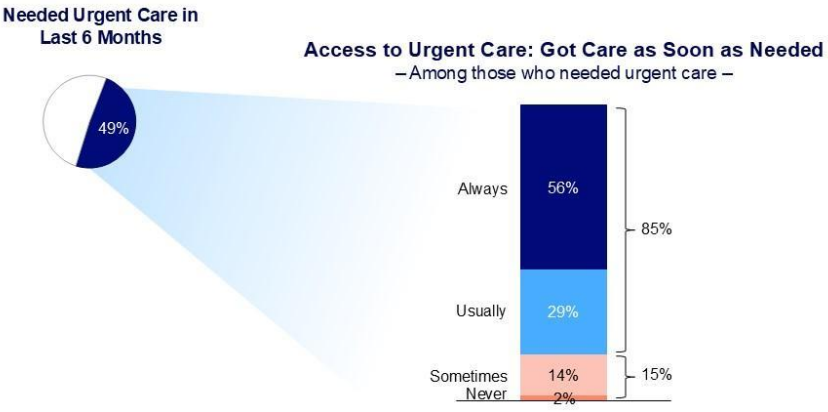
Access to Urgent Care

About half of members report having an illness, injury, or condition that needed care right away, and of them, 85% report always or usually getting care as soon as needed.

- 56% of those who needed urgent care report always being able to get care as soon as needed.



Q1 In the last 6 months, did you have an illness, injury, or condition that **needed care right away**? (n=1,849)
Q2 In the last 6 months, when you **needed care right away**, how often did you get care as soon as you needed? (n=913)

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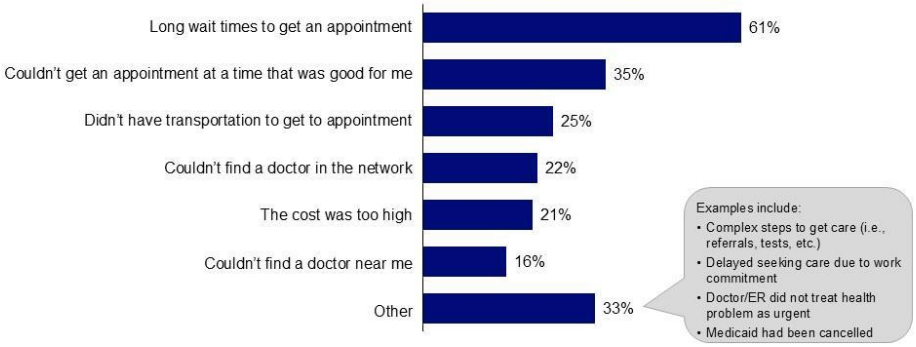
Lack of Access to Urgent Care

Reasons for lack of access center largely around long wait times for an appointment and, to a lesser extent, inability to get an appointment at a convenient time.

- Additional reasons include lack of transportation, inability to find a doctor in the network, and high cost of care.

Reasons Could Not Get Care as Soon as Needed
– Among those who sometimes/never got care as soon as needed –



Q3 Why were you not able to get care as soon as you needed? *Please select all that apply.* (n=134)

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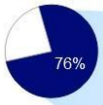
Access to Non-Urgent Care

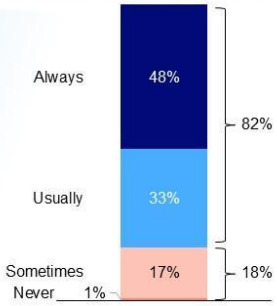
Roughly three-quarters of members report making an appointment for routine care in the past six months, and of them, 82% report always or usually getting the appointment as soon as needed.

- 48% of those who needed an appointment for routine care report always being able to get the appointment as soon as needed.

Made Appointment for Routine Care in Last 6 Months



Got Appointment for Routine Care as Soon as Needed
– Among those who made an appointment –



Q4 In the last 6 months, did you make any in-person, phone, or video appointments for a **check-up or routine care**? (n=1,851)
Q5 In the last 6 months, how often did you get an appointment for a **check-up or routine care** as soon as you needed? (n=1,396)

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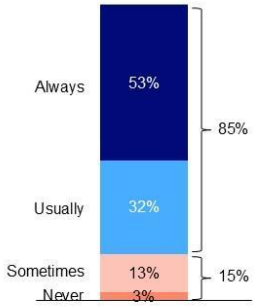
Ease of Accessing Care, Tests, or Treatment

Most members (85%) report it was always or usually easy to get the care, tests, or treatment they needed in the past six months.

- Just over half the members select the highest rating of "always" on this access measure.

Easily Got Needed Care, Tests, or Treatment in Last 6 Months



Q6 In the last 6 months, how often was it easy to get the care, tests, or treatment you needed? (n=1,831)

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Primary Care

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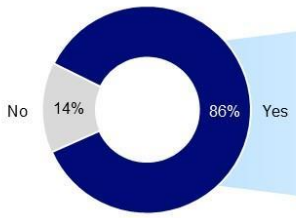
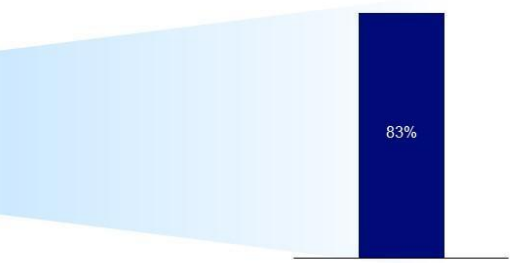
Access to Primary Care

86% of members report having a personal doctor (i.e., primary care provider), and of them, 83% report having had a visit with their PCP in the last six months.

Have a Personal Doctor



Had a Visit With Personal Doctor in Last 6 Months
– Among those who have a personal doctor –



Q7 A personal doctor is the one you would talk to if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? (n=1,850)
Q8 In the last 6 months, did you have an in-person, phone, or video visit with your personal doctor about your health? (n=1,588)

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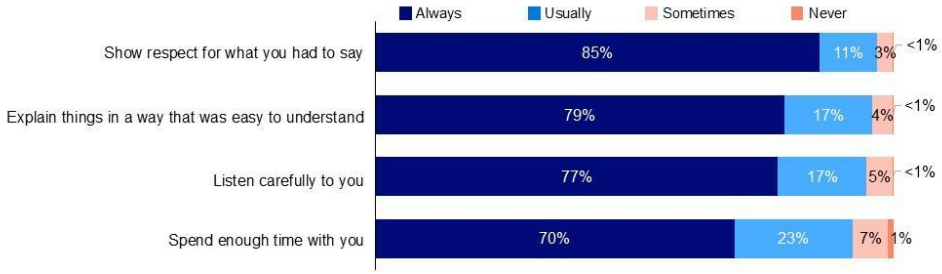
How Well Providers Communicate

Member perceptions of how well their PCP communicates with them are relatively positive, particularly on treating them with respect, explaining things in a way that is easy to understand, and listening carefully.

- Member perceptions of their PCP spending enough time with them show a somewhat wider gap for improvement.

Perceptions of Communication with Personal Doctor
– Among those who had a visit with personal doctor in last 6 months –



Q12 In the last 6 months, how often did your personal doctor show respect for what you had to say? (n=1,306)
Q9 In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? (n=1,311)
Q10 In the last 6 months, how often did your personal doctor listen carefully to you? (n=1,306)
Q13 In the last 6 months, how often did your personal doctor spend enough time with you? (n=1,308)

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Providers' Use of Information to Coordinate Patient Care

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Member perceptions of their PCP's use of information to coordinate their care show several gaps, particularly on knowing important information about their medical history and being informed about specialist care, tests, and results.

- There is also a perceived gap on discussing all prescription medications that the patient is taking.

Personal Doctors' Use of Information to Coordinate Care
– Among those who had a visit with personal doctor in last 6 months –

Q11 In the last 6 months, how often did your personal doctor seem to know the important information about your medical history? (n=1,307)
Q16 In the last 6 months, did you take any prescription medicine? (n=1,310)
Q17 In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? (n=1,256)
Q20 Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you have an in-person, phone, or video visit with a specialist? (n=1,301)
Q21 In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? (n=811)
Q22 In the last 6 months, how often did your personal doctor know about any tests or results you got from specialists? (n=737)

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Shared Decision Making

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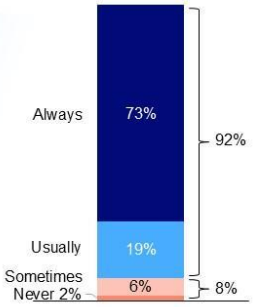
Nearly 90% of members who had a PCP visit in the last six months needed medical treatment, and of them, nearly three-quarters report that their PCP always involved them when developing their treatment plan.

Needed Medical Treatment in Last 6 Months
– Among those who had a visit with personal doctor in last 6 months –

Personal Doctor Involved Patient in Treatment Plan
– Among those who needed medical treatment in last 6 months –



Q14 In the last 6 months, did you need any medical treatment, such as medicine or a procedure? (n=1,303)
Q15 In the last 6 months, how often did your personal doctor work with you to make a treatment plan that works best for you? (n=1,155)

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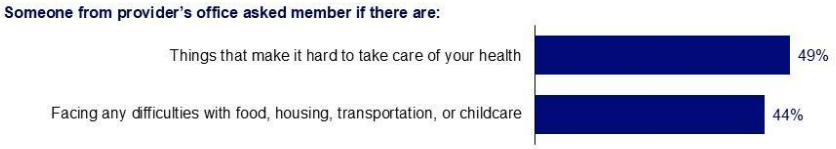
Social Determinants of Health

Less than half of members report that someone from their PCP's office asked them if there were things that make it difficult for them to take care of their health or if they are facing any difficulties related to social determinants of health.

Social Determinants of Health
– Among those who had a visit with personal doctor in last 6 months –



Q18 In the last 6 months, did someone from your personal doctor's office ask you if there are things that make it hard for you to take care of your health? (n=1,280)
Q19 In the last 6 months, did someone from your personal doctor's office ask if you are facing any difficulties in other areas of your life, such as food, housing, transportation, or childcare? (n=1,290)

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Mental Health Care

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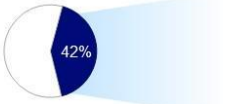
Access to Mental Health Care

42% of members report needing mental health counseling in the last six months, and of them, nearly 80% were able to get mental health counseling.

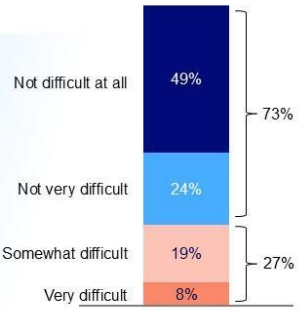
- Nearly half of those who got mental health counseling report experiencing no difficulty in finding a counselor, while 27% report that it was somewhat or very difficult to find a counselor.

Needed Mental Health Counseling in Last 6 Months



Got Mental Health Counseling in Last 6 Months
– Among those with need –

Difficulty Finding Mental Health Counselor
– Among those who got counseling in last 6 months–



Q23 By mental health we mean your sense of wellbeing and emotional health. In the last 6 months, did you **need** any mental health counseling for any reason? (n=1,847)
Q24 In the last 6 months, did you **get** any mental health counseling for any reason? (n=766)
Q25 In this survey, your **main mental health counselor** is the mental health counselor you talked with most often in the last 6 months. How difficult was it to find this mental health counselor? (n=580)

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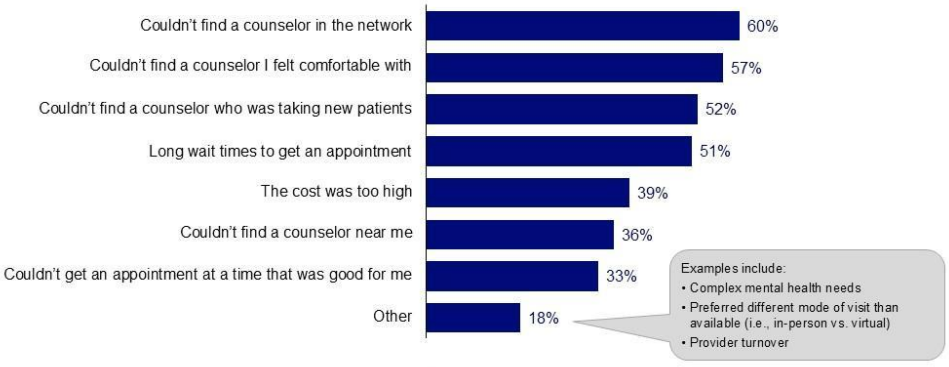
Lack of Access to Mental Health Counseling

Reasons for lack of access center largely around not being able to find a counselor in the network, someone they felt comfortable with, or who was accepting new patients.

- Long wait times to get an appointment also comprise a relatively common reason for lack of access.

Reasons It Was Difficult to Find a Mental Health Counselor
– Among those who found it somewhat/very difficult to find a counselor –



Q26 Why was it difficult to find your main mental health counselor? *Please select all that apply.* (n=150)

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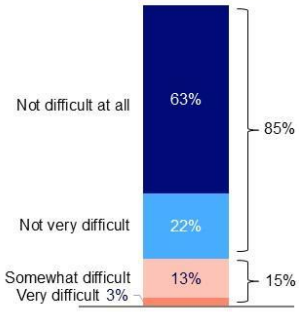
Accessing a Mental Health Counselor

The majority of those who got mental health counseling (85%) do not report experiencing much difficulty in making appointments with their counselor.

- 15% report that it was either somewhat or very difficult to get an appointment with their counselor.

Difficulty Making Appointments with Mental Health Counselor
– Among those who got counseling in last 6 months –



Q27 In the last 6 months, how difficult was it to make appointments with your main mental health counselor? (n=589)

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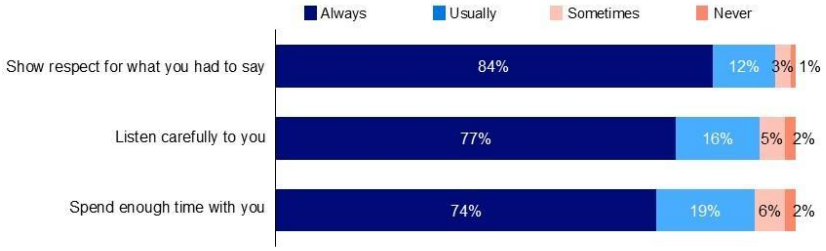
How Well Mental Health Counselors Communicate

Member perceptions of how well their mental health counselor communicates with them are relatively positive, particularly on treating them with respect and listening to them carefully.

- Member perceptions of their counselor spending enough time with them show a slightly wider gap for improvement.

Perceptions of Communication with Mental Health Counselor
– Among those who got counseling in last 6 months –



Q28 In the last 6 months, how often did your main mental health counselor listen carefully to you? (n=589)
Q29 In the last 6 months, how often did your main mental health counselor show respect for what you had to say? (n=589)
Q30 In the last 6 months, how often did your main mental health counselor spend enough time with you? (n=590)

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Shared Decision Making

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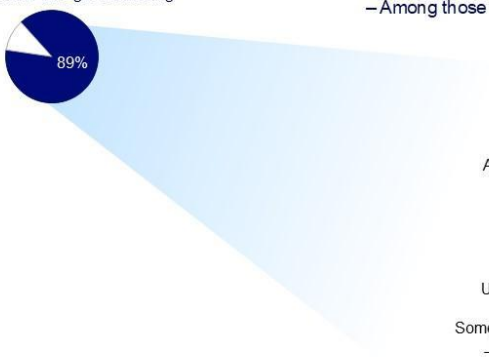
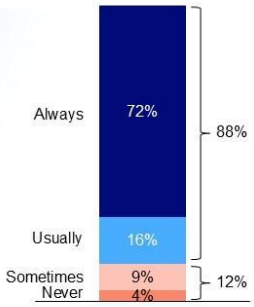
Nearly 90% of members who got mental health counseling in the last six months needed treatment, and of them, 88% report that their counselor always or usually involved them when developing their treatment plan.

Needed Mental Health Treatment in Last 6 Months
– Among those who got counseling –



Counselor Involved Patient in Treatment Plan
– Among those who needed treatment in last 6 months–



Q31 In the last 6 months, did you need any mental health treatment, such as medicine or a therapy? (n=590)
Q32 In the last 6 months, how often did your main mental health counselor work with you to make a treatment plan that works best for you? (n=519)

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Substance Use Treatment

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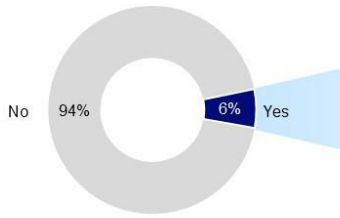
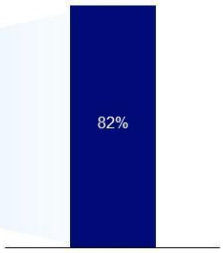
Access to Substance Use Treatment

Six percent of members report needing any health care services in the last six months to help them with alcohol or drug use, and of them, 82% report getting treatment or services.

Needed Substance Use Treatment in Last 6 Months



Got Substance Use Treatment
– Among those who needed treatment in last 6 months –



Q39 In the last 6 months, did you **need** any health care services to help you with alcohol use or drug use? (n=1,847)
Q40 In the last 6 months, did you **get** any health care services to help you with alcohol use or drug use? (n=114)

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Medication Management

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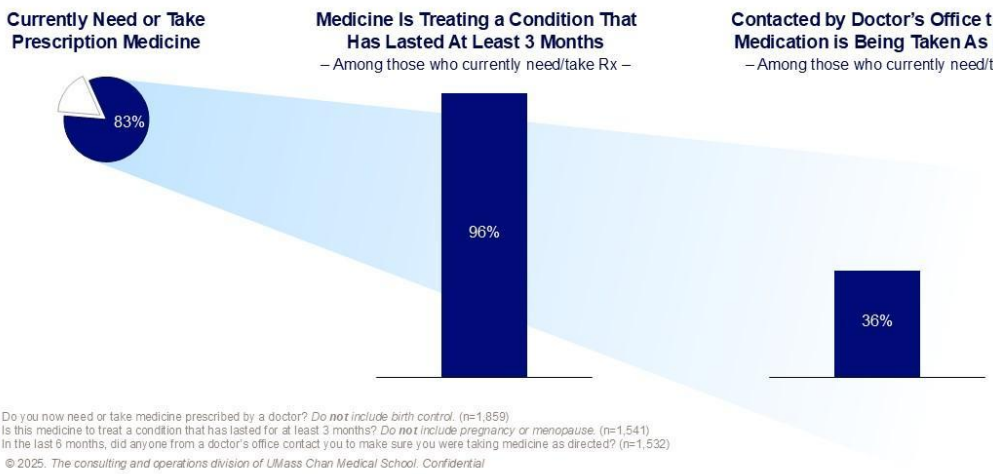
Rx Needs and Provider Communication

83% of members report currently taking prescription medication, mostly for a condition that has lasted for at least three months; however, only 36% report that their provider's office contacted them to ensure they were taking the medication as directed.



Q35 Do you now need or take medicine prescribed by a doctor? *Do **not** include birth control.* (n=1,859)
Q36 Is this medicine to treat a condition that has lasted for at least 3 months? *Do **not** include pregnancy or menopause.* (n=1,541)
Q37 In the last 6 months, did anyone from a doctor's office contact you to make sure you were taking medicine as directed? (n=1,532)

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Dental Services

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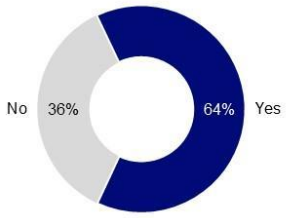
Awareness of Dental Benefit

Over a third of members (36%) are not aware that their Medicaid plan covers dental services.

Awareness that Health Insurance Covers Dental Services



Q38 Does your health insurance cover any dental services, such as routine cleanings? (n=1,511)

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Conclusions

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Health Care Access

- **There are some gaps in member access to urgent care.**
  - 56% of members who needed urgent care report always being able to get the care as soon as they needed, indicating a gap of 44%.
  - Among members who report sometimes or never getting urgent care as soon as needed, reasons for lack of access center primarily around long wait times for an appointment and, to a lesser extent, inability to get an appointment at a convenient time.
- **There are also some gaps in member access to routine care.**
  - Among members who made an appointment for a check-up or routine care, just over half (52%) report not always being able to get an appointment as soon as they needed.
- **Similarly, there is a gap in members' ease of accessing medical care, tests, or treatment.**
  - Overall, 53% of members report always finding it easy to get the care, tests, or treatment they needed, indicating a gap of 47%.

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Access to and Perceptions of Primary Care

- **There appears to be some gap in access to primary care.**
  - 14% of members report not having a personal doctor (i.e., a primary care provider).
- **Perceptions of how well primary care providers communicate are relatively positive.**
  - Member perceptions of how well their PCP communicates with them are relatively positive, particularly on treating them with respect, explaining things in a way that is easy to understand, and listening carefully.
  - Member perceptions of their PCP spending enough time with them show some room for improvement.
- **There is some room for improvement on care coordination.**
  - Member perceptions of their PCP's use of information to coordinate their care show several gaps, particularly on knowing important information about their medical history and being informed about specialist care, tests, and results.
  - There is also a perceived gap on discussing all prescription medications that the patient is taking.
- **Perceptions of shared decision-making are relatively positive.**
  - Nearly three-quarters (73%) of members who had a PCP visit and needed medical treatment in the last six months report that their PCP always involved them when developing their treatment plan.
- **Providers' focus on members' social determinants of health appears to be limited.**
  - Less than half of members report that someone from their PCP's office asked them if there were things that make it difficult for them to take care of their health or if they are facing any difficulties related to social determinants of health.

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Access to and Perceptions of Mental Health Care

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- **Some members experience difficulty in accessing mental health care.**
  - 42% of members report needing mental health counseling in the last six months, and of them, nearly 80% report getting mental health counseling.
  - Nearly half of those who got mental health counseling report experiencing no difficulty in finding a counselor, while 27% report that it was somewhat or very difficult to find a counselor.
  - Reasons for lack of access center largely around not being able to find a counselor in the network, someone the member felt comfortable with, or who was accepting new patients.
  - 63% of those who got mental health counseling do not report experiencing any difficulty in making appointments with their counselor; however, 15% report that it was somewhat or very difficult to make an appointment.
- **Perceptions of how well mental health counselors communicate are largely positive.**
  - Member perceptions of how well their mental health counselor communicates with them are relatively positive, particularly on treating them with respect and listening to them carefully.
  - Member perceptions of their counselor spending enough time with them show a slightly wider gap for improvement.
- **Perceptions of shared decision-making are positive.**
  - Nearly three-quarters (72%) of members who got mental health counseling and needed treatment in the last six months report that their counselor always involved them when developing their treatment plan.
- **A majority of members who need substance use treatment report being able to access it.**
  - Among the six percent of members who report needing health care services related to substance use in the last six months, 82% report getting treatment or services.
  - There is a gap in access for the 18% of members who were unable to get substance use treatment or services.

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Medication Management and Awareness of Dental Benefit

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- **Provider follow up for medication management appears limited.**
  - Among members currently taking prescription medication for a condition that has lasted for at least three months, only 36% report being contacted by their provider's office to ensure they were taking the medication as directed.
- **There is a need for greater communication of the available dental benefit to members.**
  - Over a third of members (36%) are not aware that their Medicaid plan covers dental services.

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Appendix

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Subgroup Differences

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Subgroup Analysis

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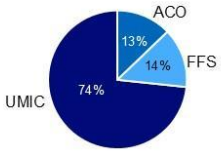
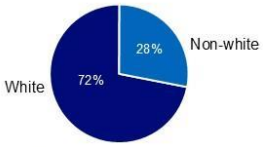
This section compares survey results by Member Type and Race & Ethnicity subgroups.

Member Type



Race & Ethnicity*



** Rebased by removing 46% of members for whom race/ethnicity data are not available in the Utah Medicaid Member database.*

Note:

- Only those measures are included in this section on which the subgroups show statistically significant differences at the 95% confidence level.
- Survey measures on which there are no significant differences between subgroups are not displayed.
  - In such instances, it can be assumed that the results displayed for members overall are consistent across subgroups.
  - For certain measures where the base size is too low due to skip logic in questions (e.g., "reasons for lack of access to urgent care" has low base sizes among ACO and FFS members), the ability to detect significant differences at the 95% confidence level would be limited.
- For measures where the results are based on a low base size (n<75), a footnote is included to suggest caution in interpreting those findings.

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Differences by Member Type: Primary Care

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Access to primary care appears to be strongest among ACO members compared to UMIC members and member perceptions of their PCP are stronger among ACO and UMIC members compared to FFS members.

		UMIC (U)	ACO (A)	FFS (F)
Access to Primary Care	Have a personal doctor	84%	**92%**^{U}	88%
How Well Providers Communicate*	**Always/usually** explained things in a way that was easy to understand	**96%**^{F}	97%	92%
Care Coordination*^	Personal doctor **usually** seemed informed and up-to-date about specialist care	**27%**^{F}	**32%**^{F}	18%
Social Determinants of Health*	Someone from provider's office asked about difficulties with food, housing, transportation, or childcare	**44%**^{F}	**48%**^{F}	36%

**Among those who had a visit with their personal doctor in the last 6 months*

^Among those who had a visit with a specialist in the last 6 months

U/A/F: Significantly higher than specified group at 95% confidence level

Q7 A personal doctor is the one you would talk to if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? (UMIC n=1356; ACO n=236; FFS n=258)
Q9 In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? (UMIC n=957; ACO n=173; FFS n=181)
Q21 In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists? (UMIC n=596; ACO n=97; FFS n=118)
Q19 In the last 6 months, did someone from your personal doctor's office ask if you are facing any difficulties in other areas of your life, such as food, housing, transportation, or childcare? (UMIC n=941; ACO n=169; FFS n=165)

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Differences by Member Type: Mental Health

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Ratings of overall mental health are stronger among FFS members compared to UMIC members, while ACO members are more likely than UMIC members to report no difficulty in finding a mental health counselor.

- FFS members are more likely than UMIC members to report having some difficulty in making appointments with their mental health counselor.

		UMIC (U)	ACO (A)	FFS (F)
Overall Mental or Emotional Health	**Very good** overall mental or emotional health	19%	21%	**25%**^{U}
	Fair/poor overall mental or emotional health	**38%**^{F}	33%	30%
Accessing a Mental Health Counselor*	**Not difficult at all** to find mental health counselor	47%	**62%**$^{U\wedge}$	53%
	Somewhat difficult to make appointments with mental health counselor	12%	11%	**21%**^{U}

**Among those who got mental health counseling in last 6 months*

U/A/F: Significantly higher than specified group at 95% confidence level

^Low base size; interpret results with caution

Q25 In this survey, your **main mental health counselor** is the mental health counselor you talked with most often in the last 6 months. How difficult was it to find this mental health counselor? (UMIC n=439; ACO n=65; FFS n=76)
Q27 In the last 6 months, how difficult was it to make appointments with your main mental health counselor? (UMIC n=448; ACO n=67; FFS n=74)
Q34 In general, how would you rate your overall **mental or emotional** health? (UMIC n=1,356; ACO n=237; FFS n=258)

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Differences by Member Type: Awareness of Dental Benefit

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FFS members are more aware than UMIC members of their dental coverage.

		UMIC (U)	ACO (A)	FFS (F)
Awareness of Dental Benefit	Aware that health insurance covers dental services	63%	64%	**71%**^{U}

U/A/F: Significantly higher than specified group at 95% confidence level

Q38 Does your health insurance cover any dental services, such as routine cleanings? (UMIC n=1110; ACO n=196; FFS n=205)

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Differences by Race & Ethnicity: Member Health

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The status of self-reported overall health and mental health is somewhat stronger among non-white than among white members.

		White (W)	Non-White (N)
Overall Health	Excellent/Very good	26%	25%
	Good	32%	**40%**[W]
	Fair/Poor	42%	35%
Overall Mental or Emotional Health	Excellent/Very good	28%	32%
	Good	32%	37%
	Fair/Poor	**40%**[N]	31%

W/N: Significantly higher than specified group at 95% confidence level

Q33 In general, how would you rate your overall health? (White n=675; Non-White n=240)
Q34 In general, how would you rate your overall mental or emotional health? (White n=677; Non-White n=242)

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Differences by Race & Ethnicity: Health Care Access

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White members are more likely than non-white members to report having made an appointment for non-urgent care in the last six months.

		White (W)	Non-White (N)
Access to Non-Urgent Care	Made an appointment for non-urgent care in last 6 months	**79%**[N]	69%

W/N: Significantly higher than specified group at 95% confidence level

Q4 In the last 6 months, did make any in-person, phone, or video appointments for a **check-up or routine care**? (White n=682; Non-White n=244)

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Differences by Race & Ethnicity: Primary Care

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Access to primary care is somewhat stronger among white than non-white members and while white members have slightly more positive perceptions of provider communication, perceptions of care coordination are somewhat stronger among non-white members.

		White (W)	Non-White (N)
Access to Primary Care	Has a personal doctor	**88%^{N}**	82%
How Well Providers Communicate*	Always listened carefully to patient	76%	82%
	Usually listened carefully to patient	**19%^{N}**	10%
	Sometimes/Never listened carefully to patient	5%	8%
Care Coordination*	**Always** seemed to know important information about patient's medical history	62%	**73%^{W}**
	Never knew about tests or results from specialists^	**6%^{N}**	1%

*Among those who had a visit with their personal doctor in the last 6 months

^Among those who had a visit with a specialist in the last 6 months

W/N: Significantly higher than specified group at 95% confidence level

Q7 A personal doctor is the one you would talk to if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor? (White n=680; Non-White n=243)
Q10 In the last 6 months, how often did your personal doctor listen carefully to you? (White n=494; Non-White n=165)
Q11 In the last 6 months, how often did your personal doctor seem to know the important information about your medical history? (White n=495; Non-White n=166)
Q22 In the last 6 months, how often did your personal doctor know about any tests or results you got from specialists? (White n=267; Non-White n=95)

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Differences by Race & Ethnicity: Mental Health Care

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Consistent with lower ratings on their self-reported mental health status, white members are more likely than non-white members to have experienced a need for mental health counseling and treatment in the past six months.

		White (W)	Non-White (N)
Need for Mental Health Care	Needed mental health counseling in the last 6 months	**45%^{N}**	32%
	Needed mental health treatment in the last 6 months*	**92%^{N}**	81%^

*Among those who got mental health counseling in the last 6 months

W/N: Significantly higher than specified group at 95% confidence level

^Low base size; interpret results with caution

Q23 By mental health we mean your sense of wellbeing and emotional health. In the last 6 months, did you need any mental health counseling for any reason? (White n=682; Non-White n=239)
Q31 In the last 6 months, did you need any mental health treatment, such as medicine or a therapy? (White n=226; Non-White n=62)

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Differences by Race & Ethnicity: Medication Management

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White members are more likely than non-white members to report taking prescription medication; however, non-white members are more likely to report provider involvement in medication management.

		White (W)	Non-White (N)
Need Prescription Medicine for Condition	Currently need or take prescription medicine	**84%N**	75%
	Medicine is treating a condition that has lasted 3 months or more*	**97%N**	89%
Doctor's Office Communication about Medicine*	Contacted by doctor's office to make sure they were taking medicine as directed	35%	**46%W**

**Among those who currently need or take prescription medicine* *W/N: Significantly higher than specified group at 95% confidence level*

Q35 Do you now need or take medicine prescribed by a doctor? *Do **not** include birth control.* (White n=686; Non-White n=243)
Q36 Is this medicine to treat a condition that has lasted for at least 3 months? *Do **not** include pregnancy or menopause.* (White n=578; Non-White n=186)
Q37 In the last 6 months, did anyone from a doctor's office contact you to make sure you were taking medicine as directed? (White n=577; Non-White n=184)

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Disposition Report

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Final Disposition Report

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	Counts	% of Total Sample
Total Sample	**6,000**	
Interviews:	**1865**	**31%**
Completes	1862	31%
Mail	332	6%
Phone	1193	20%
Web	337	6%
Partials (any mode)*	3	0.1%
Eligible, Non-Interviews:	**38**	**0.6%**
Break-offs*	38	0.6%
Unknown Eligibility, Non-Interviews:	**4015**	**67%**
Answering machine or voicemail	2449	41%
Refusal	455	8%
Non-working/disconnected/wrong number	464	8%
No reply	387	6%
Respondent not available	100	2%
Busy	160	3%
Ineligible:	**82**	**1%**
Language barrier	31	0.5%
Not a Utah Medicaid Member	28	0.5%
Mentally/physically unable to complete survey and no available proxy	14	0.2%
Invalid address and phone number	6	0.1%
Deceased	3	0.1%
Response Rate**	**32%**	

	Counts	% of Completed Interviews
Completed Interviews	**1865**	
By Language		
English	1802	96.6%
Spanish	63	3.4%

*Partials: those who answered at least through Q33 are included in analysis; Break-offs: those who broke off before Q33 are not included in analysis.

**AAPOR Response Rate 4, calculated as $\frac{(I+P)}{(I+P)+(ENI)+e(UE)} = \frac{1865}{(1865)+(38)+0.9587(4015)} = 32.4\%$, where e is the estimated proportion of eligible cases among cases of unknown eligibility.

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Project Team

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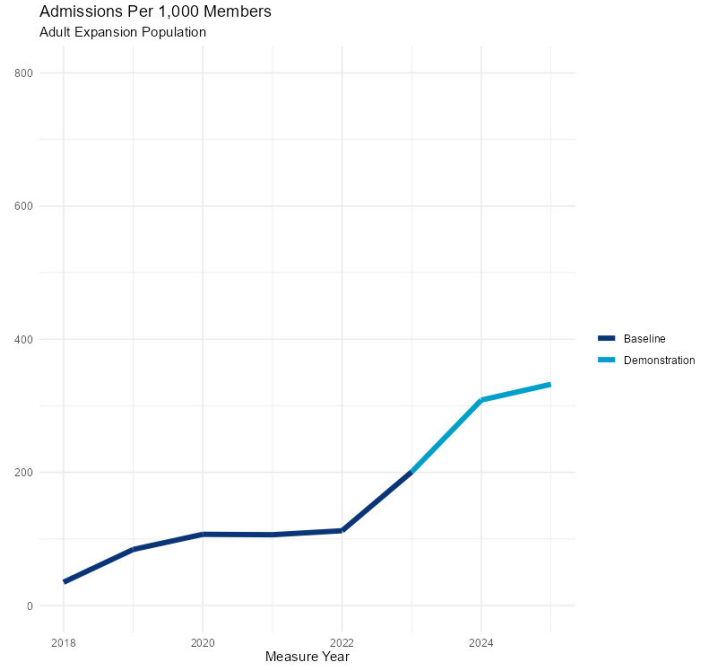
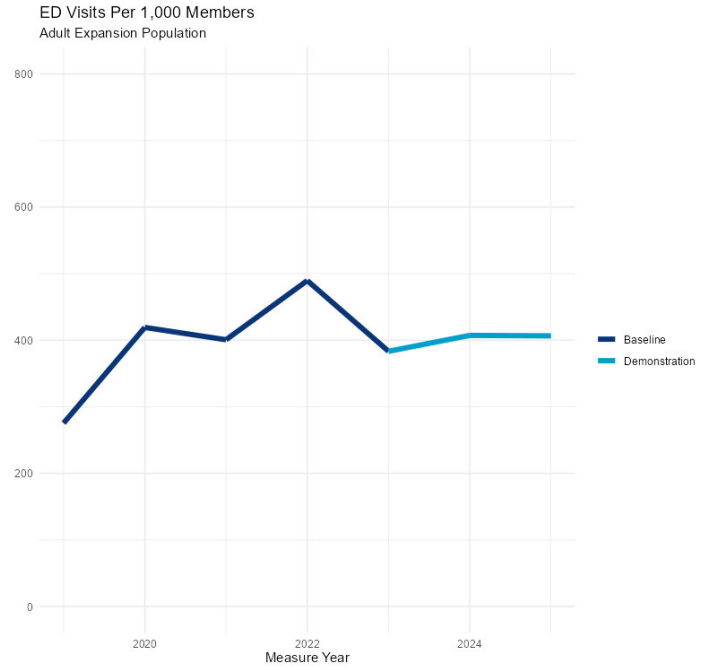
5. Adult Expansion: Trend Over Time Results by Measure

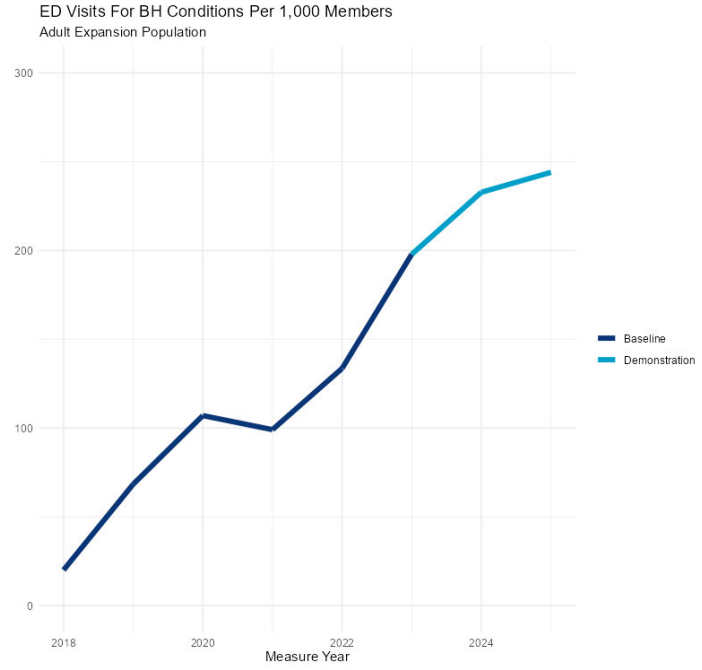
Acute Hospital Utilization (AHU)



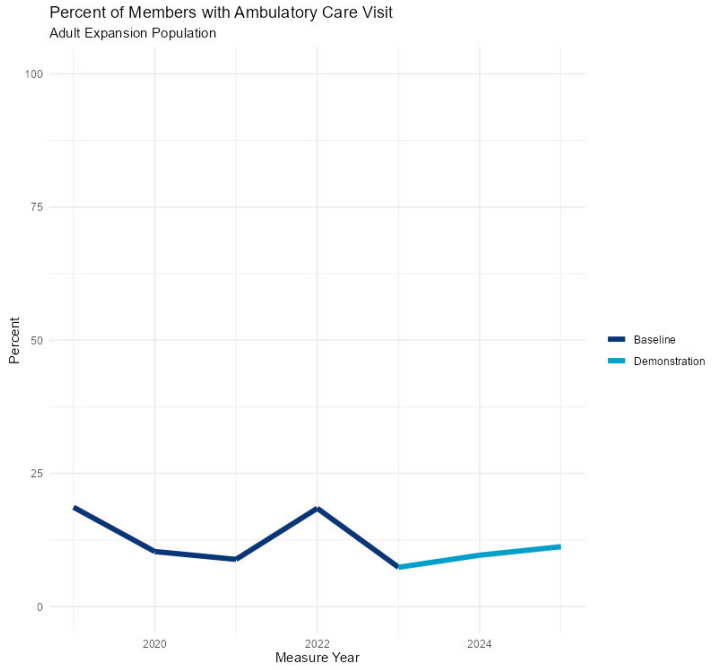
Emergency Department Utilization (EDU)



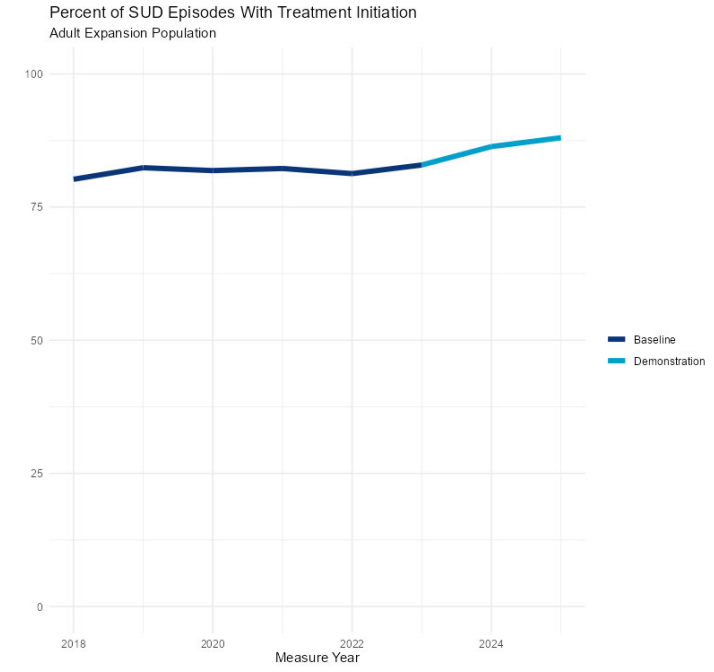
Emergency Department Utilization, Behavioral Health Condition (EDU-BH)



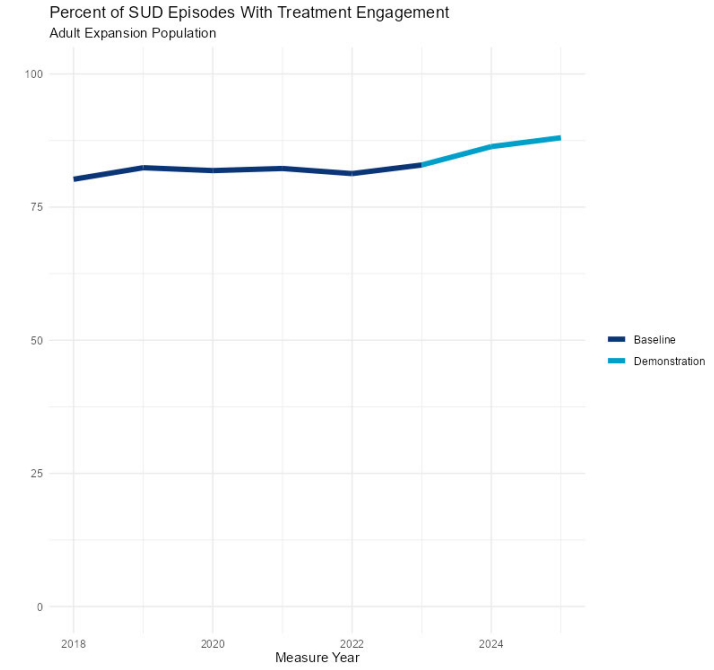
Adult Access to Ambulatory/Preventive Care (AAP)



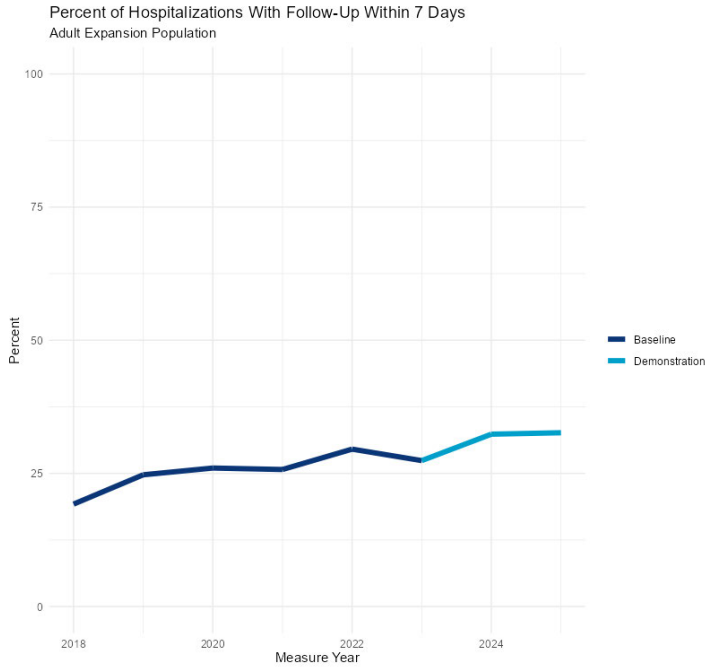
Initiation and Engagement in SUD Treatment (IET), Initiation



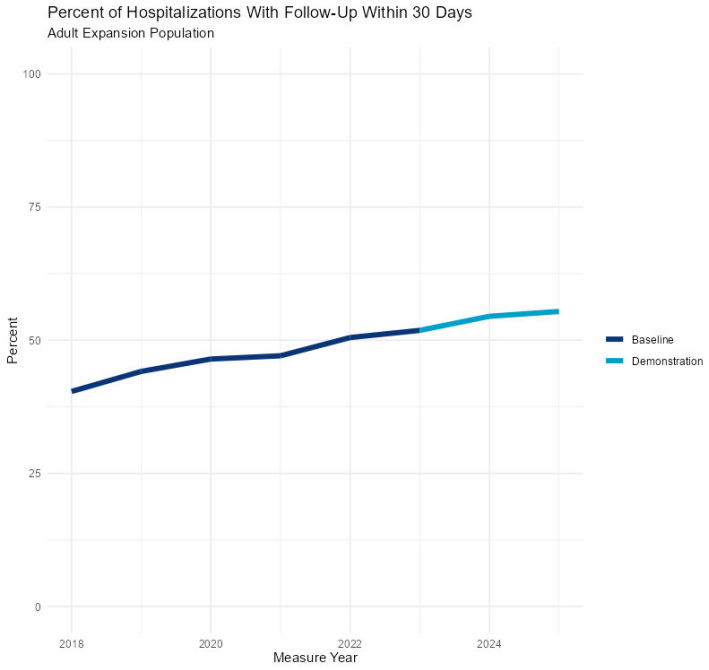
Initiation and Engagement in SUD Treatment (IET), Engagement



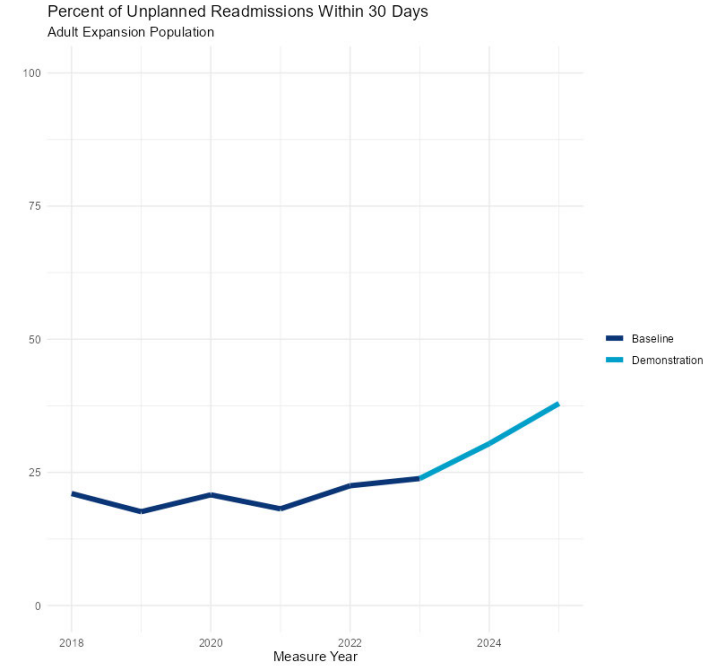
Follow-Up After Hospitalization for Mental Illness (FUH), 7-Day



Follow-Up After Hospitalization for Mental Illness (FUH), 30-Day

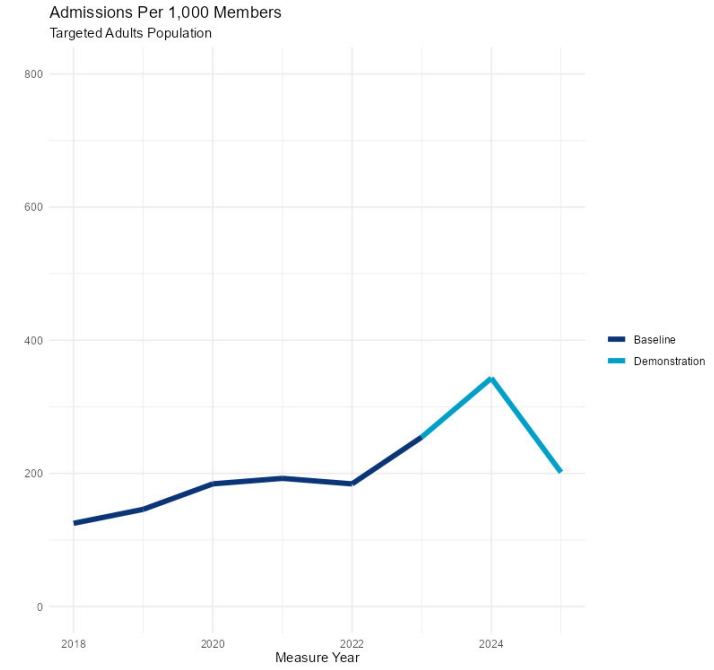


30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF)

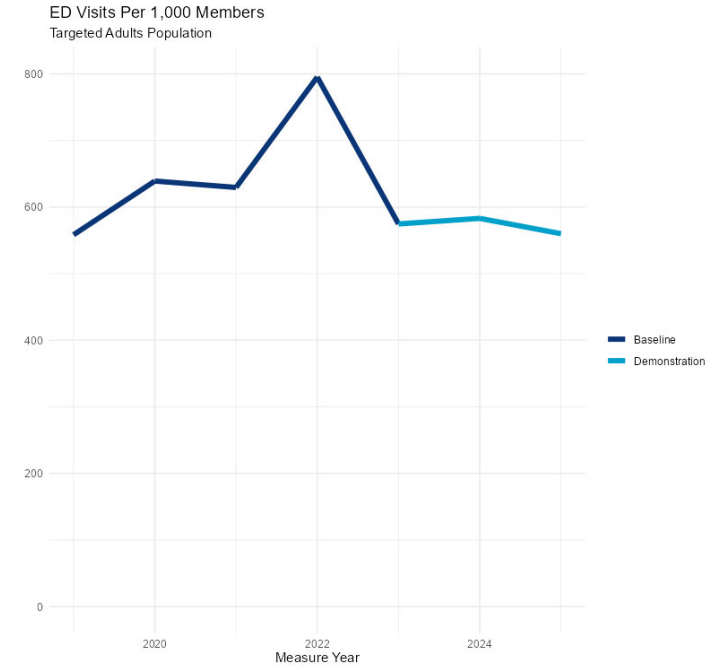


6. Targeted Adult Medicaid: Trend Over Time Results by Measure

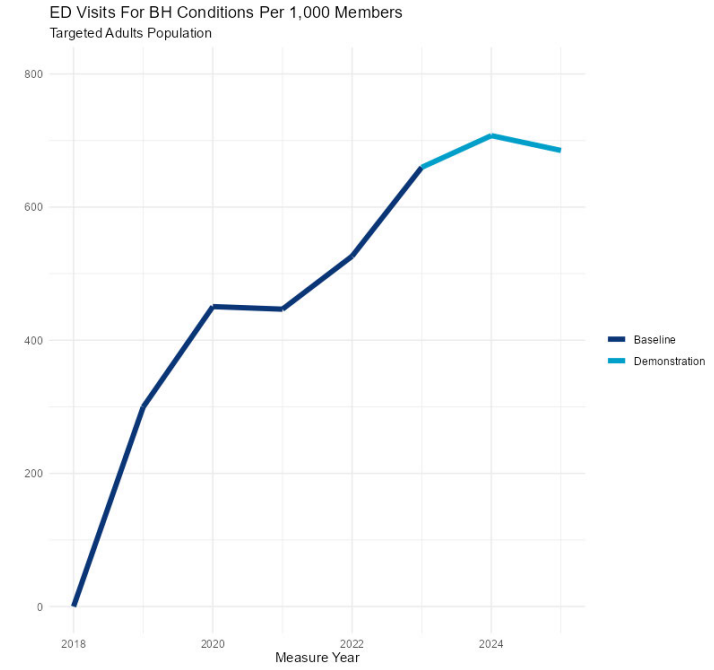
Acute Hospital Utilization (AHU)



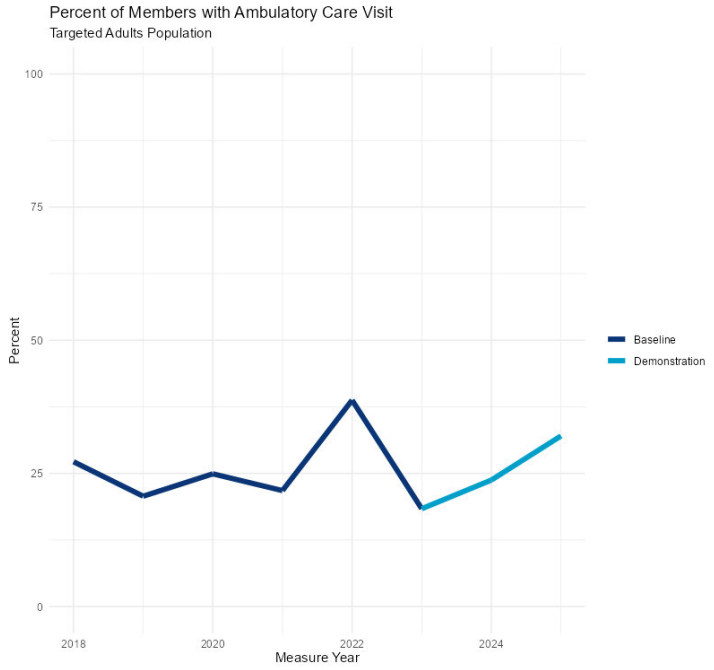
Emergency Department Utilization (EDU)



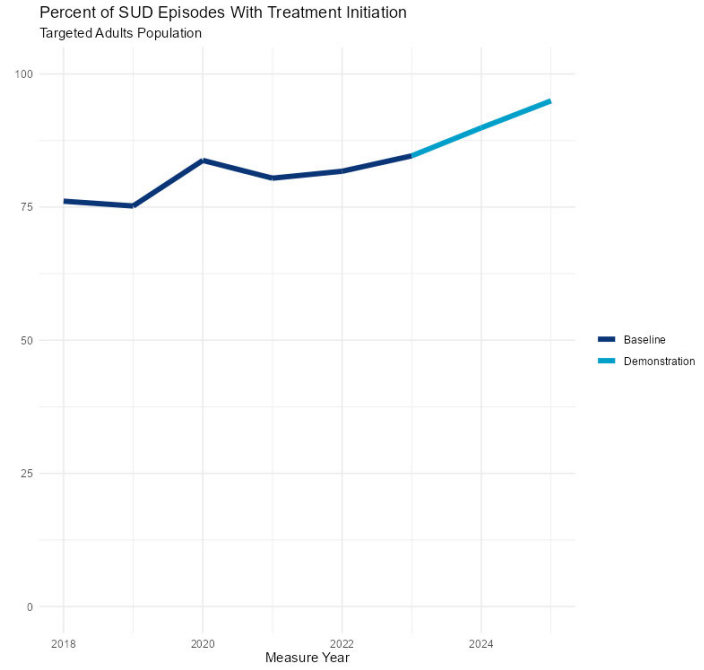
Emergency Department Utilization, Behavioral Health Condition (EDU-BH)



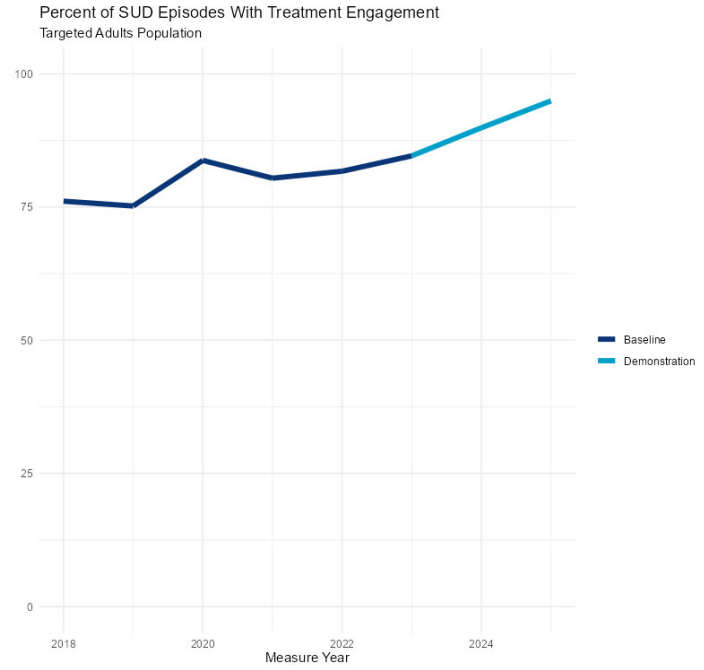
Adult Access to Ambulatory/Preventive Care (AAP)



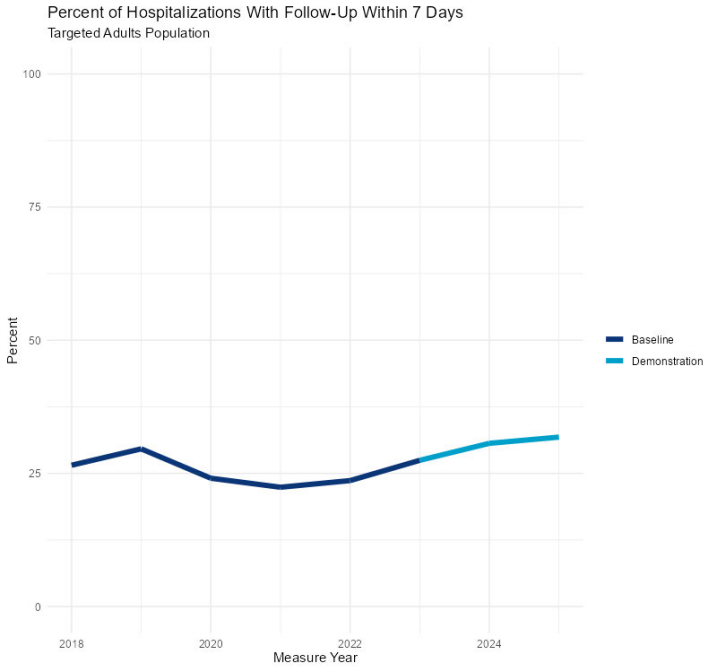
Initiation and Engagement in SUD Treatment (IET), Initiation



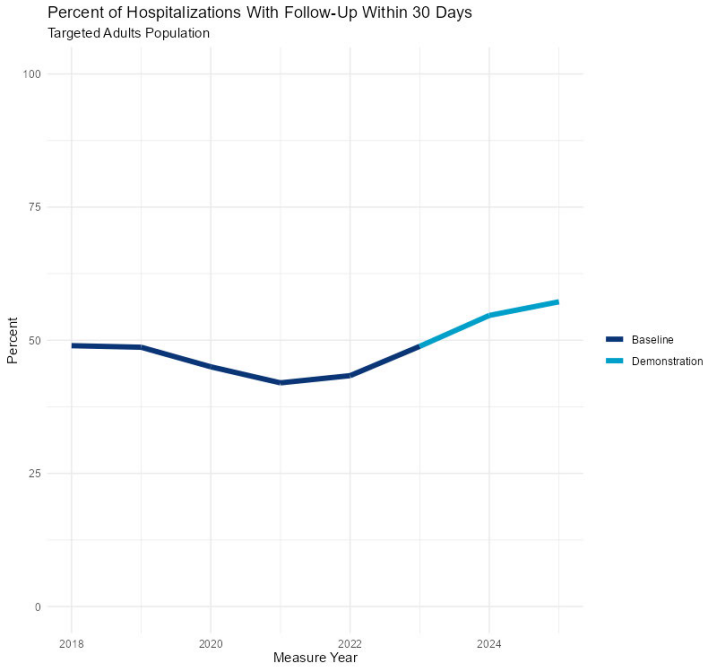
Initiation and Engagement in SUD Treatment (IET), Engagement



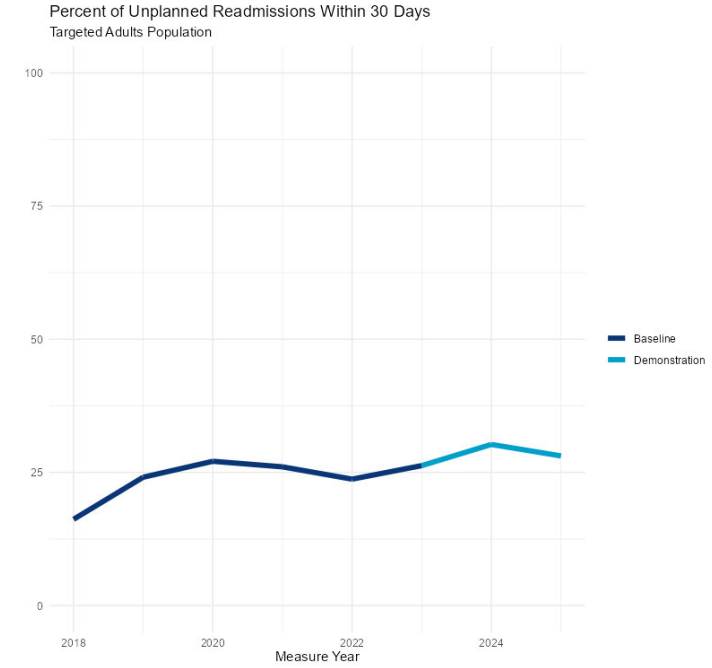
Follow-Up After Hospitalization for Mental Illness (FUH), 7-Day



Follow-Up After Hospitalization for Mental Illness (FUH), 30-Day



30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF)



7. Adult Expansion: Regression Results by Measure

Acute Hospital Utilization (AHU)

	Adjusted	SE	CI
Measure Year	0.028	0.023	[-0.018, 0.074]
Post-Demonstration*Measure Year	0.159***	0.033	[0.094, 0.224]
Age	0.042***	0.002	[0.038, 0.047]
Gender			
Male	Ref	-	-
Female	-0.381***	0.054	[-0.487, -0.275]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-0.007	0.078	[-0.159, 0.145]
Race			
White	Ref	-	-
Non-White	-0.003	0.042	[-0.086, 0.080]
Other or Missing	-0.018	0.031	[-0.078, 0.043]
N	314,247		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Emergency Department Utilization (EDU)

	Adjusted	SE	CI
Measure Year	43.555***	3.104	[37.471 ,49.639]
Post-Demonstration*Measure Year	-67.164***	7.094	[-81.071, -53.257]

Age	-0.469*	0.187	[-0.835, -0.103]
Gender			
Male	Ref	-	-
Female	-36.053***	4.967	[-45.791, -26.316]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	41.590***	5.160	[31.474, 51.705]
Race			
White	Ref	-	-
Non-White	13.527*	6.104	[1.561, 25.492]
Other or Missing	-17.988**	6.090	[-29.926, -6.050]
N	8,170		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Emergency Department Utilization, Behavioral Health Condition (EDU-BH)

	Adjusted	SE	CI
Measure Year	19.437***	4.890	[9.850, 29.025]
Post-Demonstration*Measure Year	2.603	13.132	[23.146, 28.352]
Age	-0.015	0.346	[-0.693, 0.663]
Gender			
Male	Ref	-	-
Female	-98.963***	9.416	[-117.326, -80.400]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-14.120	9.555	[-32.855, 4.616]
Race			
White	Ref	-	-
Non-White	2.470	10.560	[-15.236, 26.177]
Other or Missing	-33.174*	13.953	[-60.532, -5.815]
N	2,983		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Adult Access to Ambulatory/Preventive Care (AAP)

	Adjusted	SE	CI
Measure Year	-0.843***	0.204	[-1.243, -0.444]
Post-Demonstration*Measure Year	2.790***	0.485	[1.840, 3.741]
Age	0.150***	0.013	[0.125, 0.175]
Gender			
Male	Ref	-	-
Female	2.258***	0.347	[1.578, 2.938]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-1.510***	0.350	[-2.196, -0.824]

Race			
White	Ref	-	-
Non-White	-1.055**	0.390	[-1.820, -0.290]
Other or Missing	-0.366	0.511	[-1.369, 0.637]
N	2,875		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Initiation and Engagement in SUD Treatment (IET), Initiation

	Adjusted	SE	CI
Measure Year	0.982	0.026	[0.932, 1.035]
Post-Demonstration*Measure Year	1.387***	0.119	[1.171, 1.642]
Age	1.010**	0.003	[1.004, 1.016]
Gender			
Male	Ref	-	-
Female	1.163***	0.040	[1.088, 1.244]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	0.823***	0.033	[0.761, 0.891]
Race			
White	Ref	-	-
Non-White	0.778	0.102	[0.602, 1.007]
Other or Missing	1.085	0.064	[0.966, 1.218]
N	45,241		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Initiation and Engagement in SUD Treatment (IET), Engagement

	Adjusted	SE	CI
Measure Year	0.820	0.444	[-0.050, 1.690]
Post-Demonstration*Measure Year	3.546**	1.350	[0.900, 6.192]
Age	-0.012	0.036	[-0.082, 0.059]
Gender			
Male	Ref	-	-
Female	2.904**	0.968	[1.007, 4.802]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-2.387*	1.022	[-4.392, -0.383]
Race			
White	Ref	-	-
Non-White	-2.817*	1.095	[-4.963, -0.671]
Other or Missing	1.009	1.467	[-1.867, 3.885]
N	2,785		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Follow-Up After Hospitalization for Mental Illness (FUH), 7-Day

	Adjusted	SE	CI
Measure Year	1.100***	0.029	[1.045, 1.158]
Post-Demonstration*Measure Year	1.021	0.041	[0.944, 1.105]
Age	0.996*	0.002	[0.992, 1.000]
Gender			
Male	1	-	[1, 1]
Female	1.343***	0.037	[1.271, 1.418]
Ethnicity			
Non-Hispanic	1	-	[1, 1]
Hispanic	0.713**	0.072	[0.586, 0.868]
Race			
White	1	-	[1, 1]
Non-White	0.891**	0.039	[0.819, 0.970]
Other or Missing	0.834*	0.065	[0.717, 0.971]
N	16,003		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Follow-Up After Hospitalization for Mental Illness (FUH), 30-Day

	Adjusted	SE	CI
Measure Year	1.099***	0.017	[1.066, 1.132]
Post-Demonstration*Measure Year	0.977	0.031	[0.918, 1.040]
Age	0.999	0.002	[0.995, 1.002]
Gender			
Male	1	-	[1, 1]
Female	1.383***	0.049	[1.290, 1.482]
Ethnicity			
Non-Hispanic	1	-	[1, 1]
Hispanic	0.624***	0.054	[0.527, 0.739]
Race			
White	1	-	[1, 1]
Non-White	0.883***	0.031	[0.824, 0.947]
Other or Missing	0.807***	0.044	[0.726, 0.897]
N	16,003		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF)

	Adjusted	SE	CI
Measure Year	1.037	0.051	[0.942, 1.142]
Post-Demonstration*Measure Year	1.287***	0.068	[1.160, 1.427]

Age	1.039***	0.002	[1.036, 1.042]
Gender			
Male	Ref	-	-
Female	0.705***	0.031	[0.648, 0.768]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	1.057	0.084	[0.905, 1.236]
Race			
White	Ref	-	-
Non-White	1.066	0.071	[0.935, 1.215]
Other or Missing	1.071	0.099	[0.893, 1.284]
N	21,197		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

8. Targeted Adult Medicaid: Regression Results by Measure

Acute Hospital Utilization (AHU)

	Adjusted	SE	CI
Measure Year	0.010	0.037	[-0.062, 0.082]
Post-Demonstration*Measure Year	-0.087	0.054	[-0.193, 0.019]
Age	0.029***	0.002	[0.025, 0.033]
Gender			
Male	Ref	-	-
Female	0.099	0.053	[-0.005, 0.203]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-0.062	0.100	[-0.258, 0.133]
Race			
White	Ref	-	-
Non-White	-0.119*	0.047	[-0.211, -0.278]
Other or Missing	0.094	0.133	[-3.105, -2.582]
N	28,147		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Emergency Department Utilization (EDU)

	Adjusted	SE	CI
Measure Year	0.982	0.013	[0.957, 1.007]
Post-Demonstration*Measure Year	0.913***	0.023	[0.869, 0.960]
Age	1.004***	0.001	[1.003, 1.005]
Gender			
Male	1	-	[1, 1]
Female	1.102***	0.027	[1.050, 1.157]
Ethnicity			
Non-Hispanic	1	-	[1, 1]

Hispanic	1.011	0.042	[0.932, 1.098]
Race			
White	1	-	[1, 1]
Non-White	1.056*	0.027	[1.004, 1.111]
Other or Missing	0.864**	0.043	[0.783, 0.953]
N	36,719		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Emergency Department Utilization, Behavioral Health Condition (EDU-BH)

	Adjusted	SE	CI
Measure Year	46.577**	17.366	[15.521, 83.633]
Post-Demonstration*Measure Year	-45.816	38.642	[-121.594, 29.963]
Age	-2.379*	1.164	[-4.661, -0.096]
Gender			
Male	Ref	-	-
Female	-13.620	28.938	[-70.370, 43.130]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-55.068	30.582	[-115.041, 4.906]
Race			
White	Ref	-	-
Non-White	919.188	32.760	[-83.433, 45.056]
Other or Missing	-160.314***	41.699	[-242.088, -78.540]
N	2,172		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Adult Access to Ambulatory/Preventive Care (AAP)

	Adjusted	SE	CI
Measure Year	1.041**	0.014	[1.013, 1.069]
Post-Demonstration*Measure Year	1.314***	0.026	[1.265, 1.366]
Age	1.004**	0.001	[1.001, 1.006]
Gender			
Male	1	-	[1, 1]
Female	1.627***	0.112	[1.422, 1.861]
Ethnicity			
Non-Hispanic	1	-	[1, 1]
Hispanic	0.838***	0.026	[0.789, 0.891]
Race			
White	1	-	[1, 1]
Non-White	0.876***	0.012	[0.853, 0.899]
Other or Missing	0.922***	0.011	[0.902, 0.943]
N	89,355		

95% confidence intervals in brackets

*p < 0.05, **p < 0.01, ***p < 0.001

Initiation and Engagement in SUD Treatment (IET), Initiation

	Adjusted	SE	CI
Measure Year	1.571**	0.526	[0.539, 2.603]
Post-Demonstration*Measure Year	3.611*	1.434	[0.799, 6.422]
Age	0.044	0.045	[-0.045, 0.132]
Gender			
Male	Ref	-	-
Female	-1.002	1.095	[-3.150, 1.146]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	1.159	1.208	[-1.209, 3.527]
Race			
White	Ref	-	-
Non-White	-3.287**	1.235	[-5.709, -0.865]
Other or Missing	-0.443	1.618	[-3.616, 2.730]
N	1,993		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Initiation and Engagement in SUD Treatment (IET), Engagement

	Adjusted	SE	CI
Measure Year	0.993	0.019	[0.956, 1.031]
Post-Demonstration*Measure Year	1.483***	0.032	[1.421, 1.548]
Age	1.003*	0.002	[1.000, 1.006]
Gender			
Male	Ref	-	-
Female	0.943	0.040	[0.966, 1.025]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	1.038	0.040	[0.962, 1.120]
Race			
White	Ref	-	-
Non-White	0.896***	0.014	[0.868, 0.924]
Other or Missing	1.002	0.030	[0.945, 1.063]
N	14,378		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Follow-Up After Hospitalization for Mental Illness (FUH), 7-Day

	Adjusted	SE	CI
Measure Year	1.030	0.019	[0.993, 1.069]
Post-Demonstration*Measure Year	1.141*	0.064	[1.022, 1.273]

Age	1.003	0.005	[0.993, 1.013]
Gender			
Male	1	-	[1, 1]
Female	1.203	0.117	[0.994, 1.456]
Ethnicity			
Non-Hispanic	1	-	[1, 1]
Hispanic	0.954	0.135	[0.722, 1.260]
Race			
White	1	-	[1, 1]
Non-White	0.951	0.093	[0.785, 1.151]
Other or Missing	1.029	0.109	[0.836, 1.267]
N	2,879		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Follow-Up After Hospitalization for Mental Illness (FUH), 30-Day

	Adjusted	SE	CI
Measure Year	1.026	0.023	[0.981, 1.073]
Post-Demonstration*Measure Year	1.044	0.062	[0.929, 1.173]
Age	1.005	0.003	[0.999, 1.011]
Gender			
Male	1	-	[1, 1]
Female	1.279**	0.108	[1.084, 1.510]
Ethnicity			
Non-Hispanic	1	-	[1, 1]
Hispanic	1.091	0.170	[0.803, 1.482]
Race			
White	1	-	[1, 1]
Non-White	1.085	0.076	[0.972, 1.211]
Other or Missing	1.007	0.076	[0.869, 1.166]
N	2,879		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF)

	Adjusted	SE	CI
Measure Year	0.995	0.080	[0.849, 1.165]
Post-Demonstration*Measure Year	0.978	0.065	[0.859, 1.113]
Age	1.026***	0.003	[1.020, 1.032]
Gender			
Male	Ref	-	-
Female	0.658***	0.043	[0.579, 0.747]
Ethnicity			

Non-Hispanic	Ref	-	-
Hispanic	1.263	0.232	[0.881, 1.809]
Race			
White	Ref	-	-
Non-White	1.049	0.048	[0.959, 1.147]
Other or Missing	0.910	0.114	[0.712, 1.163]
N	4,383		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

9. SMI/SUD Demonstrations: Regression Results by Measure

Initiation and Engagement in SUD Treatment (IET), Initiation, SUD

	Adjusted	SE	CI
Measure Year	0.990	0.019	[0.954, 1.028]
Post-Demonstration*Measure Year	1.406***	0.060	[1.294, 1.528]
Age	1.014***	0.001	[1.011, 1.017]
Gender			
Male	Ref	-	-
Female	1.083*	0.039	[1.010, 1.162]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	0.870***	0.022	[0.828, 0.915]
Race			
White	Ref	-	-
Non-White	0.769**	0.067	[0.648, 0.912]
Other or Missing	1.028	0.043	[0.947, 1.116]
N	75,605		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

Initiation and Engagement in SUD Treatment (IET), Engagement, SUD

	Adjusted	SE	CI
Measure Year	0.987	0.012	[0.964, 1.010]
Post-Demonstration*Measure Year	1.270***	0.040	[1.193, 1.351]
Age	0.993***	0.001	[0.992, 0.995]
Gender			
Male	Ref	-	-
Female	0.987	0.023	[0.943, 1.033]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	0.877***	0.027	[0.826, 0.931]
Race			
White	Ref	-	-
Non-White	0.857***	0.038	[0.786, 0.934]

Other or Missing	1.004	0.016	[0.973, 1.035]
N	75,605		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

30-Day All-Cause Unplanned Readmission Following Hospitalization in an Inpatient Psychiatric Facility (IPF), SMI

	Adjusted	SE	CI
Measure Year	3.020***	0.383	[2.269, 3.771]
Post-Demonstration*Measure Year	4.815***	1.177	[2.507, 7.122]
Age	1.150***	0.21	[1.108, 1.192]
Gender			
Male	Ref	-	-
Female	-1.714*	0.871	[3.422, -0.006]
Ethnicity			
Non-Hispanic	Ref	-	-
Hispanic	-15.794***	0.968	[-17.693, -13.896]
Race			
White	Ref	-	-
Non-White	-4.304***	0.993	[-6.250, -2.358]
Other or Missing	-0.629	1.303	[-3.183, 1.925]
N	3,687		

95% confidence intervals in brackets
*p < 0.05, **p < 0.01, ***p < 0.001

2027-2032 Renewal

Attachment 2

Annual External Quality Review Report

State of Utah

Department of Health and Human Services

Office of Managed Care

Annual External Quality Review Report of Results

April 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

The Balanced Budget Act of 1997 (BBA) and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) require states that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) ensure that a qualified external quality review organization (EQRO) conduct an annual external quality review (EQR) and prepare a detailed annual technical report of results that summarizes findings on the quality and timeliness of, and access to care. In May 2016, the Centers for Medicare & Medicaid Services (CMS) released revised Medicaid and Children's Health Insurance Program (CHIP) managed care regulations. In February 2018 CHIP was reauthorized via House Bill 195 and the Bipartisan Budget Act of 2018 and in December 2022, the Consolidated Appropriations Act extended federal funding for CHIP for an additional two years and made permanent a state option to provide 12 months of postpartum coverage in Medicaid and CHIP. HSAG developed this EQR technical report to comply with 42 Code of Federal Regulations (CFR) §438.364 as articulated in the May 2016 regulations with revisions released in November 2020, effective December 2020. The Utah Department of Health and Human Service (DHHS), formerly the Utah Department of Health, is the Utah State agency responsible for the administration of Utah's Medicaid and CHIP programs. DHHS has contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to prepare this report.

To provide medical services in calendar year (CY) 2025, DHHS contracted with accountable care organizations (ACOs) and prepaid mental health plans (PMHPs) to serve the Medicaid population and contracted with MCOs to serve the Medicaid and CHIP populations. To provide dental services, DHHS contracted with two dental PAHPs—one serving the Medicaid population and one serving both the Medicaid and CHIP populations. Throughout this report, these entities are referred to as "health plans" unless there is a need to distinguish a particular health plan type. DHHS does not exempt any of its health plans from EQR.

The Utah Managed Care Delivery System

Table 1-1—Summary of Health Plans in CY 2025 by Type and Operating Authority

Health Plan Type	Operating Authority
Four Medicaid ACOs	1915(b) Choice of Health Care Delivery waiver
One Medicaid mental and physical health MCO	1915(a) Contracting authority
Four Medicaid mental and physical health MCOs	1115 Demonstration waiver
Eleven PMHPs (PIHPs)	1915(b) PMHP waiver
Three CHIP MCOs	CHIP authority

Health Plan Type	Operating Authority
Two Medicaid dental PAHPs	1915(b) Choice of Dental Care Delivery Program waiver
One CHIP dental PAHP	CHIP authority

Four ACOs Operating Under the 1915(b) Demonstration Waiver

DHHS has been operating the 1915(b) Demonstration waiver program since 1982. Under this waiver, DHHS provided physical health care through MCOs. Since 1995, enrollment in an MCO has been mandatory for members living in Utah's urban counties. Effective January 1, 2013, the MCOs began administering the Medicaid pharmacy benefit for their members with the exception of mental health, substance use disorder (SUD), hemophilia, and transplant immunosuppressant drugs. In 2015, DHHS expanded mandatory ACO enrollment to include nine rural counties. During CY 2025, DHHS contracted with the following ACOs:

Health Choice Utah (Health Choice)

Healthy U

Molina Healthcare of Utah (Molina)

Select Health Community Care (Select Health CC)

One MCO Operating Under 1915(a) Contracting Authority

In 2001, DHHS implemented a specialty MCO, **Healthy Outcomes Medical Excellence (HOME)**, under 1915(a) contracting authority. HOME provides both physical health and mental health services using a medical home model of care for members dually diagnosed with a developmental disability and a mental illness. Enrollment into HOME is voluntary. In 2006, DHHS transformed HOME into a risk-based, capitated MCO.

Four MCOs Operating Under an 1115 Demonstration Waiver

On January 1, 2020, DHHS launched its Utah Medicaid Integrated Care (UMIC) plans providing both physical health and behavioral health services to Utah's adult Medicaid expansion population in Davis, Salt Lake, Utah, Washington, and Weber counties. During CY 2025, DHHS continued to contract with four UMIC plans:

Health Choice Utah (Health Choice UMIC)

Healthy U (Healthy U Integrated)

Molina Healthcare of Utah (Molina UMIC)

Select Health Community Care (Select Health CC UMIC)

Eleven PMHPs Operating Under the 1915(b) Prepaid Mental Health Plan Waiver

DHHS has been operating the 1915(b) PMHP waiver program since 1991. Under this waiver, DHHS provides behavioral health care through the PMHPs.

Bear River Mental Health (Bear River)

Central Utah Counseling Center (Central)

Davis Behavioral Health (Davis)

Four Corners Community Behavioral Health (Four Corners)

Healthy U Behavioral

Northeastern Counseling Center (Northeastern)

Optum (Optum/Tooele)

Salt Lake County Division of Behavioral Health Services (Salt Lake)

Southwest Behavioral Health Center (Southwest)

Wasatch Behavioral Health (Wasatch)

Weber Human Services (Weber)

Three MCOs Operating Under Title XXI Authority

Created in 1997 under Title XXI of the Social Security Act, CHIP provides low-cost health insurance coverage for children in working families who do not qualify for Medicaid. Utah began operating its CHIP program in 1997. Healthy U CHIP is the newest managed care CHIP entity in Utah, initiating operations on July 1, 2024.

Molina Healthcare of Utah CHIP (Molina CHIP)

Select Health CHIP

Healthy U CHIP

Two Medicaid Dental PAHPs Operating Under the 1915(b) Choice of Dental Care Delivery Program Waiver

Premier Access

MCNA Dental [MCNA Insurance Company and Managed Care of North America, Inc.] (MCNA)

One CHIP Dental PAHP Operating Under Title XXI Authority

Premier Access CHIP

The State of Utah Managed Care Quality Strategy

In alignment with CMS recommendations, Utah's Managed Care Quality Strategy (MCQS) serves as a framework for enhancing the quality of health care delivered by contracted managed care health plans.[1] Utah designed its primary system of health care delivery and payment to improve the quality of care that Utah's Medicaid and CHIP members receive. Utah's MCQS is built on the principle of results-based accountability. It prioritizes health equity, whole-person care, and the integration of physical and behavioral health. Based on results from CY 2025 EQR-related activities, HSAG offers observations and recommendations related to the following targeted goals.

Goals and Objectives

The following recommendations align the audit findings with DHHS' five quality aims framework: Advance Health Equity, Improve Whole-Person Health, Enhance Member Journey, Improve Provider Experience, and Financial Stewardship.

Aim 1: Advance Health Equity

HSAG finding: The ACOs and UMICs did not meet benchmarks for *Breast Cancer Screening* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*. DHHS' MCQS mandates a focus on closing disparity gaps by geography and ethnicity.

HSAG recommends that DHHS use its quality incentive pool to reward health plans that show a reduction in the disparity gap for cancer screenings. Health plans could deploy community health workers (CHWs) to reach marginalized populations, specifically targeting the identified discrepancy in rural areas and among members with behavioral health diagnoses.

Aim 2: Improve Whole-Person Health (Integrated Care)

HSAG finding: The UMICs excelled in SUD treatment but struggled with seven-day follow-ups for mental illness. One MCO and PMHPs showed inconsistent PIP results. DHHS' vision includes reducing fragmented care.

[1] Division of Medicaid and Health Financing: Bureau of Managed Health Care. State of Utah Managed Care Quality Strategy. Available at: https://medicaid.utah.gov/Documents/pdfs/Utah%20Managed%20Care%20Quality%20Strategy%202021.pdf. Accessed on: Jan 5, 2026.

To support this vision, HSAG recommends that DHHS:

- Implement collective PIPs (a key MCQS initiative) focused specifically on the *Follow-Up After Hospitalization for Mental Illness* measure. This encourages a collective approach for data sharing and best practices across the physical (ACO) and mental (PMHP) health sectors to ensure a seamless transition for members.
- Strengthen the state-modified HEDIS measures that the PMHPs and HOME use to include stricter accountability targets that mirror the national averages used for ACOs.

Aim 3: Enhance Member Journey and Experience

HSAG finding: Nearly all health plan types struggled with compliance for member letter readability and language format referenced at 42 CFR §438.10(c). A primary goal of DHHS' MCQS is to design a system that is member-friendly and ensure information is available in multiple formats.

To support this goal, HSAG recommends that DHHS consider:

- Conducting a statewide health literacy audit.
- Encouraging health plans to adopt the "Ask Me 3"[2] framework in their communications and use the state-directed Well-Child Visit Tracking Cards to simplify complex health schedules for parents.
- Leveraging Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3] member experience data to pinpoint exactly where members feel the appeal and grievance process is breaking down and using these insights to redesign the letters that HSAG flagged.

Aim 4: Improve Provider and Staff Experience

HSAG finding: NAV compliance was generally high, but clinical quality metrics for childhood immunizations and well-child visits were found to be trending downward. DHHS' strategy emphasizes the provider journey and reduces administrative burden.

HSAG recommends that Utah consider automated incentive payments for providers who meet the *Well-Child Visits in the First 30 Months of Life* metric.

Aim 5: Financial Stewardship and Accountability

HSAG finding: One MCO and some PMHPs received *No Confidence* ratings for PIP methodology, risking the validity of their quality data. DHHS uses pay for performance as a key component of its quality

[2] Institute for Healthcare Improvement. Ask Me 3: Good Questions for Your Good Health. Available at: https://www.ihi.org/library/tools/ask-me-3-good-questions-your-good-health. Accessed on: Feb 10, 2026.
[3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

strategy, including a quality-based capitation withhold to ensure health plans meet performance benchmarks.

HSAG recommends that DHHS consider:

- Linking quality capitation withhold funds specifically to PIP Validation Rating 1 (Methodology).
- Encouraging health plans that have struggled with PIP validation to seek technical assistance to strengthen confidence ratings and ensure that PIPs are scientifically sound. Health plans that continue to receive *Low Confidence* or *No Confidence* ratings could forfeit a portion of their incentive pool. This aligns with the "accountability" value of DHHS' MCQS.

Purpose of the Report

This report provides the results of the four mandatory EQR activities HSAG completed in CY 2025. DHHS contracted with HSAG to conduct validation of performance improvement projects (PIPs) following CMS' *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 1)[4]; validation of performance measures following CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 2)[5]; an assessment of compliance with Medicaid managed care regulations following CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 3)[6] (i.e., compliance review); and validation of network adequacy[7] (protocol not yet released) for all health plans. This report also presents health plan-specific and statewide assessments of strengths and weaknesses (listed as opportunities for improvement throughout this report) regarding health care quality, timeliness, and access to care furnished by the health plans; conclusions drawn; and recommendations for performance improvement with statewide recommendations in this section (Section 1. Executive Summary) and health plan-specific recommendations in Section 2. Evaluation of Utah Medicaid and CHIP Health Plans.

[4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 6, 2026.

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 6, 2026.

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: CMS External Quality Review (EQR) Protocols. Accessed on: Jan 6, 2026.

[7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 6, 2026.

HSAG used the following definitions to evaluate and draw conclusions about the performance of the health plans in each of these domains. The icons below (i.e.,) are present thought the report and indicate that a specific strength or area for improvement relates directly to one or more of the domains.

Quality

CMS defines "quality" in the 2016 federal health care regulations at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM [primary care case management] entity increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and through interventions for performance improvement.[8]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as "the organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[9]

NCQA further states that the intent of utilization management (UM) standards is to minimize any disruption in the provision of health care. HSAG extends this definition of "timeliness" to include other managed care provisions that impact services to members and that require timely response by the MCO or PIHP, such as processing grievances and appeals, and providing timely follow-up care.

Access

CMS defines "access" in the 2016 regulations at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care health plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined

[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.
[9] National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

under 42 CFR 438.68 (Network adequacy standards) and 42 CFR 438.206 (Availability of services).[10]

Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities

Validation of Performance Improvement Projects

Statewide Strengths Related to Validation of PIPs

For CY 2025, HSAG received 52 PIPs for validation—each of the 26 health plans submitted one clinical and one nonclinical PIP. HSAG identified the following statewide strengths related to PIP validation:

- Of the 52 PIPs that HSAG validated, 46 received an overall *High Confidence* validation rating for adherence to acceptable PIP methodology. Most health plans and dental PAHPs demonstrated a thorough application of the PIP design principles and use of appropriate quality improvement (QI) activities to support improvement of PIP outcomes.

- Of the 16 clinical PIPs that included remeasurement data, 10 (for six PMHPs, two ACOs, one UMIC plan, and one Medicaid PAHP) received a *High Confidence* validation rating, and five (for one CHIP MCO, one CHIP PAHPs, two ACOs, and one UMIC plan) received a *Moderate Confidence* validation rating for achievement of significant improvement in performance indicator outcomes.

Statewide Opportunities for Improvement Related to Validation of PIPs

HSAG identified the following statewide opportunities for improvement related to PIP validation:

- Of the 52 PIPs that HSAG validated, six (five nonclinical and one clinical PIPs) had opportunities for improvement in the documentation of the PIP design or of appropriate QI activities.

[10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

- Of the four nonclinical PIPs that included remeasurement data, two PIPs (for Premier Access CHIP and Premier Access) did not achieve any improvement in performance indicator outcomes.

- One clinical PIP (for Four Corners) did not achieve any improvement in performance indicator outcomes.

Statewide Recommendations Related to PIPs

For the next annual PIP submissions, HSAG recommends that the health plans:

- Consider using QI science-based tools, such as process mapping and failure modes and effects analysis (FMEA), for causal/barrier analysis.
- Consider seeking member input during the identification of barriers in order to better understand member-related barriers to access to care, in addition to other stakeholders' input.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help the health plans to understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes. Intervention effectiveness data must guide next steps for each individual intervention.
- Ramp up and adopt health plan-wide interventions deemed successful when tested on a small-scale using Plan-Do-Study-Act (PDSA) cycles in order to impact the entire eligible population in the next measurement period.
- Include an executive sponsor (e.g., medical director, chief medical officer, or chief executive officer) in their PIP team who takes responsibility for the success of the project and can work to remove institutional barriers when needed.
- Include at a minimum one data analyst on the PIP team. Data mining and analysis are crucial components to justify topics and evaluate interventions.

Validation of Performance Measures

DHHS contracted with HSAG to conduct measurement year (MY) 2024 performance measure validation (PMV) of the DHHS custom *Follow-Up After Hospitalization for Mental Illness* measure for PMHPs. DHHS also required health plans to contract with an NCQA-licensed audit organization (LO) to conduct

an MY 2024 NCQA Healthcare Effectiveness Data and Information set (HEDIS®)[11] Compliance Audit.™[12] HSAG reviewed the Final Audit Report (FAR), provided by the health plans, to confirm no notable findings and performance measure designations.

HSAG identified statewide strengths as measured by performance at or above the MY 2024 NCQA Quality Compass®[13] (QC) Average and opportunities for improvement as measured by falling below the NCQA QC Average. Additionally, the MY 2024 Statewide Average (SWA) was used to compare performance across PMHPs for the *Follow-Up After Hospitalization for Mental Illness* measure.

Statewide Strengths Related to Validation of Performance Measures

- Three of the four ACOs performed at or above the NCQA QC average for nine of the 17 performance measure indicators.
- Three of the four UMIC plans performed at or above the NCQA QC average for six of the 20 performance measure indicators.
- CHIP and MCO plans performed at or above the NCQA QC average for two of the six performance measure indicators.
- PAHPs performed at or above the NCQA QC average for five of the eight performance measure indicators.
- Premier Access performed at or above the NCQA QC average for five of the eight performance measure indicators.
- Seven PMHPs performed at or above the SWA for the *Follow-Up After Hospitalization for Mental Illness* measure.

[11] HEDIS® is a registered trademark of NCQA.
[12] HEDIS Compliance Audit™ is a trademark of NCQA.
[13] Quality Compass® is a registered trademark of NCQA.

Statewide Opportunities for Improvement Related to Validation of Performance Measures

- Three of the four ACOs performed below the NCQA QC Average for seven of the 17 performance measure indicators.
- Three of the four UMIC plans performed below the NCQA QC Average for nine of the 20 performance measure indicators.
- One CHIP MCO performed below the NCQA QC Average for four of the six performance measure indicators.
- Four PMHPs performed below the SWA within the *Follow-Up After Hospitalization for Mental Illness* measure.

Statewide Recommendations Related to Validation of Performance Measures

Based on MY 2024 performance, HSAG recommends that the Medicaid ACOs prioritize member centric, whole-person care by improving performance across measures that fell below the NCQA QC average, focused on preventive health care screenings, child and adolescent immunizations, postpartum care, and the health of members with diabetes. Additionally, enhancing the member's journey and experience through improving well-child and child and adolescent well-care visits.

HSAG suggests that the UMIC plans emphasize preventive health care services, including timely access to ambulatory and behavioral health care services and completion of appropriate health care screenings, while enhancing provider education on the appropriate use of imaging studies for low back pain. These quality aims, populations, and conditions align with Utah's population health management framework, which focuses on keeping members healthy, managing members with emerging risks, patient safety or outcomes across settings, and managing multiple illnesses. This approach spans over the maternal health, adult and child physical health, and adult and child behavioral health pillars.[14]

To guide improvement in performance measure outcomes, HSAG recommends that health plans leverage their existing quality framework to understand key drivers of improvement among low-performing measures. As noted last year, HSAG recommends that the Utah health plans perform a

[14] Utah Department of Health & Human Services: Medicaid Managed Care Quality Strategy. Available at: https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/OMH%20Quality%20Strategy.pdf. Accessed on: Dec 9, 2025.

segmentation analysis on the eligible populations for measures that fell below the national average to determine subpopulations of members that represent notable areas of opportunity for improvement.

HSAG recommends soliciting key drivers and barriers to care through member- and provider-based focus groups, survey-based methods, and social media polls. Additionally, plans could consider tailored interventions to address population-specific needs (e.g., by age, race, gender, geography, or primary care provider [PCP]) based on findings from the analysis. Utilizing findings from the members, plans can generate ideas on how to improve care through brainstorming, member journey mapping, and the development of a key driver diagram.[15] Through testing the ideas generated and measuring the changes in the desired outcome, the plans can spread successful interventions to make a larger impact on performance measures.[16]

Compliance Monitoring

Compliance Monitoring Standards Review

HSAG conducted a full review of all compliance monitoring requirements split across CY 2023 and CY 2024. Table 1-2 lists the number of health plans for which HSAG identified findings resulting in required corrective actions for each standard as a result of the CY 2023 and CY 2024 compliance monitoring reviews. Specific strengths, opportunities for improvement, and recommendations regarding the standards reviewed in CY 2023 and CY 2024 were discussed in the 2023 Utah External Quality Review Report of Results and 2024 Utah External Quality Review Report of Results.[17] Following the CY 2023 and CY 2024 compliance monitoring reviews, HSAG required health plans to complete corrective action plans (CAPs) for requirements found to be out of compliance. HSAG supported the health plans as they developed interventions to come into compliance with requirements.

Table 1-2—Number of Health Plans (Statewide) With Findings in CY 2023 and CY 2024

Standard	Number of Health Plans (of 25 total) With At Least One Required Corrective Action
Standard I—Enrollment and Disenrollment	5
Standard II—Member Rights and Confidentiality	16
Standard III—Member Information	25

[15] Institute for Health Improvement Model for Improvement. Available at: https://www.ihi.org/library/model-for-improvement/selecting-changes. Accessed on: Dec 8, 2025.
[16] Agency for Healthcare Research and Quality. The CAHPS Ambulatory Care Improvement Guide. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/4-approach-qi-process/cahps-section-4-ways-to-approach-qi-process.pdf. Accessed on: Dec 8, 2025.
[17] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Standard	Number of Health Plans (of 25 total) With At Least One Required Corrective Action
Standard IV—Emergency and Poststabilization Services	13
Standard V—Adequate Capacity	16
Standard VI—Coordination and Continuity of Care	8
Standard VII—Coverage and Authorization of Services	16
Standard VIII—Provider Selection and Program Integrity	22
Standard IX—Subcontractual Relationships and Delegation	9
Standard X—Practice Guidelines	2
Standard XI—Health Information Systems	0
Standard XII—QAPIP	7
Standard XIII—Grievance and Appeal System	29

Compliance Monitoring Focused Review

In CY 2025, HSAG conducted a focused record review consisting of a sample of prior authorization denial, appeal, and grievance records. Table 1-2 lists the number of health plans for which HSAG identified findings resulting in required corrective actions for individual requirements within the Coverage and Authorization of Services and Grievance and Appeal System standards as a result of the CY 2025 focused review. HSAG required that health plans complete CAPs for focused record review requirements found to be out of compliance. HSAG supported the health plans as they developed interventions to come into compliance with requirements.

Table 1-3—Number of Health Plans (Statewide) With Findings in CY 2025

Standard Description	Number of Health Plans (of 26 total) With At Least One Required Corrective Action
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	10
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	13
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	15

Statewide Strengths Related to Compliance Monitoring (Standards Wherein Five or Fewer Health Plans Had Findings)

HSAG did not identify strengths across the health plans based on the results of the focused review.

Statewide Opportunities for Improvement Related to Compliance Monitoring

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Statewide Recommendations Related to Compliance Monitoring

HSAG offers the following statewide recommendations related to compliance monitoring:

- Health plans should establish comprehensive processes to ensure written member communication meets the language and format requirements of 42 CFR §438.10(c).
- Health plans should make updates to grievances processes to ensure effective communication with members and appropriate recordkeeping documentation.

Validation of Network Adequacy

While the network adequacy validation (NAV) process may be used to analyze different aspects of provider networks and members' access to care, the CY 2025 NAV focused on time/distance and provider capacity analyses for specified provider types using member and provider data files submitted to HSAG by each health plan.

Overall, HSAG's validation of the health plan-reported network adequacy time/distance results indicates a high or moderate degree of confidence in the results. In general, the health plans indicated sufficient data collection and maintenance methods. Additionally, the health plans generally used precise methods for determining the time/distance members travel to the nearest providers using Quest Analytics for the calculations. A few health plans were using less rigorous calculations; however, the alternate methods used were in alignment with the DHHS-stated requirement and adequately assessed member access.

DHHS requires that health plans ensure their Medicaid members' access to providers by setting time/distance requirements for a variety of provider categories for the Medicaid health plans. Each health plan must ensure that it contracts with an adequate number of providers to meet urbanicity-specific time or distance network requirements. However, a health plan's failure to meet a time/distance standard does not necessarily reflect a network concern, as the health plan may have DHHS' approval to use alternate methods to ensure members' access to care (e.g., community services). Additionally, a health plan's ability to meet the minimum network standard does not

guarantee all facets of access to care for all members. Regardless of each health plan's ability to meet the established time/distance standards, the scope of the CY 2025 NAV did not analyze other potential barriers members may encounter when attempting to access Medicaid services. For example, factors such as members' access to transportation, health status and needs related to disability accommodations, and appointment/service availability could account for inadequate access to care despite the CY 2025 NAV results.

Overall, the Utah CY 2025 NAV results suggest that the health plans have comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider types (e.g., pediatric specialists). Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards. HSAG determined that all strengths and opportunities for improvement relate to the access domain and as such domain tables have not been presented for this activity. For health plan-specific results, see Section 2. Evaluation of Utah Medicaid and CHIP Health Plans. For statewide comparative results, see Appendix B. Statewide Comparative Results.

Statewide Strengths Related to NAV

The following are the statewide strengths related to the health plans' provider networks:

- Most of the ACOs demonstrated improvement by meeting some time/distance standards in CY 2025 that the ACOs did not meet in CY 2024.
- Nearly all PMHPs met the minimum required time/distance standards for CY 2025, with a significant percentage showing continued strength by meeting network adequacy standards across CY 2024 and CY 2025.
- Across all health plans in the UMIC, PAHP, and CHIP dental PAHP lines of business, all time/distance standards met in CY 2024 were also met in CY 2025.
- All applicable health plans met 100 percent of the time/distance standards for pediatric and adult PCPs, prenatal care and women's health providers, hospitals, and pharmacies.

Statewide Opportunities for Improvement Related to NAV

The following are the statewide areas for improvement related to the health plans' provider networks:

- All ACOs and CHIP MCOs were unable to meet time/distance standards for the Specialist—Pediatric provider domain. It may be helpful for DHHS to collaborate with the health plans to determine if

this is due to a lack of providers, an unwillingness of available providers to contract with the health plans, or the inability to identify these providers with available data.

- Some health plans struggled to ensure member access within required time/distance standards for the Behavioral Health Facilities—All provider domain. It may be helpful for DHHS to collaborate with the health plans to determine if this is due to a lack of providers, an unwillingness of available providers to contract with the health plans, or the inability to identify these providers with available data.
- Many health plans reported encountering data consistency issues with the Provider Reimbursement Information System for Medicaid (PRISM). Data within PRISM were reported to be inconsistent from day to day, specifically enrollment status data. HSAG recommends that DHHS continue to work with health plans to ensure any data inconsistencies in PRISM are identified and corrected.
- Provider saturation analysis showed that for many provider categories, health plans could improve the number of members with access by contracting with additional available providers in the area. DHHS and the health plans should investigate the addition of those provider types to assess if those providers are willing to contract. Further, they should assess the reasons the providers are unwilling to contract with the health plans.

Statewide Recommendations Related to NAV

Based on the results and conclusions presented in this report, HSAG recommends the following for DHHS and the health plans to strengthen the Medicaid and CHIP managed care provider networks and ensure members' timely access to health care providers:

- As planned by DHHS, HSAG recommends continuing to work with the health plans to require health plan reporting of NAV metrics and conducting validation of those metrics. Along with health plan metric reporting, HSAG recommends that DHHS and HSAG continue annual follow-up with the health plans to assess their approaches and steps to improve member access to providers for categories that do not meet the time/distance standard.
- As noted in the health plans' validation of network adequacy findings, the individual health plans are using a variety of methods to assess the members' time/distance to the nearest provider. HSAG recommends that DHHS provide additional guidance and technical assistance to the health plans regarding requirements around the calculation of these metrics and expectations from DHHS.
- As the provider ratios and geographic distribution represent the potential capacity and distribution of contracted providers and may not directly reflect the availability of providers at any point in time, DHHS should use appointment availability and utilization analyses to evaluate providers' availability and members' use of services. Future studies may incorporate encounter data or secret shopper telephone survey results to assess members' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- DHHS may consider collaborating with its EQRO to design and implement a focus study to investigate selected topics regarding access to care among Medicaid members by geographic

region. Depending on available resources, study topics may include evaluating health disparities affecting access to care or the potential for providers in the network who are not providing services to Medicaid members (i.e., phantom provider network assessment).

CMS Protocol 1: Validation of Performance Improvement Projects

Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement—Medicaid

Following are strengths, opportunities for improvement, and recommendations related to CMS Protocol 1 Validation of Performance Improvement with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =

Medicaid ACOs Providing Only Physical Health Services

Health Choice of Utah (Health Choice)

For CY 2025, Health Choice continued its clinical PIP topic, *Well-Child Visits in the First 30 Months of Life*, and its nonclinical PIP topic, *Medicaid Health Risk Assessment (HRA) Process Improvement* for its ACO members. The goal of the clinical PIP is to meet or exceed the national average for the HEDIS *Well-Child Visits in the First 30 Months of Life* measure. The goal of the nonclinical PIP is to increase the percentage of newly enrolled members who have an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.

Validation Results and Interventions

Table 2-1 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-1—CY 2025 PIP Validation Results for Health Choice

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Well-Child Visits in the First 30 Months of Life	Initial Submission	94%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*Health Plan Did Not Resubmit.*					
Medicaid Health Risk Assessment (HRA) Process Improvement	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Well-Child Visits in the First 30 Months* of Life PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Health Choice had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-2 displays PIP outcome data for Health Choice's *Well-Child Visits in the First 30 Months of Life* PIP.

Table 2-2—PIP Outcomes—*Well-Child Visits in the First 30 Months of Life* for Health Choice

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024-12/31/2024)**		**Sustained Improvement**
Percentage of members with six or more well-child visits on different dates of service on or before the child's 15-month birthday.	N: 445 D: 958	46.5%	N: 412 D: 787	52.4%*	N: 320 D: 512	62.5%*	*Yes*
Percentage of members with two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	N: 637 D: 1,066	59.8%	N: 582 D: 975	59.7%	N: 302 D: 448	67.4%*	*No*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members with six or more well-child visits on different dates of service on or before the child's 15-month birthday was 46.5 percent. For Remeasurement 1, the Performance Indicator 1 rate was 52.4 percent, which represents a statistically significant increase of 5.9 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 1 rate was 62.5 percent, which represents a statistically significant increase of 16.0 percentage points over the baseline rate. Significant improvement was sustained for two consecutive remeasurement periods.

The baseline rate for the percentage of members with two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday was 59.8 percent. For Remeasurement 1, the Performance Indicator 2 rate was 59.7 percent, which represents a marginal decrease of 0.1 percentage points from the baseline. For Remeasurement 2, the Performance Indicator 2 rate was 67.4 percent, which represents a statistically significant increase of 7.6 percentage points over the baseline rate.

In CY 2025, for the nonclinical PIP, Health Choice submitted baseline data and had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-3 displays baseline data for Health Choice's *Medicaid HRA Process Improvement* PIP.

Table 2-3—PIP Outcomes—*Medicaid HRA Process Improvement* for Health Choice

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	N: 135	2.7%			
	D: 5,005				

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform within 90 days of enrollment was 2.7 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Health Choice's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Well-Child Visits in the First 30 Months of Life* PIP, Health Choice used a fishbone diagram and brainstorming for its causal/barrier analysis. Table 2-4 displays the barriers and interventions as documented by Health Choice.

Table 2-4—Interventions Implemented/Planned for *Well-Child Visit in the First 30 Months of Life*

Barriers	Interventions
Parents/guardians do not understand the schedule or know where to access the information.	Monthly distribution of comprehensive Well-Baby Packets to new plan members with infants.

Barriers	Interventions
Well-child visits due to visits not being scheduled in advance with provider offices or busy parents/guardians forgetting upcoming appointments.	Member outreach to remind parents of well-child visit gaps in care and answer questions related to well-child visits.

For the *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP, Health Choice used a fishbone diagram for its causal/barrier analysis. Table 2-5 displays the barriers and interventions as documented by Health Choice.

Table 2-5—Interventions Implemented/Planned for *Medicaid HRA Process Improvement*

Barriers	Interventions
Members were not able to directly access the HRA form via QR code. The existing QR code would take members to the log-in page of the member portal, where a member portal account would need to be created in order to log in and then navigate to the HRA form. This resulted in a barrier to completing the electronic HRA form.	Implementation of an embedded HRA webform on the health plan website for members to complete the electronic HRA form without the barrier of creating a member portal account or logging into the member portal. A QR code linking directly to the embedded HRA webform will be generated and printed on the paper HRA form that is mailed to new members.
Lack of standardization in the various HRA forms and documentation process.	Standardization of both paper and electronic HRA forms into a single version for adults and a single version for children.

Health Choice—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs (*Well-Child Visits in the First 30 Months of Life* PIP and *Medicaid HRA Process Improvement*) received a *High Confidence* rating in overall confidence of adherence to acceptable methodology of the PIP design.
- For the *Well-Child Visits in the First 30 Months of Life* PIP, during Remeasurement 2, both performance indicators achieved statistically significant improvement over the baseline.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

HSAG recommends that Health Choice:

- Continually work on the PIPs throughout the year.
- Document a significant decrease in the population size of the *Well-Child Visits in the First 30 Months of Life* PIP as a threat to the comparability of data.
- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Build on the positive momentum gained and improvement achieved.
- Apply lessons learned and knowledge gained while conducting QI processes and testing interventions.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

HSAG recommended that Health Choice:

- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Consider the use of QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions tables.
- Ensure that intervention effectiveness measure data guide the next steps for each intervention.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

Health Plan Interventions

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The remeasurement rate for one of the performance indicators for the *Well-Child Visits in the First 30 Months of Life* PIP was below the baseline. In the CY 2025 submission, the health plan addressed the

deficiency identified in CY 2024 submission. In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Health Choice's clinical PIP will likely result in long-term improvements.

Healthy U ACO

For CY 2025, Healthy U ACO continued its clinical PIP topic, *Improving Access to Well Visits in the First 15 and 30 Months of Life* and its nonclinical PIP topic, *Medicaid HRA Process Improvement*. The goal of the clinical PIP is to meet or exceed the national average for the HEDIS *Well-Child Visits in the First 30 Months of Life* measure. The goal of the nonclinical PIP is to increase the percentage of newly enrolled members who have an HRA result documented in the health plan care management platform within 90 days of enrollment.

Validation Results and Interventions

Table 2-6 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-6—CY 2025 PIP Validation Results for Healthy U ACO

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving Access to Well Visits in the First 15 and 30 Months of Life	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*Health Plan Did Not Resubmit.*					
Medicaid Health Risk Assessment (HRA) Process Improvement	Initial Submission	92%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Healthy U ACO had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-7 displays PIP outcome data for Healthy U ACO's *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP.

Table 2-7—PIP Outcomes—*Improving Access to Well Visits in the First 15 and 30 Months of Life* for Healthy U ACO

Performance Indicator Results							
Performance Indicators	**Baseline (01/0/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024–12/31/2024)**		**Sustained Improvement**
1. The percentage of eligible members who received six or more well-child visits with a PCP by 15 months of age.	N: 864 D: 1,966	44.0%	N: 623 D: 1,326	47.0%	N: 431 D: 875	49.3%*	*No*
2. The percentage of eligible members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	N: 1,504 D: 2,359	63.8%	N: 1,181 D: 1,719	68.7%*	N: 577 D: 824	70.0%*	*Yes*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members with six or more well-child visits with a PCP by 15 months of age was 44.0 percent. For Remeasurement 1 rate, the Performance Indicator 1 rate was 47.0 percent, which represents a statistically nonsignificant increase of three percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2 rate was 49.3 percent, which represents a statistically significant increase of 5.3 percentage points over the baseline rate.

The baseline rate for the percentage of members with two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday was 63.8 percent. For Remeasurement 1, the Performance Indicator 2 rate was 68.7 percent, which represents a statistically significant increase of 4.9 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2 rate was 70.0 percent, which represents a statistically significant increase of 6.2 percentage points over the baseline rate. Performance Indicator 2 demonstrated sustained improvement for two consecutive remeasurement periods.

In CY 2025, for the nonclinical PIP, Healthy U ACO submitted baseline data and had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-8 displays baseline data for Healthy U ACO's *Medicaid HRA Process Improvement* PIP.

Table 2-8—PIP Outcomes—*Medicaid HRA Process Improvement* for Healthy U ACO

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	N: 863 D: 6,978	12.4%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment was 12.4 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes.

Healthy U ACO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP, Healthy U ACO used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-9 displays the barriers and interventions as documented by Healthy U ACO.

Table 2-9—Interventions Implemented/Planned for *Improving Access to Well Visits in the First 15 and 30 Months of Life*

Barriers	Interventions
Parents are not aware of the recommended frequency of well-child visits and are not aware of the importance of obtaining timely well-child visits for young children. In addition, staying current with the frequent number of well-child visits can be a challenge for busy parents.	Development and distribution of Well Visit Record Card. Development and Distribution of "Well-Baby Packet."
Member outreach campaigns with only one mode of communication (such as mailings) may be less effective than campaigns that employ multiple modes of communication (such as mailings in addition to phone calls or text messaging, etc.).	Phone outreach to parents by health plan staff.

For the *Medicaid Health Risk Assessment (HRA) Improvement* PIP, Healthy U ACO used a fishbone diagram to identify the following barriers and plans to initiate the following interventions to address those barriers. Table 2-10 displays the barriers and interventions as documented by Healthy U ACO.

Table 2-10—Interventions Implemented/Planned for *Medicaid HRA Process Improvement*

Barriers	Interventions
Lack of an automated process to enter electronic HRA results into the MHK platform: • HRA forms submitted electronically require manual entry of HRA responses into the MHK platform. This results in a delay of entering member HRA results into the MHK platform because of the staff time needed to complete manual entry.	HRA Process Standardization and Automation.
An electronic HRA was available on the health plan member portal; however, it was not possible to create a QR code that would take members directly	Increase Options for Electronic Completion of the HRA: Create HRA embedded webform and QR Code.

Barriers	Interventions
to the HRA form. It was only possible to create a QR code that would take members to the log-in page to the member portal, where members would need to create a member portal account, log in, and then navigate to the HRA form.	

Healthy U ACO—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in the adherence to acceptable methodology for all phases of the PIP.

- For the *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP, during Remeasurement 2, both performance indicators achieved statistically significant improvement over the baseline.

Opportunities for Improvement

For Healthy U's *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP, an opportunity for improvement existed in the numerator definition of the intervention effectiveness measure.

Recommendations

As the PIPs progress, HSAG recommends that Healthy U ACO:

- Ensure the intervention effectiveness measure in the intervention worksheet is designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Healthy U ACO to understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
- Ensure that Intervention effectiveness data guide the next steps for each individual intervention.

- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Continually work on the PIPs throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The remeasurement rate for one of the two performance indicators for the *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP had some improvement over the baseline; however, the improvement was not statistically significant. In the CY 2025 submission, the health plan addressed the deficiency identified in CY 2024 submission.

In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Healthy U ACO's clinical PIP will likely result in long-term improvements.

Molina Healthcare of Utah ACO (Molina ACO)

For CY 2025, Molina ACO continued its clinical PIP topic, *Well-Child Visits in the First 30 Months of Life* and its nonclinical PIP topic, *Increasing Member Engagement and Satisfaction with Digital Channels.* The goal of the clinical PIP is to meet or exceed the national average for the HEDIS *Well-Child Visits in the First 30 Months of Life* measure. The goal of the nonclinical PIP is to increase the percentage of members 18 years and older who opt in to text messaging and/or register for the My Molina portal.

Validation Results and Interventions

Table 2-11 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-11—CY 2025 PIP Validation Results for Molina ACO

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Well-Child Visits in the First 30 Months of Life	Initial Submission	82%	88%	*Low Confidence*	75%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	75%	100%	*Moderate Confidence*
Increasing Member Engagement and Satisfaction With Digital Channels	Initial Submission	94%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Well-Child Visits in the First 30 Months of Life* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Increasing Member Engagement and Satisfaction with Digital Channels* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Molina ACO had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-12 displays PIP outcome data for Molina ACO's *Well-Child Visits in the First 30 Months of Life* PIP.

Table 2-12—PIP Outcomes—*Well-Child Visits in the First 30 Months of Life* for Molina ACO

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024-12/31/2024)**		**Sustained Improvement**
The percentage of members who had six or more well-child visits with a PCP during the first 15 months of life.	N: 1,028 D: 2,206	46.6%	N: 602 D: 1,288	46.7%	N: 497 D: 996	49.9%	*Not Assessed*
The percentage of members who had two or more well-child visits with a PCP between ages 15–30 months.	N: 1,500 D: 2,417	62.1%	N: 1,138 D: 1,746	65.2%*	N:650 D: 976	66.6%*	*Yes*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members with six or more well-child visits with a PCP during the first 15 months of life was 46.6 percent. For Remeasurement 1, the Performance Indicator 1 rate was 46.7 percent, which represents a marginal increase of 0.1 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 1 rate was 49.9 percent, which represents a statistically nonsignificant increase of 3.3 percentage points over the baseline rate. Performance Indicator 1 did not achieve statistically significant improvement during Remeasurement 1 and therefore was not assessed for sustained improvement.

The baseline rate for the percentage of members who had two or more well-child visits with a PCP between ages 15–30 months was 62.1 percent. For Remeasurement 1, the Performance Indicator 2 rate was 65.2 percent, which represents a statistically significant increase of 3.1 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2 rate was 66.6 percent, which represents a statistically significant increase of 4.5 percentage points over the baseline rate. Performance Indicator 2 achieved sustained improvement for two consecutive remeasurement periods.

In CY 2025, for the nonclinical PIP, Molina ACO submitted baseline data and had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-13 displays baseline data for Molina ACO's *Increasing Member Engagement and Satisfaction With Digital Channels* PIP.

Table 2-13—PIP Outcomes—*Increasing Member Engagement and Satisfaction With Digital Channels* for Molina ACO

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of members 18 years of age and older who opt in to text messaging during the measurement year during the measurement year.	N: 11,753 D: 23,746	49.5%			
The percentage of members 18 years of age and older who register for the My Molina portal during the measurement year.	N: 10,286 D: 63,981	16.1%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 18 years of age and older who opted in to text messaging was 49.5 percent. The percentage of members 18 years of age and older who registered for the My Molina portal was 16.1 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Molina ACO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Well-Child Visits in the First 30 Months of Life* PIP, Molina ACO used data analysis and a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-14 displays the barriers and interventions as documented by Molina ACO.

Table 2-14—Interventions Implemented/Planned for *Well-Child Visits in the First 30 Months of Life*

Barriers	Interventions
Low health literacy—members seek medical care only when ill.	Member outreach and incentive program for completing well-child visits. Well Child Text Message Series
Members lack education on the importance of well-child visits.	Mail well-child tracker card to members. The card includes information on the importance of well-child visits and lists required visits/time frames with space to track visits. Well Child Text Message Series
Providers lack understanding of the *Well-Child Visits in the First 30 Months of Life* (W30) measure and requirements.	Missing services lists are disseminated to providers who opt-in to pay-for-quality (P4Q) program, showing which members need well-child visits. Providers are offered a bonus for closing gaps.

For the *Increasing Member Engagement and Satisfaction With Digital Channels* PIP, Molina ACO used brainstorming and a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-15 displays the barriers and interventions as documented by Molina ACO.

Table 2-15—Interventions Implemented/Planned for *Increasing Member Engagement and Satisfaction With Digital Channels*

Barriers	Interventions
Lack of promotion by internal partners.	Portal Training with Case Management Staff.
No feedback loop to improve tools based on member experience.	Relay Text Message Satisfaction Survey.

Molina ACO—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.

- For the *Well-Child Visits in the First 30 Months of Life* PIP, during Remeasurement 2, one of the two performance indicators achieved statistically significant improvement over the baseline.

Opportunities for Improvement

Molina ACO's remeasurement rate for one of the two performance indicators for the *Well-Child Visits in the First 30 Months of Life* PIP had improvement over the baseline; however, the improvement was not statistically significant.

Recommendations

As the PIPs progress, HSAG recommends that Molina ACO:

- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Molina ACO understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
- Ensure that intervention effectiveness data guide the next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The remeasurement rate for one of the performance indicators for the *Well-Child Visits in the First 30 Months of Life* PIP did not demonstrate statistically significant improvement over the baseline. In the CY 2025 submission, the health plan demonstrated additional improvement in the performance

indicator rate; however, the improvement continued to be statistically nonsignificant. The health plan did not address the identified deficiency.

In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Molina ACO's clinical PIP will likely result in long-term improvements.

Select Health Community Care ACO (Select Health CC ACO)

For CY 2025, Select Health CC ACO continued its clinical PIP topic, *Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* and its nonclinical PIP topic, *Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination.* The goal of the clinical PIP is to meet or exceed the national average for the HEDIS *Well-Child Visits in the First 30 Months of Life* measure. The goal of the nonclinical PIP is to increase the percentage of Medicaid ACO members retaining health insurance through continued coverage of Select Health Medicaid or a different Select Health CC line of business when the member is identified for Medicaid redetermination.

Validation Results and Interventions

Table 2-16 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-16—CY 2025 PIP Validation Results for Select Health CC ACO

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members	Initial Submission	94%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Select Health CC ACO had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-17 displays outcome data for Select Health CC ACO's *Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* PIP.

Table 2-17—PIP Outcomes—*Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* for Select Health CC ACO

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2022—12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024–12/31/2024)**		**Sustained Improvement**
The percentage of eligible members who received six or more well-child visits with a primary care provider by 15 months of age.	N: 2,657 D: 4,524	58.7%	N: 1,941 D: 3,225	60.2%	N: 1,003 D: 1,735	57.8%	*Not Assessed*
The percentage of eligible members who received two or more well-child visits with	N: 3,810	67.3%	N: 2,795	68.1%	N: 1,248	70.2%*	*Not Assessed*

Performance Indicator Results							
Performance Indicators	Baseline (01/01/2022—12/31/2022)		Remeasurement 1 (01/01/2023–12/31/2023)		Remeasurement 2 (01/01/2024–12/31/2024)		Sustained Improvement
a primary care provider on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	D: 5,663		D: 4,107		D: 1,777		

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members who received six or well-child visits with a PCP by 15 months of age was 58.7 percent. For Remeasurement 1, the Performance Indicator 1 rate was 60.2 percent, which represents a statistically nonsignificant increase of 1.5 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 1 rate was 57.8 percent, which represents a statistically nonsignificant decrease of 0.9 percentage points under the baseline.

The baseline rate for the percentage of members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday was 67.3 percent. For Remeasurement 1, the Performance Indicator 2 rate was 68.1 percent, which represents a marginal increase of 0.8 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2 rate was 70.2 percent, which represents a statistically significant increase of 2.9 percentage points over the baseline.

In CY 2025, for the nonclinical PIP, Select Health CC ACO submitted baseline data and had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-18 displays baseline data for Select Health CC ACO's *Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination* PIP.

Table 2-18—PIP Outcomes for *Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination* for Select Health CC ACO

Performance Indicator Results					
Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
Percent of Medicaid legacy members retaining health insurance when identified for redetermination.	N: 62,780 D: 82,992	75.6%			

Performance Indicator Results					
Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
Percent of Medicaid legacy members retaining Select Health Medicaid Legacy when identified for redetermination.	N: 56,415 D: 82,992	68.0%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for percent of Medicaid legacy members retaining health insurance when identified for redetermination was 75.6 percent. The baseline rate for percent of Medicaid legacy members retaining Select Health Medicaid Legacy when identified for redetermination was 68.0 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Select Health CC ACO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* PIP, Select Health CC ACO completed a fishbone diagram and an affinity diagram to identify and prioritize the following barrier and identified the following interventions to address the barriers. Table 2-19 displays the barrier and intervention as documented by Select Health CC ACO.

Table 2-19—Interventions Planned for the *Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members* PIP

Barriers	Interventions
Member's lack of knowledge regarding well-child visits.	Health plan mailed well-child visits (W30) tracking card to remind members to schedule a well-child visit.
Providers Not Prioritizing Medicaid Members.	Educate and Provide Access to W30 Gaps in Medicaid Enrollees' Data to QPP Providers.
Lack of Understanding of Wellness & Immunization Schedule.	W30 Monthly IVR Calls to Enrollees.

For the *Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination* PIP, Select Health CC ACO completed a fishbone

diagram causal barrier analysis. Table 2-20 displays the barrier and intervention as documented by Select Health CC ACO.

Table 2-20—Interventions Implemented/Planned for *Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination*

Barriers	Interventions
Members do not know they need to reapply.	Outreach to Medicaid Legacy Members Up for Redetermination.

Select Health CC ACO—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- For the *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP, during Remeasurement 2, one of the two performance indicators demonstrated statistically significant improvement over the baseline.

Opportunities for Improvement

One of the two performance indicators for the *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP had a decline in performance compared to the baseline.

Recommendations

As the PIPs progress, HSAG recommends that Select Health CC ACO:

- Revisit the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Consider collecting the intervention effectiveness data more frequently (e.g., monthly or quarterly) unlike the annual performance indicator data. This would help Select Health CC ACO understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.

- Ensure that Intervention effectiveness data guide the next steps for each individual intervention.
- Continually work on the PIPs throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The remeasurement rate for one of the performance indicators for the *Improving Access to Well Visits in the First 15 and 30 Months of Life* PIP did not demonstrate statistically significant improvement over the baseline. In the CY 2025 submission, the performance indicator rate was below the baseline. The health plan did not address the identified deficiency.

In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Select Health CC ACO's clinical PIP will likely result in long-term improvements.

Medicaid MCOs Providing Physical Health, Mental Health, and SUD Services

Health Choice of Utah UMIC (Health Choice UMIC)

For CY 2025, Health Choice UMIC continued its clinical PIP topic, *Adults' Access to Preventive/ Ambulatory Health Services* and its nonclinical PIP topic, *Medicaid HRA Process Improvement*. The goal of the clinical PIP is to enhance member health through regular preventive or ambulatory visits. The goal of the nonclinical PIP is to increase the percentage of newly enrolled members who had an HRA result documented in the health plan care management platform within 90 days of enrollment.

Validation Results and Interventions

Table 2-21 illustrates the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-21—CY 2025 PIP Validation Results for Health Choice UMIC

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Adults' Access to Preventive/ Ambulatory Health Services (AAP)	Initial Submission	93%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Medicaid Health Risk Assessment (HRA) Process Improvement	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Health Choice UMIC had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Health Choice UMIC had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, Health Choice UMIC submitted baseline data for the clinical and nonclinical PIPs. The PIPs had not progressed to analyzing data, conducting QI activities, or reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Table 2-22 displays baseline data for Health Choice UMIC's *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP.

Table 2-22—PIP Outcomes—*Adults' Access to Preventive/Ambulatory Health Services* for Health Choice UMIC

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025-12/31/2025)**		**Sustained Improvement**
The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.	N: 2,737 D: 4,156	65.9%			

N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year was 65.9 percent.

Table 2-23 displays baseline data for Health Choice UMIC's Medicaid Health Risk Assessment (HRA) Process Improvement PIP.

Table 2-23—PIP Outcomes—*Medicaid HRA Process Improvement* for Health Choice UMIC

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	N: 140 D: 3,103	4.5%			

The baseline rate for the percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform within 90 days of enrollment was 4.5 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Health Choice UMIC's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Adults' Access to Preventive/Ambulatory Health Services* PIP, Health Choice UMIC used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-24 displays the barriers and interventions as documented by Health Choice UMIC.

Table 2-24—Interventions Implemented/Planned for *Adults' Access to Preventive/Ambulatory Health Services*

Barriers	Interventions
• Members new to health insurance—Expansion members may be unsure of how to navigate the health care system or find an in-network primary care provider. • Lack of awareness—Members may not know that annual well-visits are recommended or covered by their plan. • Perceived lack of need—Some individuals feel healthy and do not see the value in preventive care.	Member Outreach—Telephonic

Barriers	Interventions
• Fear or anxiety—Members may be concerned about a potential diagnosis or discomfort during their visit. • Language and cultural differences—These can affect understanding and trust in the healthcare system. • Transportation issues—Lack of reliable transportation can prevent access to care. • Work or family obligations—Members may have difficulty in finding time due to job schedules or caregiving responsibilities.	
• A large eligible population for the measure and limited staffing resources to make outreach calls make it challenging to reach all members with a "manual phone only" outreach approach. • Some members may be more likely to respond to a text message than a phone call.	Member Outreach—Vendor SMS Campaign

For the *Medicaid HRA Process Improvement PIP,* Health Choice UMIC used a fishbone diagram to identify the following barriers and plans to initiate the following interventions to address those barriers. Table 2-25 displays the barriers and interventions as documented by Health Choice UMIC.

Table 2-25—Interventions Implemented/Planned for *Medicaid HRA Process Improvement*

Barriers	Interventions
• Lack of standardization in the various HRA forms and documentation process. • Lack of an automated process to enter electronic HRA results into the healthcare management platform.	HRA Process Standardization and Automation
• An electronic HRA was available on the health plan member portal; however, it was not possible to create a QR code that would take members directly to the HRA form. It was only possible to create a QR code that would take members to the log-in page to the member portal, where members would need to create a member portal account, log in, and then navigate to the HRA form.	Increase Options for Electronic Completion of the HRA: Create HRA Embedded Webform and QR Code

Health Choice UMIC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG found that for both PIPs, Health Choice UMIC received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for PIP design.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Health Choice UMIC:

- Continually work on the PIPs throughout the year.
- Ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Health Choice UMIC to understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure that intervention effectiveness data guide next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

For both PIPs, Health Choice UMIC received a *Met* score for 100 percent of the applicable evaluation elements in the CY 2024 PIP Validation Tool. HSAG did not identify any opportunities for improvement related to PIP validation in CY 2024.

Healthy Outcomes Medical Excellence (HOME)

For CY 2025, HOME submitted its new clinical topic *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* and its nonclinical topic, *Implementation of Work Queue for Utilization Management.* The goal of the clinical PIP is to increase statin utilization in eligible HOME members by at least 10 percent. The goal of the nonclinical PIP is to ensure proactive engagement with providers, secure new supply orders before existing ones expire, and eliminate any delays in patient services care delivery.

Validation Results and Interventions

Table 2-26 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-26—CY 2025 PIP Validation Results for HOME

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population	Initial Submission	46%	50%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	93%	100%	*High Confidence*	*Not Assessed*[5]		
*Implementation of Work Queue for Utilization Management**	Initial Submission	0%	0%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	44%	33%	*No Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.
*The health plan changed the PIP topic for resubmission upon HSAG's recommendation.

The *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. HOME had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Implementation of Work Queue for Utilization Management* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *No Confidence* level rating for adhering to acceptable PIP methodology. HOME had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, HOME submitted baseline data for the clinical and nonclinical PIPs. The PIPs had not progressed to analyzing data, conducting QI activities, or reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Table 2-27 displays baseline data for HOME's *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* PIP.

Table 2-27—PIP Outcomes—*Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* for HOME

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Remeasurement 2 (01/01/2026–12/31/2026)**		**Sustained Improvement**
Statin utilization among eligible HOME enrollees during the measurement year.	N: 66 D: 211	31.3%					

N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for statin utilization among eligible HOME members during the measurement year was 31.3 percent.

Table 2-28 displays baseline data for HOME's *Implementation of Work Queue for Utilization Management* PIP.

Table 2-28—PIP Outcomes—*Implementation of Work Queue for Utilization Management* for HOME

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2025–08/31/2025)**		**Remeasurement 1 (10/1/2025–12/312025)**		**Sustained Improvement**
The percentage of HOME enrollees who receive monthly supply deliveries from HOME vendors and had expired orders as reported by the vendors during the measurement period.**	N: 105 D: 550	19.1%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

**The performance indicator, as documented by the health plan, was unclear. HSAG has rephrased the performance indicator for this report.

The baseline rate for the percentage of HOME members who receive monthly supply deliveries from HOME vendors and had expired orders as reported by the vendors during the measurement period was 19.1 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. HOME's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* PIP, HOME used brainstorming, member and/or provider input, and a student project on statin analysis to identify the following barriers and the interventions implemented to address those barriers. Table 2-29 displays the barriers and interventions as documented by HOME.

Table 2-29—Interventions Implemented/Planned for *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population*

Barriers	Interventions
• Lack of familiarity with updated guidelines. Providers are unsure when statins are indicated, particularly in asymptomatic patients. • Providers are unable to identify eligible patients who meet the guidelines, but are not prescribed statin therapy. • Provider hesitancy due to perceived risk of drug interactions leading to adverse effects. • Fear of patients not adhering to testing and obtaining laboratory metrics. • Failure to initiate discussion on statin therapy during patient visits due to complex co-morbid conditions and resulting pill burden.	Collaboration with PCP to address provider perceived barriers in prescribing statins: • The clinical pharmacist will collaborate with the PCP and make recommendations after reviewing the current medication regimen.
• Patients are unaware of the benefits of adding statins. • Polypharmacy and fear of adverse drug interactions by adding statins lead to patient hesitancy. • Dependence on care givers for regular administration of added prescription and pill burden.	Patient education and outreach initiatives on the significance of adding statins: • The pharmacist will reach out to the qualifying population that is not on statin therapy to discuss both the benefits and side effects as well as their perceived apprehensions.

Table 2-30 will display the barriers and interventions as documented by HOME when the *Implementation of Work Queue for Utilization Management* PIP progresses to include QI activities and interventions.

Table 2-30—Interventions Implemented/Planned for *Implementation of Work Queue for Utilization Management*

Barriers	Interventions

HOME—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HOME's *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* PIP received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- The *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* PIP had an opportunity for improvement in the design of the intervention effectiveness measure.

- The *Implementation of Work Queue for Utilization Management* PIP received a *No Confidence* rating in overall confidence of adherence to acceptable methodology for the phases of the PIP. Multiple opportunities existed for improvement in the documentation of the PIP design, including the PIP population, Aim statement, performance indicators, measurement periods, and data collection process.

Recommendations

As the PIPs progress, HSAG offers the following recommendations:

For the *Implementation of Work Queue for Utilization Management* PIP,

- Schedule a technical assistance call with HSAG to discuss the PIP design.
- Reference the final PIP validation tool for detailed feedback on the opportunities for improvement in the PIP design.

For the *Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population* PIP:

- Ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- Ensure that the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed

to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention

- Complete an intervention worksheet for each intervention listed in the barriers/intervention table.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly) unlike the annual performance indicator data. This would help HOME understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide the next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

HOME submitted two new PIP topics for CY 2025 submission. In last year's validation, HSAG had recommended the health plan to retire the clinical PIP topic and initiate a new clinical PIP. The health plan addressed the recommendation. For the nonclinical PIP, the health plan changed the PIP topic because the baseline data for the nonclinical PIP topic from last year did not have an opportunity for improvement.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to HOME's PIPs will likely result in long-term improvement.

Healthy U Integrated

For CY 2025, Healthy U Integrated continued its clinical PIP topic, *Improving Adults' Access to Preventive/Ambulatory Care Services* and its nonclinical PIP topic, *Medicaid HRA Process Improvement*. The goal of the clinical PIP is to increase the percentage of adult members receiving annual ambulatory or preventive care visits with a physician. The goal of the nonclinical PIP is to increase the percentage of newly enrolled members who have an HRA result documented in the health plan care management platform within 90 days of enrollment.

Validation Results and Interventions

Table 2-31 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-31—CY 2025 PIP Validation Results for Healthy U Integrated

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving Adults' Access to Preventive/Ambulatory Care Services	Initial Submission	92%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Medicaid Health Risk Assessment (HRA) Process Improvement	Initial Submission	92%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Healthy U Integrated had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Healthy U Integrated had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, Healthy U Integrated submitted baseline data for the clinical and nonclinical PIPs. The PIPs had not progressed to analyzing data, conducting QI activities, or reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Table 2-32 displays baseline data for Healthy U Integrated's *Improving Adults' Access to Preventive/ Ambulatory Care Services* PIP.

Table 2-32—PIP Outcomes—*Improving Adults' Access to Preventive/Ambulatory Care Services* for Healthy U Integrated

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Remeasurement 2 (01/01/2026–12/31/2026)**		**Sustained Improvement**
The percentage of members 20 years of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	N: 4,498 D: 6,316	71.2%					

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 20 years of age and older who receive one or more ambulatory or preventive care visits during the measurement year was 71.2 percent.

Table 2-33 displays baseline data for Healthy U Integrated's *Medicaid HRA Process Improvement* PIP.

Table 2-33—PIP Outcomes—*Medicaid HRA Process Improvement* for Healthy U Integrated

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	N: 528 D: 3,027	17.4%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place

The baseline rate for the percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform within 90 days of enrollment was 17.4 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Healthy U Integrated's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP, Healthy U Integrated used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-34 displays barriers and interventions as documented by Healthy U Integrated.

Table 2-34—Interventions Implemented/Planned for *Improving Adults' Access to Preventive/Ambulatory Care Services*

Barriers	Interventions
• Members New to health insurance—Expansion members may be new to health insurance and unsure of how to navigate the health care system or how to find an in-network primary care provider	Member Outreach—Telephonic.

Barriers	Interventions
• Perceived lack of need—Some individuals feel healthy and don't see the value in preventive care. Members may be unaware of the importance of establishing care with a primary care provider for maintaining overall health. • Fear or anxiety: Members are concerned about potential diagnoses or discomfort during the visit. • Language and cultural differences: These can affect understanding and trust in the healthcare system. • Transportation issues: Lack of reliable transportation can prevent access to care. • Work or family obligations: Difficulty finding time due to job schedules or caregiving responsibilities.	
• The large eligible population for the measure along with limited staffing resources to make outreach calls makes it challenging to reach all members using only a manual phone outreach approach. • In addition, some members may be more likely to respond to a text message than a phone call.	Member Outreach—Vendor SMS Campaign.

For the *Medicaid Health Risk Assessment (HRA) Improvement* PIP, Healthy U Integrated used a fishbone diagram to identify the following barriers and plans to initiate the following interventions to address those barriers. Table 2-35 displays the barriers and interventions as documented by Healthy U Integrated.

Table 2-35—Interventions Implemented/Planned for *Medicaid HRA Process Improvement*

Barriers	Interventions
Lack of standardization in the various HRA forms and documentation process: • There were differences in the HRA forms between the paper and electronic versions. • Lack of automated process to enter electronic HRA results into the MHK platform: • HRA forms submitted electronically require manual entry of HRA responses into the MHK platform.	HRA Process Standardization and Automation.

Barriers	Interventions
• This results in a delay of entering member HRA results into the MHK platform because of the staff time it takes to complete manual entry.	
An electronic HRA was available on the health plan member portal, however, it was not possible to create a QR code that would take members directly to the HRA form. It was only possible to create a QR code that would take members to the log-in page to the member portal, where members would need to create a member portal account, log in, and then navigate to the HRA form.	Increase Options for Electronic Completion of the HRA: Create HRA embedded webform and QR Code.

Healthy U Integrated—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Healthy U Integrated received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all applicable phases of both PIP.

Opportunities for Improvement

HSAG identified the following opportunity for improvement:

- For the *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP, opportunity for improvement existed in the documentation of the intervention status in the intervention worksheet.

- For the *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP, an opportunity for improvement existed in the numerator definition of the intervention effectiveness measure.

Recommendations

As the PIPs progress, HSAG recommends that Healthy U Integrated:

- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.

- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Healthy U Integrated understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide the next steps for each individual intervention.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Continually work on the PIPs throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in achievement of significant improvement in PIP outcomes for Healthy U Integrated's *Improving Adults' Access to Preventive/Ambulatory Care Services* PIP. The health plan reassigned the CY 2024 as the baseline of this PIP in this year's submission; therefore, this section is not applicable to this PIP.

In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Healthy U Integrated's clinical PIP will likely result in long-term improvements.

Molina Healthcare of Utah UMIC (Molina UMIC)

For CY 2025 validation, Molina UMIC continued its clinical PIP topic, *Follow-Up After Hospitalization for Mental Illness* and its nonclinical PIP topic, *Increasing Member Engagement and Satisfaction With Digital Channels*. The goal of the clinical PIP is to improve the percentage of integrated Medicaid members receiving a follow-up visit with a mental health practitioner within 30 days of a hospital discharge for mental illness or intentional self-harm diagnoses. Timely follow-up after hospitalization can reduce the duration of disability and, for certain conditions, the likelihood of rehospitalization. The goal of the nonclinical PIP is to increase the percentage of members 18 years of age and older who opt in to text messaging and/or register for the My Molina portal.

Validation Results and Interventions

Table 2-36 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-36—CY 2025 PIP Validation Results for Molina UMIC

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Follow-Up After Hospitalization for Mental Illness	Initial Submission	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	*Health Plan Did Not Resubmit.*					
Increasing Member Engagement and Satisfaction With Digital Channels	Initial Submission	94%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Follow-Up After Hospitalization for Mental Illness* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Increasing Member Engagement and Satisfaction With Digital Channels* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Molina UMIC had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-37 displays PIP outcome data for Molina UMIC's *Follow-Up After Hospitalization for Mental Illness* PIP.

Table 2-37—PIP Outcomes—*Follow-Up After Hospitalization for Mental Illness* for Molina UMIC

Performance Indicator Results											
Performance Indicator	**Baseline (01/01/2020–12/31/2020)**		**R1 (01/01/2021–12/31/2021)**		**R2 (01/01/2022–12/31/2022)**		**R3 (01/01/2023–12/31/2023)**		**R4 (01/01/2024–12/31/2024)**		**Sustained Improvement**
The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a 30-day follow-up visit with a mental health practitioner.	N: 104 D: 227	45.8%	N: 136 D: 277	49.1%	N: 149 D: 342	43.6%	N: 140 D: 274	51.1%	N: 130 D: 236	55.1%	*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
R–Remeasurement; N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

For the baseline measurement period, Molina UMIC reported that for 45.8 percent of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, there was a 30-day follow-up visit with a mental health practitioner. For Remeasurement 3, the performance indicator rate was 51.1 percent, which represents a statistically nonsignificant increase of 5.3 percentage points over the baseline. For Remeasurement 4, the performance indicator rate was 55.1 percent, which represents a statistically nonsignificant increase of 9.3 percentage points over the baseline.

The performance indicator has not achieved statistically significant improvement at any remeasurement period. Therefore, the health plan was not assessed for sustained improvement.

In CY 2025, for the nonclinical PIP, Molina UMIC submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Table 2-38 displays baseline data for Molina UMIC's *Increasing Member Engagement and Satisfaction With Digital Channels* PIP.

Table 2-38—PIP Outcomes—*Increasing Member Engagement and Satisfaction With Digital Channels* for Molina UMIC

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of members 18 years of age and older who opt in to text messaging.	N: 5, 944 D: 7,930	75.0%			
The percentage of members 18 years of age and older who register for the My Molina portal.	N: 3,414 D: 11,807	28.9%			

N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 18 years of age and older who opted in to text messaging was 75.0 percent. The percentage of members 18 years of age and older who registered for the My Molina portal was 28.9 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Molina UMIC's choice of interventions, combination of intervention types, and sequence of

implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Follow-Up After Hospitalization for Mental Illness* PIP, Molina UMIC used a fishbone diagram and staff feedback to identify the following barriers and implemented the following interventions to address those barriers. Table 2-39 displays the barriers and interventions as documented by Molina UMIC.

Table 2-39—Interventions Implemented/Planned for *Follow-Up After Hospitalization for Mental Illness*

Barriers	Interventions
No established behavioral health provider.	Partner with Molina UMIC Care Connections to offer members an opportunity to meet telephonically with a licensed clinical social worker (LCSW) and complete a follow-up visit within 30 days of hospitalization.
Poor outpatient treatment prior to inpatient care—no/poor patient/doctor relationship.	
Physicians are not able to monitor the effectiveness of the medication.	
Limited access to timely hospital discharge information (ADT data).	

For the *Increasing Member Engagement and Satisfaction With Digital Channels* PIP, Molina UMIC used a fishbone diagram, workgroup, and the Five Whys method to identify the following barriers and implemented the following interventions to address those barriers. Table 2-40 displays the barriers and interventions as documented by Molina UMIC.

Table 2-40—Interventions Implemented/Planned for *Increasing Member Engagement and Satisfaction With Digital Channels*

Barriers	Interventions
Lack of promotion by internal partners.	Portal Training with Case Management Staff.
No feedback loop to improve tools based on member experience.	Relay Text Message Satisfaction Survey.

Molina UMIC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

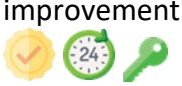
HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.

- For the *Follow-Up After Hospitalization for Mental Illness* PIP, the performance indicator achieved statistically nonsignificant improvement over the baseline.

Opportunities for Improvement

For the *Follow-Up After Hospitalization for Mental Illness* PIP, the performance indicator had some improvement over the baseline; however, the improvement was not statistically significant.



Recommendations

As the PIPs progress, HSAG offers the following recommendations:

For the *Follow-Up After Hospitalization for Mental Illness* PIP, HSAG recommends that Molina UMIC:

- Build on the positive momentum gained and improvement achieved.
- Expand the successful intervention to a large enough PIP population to realize a statistically significant improvement in the performance indicator rate.
- Determine a new PIP topic for next year's submission with consultation and approval from DHHS. Molina UMIC reported Remeasurement 4 data in this year's submission. Typically, a PIP includes a baseline and two remeasurement periods.
- Consult with HSAG for technical assistance as it determines and designs the new PIP for next year's submission.

For the *Increasing Member Engagement and Satisfaction With Digital Channels* PIP, HSAG recommends that Molina UMIC:

- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator; and is designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Molina UMIC understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes. Intervention effectiveness data must guide next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The performance indicator remeasurement rate for the *Follow-Up After Hospitalization for Mental Illness* PIP did not demonstrate statistically significant improvement over the baseline. In the CY 2025 submission, the health plan demonstrated additional improvement in the performance indicator rate; however, the improvement continued to be statistically nonsignificant. The health plan did not address the identified deficiency.

In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Molina UMIC's clinical PIP will likely result in long-term improvements.

Select Health Community Care UMIC (Select Health CC UMIC)

For CY 2025, Select Health CC UMIC continued its clinical PIP topic, *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* and its nonclinical PIP topic, *Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination.* The goal of the clinical PIP is to improve processes and outcomes of members' mental health care by increasing the percentage of members who have a follow-up visit with a mental health practitioner within seven days after a hospitalization for the treatment of mental illness or intentional self-harm. The goal of the nonclinical PIP is to increase the percentage of Select Health CC UMIC members retaining health insurance through continued coverage of Select Health CC UMIC or a different Select Health CC line of business when the member is identified for Medicaid redetermination.

Validation Results and Interventions

Table 2-41 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-41—CY 2025 PIP Validation Results for Select Health CC UMIC

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integrated Members	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*Health Plan Did Not Resubmit.*					
Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integrated Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Select Health CC UMIC had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-42 displays PIP outcome data for Select Health CC UMIC's *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* PIP.

Table 2-42—PIP Outcomes—*7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* for Select Health CC UMIC

Performance Indicator Results						
Performance Indicators	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024–12/31/2024)**	**Sustained Improvement**
Percentage of discharges for eligible Medicaid Integrated members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within 7 days after discharge.	N: 197 D: 589	33.5%	N: 213 D: 578	36.9%	N: 183 D: 422	43.4%*	*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of discharges for eligible members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within seven days after discharge was 33.5 percent. For Remeasurement 1, the performance indicator rate was 36.9 percent, which demonstrates a statistically nonsignificant increase of 3.4 percentage points over the baseline. For Remeasurement 2, the performance indicator rate was 43.4 percent, which demonstrates a statistically significant improvement of 9.9 percentage points over the baseline.

Select Health CC UMIC did not achieve statistically significant improvement during Remeasurement 1 and therefore was not assessed for sustained improvement during Remeasurement 2.

In CY 2025, for the nonclinical PIP, Select Health CC UMIC submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Table 2-43 displays baseline data for Select Health CC UMIC's *Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination* PIP.

Table 2-43—PIP Outcomes—*Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination* for Select Health CC UMIC

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percent of Medicaid Integrated members retaining health insurance when identified for redetermination.	N: 13,911 D: 21,352	65.2%			
Percent of Medicaid Integrated Members Retaining Select Health Medicaid Integrated When Identified for Redetermination.	N: 11,851 D: 21,352	55.5%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of Medicaid Integrated members retaining health insurance when identified for redetermination was 65.2 percent. The baseline rate for the percentage of Medicaid Integrated members retaining Select Health Medicaid Integrated when identified for redetermination was 55.5 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Select Health CC UMIC's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integrated Members* PIP, Select Health CC UMIC completed a cause and effect diagram, a Health Risk Stratification Tool, and a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-44 displays the barriers and interventions as documented by Select Health CC UMIC.

Table 2-44—Interventions Implemented/Planned for *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integrated Members*

Barriers	Interventions
Lack of transportation and access to care.	Provide Behavioral Health (BH) services at home.
Members cannot remember the appointment date.	Intermountain BH Navigators member engagement : BH navigators visit BH unit members to schedule FUH appointments. Navigators also call members 24 hours after discharge for appointment reminder and assistance with any barriers to attending the appointment.

For the *Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination* PIP, Select Health CC UMIC completed a fishbone diagram to identify the following barrier and implemented the following intervention to address this barrier. Table 2-45 displays the barrier and intervention as documented by Select Health CC UMIC.

Table 2-45—Interventions Implemented/Planned for *Improving the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination*

Barriers	Interventions
Members do not know they need to reapply.	Outreach to Medicaid Integrated Members Up for Redetermination.

Select Health CC UMIC—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.

- For the *7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members* PIP, the performance indicator achieved statistically significant improvement over the baseline.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Select Health CC UMIC:

- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Healthy U to understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
- Ensure that Intervention effectiveness data guide the next steps for each individual intervention.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Continually work on the PIPs throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The performance indicator remeasurement rate for the *Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Member* PIP did not demonstrate statistically significant improvement over the baseline. In the CY 2025 submission, the health plan addressed the deficiency identified in CY 2024 submission.

In last year's submission, no opportunities for improvement were identified in the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Select Health CC UMIC's clinical PIP will likely result in long-term improvement.

Medicaid PIHP PMHPs Providing Mental Health and SUD Services

Bear River Mental Health Services (Bear River)

For CY 2025, Bear River continued its clinical PIP topic, *Outcome Questionnaires or Youth Outcome Questionnaires (YOQ) (OQ/YOQ)* and its nonclinical PIP topic, *No Shows.* The goal of the clinical PIP is to improve processes and outcomes for members' mental health care by using outcome measurement instruments to increase clinician awareness of each member's current level of well-being or distress, which will provide a way to calibrate treatment interventions based on feedback as well as measure progress in treatment. The outcomes measurement instruments used in the PIP are Outcome Questionnaires (OQ 30.2) for adults 18 years and older and Youth Outcome Questionnaires (YOQ 30.2) for members 5–18 years of age. The goal of the nonclinical PIP is to increase the percentage of scheduled appointments during the measurement period where the member attends the appointment.

Validation Results and Interventions

Table 2-46 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-46—CY 2025 PIP Validation Results for Bear River

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
OQ/YOQ	Initial Submission	59%	67%	*No Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
No Shows	Initial Submission	64%	67%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	86%	100%	*Moderate Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *OQ/YOQ* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *No Shows* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *Moderate Confidence* level rating for adhering to acceptable PIP methodology. Bear River had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-47 displays PIP outcome data for Bear River's *YOQ/OQ* PIP.

Table 2-47—PIP Outcomes—*YOQ/OQ* for Bear River

Performance Indicator Results									
Performance Indicators	**Baseline (01/0/2021–12/31/2021)**		**Remeasurement 1 (01/01/2022–12/31/2022)**		**Remeasurement 2 (01/01/2023-12/31/2023)**		**Remeasurement 3 (01/01/2024-12/31/2024)**		**Sustained Improvement**
1a. Frequency of OQ completed by each member in a year.	N: 5,662 D: 15,525	36.5%	N: 7,524 D: 20,894	36.0%	N: 14,500 D: 24,188	59.9%*	N: 16,446 D: 23,420	70.2%*	*Yes*
1b. Frequency of YOQ completed by each member in a year.	N: 3,806 D: 9,052	42.0%	N: 4,631 D: 9,469	48.9%*	N: 7,771 D: 10,400	74.7%*	N: 8,040 D: 8,934	90.0%*	*Yes*
2a. Percentage of OQ reports reviewed by clinician within three days.	N: 4,354 D: 5,662	76.9%	N: 5,544 D: 7,524	73.7%	N: 12,152 D: 14,500	83.8%*	N: 14,292 D: 16,446	86.9%*	*Yes*

Performance Indicator Results									
Performance Indicators	Baseline (01/0/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023-12/31/2023)		Remeasurement 3 (01/01/2024-12/31/2024)		Sustained Improvement
2b. Percentage of YOQ reports reviewed by clinician within three days.	N: 2,527 D: 3,806	66.4%	N: 2,752 D: 4,631	59.4%	N: 6,021 D: 7,771	77.5%*	N: 6,510 D: 8,040	81.0%*	*Yes*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for percentage of eligible members who completed an OQ in a year was 36.5 percent. For Remeasurement 1, the Performance Indicator 1a rate was 36.0 percent, which represents a decrease of 0.5 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 1a rate was 59.9 percent, which represents a statistically significant increase of 23.4 percentage points over the baseline. For Remeasurement 3, the Performance Indicator 1a rate was 70.2 percent, which represents a statistically significant increase of 33.7 percentage points over the baseline.

The baseline rate for percentage of eligible members who completed a YOQ in a year was 42.0 percent. For Remeasurement 1, the Performance Indicator 1b rate increased to 48.9 percent. For Remeasurement 2, the Performance Indicator 1b rate was 74.7 percent, which represents a statistically significant increase of 32.7 percentage points over the baseline. For Remeasurement 3, the Performance Indicator 1b rate was 90.0 percent, which represents a statistically significant increase of 48.0 percentage points over the baseline.

The baseline rate for percentage of OQ reports reviewed by a clinician within three days of OQ administration was 76.9 percent. For Remeasurement 1, the Performance Indicator 2a rate was 73.7 percent, which represents a decrease of 3.2 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2a rate was 83.8 percent, which represents a statistically significant increase of 6.9 percentage points over the baseline. For Remeasurement 3, the Performance Indicator 2a rate was 86.9 percent, which represents a statistically significant increase of 10.0 percentage points over the baseline.

The baseline rate for percentage of YOQ reports reviewed by a clinician within three days of YOQ administration was 66.4 percent. For Remeasurement 1, the Performance Indicator 2b rate was 59.4 percent, which represents a decrease of 7.0 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2b rate was 77.5 percent, which represents a statistically significant increase of 11.1 percentage points over the baseline. For Remeasurement 3, the Performance Indicator 2b rate was 81.0 percent, which represents a statistically significant increase of 14.6 percentage points over the baseline.

All four Performance Indicators sustained statistically significant improvement over the baseline during Remeasurement 3.

In CY 2025, for the nonclinical PIP, Bear River submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-48 displays baseline data for the *No Shows* PIP.

Table 2-48—PIP Outcomes—*No Shows* for Bear River

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of appointments kept, out of the appointments scheduled during the measurement year.	N: 54,959 D:73,816	74.5%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for percentage of appointments kept, out of the appointments scheduled during the measurement year, was 74.5 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Bear River's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *OQ/YOQ* PIP, Bear River used data analysis and brainstorming to identify the following barrier and implemented the following intervention to address that barrier. Table 2-49 displays the barrier and intervention as documented by Bear River.

Table 2-49—Interventions Implemented/Planned for *OQ/YOQ*

Barriers	Interventions
Staff not looking at the OQ/YOQ within the required time frame.	Staff reminders and training to review the OQ/YOQ within the required three-day period.

For the *No Shows* PIP, Bear River used brainstorming to identify the following barrier and implemented the following intervention to address that barrier. Table 2-50 displays the barrier and intervention as documented by Bear River.

Table 2-50—Interventions Implemented/Planned for *No Shows*

Barriers	Interventions
Not knowing beforehand if members were planning on attending their appointments and receiving a late notice on appointment cancellations.	Allow members to respond to appointment reminders to confirm their attendance or absence from the appointment.

Bear River—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- The *OQ/YOQ* PIP received an overall *High Confidence* rating in both overall confidence of adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement.
- For the *OQ/YOQ* PIP, Bear River achieved sustained improvement in the Remeasurement 3 rate for all four performance indicators.
- The *No Shows* PIP received a *Moderate Confidence* rating for adherence to acceptable methodology for all phases of the PIP.

Opportunities for Improvement

For the *No Shows* PIP, there were opportunities for improvement in the documentation of intervention progression information and the intervention effectiveness measure.

Recommendations

As the PIPs progress, HSAG recommends the following:

- For the *OQ/YOQ* PIP, HSAG recommends that Bear River:
  - Build on the positive momentum gained and improvement achieved.

  - Expand the successful intervention to a large enough PIP population to realize a statistically significant improvement in the performance indicator rate.
  - Determine a new PIP topic for next year's submission with consultation and approval from DHHS. Molina reported Remeasurement 4 data in this year's submission. Typically, a PIP includes a baseline and two remeasurement periods.
  - Consult with HSAG for technical assistance as it determines and designs the new PIP for next year's submission.
- For the *No Shows* PIP, HSAG recommends that Bear River:
  - Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator; and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
  - Consider collecting information on how many members were denied the ability to attend the appointment when reminders were sent via text. The health plan may track the number of members who were sent text reminders as denominators and the number of members who responded "No" to attending the appointment as the numerator.
  - Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Bear River to understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
  - Ensure that Intervention effectiveness data guide the next steps for each individual intervention.
  - Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
  - Continually work on the PIP throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified opportunities for improvement in the documentation of the PIP population and the PIP Aim statement for the nonclinical *No Shows* PIP. In the CY 2025 submission, the health plan addressed the identified deficiencies.

In last year's submission, no opportunities for improvement were identified in the clinical *OQ/YOQ* PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Bear River's clinical PIP will likely result in long-term improvements.

Central Utah Counseling Center (Central)

For CY 2025, Central continued its clinical PIP topic, *Improved Integrated Care*, and its nonclinical PIP, *Screening for Social Determinants of Health (SDOH)*. The goal of the clinical PIP is to improve processes and outcomes for members' mental health care and to increase the percentage of members with a PCP included in Central's EHR. The goal of the nonclinical PIP is to increase the percentage of individuals screened for SDOH as part of their initial behavioral health evaluation.

Validation Results and Interventions

Table 2-51 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-51—CY 2025 PIP Validation Results for Central

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improved Integrated Care	Initial Submission	50%	63%	*No Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
SDOH	Initial Submission	87%	100%	*Moderate Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Improved Integrated Care* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *SDOH* PIP was validated through eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Central had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-52 displays PIP outcome data for Central's *Improvement Integrated Care* PIP.

Table 2-52—PIP Outcomes—*Improvement Integrated Care* for Central

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Remeasurement 2 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of members 5 years and older with a valid initial evaluation who had a PCP listed in the electronic health record (EHR).	N: 246 D: 1,764	13.9%	N: 673 D: 1,385	48.6%*			*Yes*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 5 years and older with a valid initial evaluation who had a PCP listed in the EHR was 13.9 percent. For Remeasurement 1, the Performance Indicator rate was 48.6 percent, which represents a statistically significant increase of 34.7 percentage points over the baseline rate.

In CY 2025, for the nonclinical PIP, Central submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. Table 2-53 displays baseline data for Central's *SDOH* PIP.

Table 2-53—PIP Outcomes—*SDOH* for Central

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Remeasurement 2 (01/01/2026–12/31/2026)**		**Sustained Improvement**
The percentage of members who received an SDOH screening as part of the initial evaluation.	N: 311 D: 923	33.7%					

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members who received a SDOH screening as part of the initial evaluation was 33.7 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Central's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Improved Integrated Care* PIP, Central reported data mining and process-level analysis as its QI processes for barrier identification. Table 2-54 displays the barrier and intervention as documented by Central.

Table 2-54—Interventions Implemented/Planned for *Improved Integrated Care*

Barriers	Interventions
There has been only one way for all staff to manually navigate to and add a PCP directly to the appropriate EHR data field. This has made adding a PCP to the EHR more difficult and less likely to occur.	EHR form templates will be adapted to allow PCP names to be added easily by Central clinical and non-clinical staff.

For the *SDOH* PIP, Central reported data mining and process-level analysis as its QI process for barrier identification. Table 2-55 displays the barrier and intervention as documented by Central.

Table 2-55—Interventions Implemented/Planned for *SDOH*

Barriers	Interventions
The Central admissions packet did not include an SDOH screening tool, limiting the ability to screen for SDOH-related needs at initial evaluation appointments.	Educate Central staff to ensure that incoming members receive updated admission paperwork packets, which now include an SDOH screening form for client completion.

Central—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- The *Improved Integrated Care* PIP received an overall *High Confidence* rating in overall confidence that the PIP achieved significant improvement.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Central:

- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Central to understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
- Ensure that Intervention effectiveness data guide the next steps for each individual intervention.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Continually work on the PIPs throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified opportunities for improvement in the documentation of the data collection procedures for the nonclinical *SDOH* PIP. In the CY 2025 submission, the health plan addresses the identified deficiencies. In last year's submission, no opportunities for improvement were identified in the clinical *Improved Integrated Care* PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Central's clinical PIP will likely result in long-term improvements

Davis Behavioral Health (Davis)

For CY 2025, Davis continued its clinical PIP, *Naloxone for Opioid Use Disorders,* and its nonclinical PIP, *Diagnosing Conflicts.* The goal of the clinical PIP is to increase the possession of naloxone for members diagnosed with an opioid use disorder to help mitigate opioid overdose deaths. The goal of the nonclinical PIP is to decrease the percentage of incompatible mental health disorder diagnoses in adult outpatient health records.

Validation Results and Interventions

Table 2-56 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-56—CY 2025 PIP Validation Results for Davis

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Naloxone for Opioid Use Disorders	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Diagnosing Conflicts	Initial Submission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Naloxone for Opioid Use Disorders* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Davis had not progressed to reporting remeasurement data; therefore, the PIP was not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Diagnosing Conflicts* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

Indicator Outcomes

In CY 2025, for the clinical PIP, Davis submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-57 displays baseline data for the *Naloxone for Opioid Use Disorders* PIP.

Table 2-57—PIP Outcomes—*Naloxone for Opioid Use Disorders* for Davis

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Remeasurement 2 (01/01/2026–12/31/2026)**		**Sustained Improvement**
The percentage of members 18 years and above who are diagnosed with opioid use disorder and possess Naloxone.	N: 708 D: 1,097	64.5%					

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 18 years and above who are diagnosed with opioid use disorder and possess Naloxone was 64.5 percent.

In CY 2025, for the nonclinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-58 displays PIP outcome data for Davis's *Diagnosing Conflicts* PIP.

Table 2-58—PIP Outcomes—*Diagnosing Conflicts* for Davis

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Remeasurement 2 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of sampled health records that have incompatible diagnosing.	N: 192 D: 1,200	16.0%	N: 157 D: 1,200	13.1%*			*Yes*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of sampled health records that had incompatible diagnosing was 16.0 percent. For Remeasurement 1, the Performance Indicator rate was 13.1 percent, which represents a statistically significant decrease (i.e., favorable outcome) of 2.9 percentage points over the baseline rate.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Davis's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Naloxone for Opioid Use Disorders* PIP, Davis's causal/barrier analysis process included the use of process mapping to identify barriers leading to the selected interventions. Table 2-59 displays the barriers and interventions as documented by Davis.

Table 2-59—Interventions Implemented/Planned for *Naloxone for Opioid Use Disorders*

Barriers	Interventions
Providers are not following the process of determining and providing Naloxone, such as ensuring and documenting the medication given.	Regular staff reminders and training to determine and prescribe Naloxone.
There are situations of not being given or prescribed Naloxone, such as refusals, leaving against medical advice, and incarceration discharge.	Outreach to those without Naloxone.

For the *Diagnosing Conflicts* PIP, Davis's causal/barrier analysis process included the use of a fishbone diagram to identify barriers leading to the selected interventions. Table 2-60 displays the barriers and interventions as documented by Davis.

Table 2-60—Interventions Implemented/Planned for *Diagnosing Conflicts*

Barriers	Interventions
Providers are not updating diagnoses to diagnose policy/procedure, such as leaving a prior diagnosis unresolved or as a more valid diagnosis.	Clinician training on comorbidity, incompatibility, and ending/updating diagnoses in Credible.
There are continued conflicts, such as not diagnosing corrections post-training.	Clinician case review of specific charts with diagnosing conflicts.
Diagnosing conflicts are largely mood disorder scenarios.	Monthly conflict notification to leadership.

Davis—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- For the *Diagnosing Conflicts* PIP, the performance indicator Remeasurement 1 rate demonstrated statistically significant improvement over the baseline.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Davis:

- Continually work on the PIPs throughout the year.
- Build on the positive momentum gained and improvement achieved.
- Apply lessons learned and knowledge gained while conducting QI processes and testing interventions.

- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Davis to understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
- Ensure that Intervention effectiveness data guide the next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Four Corners Community Behavioral Health (Four Corners)

For CY 2025, Four Corners continued its clinical PIP topic, *Improving the Completion of Substance Use Recovery Evaluator (SURE) Survey* and its nonclinical PIP topic, *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care.* The goal of the clinical PIP is to make the SURE survey a regularly used instrument in the treatment of members in the SUD treatment programs. Measuring members' recovery from drug and alcohol dependence has the potential to improve member engagement in the treatment. The goal of the nonclinical PIP is to increase the percentage of active members with a current email address.

Validation Results and Interventions

Table 2-61 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-61—CY 2025 PIP Validation Results for Four Corners

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving the Completion of the SURE Survey	Initial Submission	61%	56%	*No Confidence*	0%	0%	*No Confidence*
	Resubmission	95%	90%	*No Confidence*	0%	0%	*No Confidence*
Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care	Initial Submission	13%	13%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	31%	38%	*No Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Improving the Completion of the SURE Survey* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *No Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

The *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *No Confidence* level rating for adhering to acceptable PIP methodology. Four Corners had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-62 displays PIP outcome data for Four Corners' *Improving the Completion of the SURE Survey* PIP.

Table 2-62—PIP Outcomes—*Improving the Completion of the SURE Survey* for Four Corners

Performance Indicator Results							
Performance Indicators	**Baseline (07/01/2023–06/30/2024)**		**Remeasurement 1 (07/01/2024–06/30/2025)**		**Remeasurement 2 (07/01/2025-06/30/2026)**		**Sustained Improvement**
The percentage of completed SURE surveys.	N: 2,214 D: 6,448	34.3%	N: 1,418 D: 4,438	32.0%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of completed SURE surveys by eligible members was 34.3 percent. For Remeasurement 1, the Performance Indicator rate was 32.0 percent, which represents a decrease of 2.3 percentage points over the baseline.

In CY 2025, for the nonclinical PIP, Four Corners submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. Table 2-63 displays baseline data for Four Corners' *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care* PIP.

Table 2-63—PIP Outcomes—*Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care* for Four Corners

Performance Indicator Results					
Performance Indicators	**Baseline (CY 2024)^**		**Remeasurement 1 (CY 2025)**		**Sustained Improvement**
Current members with email address.	N: 266 D: 532	50.0%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

^ In the Step 7a data table, the health plan had documented 07/01/2023–06/30/2024 as the baseline period instead of the approved CY 2024 as the PIP baseline.

The baseline rate for the percentage of current members with email addresses was 50.0 percent. The health plan inaccurately documented the PIP measurement period in the PIP Submission Form Step 7a data table as (07/01/2023–06/30/2024) instead of CY 2024. The health plan will need to update the baseline data in the next annual submission.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Four Corners' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

Four Corners documented that brainstorming was used as the QI tool for identification of the documented barrier. For the *Improving the Completion of the SURE Survey* PIP, Table 2-64 displays the barriers and interventions as documented by Four Corners.

Table 2-64—Interventions Implemented/Planned for *Improving the Completion of the SURE Survey*

Barriers	Interventions
Front office staff not being consistent in administering/offering the SURE surveys.	Front office staff will be trained in the monthly meetings to administer the survey to the members that are enrolled in American Society of Addiction Medicine (ASAM) level of care.

Table 2-65 will display the barriers and interventions as documented by Four Corners when the *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care* PIP progresses to include QI activities and interventions.

Table 2-65—Interventions Implemented/Planned for *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care*

Barriers	Interventions

Four Corners—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

The revised Remeasurement 1 period PIP design for the *Improving the Completion of the SURE Survey* is scientifically sound supported by key research principles.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- Both PIPs received an overall *No Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- For the *Improving the Completion of the Substance Use Recovery Evaluator (SURE) Survey* PIP the health plan had revised the PIP design during Remeasurement 1. Therefore, the PIP remeasurement methodology was not comparable to the baseline. Additionally, there was no improvement in the reported remeasurement results compared to the baseline.
- For the *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care* PIP multiple opportunities for improvement existed in the documentation of the PIP design, performance indicator data, and QI activities.

Recommendations

As the PIPs progress, HSAG recommends that Four Corners:

- For the *Improving the Completion of the Substance Use Recovery Evaluator (SURE) Survey* PIP:
  - For comparability of data, reassign the Remeasurement 1 period (07/01/2024 to 06/30/2025) as the new baseline for this PIP.
- For the *Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care* PIP:
  - Address all feedback provided in the final PIP validation tool. The PIP population, performance indicator, measurement periods, and data collection methodology must be defined completely and accurately.
  - Identify barriers and implement interventions in a timely manner to impact outcomes during the remeasurement period.
  - Seek technical assistance from HSAG for any questions on the validation feedback.
- consider use of QI-science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Four Corners understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide the next steps for each individual intervention.
- Reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation HSAG identified an opportunity for improvement in the documentation of the causal barrier analysis process for the Improving the Completion of Substance Use Recovery Evaluator (SURE) PIP. The health plan addressed the identified deficient in CY 2025 submission.

In last year's validation, HSAG identified opportunities for improvement in the documentation of the PIP population, the PIP Aim statement, and the data collection process for the Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care PIP. In the CY 2025 submission, the health plan corrected the Aim statement; however, there continued to be deficiencies in the documentation of the PIP population, and the data collection process.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Four Corners' PIPs will likely result in long-term improvements.

Healthy U Behavioral

For CY 2025, Healthy U Behavioral continued its clinical PIP topic, *Improving Follow-Up After Hospitalization for Mental Illness* and its nonclinical PIP topic, *Medicaid HRA Process Improvement.* The goal of the clinical PIP is to increase the percentage of members who have a follow-up visit with a mental health practitioner within seven and 30 days after a hospitalization for the treatment of mental illness or intentional self-harm. The goal of the nonclinical PIP is to increase the percentage of newly enrolled members who have an HRA result documented in the Healthy U care management platform within 90 days of enrollment.

Validation Results and Interventions

Table 2-66 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-66—CY 2025 PIP Validation Results for Healthy U Behavioral

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving Follow-Up After Hospitalization	Initial Submission	92%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Medicaid Health Risk Assessment (HRA) Process Improvement	Initial Submission	92%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Improving Follow-Up After Hospitalization* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* rating for adherence to acceptable PIP methodology. Healthy U Behavioral had not progressed to reporting baseline and remeasurement data and was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* rating for adherence to acceptable PIP methodology. Healthy U Behavioral had not progressed to reporting baseline and remeasurement data and was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, Healthy U Behavioral submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-67 displays baseline data for Healthy U Behavioral's *Improving Follow-Up After Hospitalization* PIP.

Table 2-67—PIP Outcomes—*Improving Follow-Up After Hospitalization* for Healthy U Behavioral

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Remeasurement 2 (01/01/2026–12/31/2026)**		**Sustained Improvement**
1. Percentage of discharges for members 6 years of age and older who were hospitalized and who had a follow-up visit within 7 days of discharge.	N: 5 D: 8	63.0%					
2. Percentage of discharges for members 6 years of age and older who were hospitalized and who had a follow-up visit within 7 days of discharge.	N: 7 D: 8	88.0%					

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of discharges for members 6 years of age and older who were hospitalized and who had a follow-up visit within 7 days of discharge was 63.0 percent. The baseline rate for the percentage of discharges for members 6 years of age and older who were hospitalized and who had a follow-up visit within 30 days of discharge was 88.0 percent.

In CY 2025, for the nonclinical PIP, Healthy U Behavioral submitted baseline data had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-68 displays baseline data for Healthy U Behavioral's *HRA Process Improvement* PIP.

Table 2-68—PIP Outcomes—*Medicaid HRA Process Improvement* for Healthy U Behavioral

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	N: 10 D: 183	5.5%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform within 90 days of enrollment was 5.5 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Healthy U Behavioral's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Improving Follow-up After Hospitalization* PIP, Healthy U Behavioral used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-69 displays the barriers and interventions as documented by Healthy U Behavioral.

Table 2-69—Interventions Implemented/Planned for *Improving Follow-Up After Hospitalization*

Barriers	Interventions
• Inpatient facilities not scheduling timely follow-up visits for members prior to discharge. • Inpatient facilities not aware of in-network providers available for follow-up appointments. • Care managers do not initiate contact with discharge planners soon enough in the course of the member's hospital stay.	Care Management Outreach to Discharge Facilities

For the *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP, Healthy U Behavioral used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-70 displays the barriers and interventions as documented by Healthy U Behavioral.

Table 2-70—Interventions Implemented/Planned for *Medicaid HRA Process Improvement*

Barriers	Interventions
Lack of standardization in the various HRA forms and documentation process: • HRA results are recorded in two different locations in the MHK care management platform. • There are also differences in the HRA forms between the paper and electronic versions. Lack of an automated process to enter electronic HRA results into the MHK platform: • HRA forms submitted electronically require manual entry of HRA responses into the MHK platform. • This results in a delay of entering member HRA results into the MHK platform because of the staff time needed to complete manual entry.	HRA Process Standardization and Automation.
An electronic HRA was available on the health plan member portal; however, it was not possible to create a QR code that would take members directly to the HRA form. It was only possible to create a QR code that would take members to the log-in page to the member portal, where members would need to create a member portal account, log in, and then navigate to the HRA form.	Increase Options for Electronic Completion of the HRA: Create HRA embedded webform and QR Code.

Healthy U Behavioral—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Healthy U Behavioral reported baseline data and received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all applicable phases of the PIP.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Healthy U Behavioral:

- Implement interventions in a timely manner to impact outcomes during the remeasurement period.
- Consider the use of QI science-based tools, such as process mapping and FEMA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Healthy U Behavioral understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in achievement of significant improvement in PIP outcomes for Healthy U Behavioral's *Improving Follow-Up After Hospitalization for Mental Illness* PIP. For CY 2025 submission, the health plan reassigned the CY 2024 as the baseline of this PIP; therefore, this section is not applicable to this PIP.

In last year's validation, no opportunities for improvement were identified in the nonclinical PIP.

Northeastern Counseling Center (Northeastern)

For CY 2025, Northeastern continued its clinical PIP topic, *Improve Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed With a Schizophrenia Spectrum Disorder,* and its nonclinical PIP topic, *Increasing Health-Related Social Needs Screenings*. The goal of the clinical PIP is to decrease the risk of development of metabolic syndrome in members who are diagnosed with schizophrenia spectrum disorder and are taking antipsychotic medications. The goal of the nonclinical PIP is to increase the percentage of unduplicated PMHP members who have completed a health-related social needs (HRSN) screening during the six-month measurement periods.

Validation Results and Interventions

Table 2-71 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-71—CY 2025 PIP Validation Results for Northeastern

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Improving Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed With a Schizophrenia Spectrum Disorder	Initial Submission	82%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Increasing Health-Related Social Needs Screenings	Initial Submission	75%	75%	*Low Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Improving Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed With a Schizophrenia Spectrum Disorder* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Increasing Health-Related Social Needs Screenings* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Northeastern had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-72 displays PIP outcome data for Northeastern's *Improve Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed With a Schizophrenia Spectrum Disorder* PIP.

Table 2-72—PIP Outcomes—*Improve Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed With a Schizophrenia Spectrum Disorder* for Northeastern

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Remeasurement 2 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of eligible members who received annual Abnormal Involuntary Movement Scale (AIMS).	N: 6 D: 95	6.3%	N: 39 D: 84	46.4%*			
The percentage of eligible members who received annual hemoglobin A1c testing.	N: 22 D: 95	23.2%	N: 40 D: 84	47.6%*			
	N: 27	28.4%	N: 43	51.2%*			

Performance Indicator Results							
Performance Indicator	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)		Remeasurement 2 (01/01/2025–12/31/2025)		Sustained Improvement
The percentage of eligible members who received annual lipid panel testing.	D: 95		D: 84				

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of eligible members who were administered AIMS was 6.3 percent. For Remeasurement 1, the percentage of eligible members who were administered AIMS was 46.4 percent, which represents a statistically significant increase of 40.1 percentage points over the baseline rate.

The baseline rate for the percentage of eligible members who received annual hemoglobin A1c testing was 23.2 percent. For Remeasurement 1, the percentage of eligible members who received annual hemoglobin A1c testing was 47.6 percent, which represents a statistically significant increase of 24.4 percentage points over the baseline rate.

The baseline rate for the percentage of eligible members who received annual lip panel testing was 28.4 percent. For Remeasurement 1, the percentage of eligible members who received annual lipid panel testing was 51.2 percent, which represents a statistically significant increase of 22.8 percentage points over the baseline rate.

In CY 2025, for the nonclinical PIP, Northeastern submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-73 displays baseline data for Northeastern's *Increasing Health-Related Social Needs Screenings* PIP.

Table 2-73—PIP Outcomes—*Increasing Health-Related Social Needs Screenings* for Northeastern

Performance Indicator Results							
Performance Indicator	Baseline (07/01/2024–12/31/2024)		Remeasurement 1 (07/01/2025–12/31/2025)		Remeasurement 2 (07/01/2026–12/31/2026)		Sustained Improvement
The percentage of served PMHP enrollees who completed HRSN screening during the six-month measurement period.	N: 73 D: 1,377	5.3%					

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of served PMHP members who completed HRSN screening during the six-month measurement period was 5.3 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Northeastern's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Improving Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed With a Schizophrenia Spectrum Disorder* PIP, Northeastern used data analysis to identify the following barriers and implemented the following interventions to address those barriers. Table 2-74 displays the barriers and interventions as documented by Northeastern.

Table 2-74—Interventions Implemented/Planned for *Improving Monitoring of Selected Antipsychotic Medication Side Effects in Individuals Diagnosed with a Schizophrenia Spectrum Disorder*

Barriers	Interventions
Nurses and case managers do not identify and make obtaining an annual lipid panel and hemoglobin A1c test for members of the population a priority. Nurses lose track of this small population in daily practice.	Training meetings with nurses and case managers two times a year. Include an emailed population list provided by Administration two times a year.
Nurses do not identify and make administering AIMS to members of the population a priority. Nurses lose track of this small population in daily practice.	Reminder to medical staff about practice standards regarding AIMS at measurement year midpoint. Email the population list to nurses two times a year.

For the *Increasing Health-Related Social Needs Screening* PIP, Northeastern used brainstorming to identify the following barriers and plans to initiate the following interventions to address those barriers. Table 2-75 displays the barriers and interventions as documented by Northeastern.

Table 2-75—Interventions Implemented/Planned for *Increasing Health-Related Social Needs Screenings*

Barriers	Interventions
The scope of members being offered HRSN screening is too narrow. Most of the serious mental illness/serious emotional disturbance population of members do not complete HRSN screening when	Policy Change: When members begin TCM services or have a service plan review, the client or case manager with the client completes HRSN screening.

Barriers	Interventions
intake only is emphasized. HRSN screening needs to be incorporated into the TCM needs assessment process to capture this high-need population.	
Approximately 250 members who received an intake evaluation during the baseline period did not complete HRSN screening. This may be because the screening was not offered; the member refused to complete the screening; or health plan staff did not complete the data field.	Reminder/Training by email or in person twice a year on the purpose of HRSN, offering HRSN screening, and entering HRSN screening data. This will include TCM providers and support staff.

Northeastern—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Both PIPs received an overall *High Confidence* validation rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Northeastern:

- Implement interventions in a timely manner to impact outcomes during the remeasurement period.
- Use QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Northeastern understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.

- Ensure intervention effectiveness data guide next steps for each individual intervention.
- Seek technical assistance from HSAG and DHHS throughout the PIP process to address any questions or concerns.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Optum Tooele County (Optum/Tooele)

For CY 2025, Optum/Tooele submitted two new PIPs, its clinical PIP topic, *Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* and its nonclinical PIP topic, *Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)*. The goal of the clinical PIP is to increase member follow-up with a provider after hospitalizations for treatment of mental illness. The goal of the nonclinical PIP is to increase sharing of provider-specific member satisfaction scores with network providers. The health plan hopes that by sharing this information, providers will have the ability to determine possible root causes for member satisfaction and/or dissatisfaction, and through collaboration, address those identified elements to improve member care and experiences.

Validation Results and Interventions

Table 2-76 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-76—CY 2025 PIP Validation Results for Optum/Tooele

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64	Initial Submission	67%	60%	*Low Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		
Distribution of Provider-Specific Results of Member Satisfaction Surveys	Initial Submission	75%	75%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	92%	88%	*Low Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the Design/baseline data.

The *Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Optum/Tooele had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Distribution of Provider-Specific Results of Member Satisfaction Surveys* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *Low Confidence* level rating for adhering to acceptable PIP methodology. Optum/Tooele had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, Optum Tooele submitted the PIP Design stage, but had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess baseline data in the 2026 validation cycle. Table 2-77 will display PIP outcome data for Optum/Tooele's *Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* PIP once performance indicator outcomes are reported.

Table 2-77—PIP Outcomes—*Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* for Optum/Tooele

Performance Indicator Results							
Performance Indicators	**Baseline (01/01/2025–12/01/2025)**		**Remeasurement 1 (01/01/2026–12/01/2026)**		**Remeasurement 2 (01/01/2027–12/01/2027)**		**Sustained Improvement**
1. The percentage of discharges for which eligible members aged 18–64 years received at least one FUH service allowed by HEDIS® within 7 days after discharge from inpatient hospitalization for treatment of mental illness.							

Performance Indicator Results							
Performance Indicators	Baseline (01/01/2025–12/01/2025)		Remeasurement 1 (01/01/2026–12/01/2026)		Remeasurement 2 (01/01/2027–12/01/2027)		Sustained Improvement
2. The percentage of eligible members aged 18–64 years who received at least one FUH service allowed by HEDIS® within 30 days after discharge from inpatient hospitalization for treatment of mental illness.							

N–Numerator; D–Denominator

In CY 2025, for the nonclinical PIP, Optum/Tooele submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-78 will display baseline data for Optum/Tooele's *Distribution of Provider-Specific Results of Member Satisfaction Surveys* PIP.

Table 2-78—PIP Outcomes—*Distribution of Provider-Specific Results of Member Satisfaction Surveys* for Optum/Tooele

Performance Indicator Results					
Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
The percentage of Optum Toole County Outpatient Behavioral Health Network Providers with a provider-specific MHSIP submission ID who served ≥20 members during the calendar year immediately prior to the measurement period, met the anonymity threshold for survey responses gathered during the measurement period, and received provider-specific survey results.	N: 0 D: 6	0.0%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline percentage of Optum/Tooele Outpatient Behavioral Health Network Providers with a provider-specific MHSIP submission ID who served ≥20 members during the calendar year immediately prior to the measurement period, met the anonymity threshold for survey responses gathered during the measurement period, and received provider-specific survey results was 0.0 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Optum/Tooele's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* PIP, Table 2-79 will display the barriers and interventions as documented by Optum/Tooele when the PIP progresses to include QI activities and interventions.

Table 2-79—Interventions Implemented/Planned for *Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64*

Barriers	Interventions

For the *Distribution of Provider-Specific Results of Member Satisfaction Surveys* PIP, Optum/Tooele used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-80 displays the barriers and interventions as documented by Optum/Tooele.

Table 2-80—Interventions Implemented/Planned for *Distribution of Provider-Specific Results of Member Satisfaction Surveys*

Barriers	Interventions
Only providers who served ≥20 members during the calendar year immediately prior to the measurement period and had a unique provider submission ID can receive agency-specific MHSIP feedback.	Increase the volume of providers with provider-specific MHSIP submission IDs.
Providers need access to MHSIP results for their agency or practice.	Create reports with provider-specific MHSIP feedback.
Providers are unfamiliar with MHSIP feedback and will need guidance to navigate and interpret the results.	Create a guidance document to assist providers in interpreting results.

Optum/Tooele—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

The *Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* PIP received a *High Confidence* rating in overall confidence of adherence to acceptable methodology for the PIP design.

Opportunities for Improvement

The *Distribution of Provider-Specific Results of Member Satisfaction Surveys* PIP had an opportunity for improvement in the documentation of the eligible PIP population.

Recommendations

As the PIPs progress, HSAG recommends that Optum/Tooele:

- Update the Step 3 population documentation to align with the performance indicator denominator population, for the *Distribution of Provider-Specific Results of Member Satisfaction Surveys* PIP.
- Implement new intervention(s) in a timely manner to improve outcomes.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Optum/Tooele understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide the next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Optum/Tooele submitted two new PIP topics for CY 2025 submission; therefore, this section is not applicable.

Salt Lake County Division of Behavioral Health (Salt Lake)

For CY 2025, Salt Lake continued its clinical PIP topic, *Follow-Up After Hospitalization for Adults Aged 18–64* and submitted a new nonclinical PIP topic, *Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP).* The goal of the clinical PIP is to improve behavioral health outcomes by increasing member engagement and follow-up after discharge from inpatient hospitalization for treatment of mental illness. The goal of the nonclinical PIP is to increase the sharing of provider-specific member satisfaction scores with network providers. The health plan hopes that by sharing this information, providers will have the ability to determine possible root causes for member satisfaction and/or dissatisfaction, and through collaboration, address those identified elements to improve member care and experiences.

Validation Results and Interventions

Table 2-81 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-81—CY 2025 PIP Validation Results for Salt Lake

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Follow-Up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64	Initial Submission	88%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)	Initial Submission	88%	88%	*Low Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Follow-Up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Salt Lake had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025 for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-82 displays PIP outcome data for Salt Lake's *Follow-Up After Hospitalization for Adults Aged 18–64* PIP.

Table 2-82—PIP Outcomes—*Follow-Up After Hospitalization for Adults Aged 18–64* for Salt Lake

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2022–12/01/2022)**		**Remeasurement 1 (01/01/2023–12/01/2023)**		**Remeasurement 2 (01/01/2024–12/01/2024)**		**Sustained Improvement**
1. The percentage of discharges for which eligible members aged 18–64 years received at least one behavioral health service within seven days after discharge from inpatient hospitalization for treatment of mental illness.	N: 183 D: 507	36.1%	N: 148 D: 363	40.7%	N: 117 D: 262	44.7%*	*Not Assessed*
2. The percentage of discharges for which eligible members aged 18–64 years received at least one behavioral health service within 30 days after discharge from inpatient	N: 254 D: 507	50.1%	N: 210 D: 363	57.9*	N: 169 D: 262	64.5%*	*Yes*

Performance Indicator Results							
Performance Indicator	Baseline (01/01/2022–12/01/2022)		Remeasurement 1 (01/01/2023–12/01/2023)		Remeasurement 2 (01/01/2024–12/01/2024)		Sustained Improvement
hospitalization for treatment of mental illness.							

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of discharges for which eligible members aged 18–64 years received at least one behavioral health service within seven days after discharge from inpatient hospitalization for treatment of mental illness was 36.1 percent. For Remeasurement 1, the Performance Indicator 1 rate was 40.7 percent, which represents a statistically nonsignificant increase of 4.6 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 1 rate was 44.7 percent, which represents a statistically significant increase of 8.6 percentage points over the baseline.

The baseline rate for the percentage of discharges for which eligible members aged 18–64 years received at least one behavioral health service within 30 days after discharge from inpatient hospitalization for treatment of mental illness was 50.1 percent. For Remeasurement 1, the Performance Indicator 2 rate was 57.9 percent, which represents a statistically significant increase of 7.6 percentage points over the baseline. For Remeasurement 2, the Performance Indicator 2 rate was 64.5 percent, which represents a statistically significant increase of 14.4 percentage points over the baseline.

Performance Indicator 2 achieved sustained improvement. Performance Indicator 1 was not assessed for sustained improvement because it had not achieved statistically significant improvement during Remeasurement 1.

In CY 2025, for the nonclinical PIP, Salt Lake submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-83 displays baseline data for Salt Lake's *Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)* PIP.

Table 2-83—PIP Outcomes—*Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)* for Salt Lake

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of Optum Salt Lake County Outpatient Mental Health Network Providers with a provider-specific MHSIP submission ID, who meet the anonymity threshold for response gathered during the measurement period, and who receive provider-specific survey results.	N: 0 D: 29	0.0%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of Optum Salt Lake County Outpatient Mental Health Network Providers with a provider-specific MHSIP submission ID, who meet the anonymity threshold for response (five responses) gathered during the measurement period, and who receive provider-specific survey results was 0.0 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Salt Lake's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Follow-Up After Hospitalization for Adults Aged 18–64* PIP, Salt Lake used data analysis, provider feedback, and completed a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-84 displays the barriers and interventions as documented by Salt Lake.

Table 2-84—Interventions Implemented/Planned for *Follow-Up After Hospitalization for Adults Aged 18–64*

Barriers	Interventions
Inpatient facilities have insufficient knowledge of available network providers who offer both therapy and medication management services by the same provider within the access to care standards.	Create a Resource Guide of network providers and distribute to in and out-of-network inpatient facilities to guide discharge planning
Lack of timely follow-up appointments scheduled with a network provider at discharge.	Meet with in-network, inpatient facility leadership related to timely follow-up appointments.
Members are discharged from inpatient care with incomplete or insufficient discharge plans.	Engage Care Navigator to outreach members and link to providers for needed follow-up treatment and supports.
Members are discharged from inpatient care with incomplete or insufficient discharge plans. Members are discharged without a scheduled date and time for the FUH appointment with an outpatient provider.	Monitor care advocate responsibilities related to discharge planning.

For the *Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)* PIP, Salt Lake completed a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-85 displays the barriers and interventions as documented by Salt Lake.

Table 2-85—Interventions Implemented/Planned for *Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)*

Barriers	Interventions
Only providers with a unique provider submission ID can receive agency-specific MHSIP feedback.	Increase the volume of providers with provider-specific MHSIP submission IDs.
Providers need access to MHSIP results for their agency or practice.	Create reports with provider-specific MHSIP feedback.
Providers are unfamiliar with MHSIP feedback and will need guidance to navigate and interpret the results.	Create a guidance document to assist providers in interpreting results.

Salt Lake—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received an overall *High Confidence* rating in overall confidence of adherence to acceptable methodology for all applicable phases of the PIP.
- For the *Follow-Up After Hospitalization for Adults Aged 18–64* PIP, both performance indicators achieved statistically significant improvement over the baseline.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Salt Lake:

- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator; and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Salt Lake to understand intervention effectiveness and make updates to interventions in a timely manner to impact remeasurement outcomes.
- Ensure that Intervention effectiveness data guide the next steps for each individual intervention.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Continually work on the PIPs throughout the year.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in the clinical PIP. The remeasurement rate for one of the performance indicators for the *Follow-Up After Hospitalization for Adults Aged 18–64* PIP did not demonstrate statistically significant improvement over the baseline. In the CY 2025 submission, the health plan addressed the deficiency identified in CY 2024 submission. The health plan submitted a new nonclinical PIP topic. This section is not applicable for the nonclinical PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Salt Lake's clinical PIP will likely result in long-term improvements.

Southwest Behavioral Health Center (Southwest)

For CY 2025, Southwest submitted its new clinical PIP topic, *OQ/YOQ Outcome Suicide Ideation Questionnaire Project* and continued its nonclinical PIP topic, *Increase Staff Level of Comfort With Suicide Screening*. The goal of the clinical PIP is to improve suicidal ideation rates among members, identified by a decrease in the percentage of "Almost Always" or "Frequently" responses for suicide ideation questions on OQ/YOQ Questionnaires. The goal of the nonclinical PIP is to increase the percentage of staff members comfortable with screening members for suicidal ideation.

Validation Results and Interventions

Table 2-86 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-86—CY 2025 PIP Validation Results for Southwest

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
OQ/YOQ Outcome Suicide Ideation Questionnaire Project	Initial Submission	76%	67%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	94%	100%	*High Confidence*	*Not Assessed*[5]		
Increase Staff Level of Comfort With Suicide Screening	Initial Submission	56%	44%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	75%	78%	*Low Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *OQ/YOQ Outcome Suicide Ideation Questionnaire Project* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Southwest had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Increase Staff Level of Comfort With Suicide Screening* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *Low Confidence* level rating for adherence to acceptable PIP methodology. Southwest had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, Southwest submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-87 displays baseline data for Southwest's *OQ/YOQ Outcome Suicide Ideation Questionnaire Project* PIP.

Table 2-87—PIP Outcomes—*OQ/YOQ Outcome Suicide Ideation Questionnaire Project* for Southwest

Performance Indicator Results					
Performance Indicators	**Baseline (07/01/2024–06/30/2025)**		**Remeasurement 1 (07/01/2025–06/30/2026)**		**Sustained Improvement**
The percentage of MH survey instruments completed where members answered "Almost Always" or "Frequently" for suicide ideation question 7 on the OQ instrument/survey and question 19 on the YOQ instrument/survey during the measurement period.	N: 504 D: 9,323	5.4%			*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of MH survey instruments completed where members answered "Almost Always" or "Frequently" for suicide ideation question 7 on the OQ instrument/survey and question 19 on the YOQ instrument/survey during the measurement period was 5.4 percent.

In CY 2025, for the nonclinical PIP, Southwest submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-88 displays baseline data for Southwest's *Increase Staff Level of Comfort With Suicide Screening* PIP.

Table 2-88—PIP Outcomes—*Increase Staff Level of Comfort With Suicide Screening* for Southwest

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of staff answering suicide screening comfort level survey questions with agree or strongly agree.	N: 138 D: 152	90.8%			*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of staff answering suicide screening comfort level survey questions with agree or strongly agree was 90.8 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Southwest's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *OQ/YOQ Outcome Suicide Ideation Questionnaire Project* PIP, Southwest used brainstorming to identify the following barrier and implemented the following intervention to address this barrier. Table 2-89 displays the barrier and intervention as documented by Southwest.

Table 2-89—Interventions Implemented/Planned for the *OQ/YOQ Outcome Suicide Ideation Questionnaire Project*

Barriers	Interventions
Allow clinical staff to instantly access survey answers when meeting with members to review their survey	Add the OQ link to progress notes in the EHR.

Barriers	Interventions
answers by accessing through the electronic health record (EHR) rather than logging into a second system a.	

For the *Increase Staff Level of Comfort With Suicide Screening* PIP, Southwest used brainstorming to identify the following barrier and implemented the following intervention to address this barrier. Table 2-90 displays the barrier and intervention as documented by Southwest.

Table 2-90—Interventions Implemented/Planned for *Increase Staff Level of Comfort With Suicide Screening*

Barriers	Interventions
Increase staff knowledge of the PIP process to receive more buy-in for the project, increase the number of staff surveys, and increase the level of comfort.	Train Program Managers and therapists on PIP Project alignment with Zero Suicide Grant funding.

Southwest—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

The *OQ/YOQ Outcome Suicide Ideation Questionnaire Project* PIP received a *High Confidence* rating for adherence to acceptable methodology for all phases of the PIP.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- The *OQ/YOQ Outcome Suicide Ideation Questionnaire Project* PIP had an opportunity for improvement in the documentation of the intervention testing data.
- The *Increase Staff Level of Comfort With Suicide Screening* PIP received a *Low Confidence* level for adherence to acceptable methodology for all phases of the PIP. There were opportunities for improvement in the documentation of the performance indicator data collection process, intervention effectiveness measure denominator and numerator, descriptions, and summary of intervention testing results.

Recommendations

As the PIPs progress, HSAG recommends that Southwest:

- Address the validation feedback in the final PIP validation tools.
- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Southwest make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Must reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

For CY 2025, Southwest submitted a new clinical PIP, *OQ/YOQ Outcome Suicide Ideation Questionnaire Project*. Therefore, this section is not applicable to this PIP. In last year's validation, no opportunities for improvement were identified in the nonclinical PIP.

Wasatch Behavioral Health (Wasatch)

For CY 2025, Wasatch continued its clinical PIP topic, *Increasing SURE Utilization in SUD* and its nonclinical PIP topic, *Increasing Social Supports in Substance Use Services*. The goal of the clinical PIP is to improve the monthly administration of SURE to members receiving treatment for a primary SUD. According to the PIP documentation, the administration of SURE may help to detect and ultimately improve substance use recovery outcomes. The goal of the nonclinical PIP is to increase the proportion of members who have social supports at termination of treatment.

Validation Results and Interventions

Table 2-91 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-91—CY 2025 PIP Validation Results for Wasatch

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Increasing SURE Utilization in SUD	Initial Submission	94%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Increasing Social Supports in SUD	Initial Submission	44%	75%	*No Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Increasing SURE Utilization in SUD* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Increasing Social Supports in Substance Use Services* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-92 displays PIP outcome data for Wasatch's *Increasing SURE Utilization in SUD* PIP.

Table 2-92—PIP Outcomes—*Increasing SURE Utilization in SUD* for Wasatch

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024–12/31/2024)**		**Sustained Improvement**
The percentage of members diagnosed with a primary SUD who receive treatment at one of the eligible substance use treatment programs and who complete the SURE questionnaire each month.	N: 19 D: 7,132	0.3%	N: 1,874 D: 6,256	30.0%*	N: 4,174 D: 6,668	62.6%*	Yes

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members diagnosed with a primary SUD who receive treatment at one of the eligible substance use treatment programs and who complete the SURE questionnaire each month was 0.3 percent. For Remeasurement 1, the performance indicator rate was 30.0 percent, which represents a statistically significant increase of 29.7 percentage points over the baseline. For Remeasurement 2, the performance indicator rate was 62.6 percent, which represents a statistically significant increase of 62.3 percentage points over the baseline.

Wasatch sustained statistically significant improvement in the performance indicator rate that was achieved during Remeasurement 1.

In CY 2025, for the nonclinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-93 displays PIP outcome data for Wasatch's *Increasing Social Supports in Substance Use Services* PIP.

Table 2-93—PIP Outcomes—*Increasing Social Supports in Substance Use Services* for Wasatch

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Sustained Improvement**
The proportion of members who have social supports at termination will increase over time after training staff in social supports.	N: 660 D: 1,609	41.0%	N: 1,043 D: 1,569	66.5%*	*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the proportion of members who have social supports at termination will increase over time after training staff in social supports was 41.0 percent. For Remeasurement 1, the performance indicator rate was 66.5 percent, which represents a statistically significant increase of 25.5 percentage points over the baseline.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Wasatch's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Increasing SURE Utilization in SUD* PIP, Wasatch used staff feedback and data analysis to identify the following barriers and implemented the following interventions to address those barriers. Table 2-94 displays the barriers and interventions as documented by Wasatch.

Table 2-94—Interventions Implemented/Planned for *Increasing SURE Utilization in SUD*

Barriers	Interventions
Lack of staff awareness about the importance of measurement-based care, availability of SUD-specific outcome measures, process for administering an outcome measure, performance of SUD clinics in	Trained staff on the importance of SURE administration. SUD division director and program managers will receive reports each month outlining the total number of administrations of SURE in SUD services. Progress toward the goal of improving administration of SURE will be discussed at least

Barriers	Interventions
administering outcomes measures, and staff accountability in SURE administration.	monthly at a meeting of Wasatch's executive team and program managers.
Lack of automated administration of SURE questionnaires to members with SUD.	Increase access to the SURE questionnaires so that the members can take the questionnaire either 1) before arriving to their appointments, or 2) after arriving to their appointments but without relying on the clinic's front-end staff to manually administer the questionnaire.

For the *Increasing Social Supports in Substance Use Services* PIP, Wasatch used staff feedback and data analysis to identify the following barrier and implemented the following intervention to address this barrier Table 2-95 displays the barrier and intervention as documented by Wasatch.

Table 2-95—Interventions Implemented/Planned for *Increasing Social Supports in Substance Use Services*

Barriers	Interventions
Staff in SUD treatment facilities were unaware of what social supports were and some believed that formal groups (e.g., Alcoholics Anonymous) were the only social support to document in the electronic health record. Some staff were rigid in this mindset.	Train staff at staff meetings on improving social supports.

Wasatch—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- The *Increasing SURE Utilization in SUD* PIP received an overall *a High Confidence* rating in both overall confidence of adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement.
- For the *Increasing SURE Utilization in SUD* PIP, the performance indicator sustained statistically significant improvement over the baseline during Remeasurement 2.
- The *Increasing Social Supports in Substance Use Services* PIP received a *High Confidence* rating in both overall confidence of adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Wasatch:

- Continually work on the PIPs throughout the year.
- Build on the positive momentum gained and improvement achieved.
- Apply lessons learned and knowledge gained while conducting QI processes and testing interventions.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Retire *Increasing SURE Utilization in SUD* PIP and determine a new clinical PIP topic for next year's submission with consultation and approval from DHHS. Wasatch reported Remeasurement 2 data in this year's submission and demonstrated sustained improvement in outcomes.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Weber Human Services (Weber)

For CY 2025, Weber continued its clinical PIP topic, *Treating Anxiety and Depression with Evidence-Based Treatment (EBT)* and its nonclinical PIP topic, *Reducing Clinician Burnout.* The goal of the clinical PIP is to improve processes and outcomes of members' behavioral health care by increasing the use of an EBT called Unified Protocol in members diagnosed with anxiety or depression. Weber documented that there is treatable overlap in these two disorders, and that individuals treated using Unified Protocol improve at greater rates than those treated with traditional talk therapy. The PIP's focus is to increase the number of members receiving at least eight individual therapy sessions in which the Unified Protocol is used within four months of the initial therapy session. The goal of the nonclinical PIP is to decrease clinician burnout as measured by the Professional Quality of Life (ProQOL) Burnout scale.

Validation Results and Interventions

Table 2-96 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-96—CY 2025 PIP Validation Results for Weber

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Treating Anxiety and Depression With EBT	Initial Submission	88%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Reducing Clinician Burnout	Initial Submission	47%	56%	*No Confidence*	*Not Assessed*[5]		
	Resubmission	94%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Treating Anxiety and Depression With EBT* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Reducing Clinician Burnout* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Weber had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcome data. Table 2-97 displays PIP outcome data for Weber's *Treating Anxiety and Depression With EBT* PIP.

Table 2-97—PIP Outcomes—*Treating Anxiety and Depression With EBT* for Weber

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2022–12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024–12/31/2024)**		**Sustained Improvement**
The percent of members with an anxiety or depression diagnosis who are participating in the Unified Protocol.	N: 0 D: 324	0.0%	N: 60 D: 417	14.4%*	N: 100 D: 497	20.1%*	*Yes*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members with an anxiety or depression diagnosis who are participating in the Unified Protocol was 0.0 percent. For Remeasurement 1, the performance indicator rate was 14.4 percent, which represents a statistically significant improvement over the baseline. For Remeasurement 2, the performance indicator rate was 20.1 percent, which represents a statistically

significant improvement over the baseline. Weber sustained statistically significant improvement in the performance indicator rate achieved during Remeasurement 1.

For the nonclinical PIP, Weber submitted baseline data and had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-98 displays baseline data for Weber's *Reducing Clinician Burnout* PIP.

Table 2-98—PIP Outcomes—*Reducing Clinician Burnout* for Weber

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percentage of eligible providers who scored average or higher for clinician burnout as measured by the ProQOL burnout scale during the measurement period.	N: 20 D: 20	100%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of eligible providers who scored average or higher for clinician burnout as measured by the ProQOL burnout scale during the measurement period was 100 percent. The performance indicator is an inverse measure; therefore, a lower rate is a desired outcome.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Weber's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Treating Anxiety and Depression With EBT* PIP, Weber used data analysis and provider input to identify the following barrier and implemented the following intervention to address this barrier. Table 2-99 displays the barrier and intervention as documented by Weber.

Table 2-99—Interventions Implemented/Planned *Treating Anxiety and Depression With EBT*

Barriers	Interventions
Shortage of staff trained and certified in the Unified Protocol.	Two clinical quality supervisors will be certified as supervisors/trainers in the Unified Protocol and twelve clinicians will be trained/certified in the Unified Protocol.

For the *Reducing Clinician Burnout* PIP, Weber used brainstorming and provider input to identify the following barrier and implemented the following intervention to address this barrier. Table 2-100 displays the barrier and intervention as documented by Weber.

Table 2-100—Interventions Implemented/Planned for *Reducing Clinician Burnout*

Barriers	Interventions
Clinician burnout due to secondary trauma, back-to-back sessions without breaks, or acuity of members served.	Clinicians attending a self-care course.

Weber—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- The *Treating Anxiety and Depression With EBT* PIP received a *High Confidence* rating in both overall confidence of adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement.
- The *Reducing Clinician Burnout* PIP received a *High Confidence* rating for adherence to acceptable methodology for the PIP design.

Opportunities for Improvement

The *Reducing Clinician Burnout* PIP, there was opportunity for improvement in the documentation of quantitative data summary in the intervention worksheet.

Recommendations

As the PIPs progress, HSAG recommends that Weber:

- Continually work on the PIPs throughout the year.

- Build on the positive momentum gained and improvement achieved.
- Apply lessons learned and knowledge gained while conducting QI processes and testing interventions.
- Revisit causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Retire *Treating Anxiety and Depression With EBT* PIP and determine a new clinical PIP topic for next year's submission with consultation and approval from DHHS. Wasatch reported Remeasurement 2 data in this year's submission and demonstrated sustained improvement in outcomes.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Medicaid PAHPs Providing Dental Services

Managed Care of North America Dental (MCNA)

For CY 2025, MCNA continued its clinical PIP topic, *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* and its nonclinical PIP topic, *Increasing the Rate of Providers Reporting Member No-Shows Using Current Dental Terminology (CDT) Codes.* The goal of the clinical PIP is to reduce the incidence of dental caries in children by increasing application of fluoride varnishes as preventive treatment. The goal of the nonclinical PIP is to improve the rate of all active general dentists, pediatric dentists, and specialty providers reporting member no-shows using CDT code D9986 during the MY.

Validation Results and Interventions

Table 2-101 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-101—CY 2025 PIP Validation Results for MCNA

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Increasing the Rate of Providers Reporting Member No-shows Using CDT Codes	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. MCNA had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes PIP* was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. MCNA had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, MCNA submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-102 displays baseline data for MCNA's *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* PIP.

Table 2-102—PIP Outcomes—*Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* for MCNA

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year.	N: 1,309 D: 6,479	20.2%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year was 20.2 percent.

In CY 2025, for the clinical PIP, MCNA submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-103 displays baseline data for MCNA's *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes* PIP.

Table 2-103—PIP Outcomes—*Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes* for MCNA

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of providers reporting member no-shows using CDT code D9986.	N: 15 D: 475	3.2%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of providers reporting member no-shows using CDT code D9986 was 3.2 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. MCNA's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* PIP, MCNA used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-104 displays the interventions as documented by MCNA.

Table 2-104—Interventions Implemented/Planned for *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride*

Barriers	Interventions
• Lack of knowledge of benefit coverage and the role topical fluoride plays in preventing caries. • Lack of knowing of the need to see a dentist when not in pain and the long-term health effects of poor oral health.	1. Targeted member outreach through fluoride outbound calls. 2. Targeted member outreach through fluoride text messages.

For the *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes* PIP, MCNA used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-105 displays the interventions as documented by MCNA.

Table 2-105—Interventions Implemented/Planned for *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes*

Barriers	Interventions
• Providers may be unaware of new missed appointment reporting CDT code 9986. • Providers may feel that reporting no-shows does not lead to meaningful follow-up or intervention.	1. Targeted provider outreach through provider outreach calls. 2. Targeted provider outreach through provider webinars.

MCNA—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Both PIPs received a *High Confidence* rating for adherence to acceptable PIP methodology for all applicable phases of the PIP.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that MCNA:

- Implement interventions in a timely manner to impact outcomes during the remeasurement period.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help MCNA understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide the next steps for each individual intervention.
- For the Increasing the *Rate of Providers Reporting Member No-shows Using CDT Codes* PIP, to better understand the effectiveness of the provider outreach and webinars, the health plan must

also collect data on whether the provider office staff members were contacted and educated, or if providers who attended webinars began reporting no-shows using the claims code. Alternatively, if the health plan is unable to collect quantitative data, the health plan may conduct surveys to collect feedback from the providers about the effectiveness of the webinars and outreach and report the survey results as qualitative data measuring effectiveness.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Premier Access

For CY 2025, Premier Access continued its clinical PIP topic, *School Based Care for Medicaid Members* and submitted its nonclinical PIP topic, *Oral Health Information Form (OHIF) Completion for New Medicaid Members.* The goal of the clinical PIP is to increase dental care delivery in a school-based setting to improve dental care utilization. The goal of the nonclinical PIP is to increase the percentage of members who complete an OHIF within 90 days of enrollment.

Validation Results and Interventions

Table 2-106 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-106—CY 2025 PIP Validation Results for Premier Access

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
School Based Care for Medicaid Members	Initial Submission	83%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	94%	100%	*High Confidence*	100%	100%	*High Confidence*
Oral Health Information Form (OHIF) Completion for New Medicaid Members	Initial Submission	78%	89%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	94%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *School Based Care for Medicaid Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *OHIF Completion for New Medicaid Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-107 displays PIP outcome data for the *School Based Care for Medicaid Members* PIP.

Table 2-107—PIP Outcomes—*School Based Care for Medicaid Members* for Premier Access

Performance Indicator Results									
Performance Indicators	**Baseline (06/01/2021–05/31/2022)**		**Remeasurement 1 (06/01/2022–05/31/2023)**		**Remeasurement 2 (06/01/2023–05/31/2024)**		**Remeasurement 3 (06/01/2024–05/31/2025)**		**Sustained Improvement**
Percentage of Premier Access Medicaid members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 184 D: 7,935	2.3%	N: 205 D: 10,497	2.0%	N: 120 D: 10,287	1.2%	N: 177 D: 6,180	2.9%*	*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of eligible Medicaid members 5–10 years of age who received dental care in a school was 2.3 percent. For Remeasurement 2, Premier Access reported a rate of 1.2 percent, which represents a statistically significant decline of 1.1 percentage points under the baseline. For Remeasurement 3, Premier Access reported a rate of 2.9 percent, which represents a statistically significant increase of 0.6 percentage points over the baseline.

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-108 displays PIP outcome data for Premier Access' *OHIF Completion for New Medicaid Members* PIP.

Table 2-108—PIP Outcomes—*OHIF Completion for New Medicaid Members* for Premier Access

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Remeasurement 2 (01/01/2025–12/31/2025**		**Sustained Improvement**
OHIF completion rate: The percentage of members who complete an OHIF within 90 days of enrollment.	N: 944 D: 39,626	2.4%	N: 522 D: 25,228	2.1%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the OHIF completion rate was 2.4 percent. For Remeasurement 1, Premier Access reported a rate of 2.1 percent, which represents a decline of 0.3 percentage points under the baseline.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Premier Access' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *School Based Care for Medicaid Members* PIP, Premier Access used feedback from the dental provider groups to identify the following barrier and implemented the following intervention to address this barrier. Table 2-109 displays the barrier and intervention as documented by Premier Access.

Table 2-109—Interventions Implemented/Planned for *School Based Care for Medicaid Members*

Barriers	Interventions
Members engaging with consent content do not actually complete the consent process.	Parent/guardian telephonic outreach.

For the *OHIF Completion for New Medicaid Members* PIP, Premier Access used brainstorming to identify the following barrier and implemented the following intervention to address this barrier. Table 2-110 displays the barrier and intervention as documented by Premier Access.

Table 2-110—Interventions Implemented/Planned for *OHIF Completion for New Medicaid Members*

Barriers	Interventions
Members who engage with OHIF content, but do not actually complete the forms.	Live agent reminder calls.

Premier Access—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received a *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- The *School Based Care for Medicaid Members* PIP received a *High Confidence* rating that the PIP achieved significant improvement. During Remeasurement 3, the performance indicator had a statistically significant improvement in performance compared to the baseline.

Opportunities for Improvement

HSAG identified the following opportunity for improvement:

- For both PIPs, there was opportunity for improvement in the documentation of the quantitative data summary of the intervention effectiveness measure.
- The *OHIF Completion for New Medicaid Members* PIP received a *No Confidence* rating in achievement of significant improvement. During Remeasurement 1, the performance indicator had a decline in the performance indicator rate compared to the baseline.

Recommendations

As the PIPs progress, HSAG offers the following recommendations:

For the *School Based Care for Medicaid Members* PIP, HSAG recommends that Premier Access:

- Build on the positive momentum gained and improvement achieved.

- Discuss the next steps for this PIP (i.e., continue or retire) with consultation and approval from DHHS. Premier Access reported Remeasurement 3 in this year's submission. Typically, a PIP includes a baseline and two remeasurement periods.

For the *OHIF Completion for New Medicaid Members* PIP, HSAG recommends that Premier Access:

- Consider identifying additional barriers and implement additional interventions for the project, due to lack of improvement in performance during Remeasurement 1.
- Consider the use of QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Consider collecting the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Premier Access understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in achievement of significant improvement in PIP outcomes for the *School Based Care for Medicaid Members* PIP. In the CY 2025 submission, the health plan addressed the deficiency identified in CY 2024 submission. In last year's validation, no opportunities for improvement were identified in the nonclinical *OHIF Completion for New Medicaid Members* PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Premier Access' clinical PIP will likely result in long-term improvements.

CHIP MCOs Providing Physical Health, Mental Health, and SUD Services

Healthy U CHIP

Validation of Performance Improvement Projects

Healthy U CHIP is a new plan for the CHIP line of business. For the CY 2025 validation, Healthy U CHIP submitted the first year of its clinical and nonclinical PIP topics. The clinical PIP topic is *Child and Adolescent Well-Care Visits (WCV)* and the nonclinical PIP topic is *Medicaid Health Risk Assessment (HRA) Process Improvement*. The goals of the clinical PIP are to improve well-child visit rates in alignment with federal and state priorities, and support better long-term health outcomes. The goal of the nonclinical PIP is to increase the percentage of newly enrolled members who have an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.

Validation Results and Interventions

Table 2-111 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-111—CY 2025 PIP Validation Results for Healthy U CHIP

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Child and Adolescent Well-Care Visits	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Medicaid Health Risk Assessment (HRA) Process Improvement	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Child and Adolescent Well-Care Visits* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Healthy U CHIP had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Medicaid Health Risk Assessment (HRA) Process Improvement* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. Healthy U CHIP had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, Healthy U submitted the PIP Design stage, but had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess baseline data in the 2026 validation cycle. Table 2-112 will display PIP outcome data for Healthy U CHIP's *Child and Adolescent Well-Care Visits* PIP once performance indicator outcomes are reported.

Table 2-112—PIP Outcomes—*Child and Adolescent Well-Care Visits* for Healthy U CHIP

Performance Indicator Results					
Performance Indicators	**Baseline (01/0/2025–12/31/2025)**		**Remeasurement 1 (01/01/2026–12/31/2026)**		**Sustained Improvement**
Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.					

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

In CY 2025, for the nonclinical PIP, Healthy U CHIP submitted the PIP Design stage, but had not progressed to the point of reporting and analyzing data or conducting QI activities. HSAG will assess and validate baseline data in the 2026 validation cycle. Table 2-113 will display data for Healthy U CHIP's *Medicaid HRA Process Improvement* PIP once performance indicator results are reported.

Table 2-113—PIP Outcomes—*Medicaid HRA Process Improvement* for Healthy U CHIP

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2025–12/31/2025)**		**Remeasurement 1 (01/01/2026–12/31/2026)**		**Sustained Improvement**
Percentage of newly enrolled Medicaid CHIP members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.					

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Healthy U CHIP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Child and Adolescent Well-Care Visits* PIP, Table 2-114 will display the barriers and interventions that Healthy U CHIP documents when the PIP progresses to include QI activities and interventions.

Table 2-114—Interventions Implemented/Planned for *Child and Adolescent Well-Care Visits*

Barriers	Interventions

For the *Medicaid HRA Process Improvement* PIP, Table 2-115 will display the barriers and interventions that Healthy U CHIP documents when the PIP progresses to include QI activities and interventions.

Table 2-115—Interventions Implemented/*Planned for Medicaid HRA Process Improvement*

Barriers	Interventions

Healthy U CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Both PIPs received an overall *High Confidence* rating in the adherence to acceptable methodology for the PIP design.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Healthy U CHIP:

- Continually work on the PIPs throughout the year.
- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Consider using QI-science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Ensure that selected PIP interventions are logically linked to the barriers.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions tables.
- Ensure that the intervention effectiveness measure in the intervention worksheet is the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help Healthy U CHIP understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure that intervention effectiveness data guide the next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

As a newly launched health plan, Healthy U CHIP had not progressed to the point of reporting and analyzing data or conducting QI activities; therefore, this section is not applicable.

Molina Healthcare of Utah CHIP (Molina CHIP)

For CY 2025, Molina CHIP submitted its new clinical PIP topic, *Immunizations for Adolescents* and continued its nonclinical PIP topic, *Increasing Member Engagement and Satisfaction With Digital Channels*. The goal of the clinical PIP is to increase the percentage of adolescents receiving the recommended immunizations by their 13th birthday. The goal of the nonclinical PIP is to increase the percentage of members 18 years of age and older who opt in to text messaging and/or register for the My Molina portal.

Validation Results and Interventions

Table 2-116 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-116—CY 2025 PIP Validation Results for Molina CHIP

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Immunizations for Adolescents	Initial Submission	71%	78%	*Low Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		
Increasing Member Engagement and Satisfaction With Digital Channels	Initial Submission	94%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Immunizations for Adolescents* PIP was validated through the first eight steps in the PIP Validation Tool**.** For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Molina CHIP had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Increasing Member Engagement and Satisfaction With Digital Channels* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Molina CHIP had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-117 displays baseline data for Molina CHIP's *Immunizations for Adolescents* PIP.

Table 2-117—PIP Outcomes—*Immunizations for Adolescents* for Molina CHIP

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Remeasurement 2 (01/01/2026–12/31/2026)**		**Sustained Improvement**
The percentage of adolescents 13 years of age who had one dose of Tdap vaccine, and have completed the HPV vaccine series by their 13th birthday.	N: 58	40.6%					
	D: 143						

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of adolescents 13 years of age who had one dose of Tdap vaccine and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday was 40.6 percent.

In CY 2025, for the nonclinical PIP, Molina CHIP submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-118 displays baseline data for Molina CHIP's *Increasing Member Engagement and Satisfaction With Digital Channels* PIP.

Table 2-118—PIP Outcomes—*Increasing Member Engagement and Satisfaction With Digital Channels* for Molina CHIP

Performance Indicator Results					
Performance Indicator	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of CHIP members who opt in to text messaging.	N: 780	32.2%			
	D: 2,422				
The percentage of CHIP members who register for the My Molina portal.	N: 596	10.8%			
	D: 5,520				

N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of CHIP members who opted in to text messaging was 32.2 percent. The percentage of CHIP members who registered for the My Molina portal was 10.8 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Molina CHIP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Immunizations for Adolescents* PIP, Molina CHIP used brainstorming and the Five Whys to identify the following barriers and plans to initiate the following interventions to address those barriers. Table 2-119 displays the barriers and interventions as documented by Molina CHIP.

Table 2-119—Interventions Implemented/Planned for *Immunizations for Adolescents*

Barriers	Interventions
Misinformation and cultural discomfort around adolescent sexual health.	Member outreach, education, and incentive program.
Lack of provider communication.	Provider bonus program.

For the *Increasing Member Engagement and Satisfaction With Digital Channels* PIP, Molina CHIP used brainstorming, a fishbone diagram, and the Five Whys to identify the following barriers and implemented the following interventions to address those barriers. Table 2-120 displays the barriers and interventions as documented by Molina CHIP.

Table 2-120—Interventions Implemented/Planned for *Increasing Member Engagement and Satisfaction With Digital Channels*

Barriers	Interventions
Lack of promotion by internal partners.	Portal Training with Case Management Staff.
No feedback loop to improve tools based on member experience.	Relay Text Message Satisfaction Survey.

Molina CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

The *Immunizations for Adolescents* PIP received a *High Confidence* rating in both overall confidence of adherence to acceptable methodology for all phases of the PIP.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that Molina CHIP:

- Continually work on the PIPs throughout the year.
- Implement the interventions in a timely manner to impact outcomes during the remeasurement period.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator; and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Molina CHIP understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes. Intervention effectiveness data must guide next steps for each individual intervention.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

The health plan initiated a new clinical PIP in CY 2025. In last year's submission, no opportunities for improvement were identified for the nonclinical PIP; therefore, this section is not applicable.

Select Health CHIP

For CY 2025, Select Health CHIP continued its clinical PIP topic, *Well-Child Visits for CHIP Members* and submitted its new nonclinical PIP topic, *Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination.* The goal of the clinical PIP is to improve the percentage of CHIP members who had at least one comprehensive well-care visit during the MY. The goal of the nonclinical PIP is to increase the percentage of CHIP members retaining health insurance through continued coverage of a Select Health CHIP or a different Select Health plan when the member is identified for Medicaid redetermination.

Validation Results and Interventions

Table 2-121 summarizes the PIP validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-121—CY 2025 PIP Validation Results for Select Health CHIP

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Well-Child Visits for CHIP Members	Initial Submission	94%	100%	*High Confidence*	50%	100%	*Moderate Confidence*
	Resubmission	100%	100%	*High Confidence*	50%	100%	*Moderate Confidence*
Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	100%	100%	*High Confidence*	*Not Assessed*[5]		

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Well-Child Visits for CHIP Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination* PIP was validated through the first seven steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. Select Health CHIP had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-122 displays data for Select Health CHIP's *Well-Child Visits for CHIP Members* PIP.

Table 2-122—PIP Outcomes—*Well-Child Visits for CHIP Members* for Select Health CHIP

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2022—12/31/2022)**		**Remeasurement 1 (01/01/2023–12/31/2023)**		**Remeasurement 2 (01/01/2024–12/31/2024)**		**Sustained Improvement**
The percentage of members 3–18 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrics/gynecology (OB/GYN) practitioner during the measurement year.	N: 1,403 D: 2,337	60.0%	N: 1,694 D: 2,581	65.6%*	N: 2,481 D; 3,991	62.2%	*No*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 3–18 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner was 60.0 percent. For Remeasurement 1, the performance indicator rate was 65.6 percent, which represents a statistically significant increase of 5.6 percentage points over the baseline. For Remeasurement 2, the performance indicator rate was 62.2 percent, which represents a statistically nonsignificant increase of 2.1 percentage points over the baseline. During Remeasurement 2, Select Health CHIP did not sustain the statistically significant improvement over the baseline that was achieved during Remeasurement 1.

In CY 2025, for the nonclinical PIP, HSAG reviewed baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-123 displays baseline data for Select Health CHIP's *Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination* PIP.

Table 2-123—PIP Outcomes—*Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination* for Select Health CHIP

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
Percent of Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination.	N: 2,797 D: 4,576	61.1%			
Percent of Medicaid CHIP Members Retaining Select Health Medicaid CHIP When Identified for Redetermination.	N: 2,493 D: 4,576	54.5%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of Medicaid CHIP members retaining health insurance when identified for redetermination was 61.1 percent The baseline rate for the percentage of Medicaid CHIP members retaining Select Health Medicaid CHIP when identified for redetermination was 54.5 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Select Health CHIP's choice of interventions, combination of intervention types, and sequence of

implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Well-Child Visits for CHIP Members* PIP, Select Health CHIP completed a fishbone diagram and an affinity diagram to identify and prioritize the following barriers and identified the following interventions to address those barriers. Table 2-124 displays the barriers and interventions as documented by Select Health CHIP.

Table 2-124—Interventions Planned for *Well-Child Visits for CHIP Members* PIP

Barriers	Interventions
Well-Child Visit (WCV) Open Gap, No PCP, and located in a rural area.	WCV incentive to enrollees.
Providers Not Prioritizing Medicaid Members.	Educate and Provide WCV Gaps Data to QPP Providers.

Table 2-125 will display the barriers and interventions as documented by Select Health CHIP when the *Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination* PIP progresses to include QI activities and interventions.

Table 2-125—Interventions Implemented/Planned for *Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination*

Barriers	Interventions

Select Health CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- The *Well-Child Visits for CHIP Members* PIP received an overall *High Confidence* rating in both overall confidence of adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement.
- For the *Well-Child Visits for CHIP Members* PIP, during Remeasurement 2, the performance indicator rate demonstrated some improvement compared to the baseline.
- The *Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination* PIP received a *High Confidence* rating in overall confidence of

adherence to acceptable methodology for the PIP design.

Opportunities for Improvement

For the *Well-Child Visits for CHIP Members* PIP, the improvement in the performance indicator rate compared to the baseline was statistically nonsignificant.

Recommendations

As the PIPs progress, HSAG recommends that Select Health CHIP:

- Implement interventions in a timely manner to impact outcomes during the remeasurement period.
- Revisit the causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions in order to drive improvement.
- Consider the use of QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Consider collecting the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Select Health CHIP understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator; and is designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- For the *Well-Child Visits for CHIP Members* PIP:
  - Build on the positive momentum gained and improvement achieved.
  - Discuss the next steps for this PIP (i.e., continue or retire) with consultation and approval from DHHS. Select Health CHIP reported Remeasurement 2 in this year's submission.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Medicaid PAHPs Providing Dental Services

Managed Care of North America Dental (MCNA)

For CY 2025, MCNA continued its clinical PIP topic, *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* and its nonclinical PIP topic, *Increasing the Rate of Providers Reporting Member No-Shows Using Current Dental Terminology (CDT) Codes.* The goal of the clinical PIP is to reduce the incidence of dental caries in children by increasing application of fluoride varnishes as preventive treatment. The goal of the nonclinical PIP is to improve the rate of all active general dentists, pediatric dentists, and specialty providers reporting member no-shows using CDT code D9986 during the MY.

Validation Results and Interventions

Table 2-126 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-126—CY 2025 PIP Validation Results for MCNA

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					
Increasing the Rate of Providers Reporting Member No-shows Using CDT Codes	Initial Submission	100%	100%	*High Confidence*	*Not Assessed*[5]		
	Resubmission	*Health Plan Did Not Resubmit.*					

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. MCNA had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

The *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes PIP* was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. MCNA had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Indicator Outcomes

In CY 2025, for the clinical PIP, MCNA submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-127 displays baseline data for MCNA's *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* PIP.

Table 2-127—PIP Outcomes—*Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* for MCNA

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year.	N: 1,309 D: 6,479	20.2%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year was 20.2 percent.

In CY 2025, for the clinical PIP, MCNA submitted baseline data, but had not progressed to the point of analyzing data or conducting QI activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle. Table 2-128 displays baseline data for MCNA's *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes* PIP.

Table 2-128—PIP Outcomes—*Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes* for MCNA

Performance Indicator Results					
Performance Indicators	**Baseline (01/01/2024–12/31/2024)**		**Remeasurement 1 (01/01/2025–12/31/2025)**		**Sustained Improvement**
The percentage of providers reporting member no-shows using CDT code D9986.	N: 15 D: 475	3.2%			

N–Numerator; D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of providers reporting member no-shows using CDT code D9986 was 3.2 percent.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. MCNA's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride* PIP, MCNA used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-129 displays the interventions as documented by MCNA.

Table 2-129—Interventions Implemented/Planned for *Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride*

Barriers	Interventions
• Lack of knowledge of benefit coverage and the role topical fluoride plays in preventing caries. • Lack of knowing of the need to see a dentist when not in pain and the long-term health effects of poor oral health.	3. Targeted member outreach through fluoride outbound calls. 4. Targeted member outreach through fluoride text messages.

For the *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes* PIP, MCNA used a fishbone diagram to identify the following barriers and implemented the following interventions to address those barriers. Table 2-130 displays the interventions as documented by MCNA.

Table 2-130—Interventions Implemented/Planned for *Increasing the Rate of Providers Reporting Member No-Shows Using CDT Codes*

Barriers	Interventions
• Providers may be unaware of new missed appointment reporting CDT code 9986. • Providers may feel that reporting no-shows does not lead to meaningful follow-up or intervention.	3. Targeted provider outreach through provider outreach calls. 4. Targeted provider outreach through provider webinars.

MCNA—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

Both PIPs received a *High Confidence* rating for adherence to acceptable PIP methodology for all applicable phases of the PIP.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement.

Recommendations

As the PIPs progress, HSAG recommends that MCNA:

- Implement interventions in a timely manner to impact outcomes during the remeasurement period.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help MCNA understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Ensure intervention effectiveness data guide the next steps for each individual intervention.
- For the Increasing the Rate of Providers Reporting Member No-shows Using CDT Codes PIP, to better understand the effectiveness of the provider outreach and webinars, the health plan must

also collect data on whether the provider office staff was contacted and educated, or if providers who attended webinars began reporting no-shows using the claims code. Alternatively, if the health plan is unable to collect quantitative data, the health plan may conduct surveys to collect feedback from the providers about the effectiveness of the webinars and outreach and report the survey results as qualitative data measuring effectiveness.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's submission, no opportunities for improvement were identified for both PIPs; therefore, this section is not applicable.

Premier Access

For CY 2025, Premier Access continued its clinical PIP topic, *School Based Care for Medicaid Members* and submitted its nonclinical PIP topic, *OHIF Completion for New Medicaid Members.* The goal of the clinical PIP is to increase dental care delivery in a school-based setting to improve dental care utilization. The goal of the nonclinical PIP is to increase the percentage of members who complete an OHIF within 90 days of enrollment.

Validation Results and Interventions

Table 2-131 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-131—CY 2025 PIP Validation Results for Premier Access

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
School Based Care for Medicaid Members	Initial Submission	83%	88%	*Low Confidence*	100%	100%	*High Confidence*
	Resubmission	94%	100%	*High Confidence*	100%	100%	*High Confidence*
Oral Health Information Form (OHIF) Completion for New Medicaid Members	Initial Submission	78%	89%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	94%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

[5] **Not Assessed**—HSAG did not assess Validation Rating 2, as the health plan reported the baseline data.

The *School Based Care for Medicaid Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *OHIF Completion for New Medicaid Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-132 displays PIP outcome data for the *School Based Care for Medicaid Members* PIP.

Table 2-132—PIP Outcomes—*School Based Care for Medicaid Members* for Premier Access

Performance Indicator Results									
Performance Indicators	**Baseline (06/01/2021–05/31/2022)**		**Remeasurement 1 (06/01/2022–05/31/2023)**		**Remeasurement 2 (06/01/2023–05/31/2024)**		**Remeasurement 3 (06/01/2024–05/31/2025)**		**Sustained Improvement**
Percentage of Premier Access Medicaid members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 184 D: 7,935	2.3%	N: 205 D: 10,497	2.0%	N: 120 D: 10,287	1.2%	N: 177 D: 6,180	2.9%*	*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of eligible Medicaid members 5–10 years of age who received dental care in a school was 2.3 percent. For Remeasurement 2, Premier Access reported a rate of 1.2 percent, which represents a statistically significant decline of 1.1 percentage points under the baseline. For Remeasurement 3, Premier Access reported a rate of 2.9 percent, which represents a statistically significant increase of 0.6 percentage points over the baseline.

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-133 displays PIP outcome data for Premier Access' *OHIF Completion for New Medicaid Members* PIP.

Table 2-133—PIP Outcomes—*OHIF Completion for New Medicaid Members* for Premier Access

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Remeasurement 2 (01/01/2025–12/31/2025**		**Sustained Improvement**
OHIF completion rate: The percentage of members who complete an OHIF within 90 days of enrollment.	N: 944 D: 39,626	2.4%	N: 522 D: 25,228	2.1%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the OHIF completion rate was 2.4 percent. For Remeasurement 1, Premier Access reported a rate of 2.1 percent, which represents a decline of 0.3 percentage points under the baseline.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Premier Access' choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the School Based Care for Medicaid Members PIP, Premier Access used feedback from the dental provider groups to identify the following barrier and implemented the following intervention to address this barrier. Table 2-134 displays the barrier and intervention as documented by Premier Access.

Table 2-134—Interventions Implemented/Planned for *School Based Care for Medicaid Members*

Barriers	Interventions
Members engaging with consent content do not actually complete the consent process.	Parent/guardian telephonic outreach.

For the *OHIF Completion for New Medicaid Members* PIP, Premier Access used brainstorming to identify the following barrier and implemented the following intervention to address this barrier. Table 2-135 displays the barrier and intervention as documented by Premier Access.

Table 2-135—Interventions Implemented/Planned for *OHIF Completion for New Medicaid Members*

Barriers	Interventions
Members who engage with OHIF content, but do not actually complete the forms.	Live agent reminder calls.

Premier Access—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received a *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- The *School Based Care for Medicaid Members* PIP received a *High Confidence* rating that the PIP achieved significant improvement. During Remeasurement 3, the performance indicator had a statistically significant improvement in performance as compared to the baseline.

Opportunities for Improvement

HSAG identified the following opportunity for improvement:

- For both PIPs, there was opportunity for improvement in the documentation of the quantitative data summary of the intervention effectiveness measure.
- The *OHIF Completion for New Medicaid Members* PIP received a *No Confidence* rating in achievement of significant improvement. During Remeasurement 1, the performance indicator had a decline in the performance indicator rate as compared to the baseline.

Recommendations

As the PIPs progress, HSAG offers the following recommendations:

For the *School Based Care for Medicaid Members* PIP, HSAG recommends that Premier Access:

- Build on the positive momentum gained and improvement achieved.

- Discuss the next steps for this PIP (i.e., continue or retire) with consultation and approval from DHHS. Premier Access reported Remeasurement 3 in this year's submission. Typically, a PIP includes a baseline and two remeasurement periods.

For the *OHIF Completion for New Medicaid Members* PIP, HSAG recommends that Premier Access:

- Consider identifying additional barriers and implement additional interventions for the project, due to lack of improvement in performance during Remeasurement 1.
- Consider the use of QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Consider collecting the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Premier Access understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in achievement of significant improvement in PIP outcomes for the *School Based Care for Medicaid Members* PIP. In the CY 2025 submission, the health plan addressed the deficiency identified in CY 2024 submission. In last year's validation, no opportunities for improvement were identified in the nonclinical *OHIF Completion for New Medicaid Members* PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Premier Access' clinical PIP will likely result in long-term improvements.

CHIP PAHP Providing Dental Services

Premier Access CHIP (Premier Access CHIP)

For CY 2025, Premier Access CHIP continued its clinical PIP topic, *School Based Care for CHIP Members* and its nonclinical PIP topic, *OHIF Completion for New CHIP Members.* The goal of the clinical PIP is to increase dental care delivery in a school-based setting to improve dental care utilization. The goal of the nonclinical PIP is to increase the percentage of members who complete an OHIF within 90 days of enrollment.

Validation Results and Interventions

Table 2-136 summarizes the validation scores and confidence levels for each PIP validated for CY 2025.

Table 2-136—CY 2025 PIP Validation Results for Premier Access CHIP

PIP Topic	Type of Review[1]	Validation Rating 1			Validation Rating 2		
		Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
		Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Confidence Level[4]
School Based Care for CHIP Members	Initial Submission	72%	63%	*Low Confidence*	67%	100%	*Moderate Confidence*
	Resubmission	94%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Oral Health Information Form (OHIF) Completion for New CHIP Members	Initial Submission	72%	78%	*Low Confidence*	33%	100%	*No Confidence*
	Resubmission	94%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Type of Review**—Designates the PIP review as an initial submission or resubmission. A resubmission means the health plan resubmitted the PIP with updated documentation because it did not meet HSAG's initial validation feedback.

[2] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *School Based Care for CHIP Members* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *OHIF Completion for New CHIP Members* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adherence to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

Indicator Outcomes

In CY 2025, for the clinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-137 displays data for Premier Access CHIP's *School Based Care for CHIP Members* PIP.

Table 2-137—PIP Outcomes—*School Based Care for CHIP Members* for Premier Access CHIP

Performance Indicator Results									
Performance Indicators	**Baseline (06/01/2021–05/31/2022)**		**Remeasurement 1 (06/01/2022–05/31/2023)**		**Remeasurement 2 (06/01/2023–05/31/2024)**		**Remeasurement 3 (06/01/2024–05/31/2025)**		**Sustained Improvement**
Percentage of Premier Access CHIP members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	N: 13 D: 681	1.9%	N: 1 D: 525	0.2%	N: 11 D: 994	1.1%	N: 37 D: 1,185	3.1%	*Not Assessed*

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of eligible CHIP members 5–10 years of age who received dental care in a school was 1.9 percent and for Remeasurement 1, the rate was 0.2 percent. For Remeasurement 2, Premier Access CHIP reported a rate of 1.1 percent, which represents a decline of

0.8 percentage points over the baseline. For Remeasurement 3, the rate was 3.1 percent, which represents a statistically nonsignificant increase of 1.2 percentage points over the baseline.

In CY 2025, for the nonclinical PIP, HSAG reviewed baseline and remeasurement outcomes. Table 2-138 displays data for Premier Access CHIP's *OHIF Completion for New CHIP Members* PIP.

Table 2-138—PIP Outcomes—*OHIF Completion for New CHIP Members* for Premier Access CHIP

Performance Indicator Results							
Performance Indicator	**Baseline (01/01/2023–12/31/2023)**		**Remeasurement 1 (01/01/2024–12/31/2024)**		**Remeasurement 2 (01/01/2025–12/31/2025**		**Sustained Improvement**
OHIF completion rate: The percentage of members who complete an OHIF within 90 days of enrollment.	N: 123 D: 4,750	2.6%	N: 290 D: 15,059	1.9%			

*Rate indicates statistically significant improvement over the baseline rate.
N–Numerator; D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the OHIF completion rate was 2.6 percent. For Remeasurement 1, Premier Access CHIP reported a rate of 1.9 percent, which represents a decline of 0.7 percentage points over the baseline.

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. Premier Access CHIP's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

For the *School Based Care for CHIP Members* PIP, Premier Access CHIP used feedback from the dental provider groups to identify the following barrier and implemented the following intervention to address this barrier. Table 2-139 displays the barrier and intervention as documented by Premier Access CHIP.

Table 2-139—Interventions Implemented/Planned for *School Based Care for CHIP Members*

Barriers	Interventions
Members engaging with the consent content do not actually complete the consent process.	Provider telephonic outreach to parent/guardian.

For the *OHIF Completion for New CHIP Members* PIP, Premier Access CHIP used brainstorming to identify the following barrier and implemented the following intervention to address this barrier. Table 2-140 displays the barrier and intervention as documented by Premier Access CHIP.

Table 2-140—Interventions Implemented/Planned for *OHIF Completion for New CHIP Members*

Barriers	Interventions
Members who engage with OHIF content, but do not actually complete the forms.	Live agent reminder calls.

Premier Access CHIP—Quality, Timeliness, and Access to Care—Performance Improvement Projects

Strengths

HSAG identified the following strengths:

- Both PIPs received a *High Confidence* rating in overall confidence of adherence to acceptable methodology for all phases of the PIP.
- The *School Based Care for CHIP Members* PIP received a *Moderate Confidence* rating that the PIP achieved significant improvement. During Remeasurement 3, the performance indicator had some improvement in performance compared to the baseline.

Opportunities for Improvement

HSAG identified the following opportunity for improvement:

- For both PIPs, there was opportunity for improvement in the documentation of the quantitative data summary of the intervention effectiveness measure.
- The *OHIF Completion for New CHIP Members* PIP received a *No Confidence* rating in achievement of significant improvement. During Remeasurement 1, the performance indicator had a decline in the performance indicator rate compared to the baseline.

Recommendations

As the PIPs progress, HSAG offers the following recommendations:

For the *School Based Care for Medicaid Members* PIP, HSAG recommends that Premier Access CHIP:

- Build on the positive momentum gained and improvement achieved.
- Discuss the next steps for this PIP (i.e., continue or retire) with consultation and approval from DHHS. Premier Access CHIP reported Remeasurement 3 in this year's submission. Typically, a PIP includes a baseline and two remeasurement periods.

For the *OHIF Completion for New CHIP Members* PIP, HSAG recommends that Premier Access CHIP:

- Consider identifying additional barriers and implement additional interventions for the project, due to lack of improvement in performance during Remeasurement 1.
- Consider the use of QI science-based tools, such as process mapping and FMEA, for causal/barrier analysis.
- Complete an intervention worksheet for each intervention listed in the barriers/interventions table.
- Ensure the intervention effectiveness measure in the intervention worksheet is not the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- Consider collecting the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help Premier Access CHIP understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In last year's validation, HSAG had identified an opportunity for improvement in achievement of significant improvement in PIP outcomes for the *School Based Care for CHIP Members* PIP. In the CY 2025 submission, the health plan demonstrated additional improvement in the performance indicator rate; however, the improvement was statistically nonsignificant. The health plan did not address the identified deficiency.

In last year's validation, no opportunities for improvement were identified in the nonclinical *OHIF Completion for New CHIP Members* PIP.

Assessment of Health Plan's Approach to Addressing Prior Year Recommendations

HSAG recognizes that interventions to Premier Access CHIP's clinical PIP will likely result in long-term improvements.

CMS Protocol 2: PMV

Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement

Following are health plan-specific strengths, opportunities for improvement, and recommendations for MY 2025 related to CMS Protocol 2: PMV with an assessment of the relationship to the quality, timeliness, and access to health care services.

Quality =

Timeliness =

Access =

Medicaid ACOs Providing Physical Health Services

Health Choice Utah (Health Choice)

Results and Outcomes

Validation Results

HSAG's review of the final audit report (FAR) for HEDIS MY 2024 showed that Health Choice's HEDIS compliance auditor found Health Choice's information systems (IS) and processes to be compliant with the applicable IS standards and reporting requirements. Health Choice contracted with an external HEDIS Certified Measures Vendor℠,[18] for measure production and rate calculation. HSAG reviewed Health Choice's HEDIS MY 2024 FAR and determined no notable findings. Health Choice obtained a *Reportable* designation for all measures.

Performance Measure Outcomes

Table 2-141 shows Health Choice's HEDIS MY 2024 results compared to the MY 2024 NCQA Quality Compass (QC) average rates using ˅ to indicate performance that fell below the NCQA QC average.

[18] HEDIS Certified Measures [SM] is a service mark of the NCQA.

Table 2-141—Health Choice HEDIS MY 2024 Results

HEDIS Measure	Health Choice MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	78.00%	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	72.48%	64.05%
Appropriate Treatment for Upper Respiratory Infection		
Total	94.54%	88.10%
Breast Cancer Screening		
Breast Cancer Screening	39.93%ᵛ	55.81%
Cervical Cancer Screening		
Cervical Cancer Screening	56.93%	56.91%
Childhood Immunization Status		
Combination 3	63.75%ᵛ	66.18%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	65.29%	58.65%
*Glycemic Status >9.0%**	24.79%	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	54.55%ᵛ	56.06%
Controlling High Blood Pressure		
Controlling High Blood Pressure	76.67%	66.66%
Immunizations for Adolescents		
Combination 2	33.68%ᵛ	37.84%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	90.68%	84.87%
Postpartum Care	79.93%ᵛ	80.76%
Use of Imaging Studies for Low Back Pain		
Total	72.73%	70.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
Body Mass Index (BMI) Percentile—Total	85.16%	80.87%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.50%	61.92%
Child and Adolescent Well-Care Visits		
Total	45.27%ᵛ	55.41%

ᵛ *Indicates that the rate fell below the Quality Compass average.*
* *For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Health Choice exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Upper Respiratory Infection*
- *Cervical Cancer Screening*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

Opportunities for Improvement

Health Choice fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 2*
- *Eye Exam for Patients With Diabetes*

- *Prenatal and Postpartum Care—Postpartum Care*
- *Child and Adolescent Well-Care Visits*

Recommendations

HSAG observed that six of the 17 reported indicators for Health Choice fell below the MY 2024 NCQA Quality Compass average, indicating opportunities for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Health Choice identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Health Choice implement interventions focused on reducing barriers to care. HSAG suggests that Health Choice consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Health Choice leverage October, Breast Cancer Awareness Month, or the member's birth month to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. HSAG also recommends that Health Choice work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[19]
- Regarding the *Childhood Immunization Status—Combination 3* and *Immunizations for Adolescents—Combination 2* measures, HSAG recommends that Health Choice provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including acute illness visits.[20] HSAG recommends that Health Choice consider implementing strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays) and ensuring vaccination records are accurate. To increase adolescent immunization rates, HSAG recommends offering tips and techniques to providers on how to reframe conversations utilizing evidence-based recommendations, such as discussing the benefits of vaccines for an adolescent's long-term health and wellbeing, and utilizing metaphors to explain how the immune system improves performance and responds to viruses

[19] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.

[20] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

through vaccinations.[21] Furthermore, Health Choice could provide resource guides to providers such as the Adolescent Immunization Resource Guide[22] to identify interventions to improve adolescent immunization rates, including working with schools to update vaccination language on high school sports physical forms. The American Academy of Pediatrics has immunization discussion guides for providers to guide them when encouraging immunization completion with patients.[23] Additional interventions could include offering incentives or engaging partners, such as school-based health clinics or pharmacies.

- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Health Choice conduct a disparity analysis to determine how disparities may influence various factors contributing to barriers to care. HSAG also recommends that Health Choice consider additional member outreach and education on the importance of timely scheduling of annual eye exams. To promote eye exams for members with diabetes, Health Choice could consider alternative methods for conducting eye exams such as offering diabetic retinopathy screenings within the PCP's office and partnering with servicing entities that offer in-home diabetic retinopathy screenings, which provide convenient access to diagnostic testing and treatment for eye diseases.[24] Health Choice could also consider evaluating member incentives with DHHS to complete diabetes screenings. Additionally, HSAG recommends enhancing provider education on navigating patient refusals to schedule eye exams.
- Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, HSAG recommends that Health Choice consider conducting a disparity analysis including the evaluation of social determinants of health (SDOH) to support identifying targeted interventions. Health Choice could also consider interventions to reduce barriers to care such as mother and infant dyad programs (care for the mother and infant simultaneously) for postpartum care to support mothers, who often prioritize the infant's care over their own care.[25] Strategies could include evaluating access to care barriers to determine opportunities to expand access to appointments outside of business hours. Additional interventions could assist with known barriers to postpartum visits such as

[21] Frameworks Institute. Reframing the Conversation about Child and Adolescent Vaccinations. Available at: https://www.frameworksinstitute.org/app/uploads/2023/01/reframing-the-conversation-about-child-and-adolescent-vaccinations_Jan272023.pdf. Accessed on: Dec 4, 2025.

[22] Association of Immunization Managers. Adolescent Immunization Resource Guide. Available at: https://www.immunizationmanagers.org/content/uploads/2022/03/Adolescent-Resource-Guide_033022.pdf. Accessed on: Dec 4, 2025.

[23] American Academy of Pediatrics. Communication Aids. Available at: https://www.aap.org/en/patient-care/immunizations/communication-aids/. Accessed on: Dec 4, 2025.

[24] Retina Labs. In-Home Preventative Care and Diagnostic Services. Available at: https://www.retina-labs.com/in-home-preventive-screening. Accessed on: Dec 9, 2025.

[25] Journal of the American Medical Association. Newborn Visits as Touchpoints to Bridge Postpartum Care Gaps. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2839234. Accessed on: Dec 4, 2025.

managing a new schedule, the change in lifestyle, and the need for childcare.[26] HSAG recommends creating a diagram of the member's journey from the member's perspective to identify and address office flow inefficiencies[27] and barriers to care. HSAG also suggests evaluating potential interventions, including promoting the doula program to support high-risk groups, primarily African American women, and utilizing obstetric (OB) care managers for high-risk groups.[28] HSAG suggests scheduling postpartum appointments during prenatal care or while in the hospital after delivery, which may increase postpartum attendance rates.[29]

- Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends encouraging teen-centered care by reminding providers to use language that is appropriate and engaging for adolescents, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Health Choice and providers develop partnerships with community stakeholders such as schools.[30] HSAG recommends that Health Choice provide education to providers on encouraging preventive care during visits for acute illness, sports physicals, and other encounters. Additionally, HSAG recommends that Health Choice promote well visits on social media, through emails, or personalized outreach. Partnering with school-based health clinics, faith-based organizations, community agencies, and after-school programs may improve well-care visit rates.[31] HSAG encourages Health Choice to use creative strategies to engage this population in well-care visits. Finally, HSAG recommends evaluating the effectiveness of incentives with DHHS to increase timely visits.

[26] National Library of Medicine. Understanding Factors Associated with Postpartum Visit Attendance and Contraception Choices: Listening to Low-Income Postpartum Women and Health Care Providers. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC5290059/. Accessed on: Dec 4, 2025.

[27] National Association of Community Health Centers. Improving Quality in Pregnancy and Postpartum Care. Available at: https://www.nachc.org/wp-content/uploads/2024/08/NACHC-WHPP-Implementation-Guide-2024_3.pdf. Accessed on: Dec 4, 2025.

[28] Centers for Medicare & Medicaid Services Maternal and Infant Health Initiative. Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improve-postpartum-care.pdf. Accessed on: Dec 4, 2025.

[29] American College of Obstetricians and Gynecologists. Optimizing Postpartum care. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. Accessed on: Dec 8, 2025.

[30] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

[31] Partnership Health Plan of California. 2025 Best Practices Child and Adolescent Well-Care Visits. Available at: https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%20IMO%20Webinars%20Current/Best%20Practices%20Child%20Adolescent%20Well%20Care%20Visits.pdf. Accessed on: Dec 4, 2025.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Health Choice fell below the MY 2023 NCQA Quality Compass average for 5 of the 17 performance indicators (29.41 percent), an improvement from the prior MY, but still indicating areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Childhood Immunization Status—Combination 3* and *Immunizations for Adolescents—Combination 2* measures, HSAG recommends that Health Choice provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including acute illness visits.[32] HSAG also recommends that Health Choice consider implementing strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays), developing reports based on vaccinations due and disseminating the reports to providers, and ensuring vaccination records are accurate. Reminder/recall systems can be effective for members/families and providers.[33,34]
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Health Choice identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states. For instance, California and Virginia have a QI initiative focused on delays in newborn enrollment data, and Missouri and Texas developed a QI initiative focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach.[35] HSAG recommends that Health Choice identify other barriers to care and conduct a focus group to identify interventions to address barriers.
- Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Health Choice and providers develop partnerships with community stakeholders such as schools.[36] HSAG also recommends that Health Choice conduct provider education about

[32] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.
[33] Das JK, Salam RA, Arshad A, et al. Systematic review and meta-analysis of interventions to improve access and coverage of adolescent immunizations. *Journal of Adolescent Health*. 2016 Oct;59(4S):S40–S48.
[34] American Academy of Pediatrics. Immunization News and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: https://publications.aap.org/redbook/resources/23648/Immunization-Strategies-and-Resources. Accessed on: Dec 4, 2025.
[35] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Dec 4, 2025.
[36] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. Additionally, HSAG recommends that health plans promote well visits on social media, through emails, or personalized outreach. Finally, HSAG recommends that Health Choice incentivize providers, members, and parents to complete visits.

- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that Health Choice ensure providers are aware of best practices regarding imaging studies for low back pain, such as avoiding diagnostic imaging in the first four weeks of new-onset back pain unless red flags or other conditions are present and encouraging management of back pain through regular physical activity, healthy back exercises, and education on injury prevention.[37]
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Health Choice identify disparities or SDOH within its populations that contribute to low breast cancer screening rates. Upon identification of any disparities, HSAG recommends that Health Choice implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Health Choice provide scheduled reminders and messages directly from providers, and utilize personalized outreach for overdue patients. Communication and messages should be clear and concise, and include information on the procedure time.

Health Plan Interventions

Health Choice Utah reported the following improvement efforts in response to HSAG's MY 2023 recommendations:[38]

- Regarding the *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the First 30 Months of Life* measures, Health Choice Utah (HCU) reported that through its Provider Engagement program, proactive scheduling and outreach for well-child visits and immunizations was implemented. Gap reports were distributed to providers, highlighting members who were due for services. Members and providers were supplied with fridge magnets with the well-child schedule, and immunization cards, which were also included in new member and Well Baby Packets for members 0–28 months of age that contained educational resources on milestones, car seat safety, and finding pediatric care. HCU reported participating in the ACO Immunizations Collaborative with other Utah ACOs to address barriers and share strategies. HCU's Chief Medical Officer and Marketing Team produced social media videos to promote immunizations.
- Regarding *Immunizations for Adolescents—Combination 2* measure, HCU educated providers on discussing adolescent vaccinations and offered a targeted monetary incentive for the HPV vaccination. HCU also ensured that provider directories highlighted PCPs who offered extended-

[37] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[38] Please note that the health plan improvement efforts included in this section were provided by the health plans, and HSAG has not altered this content other than minor formatting.

hours. HCU collaborated with the ACO Immunizations Collaborative and promoted immunizations through social media campaigns led by health plan executives.

- Regarding the *Child and Adolescent Well-Care Visits* measure, HCU launched its second annual large-scale outreach campaign through the Customer Services Team, contacting over 28,000 members and successfully reaching more than 11,000. HCU also implemented provider engagement activities, including gap reporting and education.
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HCU's Provider Engagement program reinforced best practices during office visits by emphasizing the avoidance of unnecessary imaging and promoting alternative initial therapies. The HCU Quality Improvement Advisory Council updated clinical practice guidelines related to low back pain which will be posted on the HCU website for providers to access.
- Regarding the *Breast Cancer Screening* measure, HCU implemented a multi-pronged approach to improve breast cancer screening rates. In 2023, HCU launched an Interactive Voice Response (IVR) campaign that educated members on the importance of timely screenings and offered warm transfers to imaging centers for immediate scheduling. Additionally, HCU added imaging centers, including southern Utah, to improve accessibility for rural members. HCU reported actively planning a multi-channel strategy that incorporated short message service (SMS/text) reminders to complement IVR outreach, ensuring members received timely prompts through their preferred communication method. HCU sent incentive announcements to members who had not yet completed their screenings, providing education on the benefits of early detection and offering a monetary incentive for completing the screening by year-end. HCU reported aiming to reduce barriers, increase convenience, and motivate members to prioritize preventive care.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG also recognizes Health Choice's work with the ACO Immunizations Collaborative. HSAG encourages Health Choice to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Healthy U

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Healthy U's HEDIS compliance auditor found Healthy U's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements. Healthy U contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Healthy U's HEDIS MY 2024 FAR and determined no notable findings. Healthy U obtained a *Reportable* designation for all measures.

Performance Measure Outcomes

Table 2-142 shows Healthy U's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using v to indicate performance that fell below the NCQA QC average.

Table 2-142—Healthy U HEDIS MY 2024 Results

HEDIS Measure	Healthy U ACO MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	82.47%	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	67.99%	64.05%
Appropriate Treatment for Upper Respiratory Infection		
Total	94.69%	88.10%
Breast Cancer Screening		
Breast Cancer Screening	39.64%v	55.81%
Cervical Cancer Screening		
Cervical Cancer Screening	52.80%v	56.91%
Childhood Immunization Status		
Combination 3	69.34%	66.18%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	68.13%	58.65%
*Glycemic Status >9.0%**	23.60%	32.66%
Eye Exam for Patients With Diabetes		

HEDIS Measure	Healthy U ACO MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Eye Exam for Patients With Diabetes	54.26%ᵛ	56.06%
Controlling High Blood Pressure		
Controlling High Blood Pressure	76.84%	66.66%
Immunizations for Adolescents		
Combination 2	35.77%ᵛ	37.84%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	88.11%	84.87%
Postpartum Care	78.96%ᵛ	80.76%
Use of Imaging Studies for Low Back Pain		
Total	71.83%	70.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI percentile—Total	86.60%	80.87%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	49.26%ᵛ	61.92%
Child and Adolescent Well-Care Visits		
Total	48.70%ᵛ	55.41%

ᵛ *Indicates the rate fell below the Quality Compass average.*
** For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Healthy U exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*

- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

Opportunities for Improvement

Healthy U fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Eye Exam for Patients With Diabetes*
- *Immunizations for Adolescents—Combination 2*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits*

Recommendations

Healthy U fell below the MY 2024 NCQA Quality Compass average for seven of the 17 performance indicators (41.18 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Healthy U identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Healthy U implement interventions focused on reducing barriers to care. Healthy U could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Healthy U leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of

communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. Healthy U could work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[39]

- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Healthy U consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[40] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Healthy U provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is a lack of knowledge. Manual or electronic reminders for providers that members are due for cancer screenings, giving feedback on individual or clinic screening rates, flexible hours, transportation assistance, and patient reminders, such as through a patient portal or text messages, may increase screening completion.[41,42]
- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Healthy U conduct a disparity analysis to determine how disparities may influence various factors contributing to barriers to care. HSAG also recommends that Healthy U consider additional member outreach and education on the importance of timely scheduling of annual eye exams. To promote eye exams for members with diabetes, Healthy U could consider alternative methods for conducting eye exams such as offering diabetic retinopathy screenings within the PCP's office and partnering with servicing entities that offer in-home diabetic retinopathy screenings, which provide convenient access to diagnostic testing and treatment for eye diseases.[43] Healthy U could consider evaluating member incentives with DHHS to complete diabetes screenings. Additionally, HSAG recommends enhancing provider education on navigating patient refusals to schedule eye exams.
- Regarding the *Immunizations for Adolescents—Combination 2* measure, HSAG recommends that Healthy U implement strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays), developing reports based on vaccinations due and disseminating the reports to providers, ensuring that providers are administering all recommended vaccinations at each visit, and ensuring vaccination records are accurate. Reminder/recall systems can be effective

[39] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.

[40] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[41] U.S. Centers for Disease Control. Provider Reminders. Available at: https://www.cdc.gov/cancer/php/interventions/provider-reminders.html. Accessed on: Dec 4, 2025.

[42] National Indian Health Board. Evidence-Based Interventions to Increase Cancer Screening: Provider Reminders. Available at: https://nihbcancerscreening.nptoolkit.org/wp-content/uploads/sites/41/2019/09/NIHB-Toolkit-CDC-Screen-Out-Cancer-Guides-pp-44-51-1.pdf. Accessed on: Dec 4, 2025.

[43] Retina Labs. In-Home Preventative Care and Diagnostic Services. Available at: https://www.retina-labs.com/in-home-preventive-screening. Accessed on: Dec 9, 2025.

for members/families and providers as well.[44,45] To increase adolescent immunization rates, HSAG recommends offering tips and techniques to providers on how to reframe conversations utilizing evidence-based recommendations[46] such as discussing the benefits of vaccinations for an adolescent's long-term health and wellbeing, and utilizing metaphors to explain how the immune system improves performance and responds to viruses through vaccinations. Furthermore, providing resource guides to providers such as the Adolescent Immunization Resource Guide[47] to identify interventions to improve adolescent immunization rates such as working with schools to update vaccine language on high school sports physical forms. Additional interventions that may improve immunization rates include offering incentives or engaging partners, such as school-based health clinics or pharmacies. The American Academy of Pediatrics has immunization discussion guides for providers to guide them when encouraging completion of immunizations with patients.[48]

- Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, HSAG recommends that Healthy U consider conducting a disparity analysis, including the evaluation of SDOH to support identifying targeted interventions. Healthy U could consider interventions to reduce barriers to care such as mother and infant dyad programs (care for the mother and infant simultaneously) for postpartum care to support mothers, who often prioritize the infant's care over their own care.[49] Strategies could include evaluating access to care to determine opportunities to expand access to appointments outside of business hours to accommodate access barriers. Additionally, the following interventions may assist with known barriers to postpartum visits: managing a new schedule, the change in lifestyle, and the need for childcare.[50] HSAG recommends creating a diagram of the member's journey from the member's perspective to identify and address office flow inefficiencies[51] and member barriers to care. HSAG also suggests evaluating potential

[44] Das JK, Salam RA, Arshad A, et al. Systematic review and meta-analysis of interventions to improve access and coverage of adolescent immunizations. *Journal of Adolescent Health*. 2016 Oct;59(4S):S40–S48.
[45] American Academy of Pediatrics. Immunization News and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: https://publications.aap.org/redbook/resources/23648/Immunization-Strategies-and-Resources. Accessed on: Dec 4, 2025.
[46] Frameworks Institute. Reframing the Conversation about Child and Adolescent Vaccinations. Available at: https://www.frameworksinstitute.org/app/uploads/2023/01/reframing-the-conversation-about-child-and-adolescent-vaccinations_Jan272023.pdf. Accessed on: Dec 4, 2025.
[47] Association of Immunization Managers. Adolescent Immunization Resource Guide. Available at: https://www.immunizationmanagers.org/content/uploads/2022/03/Adolescent-Resource-Guide_033022.pdf. Accessed on: Dec 4, 2025.
[48] American Academy of Pediatrics. Communication Aids. Available at: https://www.aap.org/en/patient-care/immunizations/communication-aids/. Accessed on: Dec 4, 2025.
[49] Journal of the American Medical Association. Newborn Visits as Touchpoints to Bridge Postpartum Care Gaps. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2839234. Accessed on: Dec 4, 2025.
[50] National Library of Medicine. Understanding Factors Associated with Postpartum Visit Attendance and Contraception Choices: Listening to Low-Income Postpartum Women and Health Care Providers. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC5290059/. Accessed on: Dec 4, 2025.
[51] National Association of Community Health Centers. Improving Quality in Pregnancy and Postpartum Care. Available at: https://www.nachc.org/wp-content/uploads/2024/08/NACHC-WHPP-Implementation-Guide-2024_3.pdf. Accessed on: Dec 4, 2025.

interventions, including promoting the doula program to support high-risk groups, primarily African American women, and utilizing OB care managers for high-risk groups.[52] HSAG suggests scheduling postpartum appointments during prenatal care or while in the hospital after delivery, which may increase postpartum attendance rates.[53]

- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Healthy U identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states such as South Dakota and California.[54] HSAG also recommends that Healthy U identify barriers to care and conduct a focus group to identify interventions to address barriers. Addressing SDOH with interventions such as extended hours, weekend hours, back-to-back sibling well-child visits, and transportation could increase attendance to well-child visits. Lastly, utilizing EHR to identify patients overdue, scheduling the next appointment at check-out, and providing incentives are techniques that have been utilized to increase well-care visits. HSAG encourages Healthy U to continue with the ACO Immunizations Collaborative to share strategies to address barriers.
- Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Healthy U and providers develop partnerships with community stakeholders such as schools.[55] HSAG also recommends that Healthy U conduct provider education about encouraging preventive care when members are seen for acute illness, sports physicals, and other encounters. HSAG further recommends that Healthy U promote well-care visits on social media, through emails, or personalized outreach. Partnering with school-based health clinics, faith-based organizations, community agencies, and after-school programs may improve well-care visit rates.[56] Finally, HSAG recommends evaluating the effectiveness of incentives with DHHS to increase timely visits.

[52] Centers for Medicare & Medicaid Services Maternal and Infant Health Initiative. Resources on Strategies to Improve Postpartum Care Among Medicaid and CHIP Populations. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/strategies-to-improve-postpartum-care.pdf. Accessed on: Dec 4, 2025.

[53] American College of Obstetricians and Gynecologists. Optimizing Postpartum care. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. Accessed on: Dec 8, 2025.

[54] Centers for Medicare & Medicaid Services. CMS Affinity Group State Spotlights: Improving Infant Well-Child Visits, 0-15 months. https://www.medicaid.gov/medicaid/quality-of-care/downloads/iwc-statespotlights-slides.pdf. Access on: Dec 8, 2025

[55] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

[56] Partnership Health Plan of California. 2025 Best Practices Child and Adolescent Well-Care Visits. Available at: https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%20IMO%20Webinars%20Current/Best%20Practices%20Child%20Adolescent%20Well%20Care%20Visits.pdf. Accessed on: Dec 4, 2025.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

- Healthy U fell below the MY 2023 NCQA Quality Compass average for six of the 17 performance indicators (35.29 percent), indicating areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:
- Regarding the *Immunizations for Adolescents—Combination 2* measure, HSAG recommends that Healthy U implement strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays), developing reports based on vaccinations due and disseminating the reports to providers, ensuring that providers are administering all recommended vaccinations at every visit, and ensuring vaccination records are accurate. Reminder/recall systems can be effective for members/families and providers as well.[57,58]
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Healthy U consider utilizing one-on-one interactions with a health care professional, such as community health workers (CHWs), which have been shown to improve cervical cancer screening.[59] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Healthy U provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Healthy U identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states. For instance, California and Virginia have a QI initiative focused on delays in newborn enrollment data, and Missouri and Texas developed a QI initiative focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach.[60] HSAG recommends that Healthy U identify other barriers to care and conduct a focus group to identify interventions to address barriers.
- Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Healthy U and providers develop partnerships with community stakeholders

[57] Das JK, Salam RA, Arshad A, et al. Systematic review and meta-analysis of interventions to improve access and coverage of adolescent immunizations. *Journal of Adolescent Health*. 2016 Oct;59(4S):S40–S48.

[58] American Academy of Pediatrics. Immunization News and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: https://publications.aap.org/redbook/resources/23648/Immunization-Strategies-and-Resources. Accessed on: Dec 4, 2025.

[59] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[60] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Dec 4, 2025.

such as schools.[61] HSAG also recommends that Healthy U conduct provider education about encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. HSAG further recommends that Healthy U promote well-visits on social media, through emails, or personalized outreach. Finally, HSAG recommends that Healthy U incentivize providers, members, and parents to complete visits.

- Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, HSAG recommends that Healthy U consider whether there are disparities/SDOH within Healthy U's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that Healthy U implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to this option could potentially increase performance for this measure. Further, HSAG recommends that Healthy U identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[62]
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Healthy U identify disparities or SDOH within its populations that contribute to low breast cancer screening rates. Upon identification of any disparities, HSAG recommends that Healthy U implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Healthy U provide scheduled reminders and messages directly from providers and utilize personalized outreach for overdue patients. Communication and messages should be clear, concise, and include information on the procedure time.

Health Plan Interventions

Healthy U reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Regarding the *Immunizations for Adolescents—Combination 2* measure, Healthy U worked with systems analysts to create a separate health plan immunization feed with the Utah Statewide Immunization Information System (USIIS) to ensure all immunizations for members were captured. Healthy U's provider directory highlights PCPs with extended hours. Healthy U also participated in the ACO Immunizations Collaborative and promoted immunizations through social media campaigns.

[61] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

[62] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Dec 4, 2025.

- Regarding the *Cervical Cancer Screening* measure, Healthy U's new Provider Engagement program emphasized education and gap reporting for this measure. Healthy U also included Cervical Cancer Screening reminders in member newsletters to provide educational materials about the importance of screening.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, Healthy U launched a Provider Engagement program which offered education, gap reports, and office visits to improve quality performance. Providers were encouraged to schedule well-child visits and immunizations together and supplied with educational materials, including fridge magnets with the well-child visit scheduled appointment date as well as an immunization schedule in the Well Baby Packets distributed to parents. Member outreach calls were conducted for reminders. Healthy U also participates in the ACO Immunizations Collaborative, where health plans share strategies to overcome barriers. Healthy U's leadership team collaborated with marketing to produce social media videos which promoted immunizations.
- Regarding the *Child and Adolescent Well-Care Visits* measure, on August 1, 2025, Healthy U launched a large-scale member outreach campaign conducted by the Customer Services team for a second year. Provider engagement activities included gap reporting and education, which reinforce efforts to improve measure performance.
- Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, Healthy U sent prenatal and postpartum emails to pregnant members which provided educational resources and timely reminders to support their maternal care journey. Gap reports were utilized to identify members due for postpartum visits. Healthy U encouraged scheduling postpartum visits during prenatal care to ensure timely follow-up.
- Regarding the *Breast Cancer Screening* measure, Healthy U implemented a multi-pronged approach to improve breast cancer screening rates. In 2023, Healthy U launched an Interactive Voice Response (IVR) campaign that educated members on the importance of timely screenings and offered warm transfers to imaging centers for immediate scheduling. Healthy U expanded initiative in 2025 include additional imaging centers, extending services to southern Utah which improved accessibility for rural members. Healthy U reported planning a multi-channel strategy that incorporates phone text SMS reminders to complement IVR outreach, ensuring members receive timely prompts through their preferred communication method.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG also recognizes Healthy U's work with the ACO Immunizations Collaborative. HSAG encourages Healthy U to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Molina Healthcare of Utah (Molina)

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Molina's HEDIS compliance auditor found Molina's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements. Molina contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Molina's HEDIS MY 2024 FAR and determined no notable findings. Molina obtained a *Reportable* designation for all measures.

Performance Measure Outcomes

Table 2-143 shows Molina's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using ˅ to indicate performance that fell below the NCQA QC average.

Table 2-143—Molina HEDIS MY 2024 Results

HEDIS Measure	Molina ACO MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	82.10%	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	69.72%	64.05%
Appropriate Treatment for Upper Respiratory Infection		
Total	93.88%	88.10%
Breast Cancer Screening		
Breast Cancer Screening	44.31%˅	55.81%
Cervical Cancer Screening		
Cervical Cancer Screening	52.07%˅	56.91%
Childhood Immunization Status		
Combination 3	59.85%˅	66.18%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	58.88%	58.65%
*Glycemic Status >9.0%**	33.09%˅	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	53.36%˅	56.06%
Controlling High Blood Pressure		

HEDIS Measure	Molina ACO MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Controlling High Blood Pressure	52.31%ᵛ	66.66%
Immunizations for Adolescents		
Combination 2	28.04%ᵛ	37.84%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	71.34%ᵛ	84.87%
Postpartum Care	73.43%ᵛ	80.76%
Use of Imaging Studies for Low Back Pain		
Total	73.31%	70.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI percentile—Total	71.05%ᵛ	80.87%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	49.90%ᵛ	61.92%
Child and Adolescent Well-Care Visits		
Total	49.58%ᵛ	55.41%

ᵛ *Indicates the rate fell below the Quality Compass average.*
**For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Molina exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*

Appropriate Treatment for Upper Respiratory Infection

Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%

- *Use of Imaging Studies for Low Back Pain*

Opportunities for Improvement

Molina fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status—Combination 3*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Eye Exam for Patients With Diabetes*
- *Controlling High Blood Pressure*
- *Immunizations for Adolescents—Combination 2*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

Molina fell below the MY 2024 NCQA Quality Compass average for 12 of the 17 performance indicators (70.58 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Molina identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Molina implement interventions focused on reducing barriers to care. Molina could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Molina leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening

recommendations. Molina could work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[63]

- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Molina consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[64] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Molina provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is a lack of knowledge. Manual or electronic reminders for providers that members are due for cancer screenings, giving feedback on individual or clinic screening rates, flexible hours, transportation assistance, and patient reminders such as patient portal messages may increase screenings.[65,66]
- Regarding the *Childhood Immunization Status—Combination 3* measure, HSAG recommends that Molina provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at each opportunity, including acute illness visits.[67] HSAG also recommends that Molina consider implementing strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays) and ensuring vaccination records are accurate. The American Academy of Pediatrics has immunization discussion guides for providers to guide them when encouraging immunization completion with patients.[68]
- Regarding the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%* measure, HSAG recommends that Molina assess how continuous glucose monitoring systems may improve diabetes control. HSAG recommends engaging members in telehealth to manage diabetes care.[69] HSAG recommends that Molina promote the Healthy Living with Diabetes program for

[63] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.
[64] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.
[65] U.S. Centers for Disease Control. Provider Reminders. Available at: https://www.cdc.gov/cancer/php/interventions/provider-reminders.html. Accessed on: Dec 4, 2025.
[66] National Indian Health Board. Evidence-Based Interventions to Increase Cancer Screening: Provider Reminders. Available at: https://nihbcancerscreening.nptoolkit.org/wp-content/uploads/sites/41/2019/09/NIHB-Toolkit-CDC-Screen-Out-Cancer-Guides-pp-44-51-1.pdf. Accessed on: Dec 4, 2025.
[67] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.
[68] American Academy of Pediatrics. Communication Aids. Available at: https://www.aap.org/en/patient-care/immunizations/communication-aids/. Accessed on: Dec 4, 2025.
[69] Health Resources and Services Administration. Engaging Patients in Telehealth for Diabetes Care. Available at: https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-diabetes-care/engaging-patients-telehealth-diabetes. Accessed on: Dec 4, 2025.

patients to learn about managing their blood sugar.[70,71] Additionally, addressing significant mental health diagnoses through psychosocial screening protocols and referrals may address symptoms that are affecting members' ability to carry out diabetes self-management activities.[72] HSAG recommends analyzing data for members with uncontrolled diabetes to identify cultural dietary patterns that may influence nutritional choices. Molina could consider providing motivational interviewing classes for providers to support positive health behaviors.

- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Molina conduct a disparity analysis to determine how disparities may influence various factors contributing to barriers to care. HSAG also recommends that Molina consider additional member outreach and education on the importance of timely scheduling of annual eye exams. To promote eye exams for members with diabetes, Molina could consider alternative methods for conducting eye exams such as offering diabetic retinopathy screenings within the PCP's office and partnering with servicing entities that offer in-home diabetic retinopathy screenings, which provide convenient access to diagnostic testing and treatment for eye diseases.[73] Molina could consider evaluating member incentives with DHHS to complete diabetes screenings. Additionally, HSAG recommends enhancing provider education on navigating patient refusals to schedule eye exams may improve screenings.
- Regarding the *Controlling High Blood Pressure* measure, HSAG recommends encouraging medication adherence, such as longer-duration prescriptions.[74] HSAG further recommends the use of automated home blood pressure monitors for patients and educating members how to take blood pressure with tools such as the American Medical Association (AMA) 7-step SMBP [self-measured blood pressure] quick guide[75] or home blood Pressure monitoring.[76] HSAG also recommends the use of telehealth for patients with high blood pressure. Molina could consider educating patients on nonpharmacological lifestyle changes such as the Dietary Approaches to Stop Hypertension (DASH) diet, reduction of alcohol, low-sodium/high-potassium salt interventions, exercise, weight reduction, stress reduction strategies, and eliminating smoking, and how these

[70] U.S. Centers for Disease Control. Background and Benefits of DSMES. Available at: https://www.cdc.gov/diabetes-toolkit/php/about-dsmes/background-dsmes.html. Accessed on: Dec 4, 2025.
[71] Molina Healthcare. Health Management. Available at: https://www.molinahealthcare.com/marketplace/ut/en-us/Providers/Health-Resources/Health-Management.aspx. Accessed on: Dec 4, 2025.
[72] American Diabetes Association. Standards of Care in Diabetes—2025 Abridged for Primary Care. Available at: https://diabetesjournals.org/clinical/article/43/2/182/157719/Standards-of-Care-in-Diabetes-2025-Abridged-for?searchresult=1. Accessed on: Dec 4, 2025.
[73] Retina Labs. In-Home Preventative Care and Diagnostic Services. Available at: https://www.retina-labs.com/in-home-preventive-screening. Accessed on: Dec 9, 2025.
[74] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 4, 2025.
[75] American Medical Association. 7-step SMBP Quick Guide. Available at: https://map.ama-assn.org/sites/default/files/2024-05/7%20Steps%20SMBP%20Quick%20Guide.pdf?. Accessed on: Dec 4, 2025.
[76] American Heart Association/American College of Cardiology. SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Available at: https://www.ahajournals.org/doi/10.1161/HYP.0000000000000249#sec-7-1-3. Accessed on: Dec 4, 2025.

influence blood pressure.[77] HSAG recommends providing education for staff members in provider offices on how to measure blood pressure accurately.[78]

- Regarding the *Immunizations for Adolescents—Combination 2* measure, HSAG recommends that Molina implement strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays), developing reports based on vaccinations due and disseminating the reports to providers, administering all recommended vaccinations at each visit, and ensuring vaccination records are accurate. Reminder/recall systems in the EHR can be effective for providers as well.[79,80] To increase adolescent immunization rates, HSAG recommends offering tips and techniques to providers on how to reframe conversations utilizing evidence-based recommendations[81] such as discussing the benefits of vaccinations for an adolescent's long-term health and wellbeing, and utilizing metaphors to explain how the immune system improves performance and responds to viruses through vaccinations. Furthermore, providing resource guides to providers like the Adolescent Immunization Resource Guide[82] to identify interventions to improve adolescent immunization rates such as working with schools to update vaccination language on high school sports physical forms. Additional interventions could include offering incentives or engaging partners, such as school-based health clinics or pharmacies.
- Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* measures, HSAG recommends that Molina consider conducting a disparity analysis including the evaluation of SDOH to support identifying targeted interventions. Molina could consider interventions to reduce barriers to care such as mother and infant dyad (care for the mother and infant simultaneously) programs for postpartum care to support mothers, who often prioritize the infant's care over their own care.[83] Strategies to improve visits could include evaluating access to care to determine opportunities to expand access to appointments outside of business hours to accommodate access barriers. Additionally, the following interventions could assist with known barriers to postpartum visits: managing a new schedule, the change in

[77] U.S. Centers for Disease Control. Managing High Blood Pressure. Available at: https://www.cdc.gov/high-blood-pressure/living-with/index.html. Accessed on: Dec 4, 2025.
[78] American Medical Association. Measure Accurately Best Practices. Available at: https://www.ama-assn.org/system/files/2019-01/measure-accurately-best-practices.pdf. Accessed on: Dec 4, 2025.
[79] Das JK, Salam RA, Arshad A, et al. Systematic review and meta-analysis of interventions to improve access and coverage of adolescent immunizations. *Journal of Adolescent Health*. 2016 Oct;59(4S):S40–S48.
[80] American Academy of Pediatrics. Immunization News and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: https://publications.aap.org/redbook/resources/23648/Immunization-Strategies-and-Resources. Accessed on: Dec 4, 2025.
[81] Frameworks Institute. Reframing the Conversation about Child and Adolescent Vaccinations. Available at: https://www.frameworksinstitute.org/app/uploads/2023/01/reframing-the-conversation-about-child-and-adolescent-vaccinations_Jan272023.pdf. Accessed on: Dec 4, 2025.
[82] Association of Immunization Managers. Adolescent Immunization Resource Guide. Available at: https://www.immunizationmanagers.org/content/uploads/2022/03/Adolescent-Resource-Guide_033022.pdf. Accessed on: Dec 4, 2025.
[83] Journal of the American Medical Association. Newborn Visits as Touchpoints to Bridge Postpartum Care Gaps. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2839234. Accessed on: Dec 4, 2025.

lifestyle, and the need for childcare. HSAG recommends creation of a diagram of the member's journey from the member's perspective to identify and address office flow inefficiencies and member barriers to care. HSAG suggests assessing interventions including promoting the doula program to support high-risk groups, primarily African American women, and utilizing OB care managers for high-risk groups. HSAG suggests scheduling postpartum appointments during prenatal care or while in the hospital after delivery, which may increase postpartum attendance rates.[84] Providing access to group prenatal care may also improve prenatal visits and early access to care.[85]

- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, HSAG recommends that Molina follow up on reports given to providers to identify members who would benefit from this service. HSAG also recommends that Molina ensure members are going to well-child appointments and a BMI is being calculated. Molina could consider educating providers to include BMI percentile in the EHR well-child templates for ease of documentation.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Molina identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states such as South Dakota and California.[86] HSAG also recommends that Molina identify barriers to care and conduct a focus group to identify interventions to address barriers. Addressing SDOH with interventions such as extended hours, weekend hours, back-to-back sibling well-child visits, and transportation could increase attendance to well-child visits. Lastly, scheduling the next appointment at check-out has been utilized to increase well-care visits.
- Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Molina and providers develop partnerships with community stakeholders such as schools.[87] HSAG also recommends that Molina conduct provider education about encouraging preventive care when members are seen for acute illness, sports physicals, and other reasons. HSAG further recommends that Molina promotes well-care visits on social media, through emails,

[84] American College of Obstetricians and Gynecologists. Optimizing Postpartum care. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. Accessed on: Dec 8, 2025.

[85] National Center for Education in Maternal and Child Health. Evidence Tools. Available at: https://www.mchevidence.org/tools/strategies/details.php?early-prenatal-care-11. Accessed on: Dec 4, 2025.

[86] Centers for Medicare & Medicaid Services. CMS Affinity Group State Spotlights: Improving Infant Well-Child Visits, 0-15 months. https://www.medicaid.gov/medicaid/quality-of-care/downloads/iwc-statespotlights-slides.pdf. Access on: Dec 8, 2025

[87] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

or personalized outreach. Partnering with school-based health clinics, faith-based organizations, community agencies, and after-school programs may improve well-care visit rates.[88] Finally, HSAG recommends evaluating the effectiveness of incentives with DHHS to increase timely visits.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Molina fell below the MY 2024 NCQA Quality Compass average for 11 of the 17 performance indicators (64.70 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Molina consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[89] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Molina provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
- Regarding the *Childhood Immunization Status—Combination 3* measure, HSAG recommends that Molina provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[90]
- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, HSAG recommends that Molina create a report to identify members who would benefit from this service and follow up with providers as necessary. HSAG also recommends that Molina ensure members are going to well appointments for BMI to be calculated.
- Regarding the *Immunizations for Adolescents—Combination 2* measure, HSAG recommends that Molina implement strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays), developing reports based on vaccinations due and disseminating the reports to providers, administering all recommended vaccinations at every visit, and ensuring

[88] Partnership Health Plan of California. 2025 Best Practices Child and Adolescent Well-Care Visits. Available at: https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%20IMO%20Webinars%20Current/Best%20Practices%20Child%20Adolescent%20Well%20Care%20Visits.pdf. Accessed on: Dec 4, 2025.

[89] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[90] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

vaccination records are accurate. Reminder/recall systems can be effective for members/families and providers.[91] [92]

- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Molina identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states. For instance, California and Virginia have a QI initiative focused on delays in newborn enrollment data, and Missouri and Texas developed a QI initiative focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach.[93] HSAG recommends that Molina identify other barriers to care and conduct a focus group to identify interventions to address barriers.
- Regarding the *Child and Adolescent Well-Care Visits—3 to 11 years* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Molina and providers develop partnerships with community stakeholders such as schools.[94] HSAG also recommends that Molina conduct provider education about encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. HSAG further recommends that Molina promote well visits on social media, through emails, or personalized outreach. Finally, HSAG recommends that Molina incentivize providers, members, and parents to complete visits.
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Molina identify disparities or SDOH within Molina's population that contribute to low breast cancer screening rates. Upon identification of a root cause, HSAG recommends that Molina implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Molina provide scheduled reminders and messages directly from providers, and utilize personalized outreach for overdue patients. Communication and messages should be clear and concise, and include information on the procedure time.
- Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Prenatal and Postpartum Care—Postpartum Care* measures, HSAG recommends that Molina consider whether there are disparities/SDOH within Molina's population that contribute to lower access to care. Upon identification of any disparities, HSAG recommends that Molina implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access

[91] Das JK, Salam RA, Arshad A, et al. Systematic review and meta-analysis of interventions to improve access and coverage of adolescent immunizations. *Journal of Adolescent Health*. 2016 Oct;59(4S):S40–S48.

[92] American Academy of Pediatrics. Immunization News and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: https://publications.aap.org/redbook/resources/23648/Immunization-Strategies-and-Resources. Accessed on: Dec 4, 2025.

[93] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Dec 4, 2025.

[94] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to this option could potentially increase performance for this measure. Further, HSAG recommends that Molina identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[95]

- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Molina identify trends within the data. HSAG also recommends that Molina provide member education to ensure diabetic members are given guidance to schedule annual eye exams. Further, HSAG recommends that Molina review a study conducted at Johns Hopkins outlining the possibility of closing care gaps with artificial intelligence (AI) to assist in scheduling eye exams.[96]
- Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that Molina identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG also recommends that Molina reduce or eliminate costs of treatments like antihypertensive medications if applicable, especially in ways that encourage medication adherence, such as longer-duration prescriptions.[97] HSAG further recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.
- Regarding the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measures, HSAG recommends that Molina consider providing coverage for personal continuous glucose monitors (CGMs) for type 1 and type 2 diabetes. Offering coverage for CGMs coupled with educating providers and members on this coverage might improve diabetes control. HSAG also recommends that Molina identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.

Health Plan Interventions

Molina reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Regarding the *Cervical Cancer Screening* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina also initiated multichannel

[95] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Dec 4, 2025.

[96] Johns Hopkins Medicine. Study Finds AI-Driven Eye Exams Increase Screening Rates for Youth with Diabetes. Available at: https://www.hopkinsmedicine.org/news/newsroom/news-releases/2024/01/study-finds-ai-driven-eye-exams-increase-screening-rates-for-youth-with-diabetes. Accessed on: Dec 4, 2025.

[97] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 4, 2025.

communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina also launched a member incentives program with educational outreach and incentive for service completion.

- Regarding the *Childhood Immunization Status—Combination 3* measure, Molina distributed education to mothers about immunization during the last weeks of pregnancy prior to delivery and distributed text messages timed to coincide with well child visits to remind parents about immunizations due during the visit. Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina reported multichannel communication was initiated to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs.
- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and distributed education about what to expect during well child visits and importance of BMI percentile tracking, which was included in text messages, emails, member mailings. Molina also launched a member incentives program with educational outreach and incentive for well care visit completion and distributed HEDIS Tip Sheets to providers to encourage use of Current Procedural Terminology (CPT II) coding.
- Regarding the *Immunizations for Adolescents—Combination 2* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and implemented a member incentives program with educational outreach and incentive for service completion. Molina focused on HPV vaccination and education as it most missed of the three Combo 2 vaccines and began member education and provider notifications when children turned nine.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, Molina provided education to mothers about well-care visits during the last weeks of pregnancy prior to delivery and delivered text messages timed to coincide with well child visit schedule to remind parents and educate on what to expect during the visit. Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs.
- Regarding the *Child and Adolescent Well-Care Visits—3 to 11 years* measure, Molina delivered text messages timed to coincide with well child visit schedules to remind parents and educate on what to expect during the visit and launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina also launched a member incentives program with educational outreach and incentive for service completion and initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs.

- Regarding the *Breast Cancer Screening* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina contracted with the Mobile Mammogram Unit to schedule women that could not get to an imaging center, invited women to health education events where services were performed, and provided access in rural areas.
- Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* measures, Molina worked with IT and Data teams to enhance identification of new mothers and new enrollees who were pregnant and initiated personal outreach calls to educate, assure access to care, and offer incentives for visit completion. Molina contracted with in-home vendor to provide in-home and telehealth visit options and launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina launched a member incentives program with educational outreach and incentive for service completion and distributed educational materials in the New Member Welcome packet.
- Regarding the *Eye Exam for Patients With Diabetes* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina also scheduled in-home services to complete an eye exam.
- Regarding the *Controlling High Blood Pressure* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina also scheduled in-home services to educate members, take blood pressure, coordinate visits with PCP if readings were outside normal limits and delivered reminders for hypertension medication adherence.
- Regarding the Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) and Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%) measures, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina scheduled in-home services to educate members, completed A1c blood draw, coordinated visits with PCP if readings were outside normal limits and delivered reminders for medication adherence.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG encourages Molina to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Select Health Community Care (Select Health CC)

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Select Health CC's HEDIS compliance auditor found Select Health CC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Select Health CC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of Select Health CC's FAR revealed that Select Health CC's HEDIS compliance auditor determined that all measures obtained a *Reportable* designation, and documented the following key findings and recommendations:

- During the audit review benchmarking session, Select Health CC staff members effectively addressed the benchmarking outlier concerns. Staff members provided the results of their investigations in addition to explanations related to the health plan's clinical interventions, data availability, and targeted measures for improvement.
- Select Health CC encouraged the use of relevant CPT II codes and experienced a subsequent increase in the use of these codes. The result was an increase in the *Controlling High Blood Pressure* administrative rate, along with an improvement in supplemental data capture. Recommendations included continuing to target measures for improvement in this manner.
- For supplemental data sources where primary source verification (PSV) was required, for example, Care Radius and the Data Exchange Tool, Select Health CC effectively provided the required support to pass those reviews. For any new supplemental data sources that are being considered for future reporting, and any existing sources where PSV may be required, recommendations included making advance preparations to provide the required PSV support, as it successfully occurred with Care Radius and the Data Exchange Tool.

Performance Measure Outcomes

Table 2-144 shows Select Health CC's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using ˅ to indicate performance that fell below the NCQA QC average.

Table 2-144—Select Health CC HEDIS MY 2024 Results

HEDIS Measure	Select Health CC ACO MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	85.62%	77.83%

HEDIS Measure	Select Health CC ACO MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Antidepressant Medication Management		
Effective Acute Phase Treatment	68.32%	64.05%
Appropriate Treatment for Upper Respiratory Infection		
Total	94.58%	88.10%
Breast Cancer Screening		
Breast Cancer Screening	48.92%ᵛ	55.81%
Cervical Cancer Screening		
Cervical Cancer Screening	61.52%	56.91%
Childhood Immunization Status		
Combination 3	61.56%ᵛ	66.18%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	68.62%	58.65%
*Glycemic Status >9.0%**	18.62%	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	65.56%	56.06%
Controlling High Blood Pressure		
Controlling High Blood Pressure	78.03%	66.66%
Immunizations for Adolescents		
Combination 2	36.18%ᵛ	37.84%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	95.20%	84.87%
Postpartum Care	86.46%	80.76%
Use of Imaging Studies for Low Back Pain		
Total	68.73%ᵛ	70.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI percentile—Total	91.09%	80.87%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	57.81%ᵛ	61.92%
Child and Adolescent Well-Care Visits		
Total	55.68%	55.41%

ᵛ *Indicates the rate fell below the Quality Compass average.*

**For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Select Health CC exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Upper Respiratory Infection*
- *Cervical Cancer Screening*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Eye Exam for Patients With Diabetes*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Child and Adolescent Well-Care Visits—Total*

Opportunities for Improvement

Select Health CC fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*

Childhood Immunization Status—Combination 3

- *Immunizations for Adolescents—Combination 2*

- *Use of Imaging Studies for Low Back Pain*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*

Recommendations

Select Health CC fell below the MY 2024 NCQA Quality Compass average for five of the 17 performance indicators (29.41 percent), indicating some areas of opportunity for improvement. Targeted improvement efforts could be focused on the following:

- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Select Health CC identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Select Health CC implement interventions focused on reducing barriers to care. Select Health CC could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG also recommends that Select Health CC leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. Select Health CC could work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[98]
- Regarding the *Childhood Immunization Status—Combination 3* and *Immunizations for Adolescents—Combination 2* measures, HSAG recommends that Select Health CC provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at each opportunity, including acute illness visits.[99] HSAG also recommends that Select Health CC consider implementing strategies such as holding vaccination clinics at convenient hours for families (e.g., evenings and Saturdays) and ensuring vaccination records are accurate. To increase adolescent immunization rates, HSAG recommends offering tips and techniques to providers on how to reframe conversations utilizing evidence-based recommendations[100] such as discussing the benefits of vaccines for an adolescent's long-term health and wellbeing, and utilizing metaphors to explain how the immune system improves

[98] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.

[99] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

[100] Frameworks Institute. Reframing the Conversation about Child and Adolescent Vaccinations. Available at: https://www.frameworksinstitute.org/app/uploads/2023/01/reframing-the-conversation-about-child-and-adolescent-vaccinations_Jan272023.pdf. Accessed on: Dec 4, 2025.

performance and responds to viruses through vaccinations. Additional strategies to increase immunization rates include, providing resource guides to providers such as the Adolescent Immunization Resource Guide[101] to identify interventions to improve adolescent immunization rates such as working with schools to update vaccine language on high school sports physical forms. The American Academy of Pediatrics has immunization discussion guides for providers to guide them when encouraging immunization completion with patients.[102] Additional interventions could include offering incentives or engaging partners, such as school-based health clinics or pharmacies.

- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends educating providers on unnecessary radiation exposure in the absence of red flags that identify patients with serious underlying conditions and educating patients through shared decision-making when considering nonpharmacologic alternatives such as cognitive behavioral therapy or exercise programs, or pharmacologic alternatives. [103,104]
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Select Health CC identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states such as South Dakota and California.[105] HSAG also recommends that Select Health CC identify other barriers to care and conduct a focus group to identify interventions to address barriers. Addressing SDOH with interventions such as extended hours, weekend hours, back-to-back sibling well-child visits, and transportation could increase attendance to well-child visits.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Select Health CC fell below the MY 2023 NCQA Quality Compass average for three of the 17 performance indicators (17.65 percent), indicating a few areas of opportunity for improvement. Targeted improvement efforts could be focused on the following:

[101] Association of Immunization Managers. Adolescent Immunization Resource Guide. Available at: https://www.immunizationmanagers.org/content/uploads/2022/03/Adolescent-Resource-Guide_033022.pdf. Accessed on: Dec 4, 2025.
[102] American Academy of Pediatrics. Communication Aids. Available at: https://www.aap.org/en/patient-care/immunizations/communication-aids/. Accessed on: Dec 4, 2025.
[103] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.
[104] American Family Physician. Management of Low Back Pain: Guidelines From the VA/DoD. Available at: https://www.aafp.org/pubs/afp/issues/2023/0400/practice-guidelines-low-back-pain.pdf. Accessed on: Dec 4, 2025.
[105] Centers for Medicare & Medicaid Services. CMS Affinity Group State Spotlights: Improving Infant Well-Child Visits, 0-15 months. https://www.medicaid.gov/medicaid/quality-of-care/downloads/iwc-statespotlights-slides.pdf. Access on: Dec 8, 2025

- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Select Health CC identify disparities or SDOH within its populations that contribute to low breast cancer screening rates. Upon identification of any disparities, HSAG recommends that Select Health CC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Select Health CC provide scheduled reminders and messages directly from providers, and utilize personalized outreach for overdue patients. Communication and messages should be clear and concise, and include information on the procedure time.
- Regarding the *Immunizations for Adolescents—Combination 2* measure, HSAG recommends that Select Health CC implement strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays), developing reports based on vaccinations due and disseminating the reports to providers, administering all recommended vaccinations at every visit, and ensuring vaccination records are accurate. Reminder/recall systems can be effective for members/families and providers.[106,107]
- Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Select Health CC and providers develop partnerships with community stakeholders such as schools.[108] HSAG also recommends that Select Health CC conduct provider education about encouraging preventive care when members are seen for acute illness, sports physicals, and other reasons. HSAG further recommends that Select Health CC promote well-care visits on social media, through emails, or personalized outreach. Partnering with school-based health clinics, faith-based organizations, community agencies, and after-school programs may improve well-care visit rates.[109] Finally, HSAG recommends evaluating the effectiveness of incentives with DHHS to increase timely visits.

Health Plan Interventions

Select Health CC reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

[106] Das JK, Salam RA, Arshad A, et al. Systematic review and meta-analysis of interventions to improve access and coverage of adolescent immunizations. *Journal of Adolescent Health*. 2016 Oct;59(4S):S40–S48.

[107] American Academy of Pediatrics. Immunization News and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: https://publications.aap.org/redbook/resources/23648/Immunization-Strategies-and-Resources. Accessed on: Dec 4, 2025.

[108] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

[109] Partnership Health Plan of California. 2025 Best Practices Child and Adolescent Well-Care Visits. Available at: https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%20IMO%20Webinars%20Current/Best%20Practices%20Child%20Adolescent%20Well%20Care%20Visits.pdf. Accessed on: Dec 4, 2025.

- Regarding the *Breast Cancer Screening* measure, Select Health CC reported that the eligible population has seen fluctuation with both increases and decreases which made it difficult to close gaps. Select Health CC conducted targeted outreach including live calls to members to schedule their mammogram, and distributed emails and mailings.
- Regarding the *Immunizations for Adolescents—Combination 2* measure, Select Health CC reported that members were offered an incentive. Select Health CC distributed social media messages from the ACO Plans' Medical Directors and conducted yearly provider education.
- Regarding the *Child and Adolescent Well-Care Visits* measure, Select Health CC's Quality Provider Program (QPP) continued to work with providers in closing wellness visit gaps. Providers received a quarterly bonus for gaps closed and performed better than those providers not in QPP. Additional outreach included "Keep Your Child Healthy-Toddler to Teen" mailings and Interactive Voice Response (IVR) calls.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG encourages Select Health CC to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Medicaid MCOs Providing Physical Health, Mental Health, and SUD Services

Health Choice Utah (Health Choice UMIC)

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Health Choice UMIC's HEDIS compliance auditor found Health Choice UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Health Choice UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Health Choice UMIC's HEDIS MY 2024 FAR and determined no notable findings. Health Choice UMIC obtained a *Reportable* designation for all measures.

Performance Measure Outcomes

Table 2-145 shows Health Choice UMIC's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using ˅ to indicate performance that fell below the NCQA QC average.

Table 2-145—Health Choice UMIC HEDIS MY 2024 Results

HEDIS Measure	Health Choice UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	65.86%˅	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	75.20%	64.05%
Breast Cancer Screening		
Breast Cancer Screening	42.26%˅	55.81%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	78.72%
Cervical Cancer Screening		
Cervical Cancer Screening	41.12%˅	56.91%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	58.49%˅	58.65%
*Glycemic Status >9.0%**	33.42%˅	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	47.44%˅	56.06%

HEDIS Measure	Health Choice UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Controlling High Blood Pressure		
Controlling High Blood Pressure	71.11%	66.66%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.69%ᵛ	82.45%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	73.25%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	32.18%ᵛ	42.57%
30-Day Follow-Up—Total	45.98%ᵛ	57.90%
Follow-Up After Emergency Department Visit for Substance Use		
7-Day Follow-Up—Total	29.11%	26.94%
30-Day Follow-Up—Total	40.38%	38.95%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	30.94%ᵛ	40.70%
30-Day Follow-Up—Total	49.72%ᵛ	61.25%
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment—Total—Total	50.35%	46.09%
Engagement of SUD Treatment—Total—Total	16.55%	15.97%
Use of Imaging Studies for Low Back Pain		
Total	68.09%ᵛ	70.71%

ᵛ *Indicates the rate fell below the Quality Compass average.*
NA indicates that the rate was not presented because the denominator was less than 30.
** For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Health Choice UMIC exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Controlling High Blood Pressure*

- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up*

Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment

Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment

Opportunities for Improvement

Health Choice UMIC fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Eye Exam for Patients With Diabetes*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Health Choice UMIC fell below the MY 2024 NCQA Quality Compass average for 12 of the 20 performance indicators (60.00 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, HSAG recommends that Health Choice UMIC consider a first-visit incentive to members who see a doctor for the first time. HSAG also recommends that Health Choice UMIC consider offering to schedule the appointment and address barriers as needed (e.g., transportation, SDOH). In addition, HSAG recommends that Health Choice UMIC ensure provider availability is within required time frames and consider expanding appointment hours to increase access to care. HSAG suggests placing reminder calls to decrease no-show rates.
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Health Choice UMIC identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Health Choice UMIC implement interventions focused on reducing barriers to care. Health Choice UMIC could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Health Choice UMIC leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. Health Choice UMIC could work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[110]
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Health Choice UMIC consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[111] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Health Choice UMIC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is a lack of knowledge. Manual or electronic reminders for providers that members are due for cancer screenings, giving feedback on individual physician or clinic screening rates, flexible hours, transportation assistance, and patient reminders such as patient portal messages or text messages may increase screenings.[112,113]

[110] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.
[111] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.
[112] U.S. Centers for Disease Control. Provider Reminders. Available at: https://www.cdc.gov/cancer/php/interventions/provider-reminders.html. Accessed on: Dec 4, 2025.
[113] National Indian Health Board. Evidence-Based Interventions to Increase Cancer Screening: Provider Reminders. Available at: https://nihbcancerscreening.nptoolkit.org/wp-content/uploads/sites/41/2019/09/NIHB-Toolkit-CDC-Screen-Out-Cancer-Guides-pp-44-51-1.pdf. Accessed on: Dec 4, 2025.

- Regarding the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%* measure indicators, HSAG recommends that Health Choice UMIC assess how continuous glucose monitoring systems may improve diabetes control. HSAG recommends engaging members in telehealth to manage diabetes care.[114] HSAG also recommends that Health Choice UMIC promote The Diabetic Program with care management for patients to learn about managing their blood sugar.[115] Additionally, addressing significant mental health diagnoses through psychosocial screening protocols and referrals may address symptoms that are affecting members' ability to carry out diabetes self-management activities.[116] HSAG recommends analyzing data for members with uncontrolled diabetes to identify cultural dietary patterns that may influence nutritional choices. Health Choice UMIC could consider providing motivational interviewing classes for providers to support positive health behaviors.
- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Health Choice UMIC conduct a disparity analysis to determine how disparities may influence various factors contributing to barriers to care. HSAG also recommends that Health Choice UMIC consider additional member outreach and education on the importance of timely scheduling of annual eye exams. To promote eye exams for members with diabetes, Health Choice UMIC could consider alternative methods for conducting eye exams such as offering diabetic retinopathy screenings within the PCP's office and partnering with servicing entities that offer in-home diabetic retinopathy screenings, which provide convenient access to diagnostic testing and treatment for eye diseases.[117] Health Choice UMIC could also consider evaluating member incentives with DHHS to complete diabetes screenings. Additionally, HSAG recommends enhancing provider education on navigating patient refusals to schedule eye exams.
- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that Health Choice UMIC evaluate barriers to screening, such as barriers coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG also recommends that Health Choice UMIC communicate with providers about building automatic screening alerts into EHR if screening tests are necessary. HSAG further recommends ensuring that members see a PCP, as people with at least one primary care

[114] Health Resources and Services Administration. Engaging Patients in Telehealth for Diabetes Care. Available at: https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-diabetes-care/engaging-patients-telehealth-diabetes. Accessed on: Dec 4, 2025.
[115] Health Choice Utah. Medical Management. Available at: https://healthchoiceutah.com/providers/medical-management. Accessed on: Dec 4, 2025.
[116] American Diabetes Association. Standards of Care in Diabetes—2025 Abridged for Primary Care. Available at: https://diabetesjournals.org/clinical/article/43/2/182/157719/Standards-of-Care-in-Diabetes-2025-Abridged-for?searchresult=1. Accessed on: Dec 4, 2025.
[117] Retina Labs. In-Home Preventative Care and Diagnostic Services. Available at: https://www.retina-labs.com/in-home-preventive-screening. Accessed on: Dec 9, 2025.

visit are more likely to be screened.[118] HSAG recommends outreach to members for missed or cancelled appointments to assist them with rescheduling appointments for testing.

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measures, HSAG recommends the following interventions, which could improve follow-up care rates after hospitalizations or ED visits for patients with mental illness: collaborative discharge planning, educating member and family about the importance of follow-up care, scheduling the follow-up appointments before the member is discharged, assigning a care manager, and engaging family members in the discharge planning process. Offering support groups, utilizing telehealth, and providing a supply of medications until members' first appointment could improve follow-up rates. [119]
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measures, HSAG recommends addressing SDOH that are creating barriers to follow-up care. Health Choice UMIC could identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs. HSAG recommends that engaging the member's support system in follow-up care and medical adherence be part of comprehensive member education. HSAG encourages the scheduling of a follow-up appointment prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends educating providers on unnecessary radiation exposure in the absence of red flags that identify patients with serious underlying conditions and in educating patients through shared decision-making when considering nonpharmacologic alternatives such as cognitive behavioral therapy or exercise programs, or pharmacologic alternatives. [120,121]

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Health Choice UMIC fell below the MY 2023 NCQA Quality Compass average for 11 of the 19 performance indicators (57.89 percent), an improvement from the previous year, but still indicating

[118] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.

[119] National Library of Medicine. Ensuring Continuity of Care: Effective Strategies for the Post-hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10863747/. Accessed on: Dec 4, 2025.

[120] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[121] American Family Physician. Management of Low Back Pain: Guidelines From the VA/DoD. Available at: https://www.aafp.org/pubs/afp/issues/2023/0400/practice-guidelines-low-back-pain.pdf. Accessed on: Dec 4, 2025.

significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measures, HSAG recommends that Health Choice UMIC consider effective interventions to reduce repeat ED visits for members with mental illness, such as the High Alert Program (HAP), the Patient-Centered Medical Home (PCMH), the Primary Behavioral Health Care Integration (PBHCI), and the Collaborative Care (CC) Program.[122]
- Regarding the *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up—Total* measures, HSAG recommends that Health Choice UMIC utilize provider insight to address patient needs and barriers. Health Choice could conduct a focus group with practitioners to gain insight into the current practices of and obstacles to providing follow-up care to patients after an ED visit for substance use. The focus group could also be used to educate providers on the effectiveness of timely follow-up visits on patient outcomes, and could be an opportunity to educate providers on best practices.
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measures, HSAG recommends that Health Choice UMIC consider effective interventions to reduce repeat hospitalizations for members with mental illness, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT), case management, and focusing on co-occurring substance abuse disorders.[123]
- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that Health Choice UMIC evaluate barriers to screening, such as barriers coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG also recommends that Health Choice UMIC communicate with providers about building automatic screening alerts into electronic health records (EHR) if screening tests are necessary. HSAG further recommends ensuring that members see a PCP, as people with at least one primary care visit are more likely to be screened.[124]
- Regarding the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, HSAG recommends that Health Choice UMIC conduct provider education regarding special considerations for diabetes treatment when members have schizophrenia, including referring patients to structured programs for weight management, performing screenings regularly, and arranging

[122] Mao W, Shalaby R, Agyapong VIO. Interventions to reduce repeat presentations to hospital emergency departments for mental health concerns: A scoping review of the literature. *Healthcare*. 2023 Apr 18;11(8):1161.

[123] Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophrenia Bulletin*. 2009 Jul;35(4):696–703.

[124] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.

frequent follow-up for treatment adherence.[125] HSAG also recommends that Health Choice UMIC provide simplified recommendations to members, as cognitive impairment (if present) can hinder comprehension.

- Regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, HSAG recommends that Health Choice UMIC consider a first-visit incentive to members who see a doctor for the first time. HSAG also recommends that Health Choice UMIC consider offering to schedule the appointment and address barriers as needed (e.g., transportation, SDOH). In addition, HSAG recommends that Health Choice UMIC ensure provider availability is within required time frames and consider increasing appointment hours.
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that Health Choice UMIC ensure providers are aware of best practices regarding imaging studies for low back pain, such as avoiding diagnostic imaging in the first four weeks of new-onset back pain unless red flags or other conditions are present and encouraging the management of back pain through regular physical activity, healthy back exercises, and education on injury prevention.[126]
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Health Choice UMIC identify disparities or SDOH within its populations that contribute to low breast cancer screening rates. Upon identification of a root cause, HSAG recommends that Health Choice UMIC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Health Choice UMIC provide scheduled reminders and messages directly from providers, and utilize personalized outreach for overdue patients. Communication and messages should be clear and concise, and include information on the procedure time.
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Health Choice UMIC consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[127] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Health Choice UMIC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Health Choice UMIC identify trends within the data. HSAG also recommends that Health Choice UMIC provide member education to ensure diabetic members are given guidance to schedule annual eye

[125] Annamalai A, Tek C. An overview of diabetes management in schizophrenia patients: office based strategies for primary care practitioners and endocrinologists. *International Journal of Endocrinology.* 2015:969182.

[126] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[127] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

exams. HSAG further recommends reviewing a study conducted at Johns Hopkins outlining the possibility of closing care gaps with AI to assist in scheduling eye exams.[128]

- Regarding the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicators, HSAG recommends that Health Choice UMIC consider providing coverage for personal CGMs for type 1 and type 2 diabetes. Offering coverage for CGMs coupled with educating providers and members on this coverage might improve diabetes control. HSAG also recommends that Health Choice UMIC identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.

Health Choice UMIC reported the following improvement efforts in response to HSAG's MY 2023 recommendations:[129]

- Regarding the *Childhood Immunization Status—Combination 3* and *Well-Child Visits in the First 30 Months of Life* measures, Health Choice UMIC reported that through its Provider Engagement program, proactive scheduling and outreach for well-child visits and immunizations was implemented. Gap reports were distributed to providers, highlighting members who were due for services. Members and providers were supplied with fridge magnets with the well-child schedule, and immunization cards, which were also included in new member and Well Baby Packets for members 0–28 months of age that contained educational resources on milestones, car seat safety, and finding pediatric care. Health Choice UMIC reported participating in the ACO Immunizations Collaborative with other Utah ACOs to address barriers and share strategies. Health Choice UMIC's Chief Medical Officer and Marketing Team produced social media videos to promote immunizations.
- Regarding *Immunizations for Adolescents—Combination 2* measure, Health Choice UMIC educated providers on discussing adolescent vaccinations and offered a targeted monetary incentive for the HPV vaccination. Health Choice UMIC also ensured that provider directories highlighted PCPs who offered extended hours. Health Choice UMIC collaborated with the ACO Immunizations Collaborative and promoted immunizations through social media campaigns led by health plan executives.
- Regarding the *Child and Adolescent Well-Care Visits* measure, Health Choice UMIC launched its second annual large-scale outreach campaign through the Customer Services Team, contacting over 28,000 members and successfully reaching more than 11,000. Health Choice UMIC also implemented provider engagement activities, including gap reporting and education.

[128] Johns Hopkins Medicine. Study Finds AI–Driven Eye Exams Increase Screening Rates for Youth with Diabetes. Available at: https://www.hopkinsmedicine.org/news/newsroom/news-releases/2024/01/study-finds-ai-driven-eye-exams-increase-screening-rates-for-youth-with-diabetes. Accessed on: Dec 4, 2025.

[129] Please note that the health plan improvement efforts included in this section were provided by the health plans, and HSAG has not altered this content other than minor formatting.

- Regarding the *Use of Imaging Studies for Low Back Pain* measure, Health Choice UMIC's Provider Engagement program reinforced best practices during office visits by emphasizing the avoidance of unnecessary imaging and promoting alternative initial therapies. The Health Choice UMIC Quality Improvement Advisory Council updated clinical practice guidelines related to low back pain which will be posted on the Health Choice UMIC website for providers to access.
- Regarding the *Breast Cancer Screening* measure, Health Choice UMIC implemented a multi-pronged approach to improve breast cancer screening rates. In 2023, Health Choice UMIC launched an Interactive Voice Response (IVR) campaign that educated members on the importance of timely screenings and offered warm transfers to imaging centers for immediate scheduling. Additionally, Health Choice UMIC added imaging centers, including southern Utah, to improve accessibility for rural members. Health Choice UMIC reported actively planning a multi-channel strategy that incorporated short message service (SMS/text) reminders to complement IVR outreach, ensuring members received timely prompts through their preferred communication method. Health Choice UMIC sent incentive announcements to members who had not yet completed their screenings, providing education on the benefits of early detection and offering a monetary incentive for completing the screening by year-end. Health Choice UMIC reported aiming to reduce barriers, increase convenience, and motivate members to prioritize preventive care.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG also recognizes Health Choice UMIC's work with the ACO Immunizations Collaborative. HSAG encourages Health Choice UMIC to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Healthy Outcomes Medical Excellence (HOME)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in HOME's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-146 presents HOME's MY 2024 performance measure results.

Table 2-146—HOME MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	HOME Rate*
Follow-Up Within 7 Days	40.54%
Follow-Up Within 30 Days	83.78%

**Rates with a small denominator are likely to be subject to large variations in performance, and interpretations should be made with caution.*

Strengths, Opportunities, and Recommendations

Strengths

HSAG identified the following strengths for HOME:

- HOME developed a clinical environment that provided a variety of services in one location, including primary care, psychiatric care, therapy, behavioral supports, in-home family therapy, early intervention, psychological testing, case management, dietary services, crisis management, billing support, speech therapy, and occupational therapy. HOME's clinic setup allowed members to receive a variety of care in one location with an integrated care team.
- HOME implemented an on-site dental clinic in partnership with the University of Utah's dental school. HOME now offers dental services to its members who might otherwise not have access to dental care.

Opportunities for Improvement

HSAG identified the following opportunities for improvement for HOME:

- HOME leveraged a manual process for data collection and performance rate reporting using a Microsoft Excel-based workbook.

Recommendations

Although HOME had robust validation processes in place, HSAG recommends that HOME evaluate whether Epic programmers can create a workbench report within Epic that will automatically extract admission and discharge data. Automating manual processes helps to prevent potential occurrences of human error.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

For MY 2023, HSAG offered the following recommendation for HOME:

- HSAG recommended that HOME involve a second staff member in the validation of data entered into the HSAG Numerator Positive Case Listing file and Rate Reporting Template against the measure specifications to ensure an additional level of validation to prevent human error.

Health Plan Interventions

HOME reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Before the results were analyzed and compiled for rate reporting to HSAG, the data were cross-checked and verified by a member of the utilization team to check the accuracy and validity of reported results.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. Secondary validation of manually produced data sets will ensure that all measure performance is reported completely and accurately. HSAG encourages HOME to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Healthy U Integrated

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Healthy U Integrated's HEDIS compliance auditor found Healthy U Integrated's IS and processes to be in compliance with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Healthy U Integrated contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Healthy U Integrated's HEDIS MY 2024 FAR and determined no notable findings and all measures obtained a *Reportable* designation.

Performance Measure Outcomes

Table 2-147 shows Healthy U Integrated's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using ˅ to indicate performance that fell below the NCQA QC average.

Table 2-147—Healthy U Integrated HEDIS MY 2024 Results

HEDIS Measure	Healthy U Integrated UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	71.22%˅	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	72.92%	64.05%
Breast Cancer Screening		
Breast Cancer Screening	44.66%˅	55.81%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	78.72%
Cervical Cancer Screening		
Cervical Cancer Screening	45.01%˅	56.91%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	67.40%	58.65%
*Glycemic Status >9.0%**	24.33%	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	48.66%˅	56.06%

HEDIS Measure	Healthy U Integrated UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Controlling High Blood Pressure		
Controlling High Blood Pressure	73.73%	66.66%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.79%ᵛ	82.45%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	73.25%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	33.00%ᵛ	42.57%
30-Day Follow-Up—Total	47.00%ᵛ	57.90%
Follow-Up After Emergency Department Visit for Substance Use		
7-Day Follow-Up—Total	31.10%	26.94%
30-Day Follow-Up—Total	40.55%	38.95%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	38.69%ᵛ	40.70%
30-Day Follow-Up—Total	60.30%ᵛ	61.25%
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment—Total—Total	48.51%	46.09%
Engagement of SUD Treatment—Total—Total	18.49%	15.97%
Use of Imaging Studies for Low Back Pain		
Total	70.00%ᵛ	70.71%

ᵛ *Indicates the rate fell below the Quality Compass average.*

NA indicates that the rate was not presented because the denominator was less than 30.

**For this indicator, a lower rate indicates better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Healthy U Integrated exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*

- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Controlling High Blood Pressure*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up*

Follow-Up After ED Visit for Substance Use—30-Day Follow-Up

Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment

Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment

Opportunities for Improvement

Healthy U Integrated fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Eye Exam for Patients With Diabetes*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*

Use of Imaging Studies for Low Back Pain

Recommendations

Healthy U Integrated fell below the MY 2024 NCQA Quality Compass average for 10 of the 20 performance indicators (50.00 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, HSAG recommends that Healthy U Integrated consider a first-visit incentive to members who see a doctor for the first time. HSAG recommends that Healthy U Integrated consider offering to schedule the appointment and address barriers as needed (e.g., transportation, SDOH). In addition, HSAG recommends that Healthy U Integrated ensure provider availability is within required time frames and consider increasing appointment hours. HSAG suggests strengthening relationships between BH and physical health providers to improve communication of findings.
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Healthy U Integrated identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Healthy U Integrated implement interventions focused on reducing barriers to care. Healthy U Integrated could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Healthy U Integrated leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. Healthy U Integrated plans to work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[130]
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Healthy U Integrated consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[131] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Healthy U Integrated provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is a lack of knowledge. Manual or electronic reminders for providers that members are due for cancer screenings, giving feedback on individual or clinic screening rates, flexible hours, transportation assistance, and patient reminders such as patient portal messages or text messages increase screenings.[132,133]

[130] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.

[131] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[132] U.S. Centers for Disease Control. Provider Reminders. Available at: https://www.cdc.gov/cancer/php/interventions/provider-reminders.html. Accessed on: Dec 4, 2025.

[133] National Indian Health Board. Evidence-Based Interventions to Increase Cancer Screening: Provider Reminders. Available at: https://nihbcancerscreening.nptoolkit.org/wp-content/uploads/sites/41/2019/09/NIHB-Toolkit-CDC-Screen-Out-Cancer-Guides-pp-44-51-1.pdf. Accessed on: Dec 4, 2025.

- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Healthy U Integrated conduct a disparity analysis to determine how disparities may influence various factors contributing to barriers to care. HSAG also recommends that Healthy U Integrated consider additional member outreach and education on the importance of timely scheduling of annual eye exams. To promote eye exams for members with diabetes, Healthy U Integrated could consider alternative methods for conducting eye exams such as offering diabetic retinopathy screenings within the PCP's office and partnering with servicing entities that offer in-home diabetic retinopathy screenings, which provide convenient access to diagnostic testing and treatment for eye diseases.[134] Healthy U Integrated could also consider evaluating member incentives with DHHS to complete diabetes screenings. Additionally, HSAG recommends enhancing provider education on navigating patient refusals to schedule eye exams.
- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that Healthy U Integrated evaluate barriers to screening, such as barriers coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG also recommends that Healthy U Integrated build automatic screening alerts into EHR if screening tests are necessary. HSAG further recommends ensuring that providers encourage members to see a PCP, as people with at least one primary care visit are more likely to be screened.[135] HSAG also recommends outreach to patients for missed or cancelled appointments to assist them with rescheduling appointments for testing.
- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends the following interventions, which could improve follow-up care rates after hospitalizations or ED visits for patients with mental illness: collaborative discharge planning, educating member and family about the importance of follow-up care, scheduling the follow-up appointments before the member is discharged, assigning a care manager, and engaging family members in the discharge planning process. Offering support groups, utilizing telehealth, and providing a supply of medications until members' first appointment could improve follow-up rates[136].
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends addressing SDOH that are creating barriers to follow-up care could improve the follow-up rates. Healthy U Integrated could identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex

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[135] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.
[136] National Library of Medicine. Ensuring Continuity of Care: Effective Strategies for the Post-hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10863747/. Accessed on: Dec 4, 2025.

needs. HSAG recommends that engaging the member's support system in follow-up care and medical adherence be part of comprehensive member education.[137] HSAG encourages the scheduling of a follow-up appointment prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.

- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends educating providers on unnecessary radiation exposure in the absence of red flags that identify patients with serious underlying conditions and educating patients through shared decision-making when considering nonpharmacologic alternatives such as cognitive behavioral therapy or exercise programs, or pharmacologic alternatives.[138,139]

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Healthy U Integrated fell below the MY 2023 NCQA Quality Compass average for 11 of the 19 performance indicators (57.89 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends that Healthy U Integrated consider effective interventions to reduce repeat ED visits for members with mental illness, such as HAP, PCMH, PBHCI, and the CC Program.[140]
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[137] National Library of Medicine. Ensuring Continuity of Care: Effective Strategies for the Post-hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10863747/. Accessed on: Dec 4, 2025.

[138] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[139] American Family Physician. Management of Low Back Pain: Guidelines From the VA/DoD. Available at: https://www.aafp.org/pubs/afp/issues/2023/0400/practice-guidelines-low-back-pain.pdf. Accessed on: Dec 4, 2025.

[140] Mao W, Shalaby R, Agyapong VIO. Interventions to reduce repeat presentations to hospital emergency departments for mental health concerns: A scoping review of the literature. *Healthcare*. 2023 Apr 18;11(8):1161.

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[142] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.

[143] Annamalai A, Tek C. An overview of diabetes management in schizophrenia patients: office based strategies for primary care practitioners and endocrinologists. *International Journal of Endocrinology.* 2015:969182.

[144] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

have been shown to improve Cervical Cancer Screening.[145] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends Healthy U Integrated provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Healthy U Integrated identify trends within the data. HSAG also recommends that Healthy U Integrated provide member education to ensure diabetic members are given guidance to schedule annual eye exams. HSAG further recommends reviewing a study conducted at Johns Hopkins outlining the possibility of closing care gaps with AI to assist in scheduling eye exams.[146]
- Regarding the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measures, HSAG recommends that Healthy U Integrated consider providing coverage for personal CGMs for type 1 and type 2 diabetes. Offering coverage for CGMs coupled with educating providers and members on this coverage might improve diabetes control. HSAG also recommends that Healthy U Integrated identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.
- Regarding the *Antidepressant Medication Management—Effective Acute Phase Treatment* measure, HSAG recommends that Healthy U Integrated consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to members and their families.[147]

Health Plan Interventions

Healthy U Integrated reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Regarding the *Immunizations for Adolescents—Combination 2* measure, Healthy U worked with systems analysts to create a separate health plan immunization feed with the Utah Statewide Immunization Information System (USIIS) to ensure all immunizations for members were captured. Healthy U's provider directory highlights PCPs with extended hours. Healthy U Integrated also participated in the ACO Immunizations Collaborative and promoted immunizations through social media campaigns.

[145] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[146] Johns Hopkins Medicine. Study Finds AI–Driven Eye Exams Increase Screening Rates for Youth with Diabetes. Available at: https://www.hopkinsmedicine.org/news/newsroom/news-releases/2024/01/study-finds-ai-driven-eye-exams-increase-screening-rates-for-youth-with-diabetes. Accessed on: Dec 4, 2025.

[147] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

- Regarding the *Cervical Cancer Screening* measure, Healthy U's new Provider Engagement program emphasized education and gap reporting for this measure. Healthy U also included Cervical Cancer Screening reminders in member newsletters to provide educational materials about the importance of screening.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, Healthy U Integrated launched a Provider Engagement program which offered education, gap reports, and office visits to improve quality performance. Providers were encouraged to schedule well-child visits and immunizations together and supplied with educational materials, including fridge magnets with the well-child visit scheduled appointment date as well as an immunization schedule in the Well Baby Packets distributed to parents. Member outreach calls were conducted for reminders. Healthy U also participates in the ACO Immunizations Collaborative, where health plans share strategies to overcome barriers. Healthy U's leadership team collaborated with marketing to produce social media videos which promoted immunizations.
- Regarding the *Child and Adolescent Well-Care Visits* measure, on August 1, 2025, Healthy U Integrated launched a large-scale member outreach campaign conducted by the Customer Services team for a second year. Provider engagement activities included gap reporting and education, which reinforce efforts to improve measure performance.
- Regarding the *Prenatal and Postpartum Care—Postpartum Care* measure, Healthy U Integrated sent prenatal and postpartum emails to pregnant members which provided educational resources and timely reminders to support their maternal care journey. Gap reports were utilized to identify members due for postpartum visits. Healthy U Integrated encouraged scheduling postpartum visits during prenatal care to ensure timely follow-up.
- Regarding the *Breast Cancer Screening* measure, Healthy U implemented a multi-pronged approach to improve breast cancer screening rates. In 2023, Healthy U launched an Interactive Voice Response (IVR) campaign that educated members on the importance of timely screenings and offered warm transfers to imaging centers for immediate scheduling. Healthy U expanded initiative in 2025 includes additional imaging centers, extending services to southern Utah which improved accessibility for rural members. Healthy U reported planning a multi-channel strategy that incorporates phone text SMS reminders to complement IVR outreach, ensuring members receive timely prompts through their preferred communication method.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG also recognizes Healthy U Integrated's work with the ACO Immunizations Collaborative. HSAG encourages Healthy U Integrated to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Molina (Molina UMIC)

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Molina UMIC's HEDIS compliance auditor found Molina UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Molina UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Molina UMIC's HEDIS MY 2024 FAR and determined no notable findings and all measures obtained a *Reportable* designation.

Performance Measure Outcomes

Table 2-148 shows Molina UMIC's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using ˅ to indicate performance that fell below the NCQA QC average.

Table 2-148—Molina UMIC HEDIS MY 2024 Results

HEDIS Measure	Molina UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	70.18%˅	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	75.22%	64.05%
Breast Cancer Screening		
Breast Cancer Screening	37.07%˅	55.81%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	78.72%
Cervical Cancer Screening		
Cervical Cancer Screening	39.17%˅	56.91%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	50.36%˅	58.65%
*Glycemic Status >9.0%**	39.42%˅	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	56.20%	56.06%
Controlling High Blood Pressure		
Controlling High Blood Pressure	51.34%˅	66.66%

HEDIS Measure	Molina UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.93%ᵛ	82.45%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	73.25%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	38.18%ᵛ	42.57%
30-Day Follow-Up—Total	49.09%ᵛ	57.90%
Follow-Up After Emergency Department Visit for Substance Use		
7-Day Follow-Up—Total	32.40%	26.94%
30-Day Follow-Up—Total	45.20%	38.95%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	36.02%ᵛ	40.70%
30-Day Follow-Up—Total	55.08%ᵛ	61.25%
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment—Total—Total	43.86%ᵛ	46.09%
Engagement of SUD Treatment—Total—Total	17.70%	15.97%
Use of Imaging Studies for Low Back Pain		
Total	66.06%ᵛ	70.71%

ᵛ *Indicates the rate fell below the Quality Compass average.*
NA indicates that the rate was not presented because the denominator was less than 30.
**For this indicator, lower rates indicate better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Molina UMIC exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Eye Exam for Patients With Diabetes*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up*

- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up*

Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment

Opportunities for Improvement

Molina UMIC fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Controlling High Blood Pressure*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up

Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up

Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up

- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Molina UMIC fell below the MY 2024 NCQA Quality Compass average for 13 of the 20 performance indicators reported (65.00 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, HSAG recommends that Molina UMIC consider a first-visit incentive to members who see a doctor for the first time. HSAG recommends that Molina UMIC consider offering to schedule the appointment and address barriers as needed (e.g., transportation, SDOH). In addition, HSAG recommends that Molina UMIC provide scheduled reminders utilizing personalized outreach for members who are overdue for their screenings. HSAG suggests strengthening relationships between BH and physical health providers to improve communication of findings.
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Molina UMIC identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Molina UMIC implement interventions focused on reducing barriers to care. Molina UMIC could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Molina UMIC leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. Molina UMIC could work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[148]
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Molina UMIC consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[149] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Molina UMIC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is a lack of knowledge. Manual or electronic reminders for providers that members are due for cancer screenings, giving feedback on individual or clinic screening rates, flexible hours, transportation assistance, and patient reminders such as patient portal messages or text messages may increase screenings.[150,151]
- Regarding the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%* measure indicators, HSAG recommends engaging patients in telehealth to manage diabetes care. HSAG

[148] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.
[149] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.
[150] U.S. Centers for Disease Control. Provider Reminders. Available at: https://www.cdc.gov/cancer/php/interventions/provider-reminders.html. Accessed on: Dec 4, 2025.
[151] National Indian Health Board. Evidence-Based Interventions to Increase Cancer Screening: Provider Reminders. Available at: https://nihbcancerscreening.nptoolkit.org/wp-content/uploads/sites/41/2019/09/NIHB-Toolkit-CDC-Screen-Out-Cancer-Guides-pp-44-51-1.pdf. Accessed on: Dec 4, 2025.

recommends that Molina UMIC promote the Diabetic Program with care management for patients to learn about managing their blood sugar. Additionally, addressing significant mental health diagnoses through psychosocial screening protocols and referrals may address symptoms that are affecting members' ability to carry out diabetes self-management activities. HSAG recommends analyzing data for members with uncontrolled diabetes to identify cultural dietary patterns that may influence nutritional choices. Molina UMIC could consider providing motivational interviewing classes for providers to support positive health behaviors.

- Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that Molina UMIC identify any disparities in gender, ages, or race and ethnicity within the data. HSAG also recommends that Molina UMIC reduce or eliminate costs of treatments like antihypertensive medications if applicable, especially in ways that encourage medication adherence, such as longer-duration prescriptions.[152] HSAG further recommends encouraging the use of automated home blood pressure monitors for patients and educate members how to take blood pressure with tools such as the AMA 7-step SMBP quick guide[153] or home blood pressure monitoring.[154] HSAG recommends the use of telehealth for patients with high blood pressure. Molina UMIC could consider educating patients on nonpharmacological lifestyle changes such as the DASH diet, reduction of alcohol, low-sodium/high-potassium salt interventions, exercise, weight reduction, stress reduction strategies, and eliminating smoking and how these influence blood pressure.[155] HSAG recommends providing education for staff members in provider offices on how to measure blood pressure accurately.[156]
- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that Molina UMIC evaluate barriers to screening, such as barriers coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG also recommends that Molina UMIC build automatic screening alerts into EHR if screening tests are necessary. HSAG further recommends ensuring that providers encourage members to see a PCP, as people with at least one primary care visit were more likely to be screened.[157]

[152] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 4, 2025.
[153] American Medical Association. 7-step SMBP Quick Guide. Available at: https://map.ama-assn.org/sites/default/files/2024-05/7%20Steps%20SMBP%20Quick%20Guide.pdf?. Accessed on: Dec 4, 2025.
[154] American Heart Association/American College of Cardiology. SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Available at: https://www.ahajournals.org/doi/10.1161/HYP.0000000000000249#sec-7-1-3. Accessed on: Dec 4, 2025.
[155] U.S. Centers for Disease Control. Managing High Blood Pressure. Available at: https://www.cdc.gov/high-blood-pressure/living-with/index.html. Accessed on: Dec 4, 2025.
[156] American Medical Association. Measure Accurately Best Practices. Available at: https://www.ama-assn.org/system/files/2019-01/measure-accurately-best-practices.pdf. Accessed on: Dec 4, 2025.
[157] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends the following interventions, which could improve follow-up care rates after hospitalizations or ED visits for patients with mental illness: collaborative discharge planning, educating member and family about the importance of follow-up care, scheduling the follow-up appointments before the member is discharged, assigning a care manager, and engaging family members in the discharge planning process. Offering support groups, utilizing telehealth, and providing a supply of medications until members' first appointment could improve follow-up rates.[158]
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends identifying and addressing disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs. HSAG recommends that engaging the member's support system in follow-up care and medical adherence be part of comprehensive member education. HSAG encourages the scheduling of a follow-up appointment prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.
- Regarding the *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total* measure, HSAG suggests using the American Society of Addiction Medicine recommendations in initiation, engagement, and retention, such as establishing patient trust and building connections with patients[159]. Molina UMIC could offer motivational interviewing techniques for providers to help members seek treatment[160].
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends educating providers on unnecessary radiation exposure in the absence of red flags that identify patients with serious underlying conditions and educating patients through shared decision-making when considering nonpharmacologic alternatives such as cognitive behavioral therapy or exercise programs, or pharmacologic alternatives. [161,162]

[158] National Library of Medicine. Ensuring Continuity of Care: Effective Strategies for the Post-hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10863747/. Accessed on: Dec 4, 2025.

[159] American Society of Addition Medication. Engagement and Retention of Non-Abstinent Patients in Substance Use Treatment. Available at: https://www.asam.org/quality-care/clinical-recommendations/asam-clinical-considerations-for-engagement-and-retention-of-non-abstinent-patients-in-treatment. Accessed on: Dec 8, 2025.

[160] Centers for Disease Control. Motivation Interviewing to Help Your Patient Seek Treatment. Available at: https://www.cdc.gov/overdose-prevention/media/pdfs/2024/07/Conversation-Starter-Motivational-Interviewing.pdf. Accessed on Dec 8, 2025.

[161] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[162] American Family Physician. Management of Low Back Pain: Guidelines From the VA/DoD. Available at: https://www.aafp.org/pubs/afp/issues/2023/0400/practice-guidelines-low-back-pain.pdf. Accessed on: Dec 4, 2025.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Molina UMIC fell below the MY 2023 NCQA Quality Compass average for 11 of the 19 performance indicators reported (57.89 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends that Molina UMIC consider effective interventions to reduce repeat ED visits for members with mental illness, such as HAP, PCMH, PBHCI, and the CC Program.[163]
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends that Molina UMIC consider effective interventions to reduce repeat hospitalizations for members with mental illness, such as CTI, ACT, case management, and focusing on co-occurring substance abuse disorders.[164]
- Regarding the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, HSAG recommends that Molina UMIC conduct provider education regarding special considerations for diabetes treatment when members have schizophrenia, including referring patients to structured programs for weight management, performing screenings regularly, and arranging frequent follow-up for treatment adherence.[165] HSAG also recommends that Molina UMIC provide simplified recommendations to members, as cognitive impairment (if present) can hinder comprehension.
- Regarding the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total* measure, HSAG recommends that Molina UMIC review member data for any patterns present by ZIP Code and other demographics for case management prioritization. One study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[166]

[163] Mao W, Shalaby R, Agyapong VIO. Interventions to reduce repeat presentations to hospital emergency departments for mental health concerns: A scoping review of the literature. *Healthcare*. 2023 Apr 18;11(8):1161.

[164] Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophrenia Bulletin*. 2009 Jul;35(4):696–703.

[165] Annamalai A, Tek C. An overview of diabetes management in schizophrenia patients: office based strategies for primary care practitioners and endocrinologists. *International Journal of Endocrinology.* 2015:969182.

[166] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

- Regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, HSAG recommends that Molina UMIC consider a first-visit incentive to members who see a doctor for the first time. HSAG recommends that Molina UMIC consider offering to schedule the appointment and address barriers as needed (e.g., transportation, SDOH). In addition, HSAG recommends that Molina UMIC ensure that provider availability is within required time frames and consider increasing appointment hours.
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that Molina UMIC ensure providers are aware of best practices regarding imaging studies for low back pain, such as avoiding diagnostic imaging in the first four weeks of new-onset back pain unless red flags or other conditions are present, and encouraging management of back pain through regular physical activity, healthy back exercises, and education on injury prevention.[167]
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Molina UMIC identify disparities or SDOH within its populations that contribute to low breast cancer screening rates. Upon identification of any disparities, HSAG recommends that Molina UMIC implement appropriate interventions to reduce barriers to care. Further, HSAG recommends that Molina UMIC provide scheduled reminders and messages directly from providers, and utilize personalized outreach for overdue patients. Communication and messages should be clear and concise, and include information on the procedure time.
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Molina UMIC consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[168] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Molina UMIC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
- Regarding the *Eye Exam for Patients With Diabetes* measure, HSAG recommends that Molina UMIC identify trends within the data. HSAG also recommends that Molina UMIC provide member education to ensure diabetic members are given guidance to schedule annual eye exams. HSAG further recommends that Molina UMIC review information in a study conducted at Johns Hopkins outlining the possibility of closing care gaps with AI to assist in scheduling eye exams.[169]
- Regarding the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measure indicators, HSAG recommends that Molina UMIC consider providing coverage for personal CGMs

[167] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[168] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[169] Johns Hopkins Medicine. Study Finds AI–Driven Eye Exams Increase Screening Rates for Youth with Diabetes. Available at: https://www.hopkinsmedicine.org/news/newsroom/news-releases/2024/01/study-finds-ai-driven-eye-exams-increase-screening-rates-for-youth-with-diabetes. Accessed on: Dec 4, 2025.

for type 1 and type 2 diabetes. Offering coverage for CGMs coupled with educating providers and members on this coverage might improve diabetes control. Additionally, HSAG recommends that Molina UMIC identify whether self-monitoring interventions might be effective, such as EpxDiabetes, which has bidirectional text and call capabilities.

- Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that Molina UMIC identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG also recommends that Molina UMIC reduce or eliminate costs of treatments like antihypertensive medications if applicable, especially in ways that encourage medication adherence, such as longer-duration prescriptions.[170] HSAG further recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.

Health Plan Interventions

Molina UMIC reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Regarding the *Cervical Cancer Screening* measure, Molina UMIC launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina also initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina also launched a member incentives program with educational outreach and incentive for service completion.
- Regarding the *Childhood Immunization Status—Combination 3* measure, Molina distributed education to mothers about immunization during the last weeks of pregnancy prior to delivery and distributed text messages timed to coincide with well child visits to remind parents about immunizations due during the visit. Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina reported multichannel communication was initiated to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs.
- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and distributed education about what to expect during well child visits and importance of BMI percentile tracking, which was included in text messages, emails, member mailings. Molina also launched a member incentives program with

[170] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 4, 2025.

educational outreach and incentive for well care visit completion and distributed HEDIS Tip Sheets to providers to encourage use of CPTII coding.

- Regarding the *Immunizations for Adolescents—Combination 2* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and implemented a member incentives program with educational outreach and incentive for service completion. Molina focused on HPV vaccination and education as it missed most of the three Combo 2 vaccines and began member education and provider notifications when children turned nine.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, Molina provided education to mothers about well-care visits during the last weeks of pregnancy prior to delivery and delivered text messages timed to coincide with well child visit schedule to remind parents and educate on what to expect during the visit. Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs.
- Regarding the *Child and Adolescent Well-Care Visits—3 to 11 years* measure, Molina delivered text messages timed to coincide with well-child visit schedules to remind parents and educate on what to expect during the visit and launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina also launched a member incentives program with educational outreach and incentive for service completion and initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs.
- Regarding the *Breast Cancer Screening* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina contracted with the Mobile Mammogram Unit to schedule women that could not get to an imaging center, invited women to health education events where services were performed, and provided access in rural areas.
- Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Prenatal and Postpartum Care—Postpartum Care* measures, Molina worked with IT and Data teams to enhance identification of new mothers and new enrollees who were pregnant and initiated personal outreach calls to educate, assure access to care, and offer incentives for visit completion. Molina contracted with in-home vendors to provide in-home and telehealth visit options and launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina launched a member incentives program with educational outreach and incentive for service completion and distributed educational materials in the New Member Welcome packet.

- Regarding the *Eye Exam for Patients With Diabetes* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina also scheduled in-home services to complete an eye exam.
- Regarding the *Controlling High Blood Pressure* measure, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina also scheduled in-home services to educate members, take blood pressure, coordinate visits with PCP if readings were outside normal limits and delivered reminders for hypertension medication adherence.
- Regarding the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measures, Molina launched a P4Q Bonus program for providers, which included provision of missing services lists and launched a member incentives program with educational outreach and incentive for service completion. Molina initiated multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications were personalized to address individual needs. Molina scheduled in-home services to educate members, completed A1c blood draw, coordinated visits with PCP if readings were outside normal limits and delivered reminders for medication adherence.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in improvements. HSAG encourages Molina UMIC to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Select Health CC (Select Health CC UMIC)

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Select Health CC UMIC's HEDIS compliance auditor found Select Health CC UMIC's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Select Health CC UMIC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of Select Health CC UMIC's FAR revealed that Select Health CC UMIC's HEDIS compliance auditor determined that all measures obtained a *Reportable* designation, and documented the following key findings and recommendations:

- During the audit review benchmarking session, Select Health CC UMIC staff members assigned to specific markets effectively addressed the benchmarking outlier concerns. The staff members were helpful in providing the results of their investigations, in addition to explanations related to the health plan's clinical interventions, data availability, and targeted measures for improvement.
- Select Health CC UMIC encouraged the use of relevant CPT II codes and experienced a subsequent increase in the use of these codes. The result was an increase in the *Controlling High Blood Pressure* administrative rate, along with an improvement in supplemental data capture. Recommendations included continuing to target measures for improvement in this manner.
- Select Health CC UMIC's use of HRA and Care Radius data, identified as electronic clinical data systems (ECDS) type care management, enabled the robust reporting of data for ECDS measures such as *Social Need Screening and Intervention (SNS-E)*, *Depression Remission or Response for Adolescents and Adults (DRR-E)*, and *Postpartum Depression Screening and Follow-Up (PDS-E)*. Recommendations included considering the expansion of such supplemental data sources for ECDS measures reporting, especially considering the scheduled growth of required ECDS measure reporting.
- For supplemental data sources where PSV was required, for example, Care Radius and the Data Exchange Tool, Select Health CC UMIC effectively provided the required support to pass those reviews. For any new supplemental data sources that are being considered for future reporting, and any existing sources where PSV may be required, recommendations included making advance preparations to provide the required PSV support, as it successfully occurred with Care Radius and the Data Exchange Tool.

Performance Measure Outcomes

Table 2-149 shows Select Health CC UMIC's HEDIS MY 2024 results compared to the MY 2024 NCQA QC average rates using v to indicate performance that fell below the NCQA QC average.

Table 2-149—Select Health CC UMIC HEDIS MY 2024 Results

HEDIS Measure	Select Health CC UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services		
Total	80.74%	77.83%
Antidepressant Medication Management		
Effective Acute Phase Treatment	66.41%	64.05%

HEDIS Measure	Select Health CC UMIC MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Breast Cancer Screening		
Breast Cancer Screening	53.42%^v	55.81%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	78.72%
Cervical Cancer Screening		
Cervical Cancer Screening	53.41%^v	56.91%
Glycemic Status Assessment for Patients With Diabetes		
Glycemic Status <8.0%	67.80%	58.65%
*Glycemic Status >9.0%**	23.66%	32.66%
Eye Exam for Patients With Diabetes		
Eye Exam for Patients With Diabetes	59.02%	56.06%
Controlling High Blood Pressure		
Controlling High Blood Pressure	74.93%	66.66%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.89%^v	82.45%
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	73.25%
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	40.31%^v	42.57%
30-Day Follow-Up—Total	57.65%^v	57.90%
Follow-Up After Emergency Department Visit for Substance Use		
7-Day Follow-Up—Total	33.79%	26.94%
30-Day Follow-Up—Total	48.63%	38.95%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	43.36%	40.70%
30-Day Follow-Up—Total	63.51%	61.25%
Initiation and Engagement of Substance Use Disorder Treatment		
Initiation of SUD Treatment—Total—Total	53.95%	46.09%
Engagement of SUD Treatment—Total—Total	20.96%	15.97%
Use of Imaging Studies for Low Back Pain		
Total	65.96%^v	70.71%

V Indicates the rate fell below the Quality Compass average.
NA indicates that the rate was not presented because the denominator was less than 30.
**For this indicator, lower rates indicate better performance.*

Strengths, Opportunities, and Recommendations

Strengths

Select Health CC UMIC exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Eye Exam for Patients With Diabetes*
- *Controlling High Blood Pressure*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment*
- *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment*

Opportunities for Improvement

Select Health CC UMIC fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*
- *Use of Imaging Studies for Low Back Pain*

Recommendations

Select Health CC UMIC fell below the MY 2024 NCQA Quality Compass average for six of the 20 performance indicators (30.00 percent), indicating some areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Select Health CC UMIC identify and address any known barriers to mammography services, such as psychosocial factors, cultural differences, or access to care barriers. Upon identification of barriers, HSAG recommends that Select Health CC UMIC implement interventions focused on reducing barriers to care. Select Health CC UMIC could consider mobile mammography screening and flexible scheduling allowing patient self-scheduling abilities. HSAG recommends that Select Health CC UMIC leverage October, Breast Cancer Awareness Month, or the member's birth month, to generate preventive screening reminders using alternative modes of communication and technology such as text messaging services. Utilizing EHR reports, HSAG suggests sharing feedback with health care providers on the frequency of providing screening recommendations. Select Health CC UMIC could work with DHHS on evaluating the use of incentives for providers to drive preventive health screening initiatives with a focus on breast cancer screening.[171]
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Select Health CC UMIC consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[172] Focusing on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Select Health CC UMIC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is a lack of knowledge. Manual or electronic reminders for providers that members are due for cancer screenings, giving feedback on individual

[171] U.S. Centers for Disease Control. Provider Assessment and Feedback Planning Guide. Available at: https://www.cdc.gov/cancer/php/ebi-planning-guides/provider-assessment-and-feedback-planning-guide.html. Accessed on: Dec 4, 2025.

[172] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

provider or clinic screening rates, flexible hours, transportation assistance, and patient reminders such as patient portal messages or text messages may increase screenings.[173, 174]

- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that Select Health CC UMIC evaluate barriers to screening, such as barriers coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG also recommends that Select Health CC UMIC build automatic screening alerts into EHR if screening tests are necessary. HSAG further recommends ensuring that providers encourage members to see a PCP, as people with at least one primary care visit were more likely to be screened.[175]
- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends the following interventions, which could improve follow-up care rates after hospitalizations or ED visits for patients with mental illness: collaborative discharge planning, educating member and family about the importance of follow-up care, scheduling the follow-up appointments before the member is discharged, assigning a care manager, and engaging family members in the discharge planning process. Offering support groups, utilizing telehealth, and providing a supply of medications until members' first appointment could improve follow-up rates.[176]
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends educating providers on unnecessary radiation exposure in the absence of red flags that identify patients with serious underlying conditions and educating patients through shared decision-making when considering nonpharmacologic alternatives such as cognitive behavioral therapy or exercise programs, or pharmacologic alternatives. [177,178]

[173] U.S. Centers for Disease Control. Provider Reminders. Available at: https://www.cdc.gov/cancer/php/interventions/provider-reminders.html. Accessed on: Dec 4, 2025.

[174] National Indian Health Board. Evidence-Based Interventions to Increase Cancer Screening: Provider Reminders. Available at: https://nihbcancerscreening.nptoolkit.org/wp-content/uploads/sites/41/2019/09/NIHB-Toolkit-CDC-Screen-Out-Cancer-Guides-pp-44-51-1.pdf. Accessed on: Dec 4, 2025.

[175] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.

[176] National Library of Medicine. Ensuring Continuity of Care: Effective Strategies for the Post-hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10863747/. Accessed on: Dec 4, 2025.

[177] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[178] American Family Physician. Management of Low Back Pain: Guidelines From the VA/DoD. Available at: https://www.aafp.org/pubs/afp/issues/2023/0400/practice-guidelines-low-back-pain.pdf. Accessed on: Dec 4, 2025.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

Select Health CC UMIC fell below the MY 2023 NCQA Quality Compass average for seven of the 18 performance indicators (38.89 percent), indicating some areas of opportunity for improvement. HSAG recommended improvement efforts focused on the following:

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends that Select Health CC UMIC consider effective interventions to reduce repeat Emergency Department visits for people with mental illness, such as HAP, PCMH, PBHCI, and the CC Program.[179]
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends Select Health CC UMIC consider effective interventions to reduce repeat hospitalizations for people with mental illness, such as CTI, ACT, case management, and focusing on co-occurring substance abuse disorders.[180]
- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that Select Health CC UMIC evaluate barriers to screening, such as barriers coordinating with laboratories or communication between behavioral health providers and PCPs. HSAG also recommends that Select Health CC UMIC build automatic screening alerts into EHR if screening tests are necessary. HSAG further recommends ensuring that providers encourage members to see a PCP, as people with at least one primary care visit were more likely to be screened.[181]
- Regarding the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, HSAG recommends that Select Health CC UMIC conduct provider education regarding special considerations for diabetes treatment when members have schizophrenia, including referring patients to structured programs for weight management, performing screenings regularly, and arranging frequent follow-up for treatment adherence.[182] HSAG also recommends that Select

[179] Mao W, Shalaby R, Agyapong VIO. Interventions to reduce repeat presentations to hospital emergency departments for mental health concerns: A scoping review of the literature. *Healthcare*. 2023 Apr 18;11(8):1161.

[180] Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophrenia Bulletin*. 2009 Jul;35(4):696–703.

[181] Mangurian C, Newcomer JW, Vittinghoff E, et al. Diabetes screening among underserved adults with severe mental illness who take antipsychotic medications. *JAMA Internal Medicine*. 2015;175:1977–1979.

[182] Annamalai A, Tek C. An overview of diabetes management in schizophrenia patients: office based strategies for primary care practitioners and endocrinologists. *International Journal of Endocrinology.* 2015:969182.

Health CC UMIC provide simplified recommendations to members, as cognitive impairment can hinder comprehension.

- Regarding the *Use of Imaging Studies for Low Back Pain* measure, HSAG recommends that Select Health CC UMIC ensure providers are aware of best practices regarding imaging studies for low back pain, such as avoiding diagnostic imaging in the first four weeks of new-onset back pain unless red flags or other conditions are present and encouraging the management of back pain through regular physical activity, healthy back exercises, and education on injury prevention.[183]
- Regarding the *Breast Cancer Screening* measure, HSAG recommends that Select Health CC UMIC identify disparities or SDOH within its populations that contribute to low breast cancer screening rates. Upon identification of any disparities, HSAG recommends that Select Health CC UMIC implements appropriate interventions to reduce barriers to care. Further, HSAG recommends that Select Health CC UMIC provide scheduled reminders messages directly from providers, and utilize personalized outreach for overdue patients. Communication and messages should be clear and concise, and include information on the procedure time.
- Regarding the *Cervical Cancer Screening* measure, HSAG recommends that Select Health CC UMIC consider utilizing one-on-one interactions with a health care professional, such as CHWs, which have been shown to improve cervical cancer screening.[184] Focusing on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that Select Health CC UMIC provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

Health Plan Interventions

Select Health CC UMIC reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Regarding the *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up—Total* measure indicators, Select Health Behavioral Health (BH) Team focused on Provider education to improve this measure. 7-Day MY2024 performance improved.
- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators, the 7-Day measure was part of the Select Health's required Process Improvement Project (PIP) and Select Health CC reported improvement. Select Health BH Navigators met with all BH admissions, scheduled follow-up visits and called patients within 24 hours of discharge. In addition, the Select

[183] Al-Hihi E, Gibson C, Lee J. et al. Improving appropriate imaging for non-specific low back pain. *British Medical Journal Open Quality*. 2022 Feb 21;11(1): e001539.

[184] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

Health BH Team met with non-Intermountain BH facilities to educate them on measure and develop collaborative initiatives. 7-Day MY2024 performance improved.

- Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, Select Health CC UMIC worked on Provider education regarding metabolic testing. MY2024 performance improved.
- Regarding the *Diabetes Monitoring for People With Diabetes and Schizophrenia* measure, Select Health CC UMIC worked on Provider education. With such a very small denominator there is a huge fluctuation in rates.
- Regarding the *Use of Imaging Studies for Low Back Pain* measure, Select Health CC UMIC reported the eligible population saw fluctuations which impacted the percent compliant and that provider education has been the focus. Unfortunately, MY2024 performance decreased.
- Regarding the *Breast Cancer Screening* measure, Select Health CC UMIC reported increased focused intervention but the eligible population has seen fluctuation with both increases and decreases which made it difficult to close gaps. Targeted outreach has included live calls to members to schedule their mammogram, emails and mailings. MY2024 performance improved.
- Regarding the *Cervical Cancer Screening* measure, Select Health CC UMIC's Quality Provider Program (QPP) added Women's Health so that gaps are identified and closed. Providers in the QPP demonstrate engagement with their assigned members which resulted in positive outcomes. Select Health CC UMIC reported that outreach to members has included postcards and IVR calls. MY2024 performance improved.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. HSAG encourages Select Health CC UMIC to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Medicaid PIHP PMHPs Providing Mental Health and/or SUD Services

Bear River Mental Health Services (Bear River)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Bear River's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-150 presents Bear River's MY 2024 performance measure results.

Table 2-150—Bear River MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Bear River Rate	Statewide PMHP Average
Follow-Up Within 7 Days	56.42%	54.04%
Follow-Up Within 30 Days	72.07%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

Bear River had improvement interventions in place for MY 2024. Bear River staff reached out to members following hospital discharges if the individuals did not keep their original appointment. The follow-up was done via in-person visits to the member's last known residence. Additionally, Bear River ran and reviewed follow-up appointment rates quarterly in order to confirm that its improvement interventions were effective.

Opportunities for Improvement

Bear River did not maintain a copy of its internal "HEDIS Detail File" report that was used for reporting its final *Follow-Up After Hospitalization for Mental Illness (FUH-UT)* data counts and rates.

Recommendations

- HSAG recommends that Bear River keep a copy of the "HEDIS Detail File" report that is generated and used for reporting the final *FUH-UT* data counts. The detailed data should be provided to HSAG for PMV in lieu of running a new report at the time of the HSAG review, as this will ensure that HSAG is able to review and validate the member-level data associated with the final reported data counts and rates.

- Regarding the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators, HSAG recommends that Bear River identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs. HSAG recommends that engaging the member's support system in follow-up care and medical adherence be part of comprehensive member education.[185] HSAG encourages the scheduling of a follow-up appointment prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Bear River focus targeted improvement efforts on the following:

Implementing internal PSV reviews on a random sample of cases prior to submitting rates or counts to HSAG to ensure that admission and discharge dates are accurate, and that member eligibility meets the measure criteria according to the State-defined measure specifications.

Health Plan Interventions

In response to HSAG's recommendations, Bear River reported the following efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators:

- Bear River has put an emphasis on the follow-up from the crisis team as members are discharged from the hospital. The crisis team followed up with each individual either through regularly scheduled appointments or at their place of residence if appointments are missed.

[185] National Library of Medicine. Ensuring Continuity of Care: Effective Strategies for the Post-hospitalization Transition of Psychiatric Patients in a Family Medicine Outpatient Clinic. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10863747/. Accessed on: Dec 4, 2025.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that this intervention may result in long-term improvements. HSAG encourages Bear River to continue leveraging a quality improvement framework to understand how the intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

Central Utah Counseling Center (Central)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Central's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-151 presents Central's MY 2024 performance measure results.

Table 2-151—Central MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Central Rate	Statewide PMHP Average
Follow-Up Within 7 Days	73.77%	54.04%
Follow-Up Within 30 Days	86.89%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

Central continued to have strong validation procedures in place as part of its data integration and measure-specific review process. Multiple staff members reviewed the discharge/follow-up service spreadsheet to ensure the accuracy and completeness of the data.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Central:

- Identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs.
- Engage in the member's support system in follow-up care and medical adherence as a part of comprehensive member education.

- Schedule a follow-up appointment prior to the member leaving the hospital, provide a list of support groups, assign a care manager to assist with the transition, and create a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

HSAG did not identify opportunities for improvement or recommendations for Central during the MY 2023 PMV review.

Health Plan Interventions

Central did not have recommendations specifically related to the MY 2023 PMV review to draw upon for improvement activities.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

Central did not have to consider prior year recommendations regarding performance measures, as HSAG did not identify opportunities for improvement or recommendations. HSAG encourages Central to continue to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Davis Behavioral Health (Davis)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Davis's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-152 presents Davis's MY 2024 performance measure results.

Table 2-152—Davis MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Davis Rate	Statewide PMHP Average
Follow-Up Within 7 Days	65.00%	54.04%
Follow-Up Within 30 Days	85.83%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

HSAG identified the following strengths:

- Davis worked closely with Pinnacle to develop a new tool for receiving and validating member enrollment and eligibility information. Pinnacle developed the 834 Credible Client Eligibility Changes Report to verify member eligibility and the 834 Credible Client Match Report to monitor and validate demographic discrepancies.

- Davis monitored all members through their date of discharge and ensured members had an appointment in place within five business days of hospital discharge. Davis made three check-in phone calls weekly to members to remind them of their appointment. Members received phone calls up to 30 days after their discharge, or until a follow-up appointment was completed. All member calls were monitored in Credible and tracked in a spreadsheet to ensure timely follow-up appointments.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- During PSV, HSAG identified one case that did not meet continuous eligibility criteria according to the state-defined measure specifications (i.e., the member was enrolled as of the date of hospital discharge and continuously enrolled through 30 days after discharge).

Recommendations

HSAG recommends that Davis:

- Review all reported cases against enrollment data in its system prior to submission to ensure the members reported meet numerator and denominator criteria according to the state-defined measure specifications.
- Identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs.
- Engage the member's support system in follow-up care and medical adherence as a part of comprehensive member education. HSAG encourages providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Davis focus targeted improvement efforts on the following:

- HSAG recommends that Davis review all reported cases against enrollment data in its system prior to submission to ensure the members reported meet numerator and denominator criteria according to the State-defined measure specifications.
- HSAG recommends that Davis communicate updates made to forms and fields within Credible to Pinnacle during its weekly meetings to ensure source code is updated in a timely manner instead of only when the Follow-Up After Hospitalization for Mental Illness report is run and validations are performed on the report (i.e., quarterly during Quality Assessment and Performance Improvement [QAPI] meetings and annually during the PMV activity).

Health Plan Interventions

In response to HSAG's recommendations, Davis reported the following ongoing efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators:

- Davis reported ongoing efforts to ensure that member coverages were reviewed to ensure they have continuous eligibility for 30 days post discharge.
- Davis reported that the recommended report of timely and routine updates to source code will be added to the Pinnacle agenda.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. Davis's ongoing review of membership following an inpatient discharge will ensure that performance is tracked accurately but will not necessarily improve rates since enrollment is not determined by Davis. Regular review of source code updates across all reporting programs will ensure that all data are up to date with the most current specifications available, capturing complete and accurate data. HSAG encourages Davis to utilize a quality improvement framework to understand how each intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

Four Corners Community Behavioral Health (Four Corners)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Four Corners' IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-153 presents Four Corners' MY 2024 performance measure results using ˅ to indicate performance that fell below the statewide PMHP average.

Table 2-153—Four Corners MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Four Corners Rate	Statewide PMHP Average
Follow-Up Within 7 Days	48.39%˅	54.04%
Follow-Up Within 30 Days	51.61%˅	70.04%

˅ *Indicates the rate fell below the statewide PMHP average.*

Strengths, Opportunities, and Recommendations

Strengths

Four Corners' staff members were receptive to HSAG's feedback and were eager to learn more about best practices for collection, validation, and calculation of the *FUH-UT* measure.

Opportunities for Improvement

HSAG identified the following opportunities for improvement:

- During preliminary review of the Numerator Positive Case Listing file that Four Corners submitted, HSAG identified members with readmissions or direct transfers within 30 days, follow-up visits that occurred on the date of discharge, and incorrectly reported dates. Four Corners corrected the Numerator Positive Case Listing file and Rate Reporting Template. HSAG then observed that the count of hospital stays and follow-up visits in the Numerator Positive Case Listing file did not match

the counts in the updated Rate Reporting Template.

- During PSV, HSAG identified errors related to incorrect discharge dates and follow-up service dates being included in the Numerator Positive Case Listing file. After the virtual review, Four Corners was able to identify the correct dates and make updates to the Numerator Positive Case Listing file accordingly.

Recommendations

HSAG recommends that Four Corners:

- Incorporate more stringent validation checks prior to submission of the Numerator Positive Case Listing file and Rate Reporting Template to HSAG, such as adding columns along with formulas that can be used to calculate criteria (e.g., age at discharge, number of days between discharge and follow-up service, readmissions within 30 days, etc.) to create an automated method to identify which members should be included in the measure and more accurately determine numerator compliance. Validation efforts should also include reviewing a statistically significant sample of cases to ensure alignment between the reported detailed data and live EHR system documentation.
- Designate at least one team member to perform additional validation prior to submission of its numerator positive cases and eligible population in the denominator against the measure specifications to reduce potential errors. Additionally, HSAG recommends that validation include a check of the counts between the Numerator Positive Case Listing file and the Rate Reporting Template, since the counts are expected to align between the files.
- Identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs. HSAG recommends that engaging the member's support system in follow-up care and medical adherence be part of comprehensive member education. HSAG encourages the scheduling of a follow-up appointment prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Four Corners focus targeted improvement efforts on the following:

- Implementation of additional validation to the hospital tracking spreadsheet, such as additional columns along with formulas that can be used to calculate criteria (e.g., age at discharge, number of days between discharge and follow-up service, readmissions within 30 days, etc.) to create an automated method to identify which members should be included in the measure and more accurately determine numerator compliance.

Health Plan Interventions

In response to HSAG's recommendations, Four Corners reported the following efforts to improve performance on the DHHS-custom *Follow-Up After Hospitalization for Mental Illness* measure indicators:

- Four Corners implemented additional measures and columns within the QAPI review to enhance the overall quality review process and ensure the evaluation of meaningful and actionable data.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

Continued improvement of validation protocols will reduce the likelihood of data errors or discrepancies. HSAG encourages Four Corners to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Healthy U Behavioral

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Healthy U Behavioral's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-154 presents Healthy U Behavioral's MY 2024 performance measure results.

Table 2-154—Healthy U Behavioral MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Healthy U Behavioral Rate	Statewide PMHP Average
Follow-Up Within 7 Days	62.50%	54.04%
Follow-Up Within 30 Days	87.50%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

Healthy U continued to demonstrate overall strength in its coordination of care. Healthy U also continued to expand its service offerings and demonstrated a commitment to improving care for its members.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Healthy U Behavioral:

- Identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs.
- Engage the member's support system in follow-up care and medical adherence to encourage comprehensive member education.

- Encourage the scheduling of a follow-up appointment prior to the member leaving the hospital, provide a list of support groups, assign a care manager to assist with the transition, and create a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Healthy U focus targeted improvement efforts on the following:

- Implementation of additional validation checks to source code if the code was used to calculate age for the measure to ensure the age is being calculated correctly (based on the date of discharge). HSAG also recommends that Healthy U Behavioral create a list of criteria using the measure specifications for reviewers to verify as they review the data files prior to submission.

Health Plan Interventions

Healthy U Behavioral did not provide a response to the *Follow-Up After Hospitalization for Mental Illness* recommendation made by HSAG for the previous year.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG cannot offer an assessment of the health plan's approach to prior year recommendations, as no response was provided.

Northeastern Counseling Center (Northeastern)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Northeastern's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-155 presents Northeastern's MY 2024 performance measure results.

Table 2-155—Northeastern MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Northeastern Rate	Statewide PMHP Average
Follow-Up Within 7 Days	70.97%	54.04%
Follow-Up Within 30 Days	87.10%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

HSAG identified the following strength for Northeastern:

- Northeastern's rates across all age stratifications and for both measure indicators improved in comparison to prior year, indicating that Northeastern has prioritized efforts to improve the quality and timeliness of care.

- Northeastern had a thorough and robust validation process for claims entry, measure calculation, and rate reporting.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Northeastern:

- Identify and address disparities in areas with limited access to psychiatrists and support training primary care physicians caring for members with less complex needs.
- Engage the member's support system in follow-up care and medical adherence as part of comprehensive member education.
- Encourage the scheduling of a follow-up appointment prior to the member leaving the hospital, provide a list of support groups, assign a care manager to assist with the transition, and create a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

HSAG did not identify opportunities for improvement or recommendations for Northeastern during the MY 2023 PMV review.

Health Plan Interventions

Northeastern did not have recommendations specifically related to the MY 2023 PMV review to draw upon for improvement activities.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

Northeastern did not have to consider prior year recommendations regarding performance measures, as HSAG did not identify opportunities for improvement or recommendations. HSAG encourages Northeastern to continue to utilize a quality improvement framework to understand how each intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

Optum/Tooele

Results and Outcomes

Validation Results and Interventions

The MY 2024 PMV activities resulted in Optum/Tooele's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-156 presents Optum/Tooele's MY 2024 performance measure results using ˅ to indicate performance that fell below the statewide PMHP average.

Table 2-156—Optum/Tooele MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Optum Tooele County Rate	Statewide PMHP Average
Follow-Up Within 7 Days	45.95%˅	54.04%
Follow-Up Within 30 Day	50.00%˅	70.04%

˅ *Indicates the rate fell below the statewide PMHP average.*

Strengths, Opportunities, and Recommendations

Strengths

Optum/Tooele noted during the virtual review that it had multiple quality improvement activities in place that aimed to increase *FUH-UT* rates. For example, Optum/Tooele invested additional resources into monitoring the *FUH-UT* rate to address any barriers or challenges Optum/Tooele's network might be facing in real time.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Optum/Tooele:

- Identify and address disparities in areas with limited access to psychiatrists and support training primary care physicians in caring for members with less complex needs.

- Engage the member's support system in follow-up care and medical adherence as part of comprehensive member education.
- Encourage the scheduling of a follow-up appointment prior to the member leaving the hospital, provide a list of support groups, assign a care manager to assist with the transition, and create a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Optum/Tooele focus targeted improvement efforts on the following: Continue efforts to improve report automation, such as creating structured opportunities for the reporting team to work closely with programming staff members to ensure measure-specific criteria are included when developing programming logic.

Health Plan Interventions

In response to HSAG's recommendations, Optum/Tooele reported the following efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators:

- Optum/Tooele migrated the HSAG PMV FUH-UT Audit Report from MS Access to Alteryx, increasing automation from approximately 40% to approximately 90%. Optum/Tooele reported that efforts continue and the goal is to bring the automation rate to approximately 95% for the PMV data files for the coming year.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. Automation of reporting significantly reduces the possibility of human error. HSAG encourages Optum/Tooele to continue to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Salt Lake County Division of Behavioral Health Services (Salt Lake)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Salt Lake's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-157 presents Salt Lake's MY 2024 performance measure results using ˅ to indicate performance that fell below the statewide PMHP average.

Table 2-157—Salt Lake MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Salt Lake Rate	Statewide PMHP Average
Follow-Up Within 7 Days	43.42%˅	54.04%
Follow-Up Within 30 Days	60.33%˅	70.04%

˅ *Indicated the rate fell below the statewide PMHP average.*

Strengths, Opportunities, and Recommendations

Strengths

Salt Lake noted during the virtual review that it had multiple quality improvement activities in place that aimed to increase *FUH-UT* rates. For example, Salt Lake invested additional resources into monitoring the *FUH-UT* rate to address any barriers or challenges Salt Lake's network might be facing in real time.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Salt Lake identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs. HSAG recommends that engaging the member's support system in follow-up care and medical adherence be part of comprehensive member education. HSAG encourages the scheduling of follow-up

appointments prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Salt Lake:

- Continue to analyze noncompliant cases to identify barriers that members experienced that prevented a follow-up visit within seven or 30 days of discharge to narrow the focus of interventions (e.g., transportation/lack of telehealth services, low motivation for treatment, cultural/language barrier, staffing issues impacting availability of services, insufficient monitoring and/or outreach procedures, etc.).
- Continue efforts to improve report automation, such as creating structured opportunities for the reporting team to work closely with programming staff members to ensure measure-specific criteria are included when developing programming logic.

Health Plan Interventions

In response to HSAG's recommendations, Salt Lake reported the following efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators:

- Salt Lake migrated the HSAG PMV FUH Audit Report from MS Access to Alteryx, increasing automation from approximately 40% to approximately 90%. Salt Lake reported that efforts continue and the goal is to bring the automation rate to approximately 95% for the PMV data files for the coming year.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. Automation of reporting significantly reduces the possibility of human error. HSAG encourages Salt Lake to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Southwest Behavioral Health Center (Southwest)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Southwest's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-158 presents Southwest's MY 2024 performance measure results.

Table 2-158—Southwest MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Southwest Rate	Statewide PMHP Average
Follow-Up Within 7 Days	54.79%	54.04%
Follow-Up Within 30 Days	70.55%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

HSAG identified the following strengths for Southwest:

- Southwest had a robust protocol for tracking and maintaining data related to the *FUH-UT* measure and ensuring that the data reported were accurate. Staff members at multiple levels checked the data prior to submission for review, and all previous issues with reporting accuracy have been resolved.

- The interventions that Southwest implemented demonstrate a commitment to providing timely care to the populations Southwest serves, such as leveraging telehealth visits to reach members in rural communities.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Southwest:

- Identify and address disparities in areas with limited access to psychiatrists and support training primary care physicians in caring for members with less complex needs.
- Engage the member's support system in follow-up care and medical adherence as part of comprehensive member education.
- Encourage the scheduling of a follow-up appointment prior to the member leaving the hospital, provide a list of support groups, assign a care manager to assist with the transition, and create a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Southwest focus targeted improvement efforts on the following:

- Conduct an annual review of the measure specifications prior to submitting the Rate Reporting Template and Numerator Positive Case Listing file. HSAG also recommends continued attendance of the Technical Assistance Webinar, hosted by HSAG, which includes a review of all measure requirements and exclusions.
- Complete additional validation of the UM form prior to submission of the HSAG Numerator Positive Case Listing file and Rate Reporting Template. HSAG also recommends that a document outlining the steps to accurately calculate counts for both the 7- Day Follow-Up and 30-Day Follow-Up indicators be readily and easily accessible for staff member reference.

Health Plan Interventions

- Southwest has formalized a process requiring a comprehensive annual review of all measure specifications prior to the commencement of the Rate Reporting Template and Numerator Positive Case Listing file preparation for the reporting cycle. Southwest plans to have relevant staff attend the HSAG Technical Assistance Webinar. They will ensure continued, active attendance to stay current on all requirements and exclusions.
- Southwest has added a dedicated, multi-step validation check on the UM form data specifically targeting the fields used in performance measure calculations. This validation is completed and signed off before the data is finalized for inclusion in the Numerator Positive Case Listing file and Rate Reporting Template.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. HSAG encourages Southwest to utilize a quality improvement framework to understand how each intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

Wasatch Behavioral Health (Wasatch)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Wasatch's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-159 presents Wasatch's MY 2024 performance measure results.

Table 2-159—Wasatch MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Wasatch Rate	Statewide PMHP Average
Follow-Up Within 7 Days	69.79%	54.04%
Follow-Up Within 30 Days	84.90%	70.04%

Strengths, Opportunities, and Recommendations

Strengths

Wasatch demonstrated its commitment to addressing the health care needs of its members through organizational stability, efforts to improve the delivery of services, and the various member-centric interventions in place. Wasatch continued the implementation of its Therapy Connect program, which uses software to quickly connect and schedule members with a therapist for urgent appointments.

Opportunities for Improvement

- HSAG identified a 12-percentage point decrease in Wasatch's *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rate for adults ages 18–64 years of age.

Recommendations

HSAG recommends that Wasatch:

- Continue its improvement efforts and monitoring to further ensure timely and accessible follow-up services for its members and increased performance.
- Identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs.
- Engage the member's support system in follow-up care and medical adherence to encourage comprehensive member education.
- Consider scheduling follow-up appointments prior to the member leaving the hospital, providing a list of support groups, assigning a care manager to assist with the transition, and creating a crisis intervention plan with the member.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

To improve its performance on the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* measure indicators, HSAG recommended that Wasatch focus targeted improvement efforts on the following:

- Regular review of all programming code to ensure that it is in compliance with the measure requirements to prevent any prohibited rounding of ages and incorrect age stratification. Additionally, for future performance measure reporting, HSAG recommends that Wasatch consult with DHHS or HSAG on whether rounding is allowed for age calculations.

Health Plan Interventions

In response to HSAG's recommendations, Wasatch reported the following efforts to improve performance on the *Follow-Up After Hospitalization for Mental Illness* measure:

- Wasatch made a revision to its code to ensure that members were put in the correct category and fixed any rounding errors that may have occurred.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. HSAG encourages Wasatch to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Weber Human Services (Weber)

Results and Outcomes

Validation Results

The MY 2024 PMV activities resulted in Weber's IS and processes to be compliant with the applicable IS standards and the reporting requirements for the performance measure. HSAG determined that the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* performance measure indicators received a *Reportable* (*R*) designation.

Performance Measure Outcomes

Table 2-160 presents Weber's MY 2024 performance measure results using ᵛ to indicate performance that fell below the statewide PMHP average.

Table 2-160—Weber MY 2024 DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	Weber Rate	Statewide PMHP Average
Follow-Up Within 7 Days	48.23%ᵛ	54.04%
Follow-Up Within 30 Days	68.79%ᵛ	70.04%

ᵛ *Indicated the rate fell below the statewide PMHP average.*

Strengths, Opportunities, and Recommendations

Strengths

HSAG identified the following strength for Weber:

- Weber continued its approach to partner with McKay-Dee Hospital to simplify the care management process and ensure timely services for members. Weber staff members embedded at the hospital facilitated the prior authorization of hospital stays, collaborated with hospital staff members during discharge planning, and scheduled follow-up services with members post-discharge.

Opportunities for Improvement

HSAG did not identify any opportunities for improvement during the MY 2024 PMV review.

Recommendations

HSAG recommends that Weber:

- Identify and address disparities in areas that lack psychiatrists and support training primary care physicians in caring for members with less complex needs.
- Engage the member's support system in follow-up care and medical adherence to encourage comprehensive member education.
- Provide a list of support groups and create a crisis intervention plan with members.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

HSAG did not identify opportunities for improvement or recommendations for Weber during the MY 2023 PMV review.

Health Plan Interventions

Weber did not have recommendations specifically related to the MY 2023 PMV review to draw upon for improvement activities.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

Weber did not have to consider prior year recommendations regarding performance measures, as HSAG did not identify opportunities for improvement or recommendations. HSAG encourages Weber to continue to utilize a quality improvement framework to understand how each intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

CHIP MCOs Providing Both Physical and Mental Health Services

Healthy U CHIP

Validation of Performance Measures

Healthy U CHIP operations launched on July 1, 2024. According to Utah regulation R428-2-9[186], a carrier that covers fewer than 2,500 individual Utah residents as of January 1 of a given year is exempt from the [reporting] requirements. Healthy U had fewer than 2,500 CHIP members during the July-December 2024 period, which would exempt Healthy U CHIP from reporting during MY 2024. Healthy U CHIP did not provide HSAG with partial year rates for MY 2024 as reporting was not required by the state for their population of under 2,500 members, so analysis of Healthy U CHIP's performance and comparison to statewide data is not displayed in this report.

[186] Utah Office of Administrative Rules. Data, Systems and Evaluation, Research and Evaluation, Health Care Statistics Rule 2: Health Data Authority Standards for Health Data. Available at: https://adminrules.utah.gov/public/rule/R428-2/Current%20Rules. Accessed on: Dec 4, 2025.

Molina Healthcare of Utah CHIP (Molina CHIP)

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Molina CHIP's HEDIS compliance auditor found Molina CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Molina CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Molina CHIP's HEDIS MY 2024 FAR and determined no notable findings. All measures obtained a *Reportable* designation.

Performance Measure Outcomes

Table 2-161 shows Molina CHIP's HEDIS MY 2024 results compared to the MY 2024 NCQA average rates using ˅ to indicate performance that fell below the NCQA QC average. QC averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table 2-161—Molina CHIP HEDIS MY 2024 Results

HEDIS Measure	Molina CHIP MCO MY 2024 Rate	MY 2024 NCQA Quality Compass Average[1]
Appropriate Treatment for Upper Respiratory Infection		
Total	92.36%	88.10%
Childhood Immunization Status		
Combination 3	65.98%˅	66.18%
Immunizations for Adolescents		
Combination 2	40.56%	37.84%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI percentile—Total	73.44%˅	80.87%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.82%˅	61.92%
Child and Adolescent Well-Care Visits		
3–11 Years	58.61%˅	62.45%

[1] *NCQA Quality Compass Averages shown in table are not specific to CHIP population.*

˅ *Indicates the rate fell below the Quality Compass average.*

Strengths, Opportunities, and Recommendations

Strengths

Molina CHIP exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

Appropriate Treatment for Upper Respiratory Infection

Immunizations for Adolescents—Combination 2

Opportunities for Improvement

Molina CHIP fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Childhood Immunization Status—Combination 3*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—3 to 11 years*

Recommendations

Molina CHIP fell below the MY 2024 NCQA Quality Compass average for 4 of the 6 performance indicators (66.67 percent), indicating significant areas of opportunity for improvement. HSAG recommends improvement efforts focused on the following:

- Regarding the *Childhood Immunization Status—Combination 3* measure, HSAG recommends that Molina CHIP provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at each opportunity, including acute illness visits.[187] HSAG recommends that Molina CHIP consider implementing strategies such as holding vaccine clinics at convenient hours for families (e.g., evenings and Saturdays) and ensuring vaccination

[187] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

records are accurate. The American Academy of Pediatrics has immunization discussion guides for providers to guide them when encouraging immunization completion with patients.[188]

- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, HSAG recommends that Molina CHIP follow up on reports given to providers to identify members who would benefit from this service. HSAG also recommends that Molina CHIP ensure members are going to well appointments for BMI to be calculated. Molina CHIP could consider educating providers to include BMI percentile in the EHR well-child templates for ease of documentation.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Molina CHIP identify performance improvement strategies to increase well-child visits, drawing from ideas in other states such as South Dakota and California.[189] HSAG recommends that Molina CHIP identify barriers to care and conduct a focus group to identify interventions to address barriers. Addressing SDOH with interventions such as extended hours, weekend hours, back-to-back sibling well-child visits, and transportation could increase attendance to well-child visits. Lastly, scheduling the next appointment at check-out has been utilized to increase well-care visits.
- Regarding the *Child and Adolescent Well-Care Visits—3 to 11 years* measure, HSAG recommends promoting teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that Molina CHIP and providers develop partnerships with community stakeholders such as schools.[190] HSAG also recommends that Molina CHIP conduct provider education about encouraging preventive care when members are seen for acute illness, sports physicals, and other reasons. HSAG further recommends that Molina CHIP promote well-care visits on social media, through emails, or personalized outreach. Partnering with school-based health clinics, faith-based organizations, community agencies, and after-school programs may improve well-care visit rates.[191] Finally, HSAG recommends evaluating the effectiveness of incentives with DHHS to increase timely visits.

[188] American Academy of Pediatrics. Communication Aids. Available at: https://www.aap.org/en/patient-care/immunizations/communication-aids/. Accessed on: Dec 4, 2025.

[189] Centers for Medicare & Medicaid Services. CMS Affinity Group State Spotlights: Improving Infant Well-Child Visits, 0-15 months. https://www.medicaid.gov/medicaid/quality-of-care/downloads/iwc-statespotlights-slides.pdf. Access on: Dec 8, 2025

[190] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 4, 2025.

[191] Partnership Health Plan of California. 2025 Best Practices Child and Adolescent Well-Care Visits. Available at: https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%20IMO%20Webinars%20Current/Best%20Practices%20Child%20Adolescent%20Well%20Care%20Visits.pdf. Accessed on: Dec 4, 2025.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In MY 2023, HSAG recommended that Molina CHIP focus its improvement efforts on the following:

- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, HSAG recommends that Molina CHIP create a report to identify members who would benefit from this service and follow up with providers as necessary. HSAG also recommends that Molina CHIP ensure members are going to well appointments for BMI to be calculated.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, HSAG recommends that Molina CHIP identify performance improvement strategies to increase well-child visits, drawing ideas from initiatives in other states. For instance, California and Virginia have a QI initiative focused on delays in newborn enrollment data, and Missouri and Texas developed a QI initiative focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach.[192] HSAG recommends that Molina CHIP identify other barriers to care and conduct a focus group to identify interventions to address barriers.

Health Plan Interventions

Molina CHIP reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- Regarding the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure, Molina CHIP launched a P4Q Bonus program for providers, which included provision of missing services lists. Molina CHIP also distributed education about what to expect during well child visits. The importance of BMI percentile tracking was included in text messages, emails, and member mailings. Molina CHIP launched a member incentives program with educational outreach and incentive for well care visit completion HEDIS Tip Sheets to providers to encourage use of CPTII coding.
- Regarding the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure, Molina CHIP distributed education to mothers about well-care visits during the last weeks of pregnancy prior to delivery. Molina CHIP delivered text messages timed to coincide with the well-child visit schedule to remind parents and educate on what to expect during the visit. Molina CHIP launched a P4Q Bonus program for providers, which included provision of missing services list, and launched a member incentives program with educational outreach and incentive

[192] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Dec 4, 2025.

for service completion. Molina CHIP also launched multichannel communication to members through IVR calls, live calls, educational mailings, emails, and text messages where communications are personalized to address individual needs.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions may result in long-term improvements. HSAG encourages Molina CHIP to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Select Health CHIP

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Select Health CHIP's HEDIS compliance auditor found Select Health CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Select Health CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation.

HSAG's review of Select Health CHIP's FAR revealed that Select Health CHIP's HEDIS compliance auditor determined that all measures obtained a *Reportable* designation, and documented the following key findings and recommendations:

- During the audit review benchmarking session, Select Health CHIP staff members assigned to specific markets effectively addressed benchmarking outlier concerns. The staff members were helpful in providing the results of their investigations, in addition to explanations related to the health plan's clinical interventions, data availability, and targeted measures for improvement.
- Select Health CHIP encouraged the use of relevant CPT II codes and experienced a subsequent increase in the use of these codes. The result was an increase in the *Controlling High Blood Pressure* administrative rate, along with an improvement in supplemental data capture. Recommendations included continuing to target measures for improvement in this manner.
- Select Health CHIP's use of HRA and Care Radius data, identified as ECDS type care management, enabled the robust reporting of data for ECDS measures such as SNS-E, DRR-E, and PDS-E. Recommendations included considering the expansion of such supplemental data sources for ECDS measures reporting, especially considering the scheduled growth of required ECDS measure reporting.
- For supplemental data sources where PSV was required, for example, Care Radius and the Data Exchange Tool, Select Health CHIP effectively provided the required support to pass those reviews. For any new supplemental data sources that are being considered for future reporting, and any existing sources where PSV may be required, recommendations include making advance preparations to provide the required PSV support, as it successfully occurred with Care Radius and the Data Exchange Tool.

Performance Measure Outcomes

Table 2-162 shows Select Health CHIP's HEDIS MY 2024 results compared to the MY 2024 NCQA average rates using ˅ to indicate performance that fell below the NCQA QC average. QC averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table 2-162—Select Health CHIP HEDIS MY 2024 Results

HEDIS Measure	Select Health CHIP MCO MY 2024 Rate	MY 2024 NCQA Quality Compass Average[1]
Appropriate Treatment for Upper Respiratory Infection		
Total	94.64%	88.10%
Childhood Immunization Status		
Combination 3	75.14%	66.18%
Immunizations for Adolescents		
Combination 2	50.00%	37.84%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI percentile—Total	89.18%	80.87%
Well-Child Visits in the First 30 Months of Life		
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	71.17%	61.92%
Child and Adolescent Well-Care Visits		
3–11 Years	64.39%	62.45%

[1] *NCQA Quality Compass Averages shown in table are not specific to CHIP population.*

Strengths, Opportunities, and Recommendations

Strengths

Select Health CHIP exceeded the MY 2024 NCQA Quality Compass average for all the reported performance indicators:

- *Appropriate Treatment for Upper Respiratory Infection*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—Total*

Opportunities for Improvement

Select Health CHIP did not fall below the MY 2024 NCQA Quality Compass average for any of the reported performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and therefore does not have any recommendations.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

HSAG did not identify opportunities for improvement or recommendations for Select Health CHIP during the MY 2023 PMV review.

Health Plan Interventions

Select Health CHIP did not have recommendations specifically related to the MY 2023 PMV review to draw upon for improvement activities.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

Select Health CHIP did not have to consider prior year recommendations regarding performance measures, as HSAG did not identify opportunities for improvement or recommendations. HSAG encourages Select Health CHIP to utilize a quality improvement framework to understand how each intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

PAHPs Providing Medicaid Dental Services

MCNA

Results and Outcomes

Validation Results

HSAG's review of the FAS for HEDIS MY 2024 showed that MCNA's HEDIS compliance auditor found MCNA's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. MCNA contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed MCNA's HEDIS MY 2024 FAR and determined no notable findings. All measures obtained a *Reportable* designation.

Performance Measure Outcomes

Table 2-163 shows MCNA's MY 2024 rates for the *Oral Evaluation, Dental Services* and *Topical Fluoride for Children* measures compared to the MY 2024 NCQA Quality Compass average rates.

Table 2-163—MCNA MY 2024 Results

HEDIS Measure	MCNA PAHP MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Oral Evaluation, Dental Services		
0–2 Years	33.46%	18.68%
3–5 Years	59.67%	46.00%
6–14 Years	62.80%	50.37%
15–20 Years	48.29%	34.76%
Total	55.70%	40.63%
Topical Fluoride for Children		
1–2 Years	11.19%	—
3–4 Years	27.99%	—
Total	19.36%	—

(–) Indicates NCQA Benchmarks are not available for this measure.

Strengths, Opportunities, and Recommendations

Strengths

MCNA exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Oral Evaluation, Dental Services—0 to 2 Years*
- *Oral Evaluation, Dental Services—3 to 5 Years*
- *Oral Evaluation, Dental Services—6 to 14 Years*
- *Oral Evaluation, Dental Services—15 to 20 Years*
- *Oral Evaluation, Dental Services—Total*

Opportunities for Improvement

MCNA did not fall below the MY 2024 NCQA Quality Compass average for any of the reported performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement and therefore does not have any recommendations.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In MY 2023, HSAG recommended that MCNA focus its improvement efforts on the following:

- Validate and report the measures required by DHHS for the EQR Technical Report.

Health Plan Interventions

MCNA reported the following improvement efforts in response to HSAG's MY 2023 recommendations:

- MCNA confirmed that the measures required by DHHS for the EQR Technical Report would be reported. MCNA submitted the IDSS export file for MY 2024, which includes the Oral Evaluation, Dental Services (OED) and Topical Fluoride for Children (TFC) measures, in alignment with NCQA specifications. These measures were calculated using audited data consistent with HEDIS compliance standards. Performance measure production and information systems (IS) were audited by a NCQA-certified HEDIS compliance auditor Healthcare Data Company (HDC). MCNA will continue to ensure that all required measures are accurately reported in accordance with DHHS and EQRO expectations.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG and DHHS will identify strategies for improved collaboration and communication of measure reporting expectations. Timely communication of measure reporting changes will improve MCNA's ability to utilize year-over-year comparison to identify areas of improvement. HSAG encourages MCNA to leverage a quality improvement framework to evaluate the impact and effectiveness of each intervention employed to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

Premier Access

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Premier Access's HEDIS compliance auditor found Premier Access's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Premier Access contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Premier Access's HEDIS MY 2024 FAR and determined no notable findings and all measures obtained a *Reportable* designation.

Performance Measure Outcomes

Table 2-164 shows Premier Access's MY 2024 rates for the *Oral Evaluation, Dental Services* and the *Topical Fluoride for Children* measures compared to the MY 2024 NCQA Quality Compass average rates.

Table 2-164—Premier Access MY 2024 Results

HEDIS Measure	Premier PAHP MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Oral Evaluation, Dental Services		
0–2 Years	25.44%	18.68%
3–5 Years	61.67%	46.00%
6–14 Years	64.85%	50.37%
15–20 Years	51.10%	34.76%
Total	56.27%	40.63%
Topical Fluoride for Children		
1–2 Years	11.61%	—
3–4 Years	29.96%	—
Total	20.98%	—

(–) Indicates NCQA Benchmarks are not available for this measure.

Strengths, Opportunities, and Recommendations

Strengths

Premier Access exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Oral Evaluation, Dental Services—0 to 2 Years*
- *Oral Evaluation, Dental Services—3 to 5 Years*
- *Oral Evaluation, Dental Services—6 to 14 Years*
- *Oral Evaluation, Dental Services—15 to 20 Years*
- *Oral Evaluation, Dental Services—Total*

Opportunities for Improvement

Premier Access CHIP did not fall below the MY 2024 NCQA Quality Compass average for any of the reported performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and therefore does not have any recommendations.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In MY 2023, HSAG recommended that Premier Access work with DHHS to ensure that performance measure data submitted for the EQR Technical Report are validated by an external entity.

Health Plan Interventions

In response to HSAG's MY 2023 recommendations Premier Access engaged with HSAG and DHHS more proactively to ensure alignment, clarify expectations, and validate approaches for performance measure rate reporting.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that this intervention may result in long-term improvements. HSAG encourages Premier Access to continue to leverage a quality improvement framework to evaluate the impact and effectiveness of the intervention to determine if it should be adopted, adapted, or abandoned, as well as a spread and sustainability plan where effectiveness is measured, noting significant improvement.

PAHP Providing CHIP Dental Services

Premier Access CHIP

Results and Outcomes

Validation Results

HSAG's review of the FAR for HEDIS MY 2024 showed that Premier Access CHIP's HEDIS compliance auditor found Premier Access CHIP's IS and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2024. Premier Access CHIP contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. HSAG reviewed Premier Access CHIP's HEDIS MY 2024 FAR and determined no notable findings and all measures obtained a *Reportable* designation.

Performance Measure Outcomes

Table 2-165 shows Premier Access CHIP's MY 2024 rates for the *Oral Evaluation, Dental Services* and *Topical Fluoride for Children* measures compared to the MY 2024 NCQA QC average rates.

Table 2-165—Premier Access CHIP MY 2024 Results

HEDIS Measure	Premier Access CHIP PAHP MY 2024 Rate	MY 2024 NCQA Quality Compass Average
Oral Evaluation, Dental Services		
0–2 Years	31.80%	18.68%
3–5 Years	61.98%	46.00%
6–14 Years	70.41%	50.37%
15–20 Years	61.05%	34.76%
Total	63.69%	40.63%
Topical Fluoride for Children*		
1–2 Years	12.66%	—
3–4 Years	28.52%	—
Total	21.33%	—

(–) Indicates NCQA Benchmarks are not available for this measure.

Strengths, Opportunities, and Recommendations

Strengths

Premier Access exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Oral Evaluation, Dental Services—0 to 2 Years*
- *Oral Evaluation, Dental Services—3 to 5 Years*
- *Oral Evaluation, Dental Services—6 to 14 Years*
- *Oral Evaluation, Dental Services—15 to 20 Years*
- *Oral Evaluation, Dental Services—Total*

Opportunities for Improvement

Premier Access did not fall below the MY 2024 NCQA Quality Compass average for any of the reported performance indicators.

Recommendations

HSAG did not identify any opportunities for improvement, and therefore does not have any recommendations.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In MY 2023, HSAG recommended that Premier Access work with DHHS to ensure that performance measure data submitted for the EQR Technical Report are validated by an external entity.

Health Plan Interventions

In response to HSAG's MY 2023 recommendations, Premier Access engaged with HSAG and DHHS more proactively to ensure alignment, clarify expectations, and validate approaches for performance measure rate reporting.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that this intervention may result in long-term improvements. HSAG encourages Premier Access to continue to utilize a quality improvement framework to understand how the intervention is impacting or not impacting the measure. Additionally, HSAG suggests obtaining and analyzing data on members out of compliance with the measures to tailor interventions specific to the population.

CMS Protocol 3: Compliance Monitoring

Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement

Following are strengths, opportunities for improvement, and recommendations related to CMS Protocol 3 Review of Compliance With Medicaid and CHIP Managed Care Regulations with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =

Medicaid ACOs Providing Only Physical Health Services

Health Choice Utah (Health Choice)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[193] Table 2-166 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-166—Summary of Scores for Health Choice

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%

[193] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	21	21	17	4	0	90%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	14	14	12	2	0	93%
CY 2024	VI—Coordination and Continuity of Care	8	8	4	3	1	69%
CY 2023	VII—Coverage and Authorization of Services	19	19	17	2	0	95%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	14	5	0	87%
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	0	4	0	50%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	5	1	0	92%
CY 2023	XIII—Grievance and Appeal System	28	28	26	2	0	96%
CY 2023	**Totals**	**75**	**75**	**71**	**4**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**58**	**19**	**1**	**87%**
Combined	**Totals**	**153**	**153**	**129**	**23**	**1**	**92%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or

Not Applicable (NA) to the relevant requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-167 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-167—Focused Review Results for Health Choice

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	1	0	2	88%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	2	1	0	1	83%
Totals	**17**	**13**	**10**	**2**	**0**	**4**	**85%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Health Choice:

- Ensure appeal resolution letters are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievance resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Coordination and Continuity of Care, Provider Selection and Program Integrity, Subcontractual Relationships and Delegation, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Health Choice revised member materials, policies, and compliance documents; updated network monitoring, care coordination, and quality improvement processes; and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and compliance documents; updates to network monitoring, care coordination, and quality improvement processes; and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvements.

Healthy U

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[194] Table 2-168 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-168—Summary of Scores for Healthy U

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	21	21	18	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	13	13	12	1	0	96%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	19	19	19	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	17	2	0	95%

[194] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	2	2	0	75%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**74**	**1**	**0**	**99%**
CY 2024	**Totals**	**77**	**77**	**69**	**8**	**0**	**95%**
Combined	**Totals**	**152**	**152**	**143**	**9**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-169 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-169—Focused Review Results for Healthy U

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	1	0	2	88%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	2	2	0	1	75%
Totals	**17**	**13**	**10**	**3**	**0**	**4**	**88%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Healthy U:

- Ensure appeal resolution letters are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievances are acknowledged and resolved within the identified time frame, and that resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards.

Health Plan Interventions

As part of its CAP, Healthy U revised member materials, policies, and delegation agreements and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and delegation agreements, and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvements.

Molina Healthcare of Utah (Molina)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[195] Table 2-170 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-170—Summary of Scores for Molina

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	6	1	0	93%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	21	21	18	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	14	14	14	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	7	1	0	94%
CY 2023	VII—Coverage and Authorization of Services	19	19	17	2	0	95%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	19	0	0	100%

[195] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**74**	**4**	**0**	**97%**
Combined	**Totals**	**153**	**153**	**144**	**9**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-171 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-171—Focused Review Results for Molina

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	4	1	0	1	90%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	5	5	0	0	1	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	3	1	0	1	88%
Totals	**17**	**14**	**12**	**2**	**0**	**3**	**93%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Molina:

- Ensure notice of adverse benefit determinations are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievances are acknowledged and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Coordination and Continuity of Care standards.

Health Plan Interventions

As part of its CAP, Molina revised member materials and policies and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies, and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvements.

Select Health Community Care (Select Health CC)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[196] Table 2-172 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-172—Summary of Scores for Select Health CC

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	21	21	16	5	0	88%
CY 2023	IV—Emergency and Poststabilization Services	11	11	8	3	0	86%
CY 2024	V—Adequate Capacity	14	14	11	3	0	89%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	19	19	19	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%

[196] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**69**	**9**	**0**	**94%**
Combined	**Totals**	**153**	**153**	**139**	**14**	**0**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-173 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-173—Focused Review Results for Select Health CC

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	3	2	0	1	80%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	6	3	3	0	0	75%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	3	0	0	2	100%
Totals	**17**	**14**	**9**	**5**	**0**	**3**	**82%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Select Health CC:

- Ensure procedures for exercising the right to request a State fair hearing are included in notice of adverse benefit determinations.
- Ensure notice of adverse benefit determinations are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure appeals are resolved within applicable time frames and that efforts to provide the member with oral notice about extensions or expedited appeals are documented within the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Select Health CC revised member materials, policies, and compliance documents, and updated provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and compliance documents and updates to provider directories will likely result in long-term improvements.

Medicaid MCOs Providing Physical Health, Mental Health, and SUD Services

Health Choice Utah (Health Choice UMIC)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[197] Table 2-174 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-174—Summary of Scores for Health Choice UMIC

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	21	21	17	4	0	90%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	14	14	12	2	0	93%
CY 2024	VI—Coordination and Continuity of Care	8	8	4	3	1	69%
CY 2023	VII—Coverage and Authorization of Services	19	19	17	2	0	95%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	13	6	0	84%

[197] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	0	4	0	50%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	5	1	0	92%
CY 2023	XIII—Grievance and Appeal System	28	28	26	2	0	96%
CY 2023	**Totals**	**75**	**75**	**71**	**4**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**57**	**20**	**1**	**86%**
Combined	**Totals**	**153**	**153**	**128**	**24**	**1**	**92%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-175 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-175—Focused Review Results for Health Choice UMIC

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	2	2	0	2	75%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	4	0	0	1	100%
Totals	**17**	**13**	**11**	**2**	**0**	**4**	**92%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Health Choice UMIC:

- Ensure appeals are resolved and that the member receives written notice of the disposition, as expeditiously as the member's health condition requires.
- Ensure appeal resolution letters are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Coordination and Continuity of Care, Provider Selection and Program Integrity, Subcontractual Relationships and Delegation, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Health Choice UMIC revised member materials, policies, and compliance documents; updated network monitoring, care coordination, and quality improvement processes; and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and compliance documents; updates to network monitoring, care coordination, and quality improvement processes; and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvements.

Healthy Outcomes Medical Excellence (HOME)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[198] Table 2-176 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-176—Summary of Scores for HOME

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	20	19	16	3	0	92%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	14	14	13	0	1	93%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%

[198] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	3	3	2	1	0	83%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**73**	**73**	**72**	**1**	**0**	**99%**
CY 2024	**Totals**	**77**	**76**	**71**	**4**	**1**	**96%**
Combined	**Totals**	**150**	**149**	**144**	**5**	**1**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-177 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-177—Focused Review Results for HOME

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	4	1	0	1	90%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	0	1	2	75%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	3	1	0	1	88%
Totals	**17**	**13**	**10**	**2**	**1**	**4**	**85%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

HSAG did not identify any strengths for HOME based on the results of the focused review.

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that HOME:

- Ensure notice of adverse benefit determinations include required content and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure appeal resolution letters are easy to understand, meet the language and format requirements of 42 CFR §438.10(c), and include the results of the resolution process and the date it was completed.
- Ensure grievance resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, HOME revised member materials, policies, and compliance documents and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach ***to Addressing Prior Year Recommendations***

HSAG recognizes that revisions to member materials, policies, and compliance documents and implementing a strategic plan to update its provider directories with accessibility information will likely result in long-term improvements.

Healthy U Integrated

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[199] Table 2-178 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-178—Summary of Scores for Healthy U Integrated

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	21	21	18	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	13	13	12	1	0	96%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	19	19	19	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	16	3	0	92%

[199] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	2	2	0	75%
CY 2023	X—Practice Guidelines	3	3	2	1	0	83%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**73**	**2**	**0**	**98%**
CY 2024	**Totals**	**77**	**77**	**68**	**9**	**0**	**94%**
Combined	**Totals**	**152**	**152**	**141**	**11**	**0**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-179 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-179—Focused Review Results for Healthy U Integrated

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	5	4	1	0	1	90%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	2	2	0	1	75%
Totals	**17**	**14**	**11**	**3**	**0**	**3**	**89%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Healthy U Integrated:

- Ensure appeal resolution letters are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievances are acknowledged and that resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards.

Health Plan Interventions

As part of its CAP, Healthy U Integrated revised member materials, policies, and delegation agreements and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and delegation agreements and implementing a strategic plan to update its provider directories with accessibility information will likely result in long-term improvements.

Molina (Molina UMIC)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[200] Table 2-180 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-180—Summary of Scores for Molina UMIC

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	6	1	0	93%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	21	21	19	2	0	95%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	14	14	14	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	7	1	0	94%
CY 2023	VII—Coverage and Authorization of Services	19	19	17	2	0	95%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	19	0	0	100%

[200] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**75**	**3**	**0**	**98%**
Combined	**Totals**	**153**	**153**	**145**	**8**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-181 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-181—Focused Review Results for Molina UMIC

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	4	1	0	1	90%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	1	0	2	88%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	2	2	0	1	75%
Totals	**17**	**13**	**9**	**4**	**0**	**4**	**85%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

HSAG did not identify strengths for Molina UMIC based on the results of the focused review.

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Molina UMIC:

- Ensure notice of adverse benefit determinations and grievance resolution letters are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievances are acknowledged and documented appropriately in the record.
- Review processes to ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making nor a subordinate of any such individual.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Coordination and Continuity of Care standards.

Health Plan Interventions

As part of its CAP, Molina UMIC revised member materials and policies and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvements.

Select Health CC (Select Health CC UMIC)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[201] Table 2-182 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-182—Summary of Scores for Select Health CC UMIC

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	93%
III	Member Information	21	21	16	5	0	88%
IV	Emergency and Poststabilization Services	11	11	8	3	0	86%
V	Adequate Capacity	14	14	11	3	0	89%
VI	Coordination and Continuity of Care	8	8	8	0	0	100%
VII	Coverage and Authorization of Services	19	19	19	0	0	100%
VIII	Provider Selection and Program Integrity	19	19	18	1	0	97%

[201] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
IX	Subcontractual Relationships and Delegation	4	4	4	0	0	100%
X	Practice Guidelines	3	3	3	0	0	100%
XI	Health Information Systems	6	6	6	0	0	100%
XII	QAPIP	6	6	6	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**69**	**9**	**0**	**94%**
Combined	**Totals**	**153**	**153**	**139**	**14**	**0**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-183 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-183—Focused Review Results for Select Health CC UMIC

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	3	2	0	1	80%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	6	5	1	0	0	92%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	3	0	0	2	100%
Totals	**17**	**14**	**11**	**3**	**0**	**3**	**89%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Grievances

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals

Recommendations

HSAG recommends that Select Health CC UMIC:

- Ensure procedures for exercising the right to request a State fair hearing are included in notice of adverse benefit determinations.
- Ensure notice of adverse benefit determinations are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure appeals are acknowledged upon receipt and that the acknowledgement is documented within the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Select Health CC UMIC revised member materials, policies, and compliance documents, and updated provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and compliance documents and updates to provider directories will likely result in long-term improvements.

Medicaid PIHP PMHPs Providing Mental Health and SUD Services

Bear River Mental Health Services (Bear River)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[202] Table 2-184 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-184—Summary of Scores for Bear River

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	5	2	0	86%
CY 2024	III—Member Information	20	20	17	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	11	11	10	1	0	95%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	7	1	0	94%
CY 2023	VII—Coverage and Authorization of Services	17	17	16	1	0	97%

[202] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	VIII—Provider Selection and Program Integrity	19	19	17	2	0	95%
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	5	1	0	92%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**71**	**71**	**67**	**4**	**0**	**97%**
CY 2024	**Totals**	**75**	**71**	**64**	**7**	**0**	**95%**
Combined	**Totals**	**146**	**142**	**131**	**11**	**0**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-185 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-185—Focused Review Results for Bear River

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	2	1	0	2	83%
Totals	**17**	**7**	**6**	**1**	**0**	**10**	**93%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Bear River:

- Ensure grievance resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Coordination and Continuity of Care, Provider Selection and Program Integrity, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Bear River revised member materials, developed policies, and updated quality improvement processes.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and updates to quality improvement processes will likely result in long-term improvements.

Central Utah Counseling Center (Central)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[203] Table 2-186 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-186—Summary of Scores for Central

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	20	20	17	2	1	90%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	12	12	11	1	0	96%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	17	2	0	95%

[203] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	5	1	0	92%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**70**	**70**	**69**	**1**	**0**	**99%**
CY 2024	**Totals**	**75**	**71**	**64**	**6**	**1**	**94%**
Combined	**Totals**	**145**	**141**	**133**	**7**	**1**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-187 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-187—Focused Review Results for Central

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	0	0	0	0	6	NA
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	2	2	0	1	75%
Totals	**17**	**4**	**2**	**2**	**0**	**13**	**75%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

HSAG did not identify any strengths for Central based on the results of the focused review.

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Central ensure that grievance resolutions are easy to understand, meet the language and format requirements of 42 CFR §438.10(c), and are documented appropriately within the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity

- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Central revised member materials, policies, provider agreements, and quality documents and updated credentialing processes.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, provider agreements, and quality documents and updates to credentialing processes will likely result in long-term improvements.

Davis Behavioral Health (Davis)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[204] Table 2-188 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-188—Summary of Scores for Davis

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	3	1	0	88%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	20	17	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	11	11	8	3	0	86%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	15	2	0	94%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	14	3	2	82%

[204] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	2	1	0	83%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**70**	**70**	**62**	**8**	**0**	**94%**
CY 2024	**Totals**	**75**	**71**	**63**	**6**	**2**	**93%**
Combined	**Totals**	**145**	**141**	**125**	**14**	**2**	**94%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-189 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-189—Focused Review Results for Davis

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	3	2	0	1	80%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	3	1	0	1	88%
Totals	**17**	**13**	**10**	**3**	**0**	**4**	**88%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Davis:

- Ensure notice of adverse benefit determinations are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure verbal appeals are accepted without requiring additional notification in writing.
- Ensure grievance resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Davis revised member materials and policies and updated credentialing and recredentialing processes.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies, and updates to credentialing and recredentialing processes will likely result in long-term improvements.

Four Corners Community Behavioral Health (Four Corners)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[205] Table 2-190 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-190—Summary of Scores for Four Corners

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	20	20	14	5	1	83%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	12	12	7	3	2	71%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%

[205] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	2	1	0	83%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	4	2	0	83%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**70**	**70**	**69**	**1**	**0**	**99%**
CY 2024	**Totals**	**75**	**71**	**57**	**11**	**3**	**88%**
Combined	**Totals**	**145**	**141**	**126**	**12**	**3**	**94%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-191 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-191—Focused Review Results for Four Corners

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	0	0	0	0	6	NA
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	3	1	0	1	88%
Totals	**17**	**4**	**3**	**1**	**0**	**13**	**88%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

HSAG did not identify any strengths for Four Corners based on the results of the focused review.

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Four Corners ensure grievance resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity

- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Coordination and Continuity of Care, Provider Selection and Program Integrity, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Four Corners revised member materials, policies, and compliance documents; updated network monitoring, care coordination, and quality improvement processes; and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and compliance documents; updates to network monitoring, care coordination, and quality improvement processes; and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvement.

Healthy U Behavioral

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[206] Table 2-192 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-192—Summary of Scores for Healthy U Behavioral

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	21	21	19	2	0	95%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	13	11	10	1	0	95%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	19	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	17	2	0	95%

[206] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	2	2	0	75%
CY 2023	X—Practice Guidelines	3	3	2	1	0	83%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**70**	**68**	**2**	**0**	**99%**
CY 2024	**Totals**	**77**	**75**	**68**	**7**	**0**	**95%**
Combined	**Totals**	**152**	**145**	**136**	**9**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-193 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-193—Focused Review Results for Healthy U Behavioral

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	4	0	0	1	100%
Totals	**17**	**8**	**8**	**0**	**0**	**9**	**100%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Healthy U Behavioral based on the results of the focused review.

Recommendations

HSAG did not identify any recommendations for Healthy U Behavioral based on the results of the focused review.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards.

Health Plan Interventions

As part of its CAP, Healthy U Behavioral revised member materials, policies, and delegation agreements and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and delegation agreements and implementing a strategic plan to update its provider directories with accessibility information will likely result in long-term improvements.

Northeastern Counseling Center (Northeastern)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[207] Table 2-194 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-194—Summary of Scores for Northeastern

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	20	18	2	0	95%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	12	12	11	1	0	96%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%

[207] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	26	2	0	96%
CY 2023	**Totals**	**70**	**70**	**67**	**3**	**0**	**98%**
CY 2024	**Totals**	**75**	**71**	**67**	**4**	**0**	**97%**
Combined	**Totals**	**145**	**141**	**134**	**7**	**0**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-195 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-195—Focused Review Results for Northeastern

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	3	0	0	2	100%
Totals	**17**	**7**	**7**	**0**	**0**	**10**	**100%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Northeastern based on the results of the focused review.

Recommendations

HSAG did not identify any recommendations for Northeastern based on the results of the focused review.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Northeastern revised member materials and policies and updated credentialing processes.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies and updates to credentialing processes will likely result in long-term improvements.

Optum/Tooele

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[208] Table 2-196 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-196—Summary of Scores for Optum/Tooele

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	19	16	3	0	92%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	16	1	0	97%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%

[208] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	1	3	0	63%
CY 2023	X—Practice Guidelines	4	4	4	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**71**	**71**	**69**	**2**	**0**	**99%**
CY 2024	**Totals**	**75**	**74**	**67**	**7**	**0**	**95%**
Combined	**Totals**	**146**	**145**	**136**	**9**	**0**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-197 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-197—Focused Review Results for Optum/Tooele

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	6	5	1	0	0	92%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	6	4	2	0	0	83%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	3	0	0	2	100%
Totals	**17**	**15**	**12**	**3**	**0**	**2**	**90%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Grievances

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals

Recommendations

HSAG recommends that Optum/Tooele:

- Ensure that it mails notice of adverse benefit determinations and appeal resolution letters within required time frames.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards.

Health Plan Interventions

As part of its CAP, Optum/Tooele revised member materials and policies, updated delegated agreements, and added accessibility information to its provider directory.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies, updates to delegated agreements, and adding accessibility information to its provider directories will likely result in long-term improvements.

Salt Lake County Division of Behavioral Health Services (Salt Lake)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[209] Table 2-198 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-198—Summary of Scores for Salt Lake

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	20	16	4	0	90%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	16	1	0	97%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%

[209] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	4	4	4	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**71**	**71**	**69**	**2**	**0**	**99%**
CY 2024	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
Combined	**Totals**	**146**	**146**	**139**	**7**	**0**	**98%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-199 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-199—Focused Review Results for Salt Lake

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	4	1	0	1	90%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	4	0	0	1	100%
Totals	**17**	**13**	**12**	**1**	**0**	**4**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services

Recommendations

HSAG recommends that Salt Lake:

- Ensure that it mails notice of adverse benefit determinations within required time frames.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Salt Lake revised member materials and policies and added accessibility information to its provider directory.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies and adding accessibility information to its provider directory will likely result in long-term improvements.

Southwest Behavioral Health Center (Southwest)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[210] Table 2-200 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-200—Summary of Scores for Southwest

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	5	2	0	86%
CY 2024	III—Member Information	20	20	15	5	0	88%
CY 2023	IV—Emergency and Poststabilization Services	11	11	9	2	0	91%
CY 2024	V—Adequate Capacity	12	12	11	1	0	96%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	15	4	0	89%

[210] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	4	2	0	83%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**70**	**70**	**66**	**4**	**0**	**97%**
CY 2024	**Totals**	**75**	**71**	**59**	**12**	**0**	**92%**
Combined	**Totals**	**145**	**141**	**125**	**16**	**0**	**94%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-201 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-201—Focused Review Results for Southwest

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	0	0	0	0	6	NA
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	1	3	0	1	63%
Totals	**17**	**4**	**1**	**3**	**0**	**13**	**63%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

HSAG did not identify any strength for Southwest based on the results of the focused review.

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends Southwest:

- Ensure grievances are acknowledged and resolved within the identified time frame, and that resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information

- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Southwest revised member materials and policies, updated credentialing processes, and developed a quality improvement plan.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies, updates to credentialing processes, and the development of a quality improvement plan will likely result in long-term improvements.

Wasatch Behavioral Health (Wasatch)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[211] Table 2-202 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-202—Summary of Scores for Wasatch

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	20	16	4	0	90%
CY 2023	IV—Emergency and Poststabilization Services	11	11	10	1	0	95%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	7	1	0	94%
CY 2023	VII—Coverage and Authorization of Services	17	17	16	1	0	97%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	15	3	1	87%

[211] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	5	0	1	83%
CY 2023	XIII—Grievance and Appeal System	28	28	26	2	0	96%
CY 2023	**Totals**	**70**	**70**	**65**	**5**	**0**	**96%**
CY 2024	**Totals**	**75**	**71**	**61**	**8**	**2**	**92%**
Combined	**Totals**	**145**	**141**	**126**	**13**	**2**	**94%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-203 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-203—Focused Review Results for Wasatch

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	0	0	0	0	6	NA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	1	0	2	88%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	2	2	0	1	75%
Totals	**17**	**8**	**5**	**3**	**0**	**9**	**81%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

HSAG did not identify any strengths for Wasatch based on the results of the focused review.

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Wasatch:

- Ensure that appeal resolutions are provided to all affected parties to the appeal.
- Ensure that appeal resolution letters include clear and accurate language related to the appeal and include State fair hearing rights and instructions.
- Ensure that grievances are resolved timely, that grievance resolutions are documented within the record and resolution letter, and that the member is made aware of the resolution.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Coordination and Continuity of Care, Provider Selection and Program Integrity, and QAPIP standards.

Health Plan Interventions

As part of its CAP, Wasatch revised member materials and policies, updated credentialing processes, and developed a quality improvement plan.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies, updates to credentialing processes, and the development of a quality improvement plan will likely result in long-term improvements.

Weber Human Services (Weber)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[212] Table 2-204 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-204—Summary of Scores for the Standards for Weber

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	4	4	4	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	5	2	0	86%
CY 2024	III—Member Information	20	20	17	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	7	1	0	94%
CY 2023	VII—Coverage and Authorization of Services	17	17	17	0	0	100%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	15	4	0	89%

[212] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	0	0	0	0	NA
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	25	3	0	95%
CY 2023	**Totals**	**70**	**70**	**65**	**5**	**0**	**96%**
CY 2024	**Totals**	**75**	**71**	**63**	**8**	**0**	**94%**
Combined	**Totals**	**145**	**141**	**127**	**14**	**0**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-205 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-205—Focused Review Results for Weber

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	3	0	0	2	100%
Totals	**17**	**12**	**12**	**0**	**0**	**5**	100%

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Weber based on the results of the focused review.

Recommendations

HSAG did not identify any recommendations for Weber based on the results of the focused review.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Coordination and Continuity of Care, and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Weber revised member materials and policies and updated its provider directory and credentialing processes.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies and updates to its provider directory and credentialing processes will likely result in long-term improvements.

CHIP MCOs Providing Physical Health, Mental Health, and SUD Services

Healthy U CHIP

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Healthy U CHIP was launched on July 1, 2024; therefore, it was not included in the 2023 or 2024 Utah External Quality Review Report of Results. HSAG will conduct a review of the standards beginning in CY 2026.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-206 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-206—Focused Review Results for Healthy U CHIP

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	1	0	2	88%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	2	0	1	2	67%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Totals	**17**	**12**	**10**	**1**	**1**	**5**	**88%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Healthy U CHIP:

- Ensure appeal resolution letters are easy to understand, meet the language and format requirements of 42 CFR §438.10(c), and include the results of the resolution process and the date it was completed.
- Ensure grievances are acknowledged and that resolutions are communicated to members and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Healthy U CHIP was launched on July 1, 2024; therefore, HSAG did not provide prior year recommendations and it was not included in the 2024 Utah External Quality Review Report of Results.

Molina Healthcare of Utah CHIP (Molina CHIP)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[213] Table 2-207 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-207—Summary of Scores for Molina CHIP

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	6	1	0	93%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	21	21	19	2	0	95%
CY 2023	IV—Emergency and Poststabilization Services	11	11	11	0	0	100%
CY 2024	V—Adequate Capacity	14	14	13	0	1	93%
CY 2024	VI—Coordination and Continuity of Care	8	8	6	2	0	88%
CY 2023	VII—Coverage and Authorization of Services	19	19	17	2	0	95%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	19	0	0	100%

[213] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**73**	**4**	**1**	**96%**
Combined	**Totals**	**153**	**153**	**143**	**9**	**1**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-208 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-208—Focused Review Results for Molina CHIP

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	6	5	1	0	0	92%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	5	5	0	0	1	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	3	1	0	1	88%
Totals	**17**	**15**	**13**	**2**	**0**	**2**	**93%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Appeals

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that Molina CHIP:

- Ensure notice of adverse benefit determinations are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievances are acknowledged and documented appropriately in the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Coordination and Continuity of Care standards.

Health Plan Interventions

As part of its CAP, Molina CHIP revised member materials and policies and developed a strategic plan to update provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies and implementing a strategic plan to update provider directories with accessibility information will likely result in long-term improvements.

Select Health CHIP

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[214] Table 2-209 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-209—Summary of Scores for Select Health CHIP

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
I	Enrollment and Disenrollment	7	7	7	0	0	100%
II	Member Rights and Confidentiality	7	7	6	1	0	93%
III	Member Information	21	21	15	6	0	86%
IV	Emergency and Poststabilization Services	11	11	8	3	0	86%
V	Adequate Capacity	14	14	11	3	0	89%
VI	Coordination and Continuity of Care	8	8	8	0	0	100%
VII	Coverage and Authorization of Services	19	19	19	0	0	100%
VIII	Provider Selection and Program Integrity	19	19	18	1	0	97%

[214] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Standard	Description	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
IX	Subcontractual Relationships and Delegation	4	4	4	0	0	100%
X	Practice Guidelines	3	3	3	0	0	100%
XI	Health Information Systems	6	6	6	0	0	100%
XII	QAPIP	6	6	6	0	0	100%
XIII	Grievance and Appeal System	28	28	27	1	0	98%
CY 2023	**Totals**	**75**	**75**	**70**	**5**	**0**	**97%**
CY 2024	**Totals**	**78**	**78**	**68**	**10**	**0**	**94%**
Combined	**Totals**	**153**	**153**	**138**	**15**	**0**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-210 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-210—Focused Review Results for Select Health CHIP

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	4	1	0	1	90%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	6	5	1	0	0	92%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	3	3	0	0	2	100%
Totals	**17**	**14**	**12**	**2**	**0**	**3**	**93%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Grievance and Appeal System: Grievances

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals

Recommendations

HSAG recommends that Select Health CHIP:

- Ensure procedures for exercising the right to request a State fair hearing are included in notice of adverse benefit determinations.
- Ensure efforts to provide the member with oral notice about appeal extensions are documented within the record.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, Select Health CHIP revised member materials, policies, and compliance documents, and updated provider directories with accessibility information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, policies, and compliance documents and updates to provider directories will likely result in long-term improvements.

Medicaid PAHPs Providing Dental Services

Managed Care of North America Dental (MCNA)

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[215] Table 2-211 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-211—Summary of Scores for MCNA

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	7	0	0	100%
CY 2024	III—Member Information	20	20	19	1	0	98%
CY 2023	IV—Emergency and Poststabilization Services	8	8	8	0	0	100%
CY 2024	V—Adequate Capacity	12	12	12	0	0	100%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	16	1	0	97%

[215] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	VIII—Provider Selection and Program Integrity	19	19	18	1	0	97%
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	4	0	0	100%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	28	0	0	100%
CY 2023	**Totals**	**70**	**70**	**69**	**1**	**0**	**99%**
CY 2024	**Totals**	**75**	**75**	**73**	**2**	**0**	**99%**
Combined	**Totals**	**145**	**145**	**142**	**3**	**0**	**99%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-212 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-212—Focused Review Results for MCNA

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	5	5	0	0	1	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	3	1	0	2	88%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	3	1	0	1	88%
Totals	**17**	**13**	**11**	**2**	**0**	**4**	**92%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services

Opportunities for Improvement

Based on the results of the focused review in CY 2025, HSAG identified opportunities for improvement within the following standard areas:

- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Recommendations

HSAG recommends that MCNA:

- Ensure appeal resolution letters are easy to understand and meet the language and format requirements of 42 CFR §438.10(c).
- Ensure grievance resolution letters clearly explain the resolution.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information and Provider Selection and Program Integrity standards.

Health Plan Interventions

As part of its CAP, MCNA revised member materials and policies.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials and policies will likely result in long-term improvements.

Premier Access

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[216] Table 2-213 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-213—Summary of Scores for Premier Access

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	20	18	2	0	95%
CY 2023	IV—Emergency and Poststabilization Services	8	8	8	0	0	100%
CY 2024	V—Adequate Capacity	12	12	9	3	0	88%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	15	1	1	91%
CY 2024	VIII—Provider Selection and Program Integrity	19	19	9	9	1	71%

[216] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	2	2	0	75%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	21	7	0	88%
CY 2023	**Totals**	**70**	**70**	**60**	**9**	**1**	**92%**
CY 2024	**Totals**	**75**	**75**	**58**	**16**	**1**	**88%**
Combined	**Totals**	**145**	**145**	**118**	**27**	**2**	**91%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-214 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-214—Focused Review Results for Premier Access

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	6	6	0	0	0	100%

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	4	0	0	1	100%
Totals	**17**	**14**	**14**	**0**	**0**	**3**	**100%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Premier Access based on the results of the focused review.

Recommendations

HSAG did not identify any recommendations for Premier Access based on the results of the focused review.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards.

Health Plan Interventions

As part of its CAP, Premier Access revised member materials, provider manuals, and policies; promoted cultural competency through training; updated credentialing processes; and executed amendments to contracts with required provisions.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, provider manuals, and policies; promoting cultural competency through training; updating credentialing processes; and executing amendments to contracts with required provisions will likely result in long-term improvements.

CHIP PAHP Providing Dental Services

Premier Access CHIP

Standards Review Scores and Focused Review Results

Standards Review Scores

During CY 2023 (review period January 1, 2022, through December 31, 2022) and CY 2024 (review period January 1, 2023, through December 31, 2023), HSAG reviewed health plan compliance with 13 standards. Strengths, opportunities, and recommendations related to the 13 standards were discussed in the 2024 Utah External Quality Review Report of Results and 2025 Utah External Quality Review Report of Results.[217] Table 2-215 presents the number of requirements within each of the standards; the number of elements assigned each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each standard; and the overall compliance score for the standards review.

Table 2-215—Summary of Scores for Premier Access CHIP

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2023	I—Enrollment and Disenrollment	7	7	7	0	0	100%
CY 2023	II—Member Rights and Confidentiality	7	7	6	1	0	93%
CY 2024	III—Member Information	20	20	17	3	0	93%
CY 2023	IV—Emergency and Poststabilization Services	8	8	8	0	0	100%
CY 2024	V—Adequate Capacity	12	12	9	3	0	88%
CY 2024	VI—Coordination and Continuity of Care	8	8	8	0	0	100%
CY 2023	VII—Coverage and Authorization of Services	17	17	15	1	1	91%

[217] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Requirements	Applicable Requirements	Met	Partially Met	Not Met	Weighted Score*
CY 2024	VIII—Provider Selection and Program Integrity	19	19	9	9	1	71%
CY 2024	IX—Subcontractual Relationships and Delegation	4	4	2	2	0	75%
CY 2023	X—Practice Guidelines	3	3	3	0	0	100%
CY 2024	XI—Health Information Systems	6	6	6	0	0	100%
CY 2024	XII—QAPIP	6	6	6	0	0	100%
CY 2023	XIII—Grievance and Appeal System	28	28	21	7	0	88%
CY 2023	**Totals**	**70**	**70**	**60**	**9**	**1**	**92%**
CY 2024	**Totals**	**75**	**75**	**58**	**16**	**1**	**88%**
Combined	**Totals**	**145**	**145**	**118**	**27**	**2**	**91%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Focused Review Results

During CY 2025, (review period January 1, 2024, through December 31, 2024) HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records. For the focused review, HSAG used record review findings to assign a score of Met, Partially Met, Not Met, or Not Applicable (NA) to each individual requirement within the Coverage and Authorization of Services and Grievance and Appeal System standards.

Table 2-216 presents the number of requirements within each of the focus areas; the number of elements assigned to each score (*Met*, *Partially Met, Not Met*, or *NA*); the compliance score for each focus area; and the overall compliance score for the standards reviewed.

Table 2-216—Focused Review Results for Premier Access CHIP

Description	Requirements	Applicable	Met	Partially Met	Not Met	Not Applicable (NA)	Weighted Score*
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	6	6	6	0	0	0	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	6	4	4	0	0	2	100%
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	5	4	4	0	0	1	100%
Totals	**17**	**14**	**14**	**0**	**0**	**3**	**100%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Strengths, Opportunities, and Recommendations

Strengths

Based on the results of the focused review in CY 2025, HSAG identified strengths within the following standard area:

- Coverage and Authorization of Services
- Grievance and Appeal System: Appeals
- Grievance and Appeal System: Grievances

Opportunities for Improvement

HSAG did not identify any opportunities for improvement for Premier Access CHIP based on the results of the focused review.

Recommendations

HSAG did not identify any recommendations for Premier Access CHIP based on the results of the focused review.

Assessment of Improvements to Address Prior Year Recommendations

Prior Year Recommendations

In CY 2024, HSAG continued a three-year compliance review cycle that included a review of the following standard areas:

- Member Information
- Adequate Capacity
- Coordination and Continuity of Care
- Provider Selection and Program Integrity
- Subcontractual Relationships and Delegation
- Health Information Systems
- QAPIP

HSAG identified required corrective actions related to the Member Information, Adequate Capacity, Provider Selection and Program Integrity, and Subcontractual Relationships and Delegation standards.

Health Plan Interventions

As part of its CAP, Premier Access revised member materials, provider manuals, and policies; promoted cultural competency through training; updated credentialing processes; and executed amendments to contracts with required provisions.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that revisions to member materials, provider manuals, and policies; promoting cultural competency through training; updating credentialing processes; and executing amendments to contracts with required provisions will likely result in long-term improvements.

CMS Protocol 4: NAV

Health Plan-Specific Results, Assessment, Conclusions, and Recommendations for Improvement

Following are strengths, opportunities for improvement, and recommendations related to CMS Protocol 4 Network Adequacy Validation with assessment of the relationship to the quality of, timeliness of, and access to care and services.

Quality =

Timeliness =

Access =

Medicaid ACOs Providing Only Physical Health Services

Health Choice Utah (Health Choice)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Health Choice's interpretation of data was accurate. Table 2-217 identifies HSAG's level of confidence for time/distance indicators.

Table 2-217—Health Choice Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 117 time/distance indicators for Health Choice. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-218 displays the number provider categories by provider domain wherein Health Choice met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-218—Compliance With Time/Distance Standards by Provider Domain—Health Choice

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	
PCP—Pediatric	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	0.0%	
Specialists—Adult	17	88.2%	47.1%	
Specialists—Pediatric	17	94.1%	0.0%	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	100.0%	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-219 displays the provider domains and categories wherein Health Choice failed to meet the time/distance standards at the statewide level.

Table 2-219—Provider Categories That Failed to Meet Time/Distance Standards—Health Choice*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Infectious Disease, Pediatric (Urban)	
Specialists—Adult	Endocrinology (Urban); Infectious Disease (Urban)	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Health Choice did not meet the time/distance standard, HSAG recommends that Health Choice assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Health Choice should ensure all providers are appropriately identified in future data submissions.
- HSAG noted during the virtual review that Health Choice used the full member population in calculating member population-specific adequacy indicators. For example, pediatric specialists were calculated for the full member population as opposed to pediatric-aged members. HSAG recommends that Health Choice explore member population-specific network adequacy indicator calculation going forward to ensure Health Choice is specifically targeting and generating accurate results for the member population-specific indicators.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions[218]

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Health Choice's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Health Choice's provider network, HSAG recommended that Health Choice assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Health Choice should ensure all providers are appropriately identified in future data submissions.

Because Health Choice only had one programmer who was trained and capable of supporting network adequacy reporting activities, HSAG recommended that Health Choice cross-train other staff members to support these activities and ensure business continuity in the development of its reports.

To address HSAG's NAV recommendations, Health Choice acknowledged that Utah has a lack of providers in the rural and frontier areas of the state. Health Choice reported that it continues to work with University of Utah Health Plans (UUHP) to align its provider networks, which will help to identify Medicaid-enrolled providers in these areas that are not in the network for possible contracts. In the

[218] Please note that the health plan interventions included in this section were provided by the health plans, and HSAG has not altered this content other than minor formatting and grammatical adjustments.

meantime, Health Choice will enter into single case agreements and encourage the use of telemedicine when clinically appropriate to address any issues regarding access to care.

In June 2025, Health Choice Utah and UUHP combined provider network services teams under the management of UUHP. Health Choice stated that by combining with UUHP, they have two data analysts who support network adequacy reporting activities for both plans, and the change provides the necessary back up.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Healthy U

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Healthy U ACO's interpretation of data was accurate. Table 2-220 identifies HSAG's level of confidence for time/distance indicators.

Table 2-220—Healthy U Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 117 time/distance indicators for Healthy U. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-221 displays the number of provider categories by provider domain wherein Healthy U met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-221—Compliance With Time/Distance Standards by Provider Domain—Healthy U

		Statewide		
Provider Domain	Number of Provider Categories in the Domain	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	🔑
PCP—Pediatric	1	100.0%	100.0%	🔑
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	🔑
Specialists—Adult	17	100.0%	94.1%	🔑

Provider Domain	Number of Provider Categories in the Domain	Statewide		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	Health Plan Percent Met (%)*	
Specialists—Pediatric	17	58.8%	58.8%	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	100.0%	100.0%	

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-222 displays the provider domains and categories wherein Healthy U failed to meet the time/distance standards at the statewide level.

Table 2-222—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Allergy & Immunology, Pediatric (Rural, Urban); Dermatology, Pediatric (Rural); General Surgery, Pediatric (Rural); Ophthalmology, Pediatric (Frontier, Rural, Urban); Otolaryngology, Pediatric (Rural); Pulmonology, Pediatric (Rural); Rheumatology, Pediatric (Rural)	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Recommendations

For the provider categories for which Healthy U did not meet the time/distance standard, HSAG recommends that Healthy U assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U should ensure all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U's provider network, HSAG recommended that Healthy U assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U should ensure all providers are appropriately identified in future data submissions.

Although Healthy U had robust validation processes in place, the process for populating Provider Genie with existing provider updates was dependent on manual data entry. HSAG recommended that Healthy U explore additional opportunities to automate manual processes, similar to the automated import process for new providers that is currently in place.

Because Healthy U had one team member who was trained and able to modify/update Quest Analytics programs, HSAG recommended that Healthy U train additional individuals on how to modify/update Quest Analytics programs so there is sufficient oversight and data quality checks on programs prior to generating results. Healthy U reported that it did not have specific contractual or regulatory time frames within which its provider network needed to update provider data. Regarding this finding, HSAG recommended that Healthy U establish time frames during which provider demographic changes are required to be reported to ensure processes are in place of ongoing management and collection of demographic data.

To address HSAG's NAV recommendations, Healthy U acknowledged that network adequacy is an ongoing effort, and the health plan continually strives to identify opportunities that can help make the provider network more robust and responsive to member needs. In order to facilitate this effort, the Provider Contracting Team reviews provider applications daily and brings them to a Contracting Committee meeting where the applications are discussed on their merit and the expected impact on members' experiences. In addition to reviewing incoming provider applications, the Provider Contracting Team uses resources such as the State's provider finder, the National Plan and Provider Enumeration System (NPPES), and Quest Enterprise Services (QES) to identify practices in areas where network adequacy is found lacking.

Healthy U indicated that one team member has a Quest Analytics Software (QAS) license, but several team members have access to, and frequently use QES for directory accuracy and network adequacy. The data for both platforms come from the same data source, Provider Genie, allowing for multiple team members to provide oversight and check the quality of the data.

Healthy U additionally stated that UUHP conducts provider data accuracy checks every 90 days, in compliance with federal requirements, which is two business days for additions and terminations and 20 business days for all other changes. As such, when an update to the provider data is required, the team works to complete any changes as quickly as possible so the provider directory reflects accurate, up-to-date information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Molina Healthcare of Utah (Molina)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Molina's interpretation of data was accurate. Table 2-223 identifies HSAG's level of confidence for time/distance indicators.

Table 2-223—Molina Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 117 time/distance indicators for Molina. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-224 displays the number of provider categories by provider domain wherein Molina met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and the ACO in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-224—Compliance With Time/Distance Standards by Provider Domain—Molina

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	
PCP—Pediatric	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Adult	17	100.0%	82.4%	
Specialists—Pediatric	17	64.7%	23.5%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	Health Plan Percent Met (%)*	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	100.0%	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-225 displays the provider domains and categories wherein Molina failed to meet the time/distance standards at the statewide level.

Table 2-225—Provider Categories That Failed to Meet Time/Distance Standards—Molina*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Allergy & Immunology, Pediatric (Frontier, Rural, Urban); Dermatology, Pediatric (Frontier, Rural, Urban); Ophthalmology, Pediatric** (Frontier, Rural, Urban); Otolaryngology, Pediatric (Rural); Pulmonology, Pediatric (Rural); Rheumatology, Pediatric (Rural)	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

For the provider categories for which Molina did not meet the time/distance standard, HSAG recommends that Molina assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina should ensure all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina's provider network and identified network inadequacies compared to DHHS' minimum time

and distance network standards. Regarding Molina's provider network, HSAG recommended that Molina assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina should ensure all providers are appropriately identified in future data submissions.

To address HSAG's NAV recommendations, Molina reported that its Network Contracting Team will continue to follow State recommendations to develop the network on an ongoing monthly basis. For all identified provider gaps, Molina will monitor for new provider opportunities entering its service areas by using the Quest Analytics Tool, Physician & Hospital Compare, NPPES, State resources, and direct outreach. Molina stated that it will make assertive recruitment efforts and contract negotiations wherever necessary to close identified provider gaps. Where insufficient providers to meet adequacy standards are identified, Molina additionally stated that it will facilitate the appropriate provider specialty exception.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Select Health Community Care (Select Health CC)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Select Health CC ACO's interpretation of data was accurate. Table 2-226 identifies HSAG's level of confidence for time/distance indicators.

Table 2-226—Select Health CC Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 117 time/distance indicators for Select Health CC. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-227 displays the number of provider categories by provider domain wherein Select Health CC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Select Health CC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-227—Compliance With Time/Distance Standards by Provider Domain—Select Health CC

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	🔑
PCP—Pediatric	1	100.0%	100.0%	🔑
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	🔑
Specialists—Adult	17	100.0%	76.5%	🔑

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	17	41.2%	0.0%	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	100.0%	100.0%	

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-228 displays the provider domains and categories wherein Select Health CC failed to meet the time/distance standards at the statewide level.

Table 2-228—Provider Categories That Failed to Meet Time/Distance Standards—Select Health CC*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Allergy & Immunology, Pediatric (Rural); Dermatology, Pediatric (Rural); Gastroenterology, Pediatric (Rural); General Surgery, Pediatric (Rural); Oncology/Hematology, Pediatric (Rural); Ophthalmology, Pediatric (Rural); Otolaryngology, Pediatric (Rural); Physical Medicine, Pediatric** (Frontier, Rural, Urban); Rheumatology, Pediatric (Rural); Urology, Pediatric (Rural)	

* To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Select Health CC did not meet the time/distance standard, HSAG recommends that Select Health CC assess if this is due to a lack of providers available in the

network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CC should ensure all providers are appropriately identified in future data submissions.

- Select Health CC built Quest Analytics indicator calculations each time the time/distance analysis was run, which can lead to inconsistencies in the reported member access. HSAG recommends that Select Health CC explore opportunities to standardize network indicator calculations to ensure consistent measurement of member access.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Select Health CC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Select Health CC's provider network, HSAG recommended that Select Health CC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CC should ensure all providers are appropriately identified in future data submissions.

Because Select Health CC only had one individual trained and capable of accessing and developing reports using Quest Analytics, HSAG recommended that other staff members be cross-trained to support network adequacy activities to ensure business continuity in the development of its reports.

HSAG noted that Select Health CC's original submission used member data from 2021, which was updated upon request. While there were no substantial changes in the results between the two submissions, HSAG noted a reduction in the total member population, which was likely due to the unwinding. In addition, instead of accurately separating the population by adult, pediatric, and female groups, Select Health CC used the same total number of members in its calculations. Therefore, the methods that Select Health CC selected were deemed not appropriate for the State Medicaid and CHIP populations.

Further, due to the member population not being accurately grouped by age and gender. Select Health CC did not produce valid or accurate results—that is, Select Health CC did not measure what it intended to measure, and its values did not reflect the true values. HSAG recommended that Select Health CC continue to monitor member access through annual network adequacy assessments based on the State's expectations. HSAG also recommended that Select Health CC continue to use the most updated member file for its network adequacy analyses. A final recommendation from HSAG was that Select Health CC group the member population into adult, pediatric, and female groups when

calculating results. This would improve the methods to ensure that they were appropriate to the population. Further, it would improve the results to ensure that they were accurate and valid.

To address HSAG's NAV recommendations, Select Health CC reported it had:

- Cross-trained another individual to run Quest Analytics. This increases the number to three individuals who may be able to perform reporting, analysis, and ongoing monitoring of network adequacy.
- Improved upon the recommendation to enhance member data by including specific details regarding gender and age to measure against the provider and facility specialty types. This has already been utilized this year and will be moving forward.
- Added the ability to examine claims data for pediatric specialty types that are not being reflected because the field types required are not mentioned in their data (i.e., pediatric allergy and immunologist or pediatric rheumatologist). This may close gaps that Select Health CC considers to not be an access issue.
- Established a restructured Network Development Steering Committee (NDSC) to serve as a cross-functional forum to identify and resolve inter-departmental barriers. Enhancements include improved follow-up on actions items, strengthening feedback loops, and increased accountability. This committee continues to prioritize health plan recruitment and provider driven recruitment strategies to support growth and access. One of the key components to discuss is adequacy gaps, survey data, appeals and grievances, understanding if there are any patterns or outliers that have led to access shortages. If any are identified, Select Health CC will actively recruit and contract any practitioners or facilities to fill the gaps.
- From 2024 to 2025, Select Health's ACO network adequacy gaps decreased from 17 to 12.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Medicaid MCOs Providing Physical Health, Mental Health, and SUD Services

Health Choice Utah (Health Choice UMIC)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Health Choice UMIC's interpretation of data was accurate. Table 2-229 identifies HSAG's level of confidence for time/distance indicators.

Table 2-229—Health Choice UMIC Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 23 time/distance indicators for Health Choice UMIC. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-230 displays the number of provider categories by provider domain wherein Health Choice UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Health Choice UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) operate in urban areas.

Table 2-230—Compliance With Time/Distance Standards by Provider Domain—Health Choice UMIC

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	Health Plan Percent Met (%)*	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Adult	17	100.0%	100.0%	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	100.0%	100.0%	
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	
*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).				

Opportunities for Improvement

HSAG identified no provider domains where Health Choice UMIC failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG noted during the virtual review that Health Choice used the full member population in calculating member population-specific adequacy indicators. For example, pediatric specialists were calculated for the full member population as opposed to pediatric-aged members. HSAG recommends that Health Choice explore member population-specific network adequacy indicator calculations going forward to ensure Health Choice is specifically targeting and generating accurate results for the member population-specific indicators.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Health Choice UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Health Choice UMIC's provider network, HSAG recommended that Health Choice UMIC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance

standard is due to data concerns, Health Choice UMIC should ensure all providers are appropriately identified in future data submissions.

Because Health Choice UMIC only had one programmer who was trained and capable of supporting network adequacy reporting activities, HSAG recommended that Health Choice cross-train other staff members to support these activities and ensure business continuity in the development of its reports.

To address HSAG's NAV recommendations, Health Choice UMIC acknowledged that Utah has a lack of providers in the rural and frontier areas of the state. Health Choice UMIC reported that it continues to work with UUHP to align provider networks, which will help to identify Medicaid-enrolled providers in these areas that are not in network for possible contracts. In the meantime, Health Choice UMIC will enter into single case agreements and encourage the use of telemedicine when clinically appropriate to address any issues regarding access to care.

In June 2025, Health Choice Utah and UUHP combined provider network services teams under the management of UUHP. Health Choice stated that by combining with UUHP, they have two data analysts who support network adequacy reporting activities for both plans, and the change provides the necessary back up.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Healthy Outcomes Medical Excellence (HOME)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if HOME's interpretation of data was accurate. Table 2-231 identifies HSAG's level of confidence for time/distance indicators.

Table 2-231—HOME Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 114 time/distance indicators for HOME. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-232 displays the number of provider categories by provider domain wherein HOME met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and HOME in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-232—Compliance With Time/Distance Standards by Provider Domain—HOME

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	🔑
PCP—Pediatric	1	100.0%	100.0%	🔑
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	🔑
Specialists—Adult	17	100.0%	100.0%	🔑

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	Health Plan Percent Met (%)*	
Specialists—Pediatric	17	88.2%	88.2%	🔑
Hospitals	1	100.0%	100.0%	🔑

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-233 displays the provider domains and categories wherein HOME failed to meet the time/distance standards at the statewide level.

Table 2-233—Provider Categories That Failed to Meet Time/Distance Standards—HOME*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialists—Pediatric	Allergy & Immunology, Pediatric** (Frontier, Rural, Urban); Ophthalmology, Pediatric (Frontier, Rural, Urban)	🔑

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

For the provider categories for which HOME did not meet the time/distance standard, HSAG recommends that HOME assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, HOME should ensure all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate HOME's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding HOME's provider network, HSAG recommended that HOME assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other

reasons. If the inability to meet the time/distance standard is due to data concerns, HOME should ensure all providers are appropriately identified in future data submissions.

Due to HOME's manual data entry method to populate and update provider data in the Provider Genie system, HSAG recommended that HOME explore options to have the data automatically or systematically uploaded from one system to another to mitigate the potential for human data entry error. HSAG additionally noted that HOME did not have specific contractual or regulatory time frames within which its provider network needed to update provider data and recommended that HOME establish time frames during which provider demographic changes are required to be reported to ensure processes are in place for ongoing management and collection of demographic data.

To address HSAG's NAV recommendations, HOME presented the findings and recommendations regarding network adequacy to UUHP, the third-party administrator responsible for managing HOME's provider network. HOME and UUHP noted they are continuing to work together to address identified gaps and enhance the overall adequacy of the provider network.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Healthy U Integrated

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Healthy U UMIC's interpretation of data was accurate. Table 2-234 identifies HSAG's level of confidence for time/distance indicators.

Table 2-234—Healthy U Integrated Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 23 time/distance indicators for Healthy U Integrated. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-235 displays the number and percentage of provider categories by provider domain wherein Healthy U Integrated met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Healthy U Integrated in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-235—Compliance With Time/Distance Standards by Provider Domain—Healthy U Integrated

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Adult	17	100.0%	100.0%	
Hospitals	1	100.0%	100.0%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	Health Plan Percent Met (%)*	
Pharmacy	1	100.0%	100.0%	
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

HSAG identified no provider domains where Healthy U Integrated failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG did not identify any opportunity for improvement and as such there are no recommendations.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U Integrated's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U Integrated's provider network, HSAG recommended that Healthy U Integrated assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U Integrated should ensure all providers are appropriately identified in future data submissions.

Because Healthy U Integrated had one team member who was trained and able to modify/update Quest Analytics programs, HSAG recommended that Healthy U Integrated train additional individuals on how to modify/update Quest Analytics programs so there is sufficient oversight and data quality checks on programs prior to generating results.

Although Healthy U Integrated had robust validation processes in place, the process for populating Provider Genie with existing provider updates was dependent on manual data entry. HSAG recommended that Healthy U Integrated explore additional opportunities to automate manual processes, similar to the automated import process for new providers that is currently in place.

Healthy U Integrated reported that it did not have specific contractual or regulatory time frames within which its provider network needed to update provider data. Regarding this finding, HSAG recommended that Healthy U Integrated establish time frames during which provider demographic changes are required to be reported to ensure processes are in place of ongoing management and collection of demographic data.

To address HSAG's NAV recommendations, Healthy U Integrated acknowledged that network adequacy is an ongoing effort as it continually strives to identify opportunities that can help make the provider network more robust and responsive to member needs. In order to facilitate this effort, the Provider Contracting Team reviews provider applications daily and brings them to a Contracting Committee meeting where the applications are discussed on their merit and the expected impact on members' experiences. In addition to reviewing incoming provider applications, the Provider Contracting Team uses resources such as the State's provider finder, NPPES, and QES to identify practices in areas where network adequacy is found lacking.

Healthy U Integrated indicated that one team member has a QAS license, but several team members have access to, and frequently use QES for directory accuracy and network adequacy. The data for both platforms come from the same data source, Provider Genie, allowing for multiple team members to provide oversight and check the quality of the data.

Healthy U Integrated additionally stated that UUHP conducts provider data accuracy checks every 90 days, in compliance with federal requirements, which is two business days for additions and terminations and 20 business days for all other changes. As such, when an update to the provider data is required, the team works to complete any changes as quickly as possible so the provider directory reflects accurate, up-to-date information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Molina (Molina UMIC)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Molina UMIC's interpretation of data was accurate. Table 2-236 identifies HSAG's level of confidence for time/distance indicators.

Table 2-236—Molina UMIC Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 23 time/distance indicators for Molina UMIC. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-237 displays the number and percentage of provider categories by provider domain wherein Molina UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Molina UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category. All MCOs (except HOME) only operate in urban areas.

Table 2-237—Compliance With Time/Distance Standards by Provider Domain—Molina UMIC

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Adult	17	100.0%	100.0%	
Hospitals	1	100.0%	100.0%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	Health Plan Percent Met (%)*	
Pharmacy	1	100.0%	100.0%	🔑
Behavioral Health Providers—All	1	100.0%	100.0%	🔑
Behavioral Health Providers—All	1	100.0%	100.0%	🔑

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

HSAG identified no provider domains where Molina UMIC failed to meet the time/distance standards at the statewide level.

Recommendations

For the provider categories for which Molina UMIC did not meet the time/distance standard, HSAG recommends that Molina UMIC assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina UMIC should ensure that all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina UMIC's provider network, HSAG recommended that Molina UMIC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina UMIC should ensure that all providers are appropriately identified in future data submissions.

To address HSAG's NAV recommendations, Molina UMIC reported that its Network Contracting Team will continue to follow State recommendations to develop the network on an ongoing monthly basis. For all identified provider gaps, Molina UMIC will monitor for new provider opportunities entering their service areas by using the Quest Analytics Tool, Physician and Hospital Compare, NPPES, State

resources, and direct outreaches. Molina UMIC stated that it will make assertive recruitment efforts and contract negotiations wherever necessary to close identified provider gaps. Where insufficient providers to meet adequacy standards are identified, Molina UMIC additionally stated that it will facilitate the appropriate provider specialty exception.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Select Health Community Care UMIC (Select Health CC UMIC)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Select Health CC UMIC's interpretation of data was accurate. Table 2-238 identifies HSAG's level of confidence for time/distance indicators.

Table 2-238—Select Health CC UMIC Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 23 time/distance indicators for Select Health CC UMIC. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-239 displays the number and percentage of provider categories by provider domain wherein Select Health CC UMIC met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Select Health CC UMIC in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-239—Compliance With Time/Distance Standards by Provider Domain—Select Health CC UMIC

		Statewide*		Statewide*
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Adult	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Adult	17	100.0%	100.0%	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	100.0%	100.0%	

Provider Domain	Number of Provider Categories	Statewide*		Statewide*
		HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	🔑
Behavioral Health Facilities—All	1	100.0%	100.0%	🔑

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

HSAG identified no provider domains where Select Health CC UMIC failed to meet the time/distance standards at the statewide level.

Recommendations

Select Health CC UMIC built Quest Analytics indicator calculations each time the time/distance analysis was run, which can lead to inconsistencies in reported member access. HSAG recommends that Select Health CC explore opportunities to standardize network indicator calculations to ensure consistent measurement of member access.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Select Health CC UMIC's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Select Health CC UMIC's provider network, HSAG recommended that Select Health CC UMIC assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CC UMIC should ensure that all providers are appropriately identified in future data submissions.

Because Select Health CC UMIC only had one individual trained and capable of accessing and developing reports using Quest Analytics, HSAG recommended that other staff members be cross-trained to support network adequacy activities to ensure business continuity in the development of its reports.

HSAG noted that Select Health CC UMIC's original submission used member data from 2021, which was updated upon request. While there were no substantial changes in the results between the two submissions, HSAG noted a reduction in the total member population, which was likely due to the

unwinding. In addition, instead of accurately separating the population by adult, pediatric, and female groups, Select Health CC UMIC used the same total number of members in its calculations. Therefore, the methods selected by Select Health CC UMIC were deemed not appropriate for the State Medicaid and CHIP populations.

Further, due to the member population not being accurately grouped by age and gender, Select Health CC did not produce valid nor accurate results—that is, Select Health CC UMIC did not measure what it intended to measure, and its values did not reflect the true values. HSAG recommended that Select Health CC UMIC continue to monitor member access through annual network adequacy assessments based on the State's expectations. HSAG also recommended that Select Health CC UMIC continue to use the most updated member file for its network adequacy analyses. A final recommendation from HSAG was that Select Health CC UMIC group the member population into adult, pediatric, and female groups when calculating results. This would improve the methods to ensure that they were appropriate to the population. Further, it would improve the results to ensure that they were accurate and valid.

To address HSAG's NAV recommendations, Select Health CC UMIC reported it had:

- Cross-trained another individual to run Quest Analytics. This increases the number to three individuals who may be able to perform reporting, analysis, and ongoing monitoring of network adequacy.
- Improved upon the recommendation to enhance member data by including specific details regarding gender and age to measure against the provider and facility specialty types. This has already been utilized this year and will be moving forward.
- Added the ability to look into claims data for pediatric specialty types that are not being reflected because the field types required are not mentioned in their data (i.e., Pediatric Allergy & Immunologist or Pediatric Rheumatologist) This may close gaps that Select Health considers to not be an access issue.
- Established a restructured NDSC to serve as a cross-functional forum to identify and resolve inter-departmental barriers. Enhancements include improved follow-up on actions items, strengthening feedback loops, and increased accountability. This committee continues to prioritize health plan recruitment and provider driven recruitment strategies to support growth and access. One of the key components to discuss is adequacy gaps, survey data, appeals and grievances, understanding if there are any patterns or outliers that have led to access shortages. If any are identified, Select Health CC UMIC will actively recruit and contract any practitioners or facilities to fill the gaps.
- From 2024 to 2025, Select Health's CHIP network adequacy gaps decreased from 43 to 40.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Medicaid PIHP PMHPs Providing Mental Health and SUD Services

Bear River Mental Health Services (Bear River)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Bear River's interpretation of data was accurate. Table 2-240 identifies HSAG's level of confidence for time/distance indicators.

Table 2-240—Bear River Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	0.0%	100.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of four time/distance indicators for Bear River. Of these indicators, 100 percent received a rating of *Moderate Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-241 displays the number of provider categories wherein Bear River met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-241—Compliance With Time/Distance Standards by Urbanicity—Bear River*

		Frontier		Rural		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Bear River's service area.

Opportunities for Improvement

HSAG identified no provider domains where Bear River failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- Bear River manually retrieved daily 834-files, and only two employees had access to file retrieval. HSAG recommends, to the extent practical and feasible, that Bear River identify opportunities to reduce the amount of manual intervention required to obtain the 834-files. Additionally, HSAG recommends that Bear River create a desktop process for processing 834-files when the two identified individuals are unavailable. This will allow other staff members to assist with the retrieval and processing of the 834-files when necessary.
- Bear River maintained provider credentialing information in a spreadsheet, which only one staff member had access to. HSAG recommends, to the extent practical and feasible, that Bear River identify additional staff members who are trained and capable of accessing and maintaining the spreadsheet housing provider data used for network adequacy reporting. Additionally, HSAG recommends that Bear River create a desktop process for updating provider information when the only individual with access is unavailable.
- Bear River did not have a formalized process to measure and calculate time/distance network adequacy indicators to internally monitor member access. HSAG recommends that Bear River explore opportunities to formally document a process to internally monitor member access through annual time and distance network adequacy indicator calculations.

Assessment of Follow-Up on Last Year's Recommendations

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Bear River's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. HSAG recommended that Bear River assess if those network inadequacies were due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons.

Although robust validation processes were in place to ensure the accuracy and completeness of provider data, Bear River's data collection and management of provider data were manual. HSAG recommended that Bear River explore ways to incorporate automation into the data collection, maintenance, and validation of provider data to mitigate any room for error and increase efficiency in data collection and management processes.

Bear River did not report any specific activities to address recommendations from the 2024 EQR technical report for NAV.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that this will not likely result in long-term improvements.

Central Utah Counseling Center (Central)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Central's interpretation of data was accurate. Table 2-242 identifies HSAG's level of confidence for time/distance indicators.

Table 2-242—Central Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of four time/distance indicators for Central. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-243 displays the number of provider categories wherein Central met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-243—Compliance With Time/Distance Standards by Urbanicity—Central*

		Frontier		Rural		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Central's service area.

Opportunities for Improvement

HSAG identified no provider domains where Central failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- Central had contracted providers who had not been recredentialed since May of 2021. HSAG recommends that Central implement a monitoring process to ensure its contracted providers are recredentialed every three years as required.
- Central used a mapping feature that creates a driving time area for the surrounding area of interest. This does not return a percentage of the surrounding area within the radius; instead, this must be manually evaluated to see if the area is sufficiently covered by the driving time. Manual evaluation allows for the possibility of human error to occur. HSAG recommends that Central continue to explore options that account for a member's physical residential address distance to a provider as compared to creating a geographic map around a provider address and manually evaluating a member's placement in the area of interest.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Central's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Central's provider network, HSAG recommended that Central assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Central should ensure all providers are appropriately identified in future data submissions.

HSAG additionally recommended that Central continue to explore options that account for a member's physical residential address distance to a provider as compared to creating a geographic map around a provider address and manually evaluating a member's placement in the area of interest, as this may allow for the possibility of human error to occur.

In response to HSAG's NAV first recommendation, Central reviewed the two categories that did not meet the time and distance requirements. In the first, Behavioral Health Hospitals with a Psychiatric Unit, Central responded that there was not one in its geographic catchment area due to the rural and frontier setting. In the secondary category, Central noted that psychiatrists are available through

telehealth in the area, but no one is currently located within Central's geographic area. Central stated that it will continue to monitor this in its network adequacy studies.

Responding to HSAG'S NAV second recommendation, Central stated that it will explore the recommendation, including evaluating the cost-benefit analysis of purchasing such a system.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Davis Behavioral Health (Davis)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Davis's interpretation of data was accurate. Table 2-244 identifies HSAG's level of confidence for time/distance indicators.

Table 2-244—Davis Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of two time/distance indicators for Davis. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-245 displays the number of provider categories wherein Davis met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-245—Compliance With Time/Distance Standards by Urbanicity—Davis*

		Urban		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Davis's service area.

Opportunities for Improvement

HSAG identified no provider domains where Davis failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- Davis manually entered member enrollment data received through the daily and monthly 834-files from DHHS, which could increase the risk of data entry errors and inefficiencies. HSAG recommends that Davis explore opportunities to automate the processing and integration of the 834-enrollment files. Reducing manual intervention may enhance data accuracy, improve efficiency, and support timely updates to member enrollment records.
- Davis did not have a formal audit process for manual edits and updates to provider data, which could increase the risk of inaccurate or incomplete provider information. HSAG recommends that Davis implement a routine audit process to review manual edits and updates to provider data, ensuring accuracy and completeness across all systems.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Davis's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Davis's provider network, HSAG recommended that Davis assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Davis should ensure all providers are appropriately identified in future data submissions.

Because Davis did not have specific time frames for which providers were required to update their information, HSAG recommended that Davis establish a time frame for which provider demographic changes were to be reported to ensure processes be in place for ongoing management and collection of updated demographic data.

In response to HSAG's NAV recommendations, Davis reported that it will assess if the time/distance standard not being met is due to a lack of providers available in the network or lack of providers in the geographic area for the following: Non-physician Prescribers, Other Behavioral Medical Physicians, Psychiatrist—Adult, Psychiatrist—Pediatric, and certified SUD providers. Davis also reported that it updates provider demographic changes in Credible within five business days.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Four Corners Community Behavioral Health (Four Corners)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Four Corners' interpretation of data was accurate. Table 2-246 identifies HSAG's level of confidence for Time/ Distance Indicators.

Table 2-246—Four Corners Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of four time/distance indicators for Four Corners. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-247 displays the number of provider categories wherein Four Corners met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-247—Compliance With Time/Distance Standards by Urbanicity—Four Corners*

		Frontier		Rural		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	100.0%	100.0%	
Behavioral Health Facilities—All	1	0.0%	100.0%	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Four Corners' service area.

Opportunities for Improvement

HSAG identified no provider domains where Davis failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Four Corners did not meet the time/distance standard, HSAG recommends that Four Corners assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Four Corners should ensure all providers are appropriately identified in future data submissions.
- Four Corners manually entered and transferred member and provider data between systems such as Credible and Paylocity. While verification processes were in place, reliance on manual transfers still left data susceptible to potential errors. HSAG recommends that Four Corners explore opportunities to automate data transfers between systems where applicable. Automation could streamline record updates, reduce staff time spent on manual entry, and reduce the risk of human error.
- Four Corners primarily confirmed the accuracy of manual edits across systems on an as-needed basis or when discrepancies were identified. While verification processes were in place, they were not conducted on a fixed schedule. HSAG recommends that Four Corners establish a routine, set scheduled time to conduct the verification process for manual edits to ensure consistent oversight and strengthen data integrity.
- Four Corners collapsed members' unique locations into ZIP Code centroid locations using Google Maps. The ZIP Code centroid locations were geographic ZIP Code centroid determined, meaning population density did not skew the "central" location of the ZIP Code. This approach can centrally locate members to areas that could be miles away from their physical residential address. As a result, members may be incorrectly assigned as having access to providers they may not actually have access to when evaluated from their physical residential address. HSAG recommends that Four Corners continue to explore options that account for members' physical residential address distance to a provider as compared to collapsing all members into a geographic ZIP Code centroid location.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Four Corners' provider network and identified network inadequacies compared to DHHS' minimum time

and distance network standards. Regarding Four Corners' provider network, HSAG recommended that Four Corners assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Four Corners should ensure all providers are appropriately identified in future data submissions.

To address Four Corners not having specific time frames for which providers were required to update their information, HSAG recommended that Four Corners establish time frames for which provider demographic changes be reported to ensure processes are in place for ongoing management and collection of updated demographic data.

In response to HSAG's NAV first recommendation, Four Corners stated that it has calculated the time and distance standards using Google Maps to ensure accuracy and consistency. Four Corners acknowledged Carbon County being classified as a rural county and that the rural standard requires that 80 percent of members have access to network providers within 35 miles or 45 minutes. For June 2025, Four Corners reported that it served 3,585 Medicaid members assigned to Carbon County and also reported that 100 percent of these members were located within 35 miles of the nearest clinic offering comprehensive adult and pediatric mental health and SUD services.

Four Corners also stated that it provides access to both employed and contracted providers within this range, ensuring strong service availability. Although the closest qualified residential facility or psychiatric hospital is approximately 70–72 miles away, Four Corners continues to work actively to support members who need higher levels of care. Bed availability within an hour's drive can be challenging due to geographic factors, but ongoing collaboration with regional partners helps mitigate this. Four Corners offers a Crisis Receiving Center and a Social Detoxification Program for individuals age 18 and older, and operates an outpatient Opioid Treatment Program providing medication-assisted treatment for opioid use disorder. Four Corners acknowledged Emery and Grand counties as frontier counties and that the frontier standard requires that 75 percent of members have access to network providers within 60 miles or 70 minutes.

In June 2025, Four Corners had 1,198 Medicaid members in Emery County and 949 Medicaid members in Grand County, and shared that 100 percent of members in both counties met the time and distance standards for outpatient mental health and SUD services. Four Corners supports these communities with a combination of dedicated employed and contracted providers, and while the nearest qualified residential facility or psychiatric hospital is located at a significant distance due to geographic realities, Four Corners maintains strong referral pathways and works diligently to secure appropriate placements when needed.

In response to HSAG's NAV second recommendation, Four Corners reported that it continually maintains and updates its network provider list on a monthly basis. Providers are encouraged to notify Four Corners promptly of any address or status changes, and all employed and contracted providers

complete an annual paperwork update. This process ensures that all provider information, including any changes not reported through the year, remains accurate, current, and reliable.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Healthy U Behavioral

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Healthy U Behavioral PMHP's interpretation of data was accurate. Table 2-248 identifies HSAG's level of confidence for time/distance indicators.

Table 2-248—Healthy U Behavioral PMHP Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of two time/distance indicators for Healthy U Behavioral PMHP. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-249 displays the number of provider categories wherein Healthy U Behavioral met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Healthy U Behavioral in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-249—Compliance With Time/Distance Standards by Urbanicity—Healthy U Behavioral*

		Rural		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities in Healthy U Behavioral's Summit County service area.

Opportunities for Improvement

HSAG identified no provider domains where Healthy U Behavioral failed to meet the time/distance standards at the statewide level.

Recommendations

For the provider categories for which Healthy U did not meet the time/distance standard, HSAG recommends that Healthy U assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U should ensure all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Healthy U Behavioral's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Healthy U Behavioral's provider network, HSAG recommended that Healthy U Behavioral explore additional opportunities to automate manual processes, similar to the automated import process for new providers that is currently in place.

Because Healthy U Behavioral had one team member who was trained and able to modify/update Quest Analytics programs, HSAG recommended that Healthy U Behavioral train additional individuals on how to modify/update Quest Analytics programs so there is sufficient oversight and data quality checks on programs prior to generating results.

Healthy U Behavioral reported that it did not have specific contractual or regulatory time frames within which its provider network needed to update provider data. Regarding this finding, HSAG recommended that Healthy U Behavioral establish time frames during which provider demographic changes are required to be reported to ensure processes are in place of ongoing management and collection of demographic data.

To address HSAG's NAV recommendations, Healthy U Behavioral acknowledged that network adequacy is an ongoing effort, and the health plan continually strives to identify opportunities that can help make the provider network more robust and responsive to member needs. In order to facilitate this effort, the Provider Contracting Team reviews provider applications daily and brings them to a Contracting Committee meeting where the applications are discussed on their merit and the expected impact on members' experiences. In addition to reviewing incoming provider applications, the Provider Contracting Team uses resources such as the State's provider finder, NPPES, and QES to identify practices in areas where network adequacy is found lacking. Healthy U Behavioral indicated that one

team member has a QAS license, but several team members have access to, and frequently use QES for directory accuracy and network adequacy. The data for both platforms come from the same data source, Provider Genie, allowing for multiple team members to provide oversight and check the quality of the data.

Healthy U Behavioral additionally stated that UUHP conducts provider data accuracy checks every 90 days, in compliance with federal requirements, which is two business days for additions and terminations and 20 business days for all other changes. As such, when an update to the provider data is required, the team works to complete any changes as quickly as possible so the provider directory reflects accurate, up-to-date information.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Northeastern Counseling Center (Northeastern)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Northeastern's interpretation of data was accurate. Table 2-250 identifies HSAG's level of confidence for time/distance indicators.

Table 2-250—Northeastern Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of two time/distance indicators for Northeastern. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-251 displays the number of provider categories wherein Northeastern met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Northeastern in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-251—Compliance With Time/Distance Standards by Urbanicity—Northeastern*

		Frontier		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Northeastern's service area.

Opportunities for Improvement

HSAG identified no provider domains where Northeastern failed to meet the time/distance standards at the statewide level.

Recommendations

No specific opportunities or recommendations were identified related to the data collection and management processes Northeastern had in place to inform network adequacy standard and indicator calculations.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Northeastern's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Northeastern's provider network, HSAG recommended that Northeastern assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Northeastern should ensure all providers are appropriately identified in future data submissions.

HSAG identified that Northeastern's validation process for manual entries to the Qualifacts system was informal and not documented. HSAG recommended that Northeastern formalize validation and reconciliation of manual entries into the Qualifacts system into policy and/or procedure documentation

To address HSAG's NAV recommendations, Northeastern reported that it completed additional outreach and credentialing to evaluate gaps in member access. Northeastern now includes two additional SUD and mental health residential programs that serve both adult and pediatric member populations.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that the interventions will likely result in long-term improvements.

Optum/Tooele

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Optum's interpretation of data was accurate. Table 2-252 identifies HSAG's level of confidence for time/distance indicators.

Table 2-252—Optum/Tooele Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of two time/distance indicators for Optum/Tooele. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-253 displays the number of provider categories wherein Optum/Tooele met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Optum/Tooele in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-253—Compliance With Time/Distance Standards by Urbanicity—Optum/Tooele*

		Frontier		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Optum's Tooele County service area.

Opportunities for Improvement

HSAG identified no provider domains where Optum failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- Optum collapsed members' unique locations into ZIP Code centroid locations using the US Census Bureau datafile specific to Zip Code Tabulation Areas, which is only produced and updated every 10 years. The ZIP Code centroid locations are population ZIP Code centroid determined, meaning population density heavily skews the "central" location of the ZIP Code. This approach can centrally locate members to areas that may be closer to business locations and could be miles away from a member's physical residential address. As a result, members may be incorrectly assigned as having access to providers they may not actually have access to when evaluated from their physical residential address. HSAG recommends that Optum continue to explore options that account for members' physical residential address distance to a provider as compared to collapsing all members into a population ZIP Code centroid location.
- Optum used Alteryx to create provider data extracts and calculate network adequacy indicator calculation, which led to a series of long and complicated data cleaning, data joins and merges, and data restriction processes occurring in tandem and sequentially. This logic within Alteryx, while robust and representative of careful consideration regarding the indicator calculation, may not be properly documented within or outside Alteryx. HSAG recommends that Optum create a formalized document outlining the network adequacy indicator calculation steps, from beginning to end, to create a historical accounting of the steps taken and changes made over the years. This legacy document can serve as a reference guide for the unique processes and checks performed to ensure accuracy for better recordkeeping and infrastructure maintenance going forward.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Optum/Tooele's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Optum/Tooele's provider network, HSAG recommended that Optum/Tooele assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Optum/Tooele should ensure that all providers are appropriately identified in future data submissions.

Optum collapsed members' unique locations into ZIP-centroid locations using the U.S. Census Bureau datafile specific to the ZIP Code tabulation areas, which was only produced and updated every 10 years. The ZIP-centroid locations were population ZIP-centroid determined, meaning population density heavily skewed the "central" location of the ZIP Code. This approach could centrally locate members to areas that may be closer to business locations and could be miles away from a member's physical residential address. As a result, members may have been incorrectly assigned as having access to providers they may not have actually had access to when evaluated from their physical residential addresses. HSAG recommended that Optum continue to explore options that account for a member's physical residential address distance to a provider as compared to collapsing all members into a population ZIP-centroid location.

In response to HSAG's NAV recommendations, Optum/Tooele reported that it was looking into options that would make it possible to calculate distance using members' physical residential address distance to a provider vs. collapsing all members into a population ZIP-centroid location.

Optum/Tooele did not respond to the recommendation of conducting ongoing assessments of its provider network.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that Optum/Tooele's intervention to address ZIP-centroid limitations will likely result in long-term improvements. As Optum/Tooele did not report any specific activities to address recommendations of conducting ongoing assessment of its provider network, HSAG cannot confirm that any ongoing interventions will likely result in long-term improvements.

Salt Lake County Division of Behavioral Health Services (Salt Lake)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Salt Lake's interpretation of data was accurate. Table 2-254 identifies HSAG's level of confidence for Time/Distance Indicators.

Table 2-254—Salt Lake Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of two time/distance indicators for Salt Lake. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-255 displays the number of provider categories wherein Salt Lake met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Salt Lake in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-255—Compliance With Time/Distance Standards by Urbanicity—Salt Lake*

		Urban		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Salt Lake's service area.

Opportunities for Improvement

HSAG identified no provider domains where Salt Lake failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- Salt Lake collapsed members' unique locations into ZIP Code centroid locations using the U.S. Census Bureau datafile specific to the Zip Code Tabulation Areas, which is only produced and updated every 10 years. The ZIP Code centroid locations are population ZIP Code centroid determined, meaning population density heavily skews the "central" location of the ZIP Code. This approach can centrally locate members to areas that may be closer to business locations and could be miles away from a member's physical residential address. As a result, members may be incorrectly assigned as having access to providers they may not actually have access to when evaluated from their physical residential address. HSAG recommends that Salt Lake continue to explore options that account for members' physical residential address distance to a provider as compared to collapsing all members into a population ZIP Code centroid location.
- Salt Lake used Alteryx to create provider data extracts and calculate network adequacy indicator calculation, which led to a series of long and complicated data cleaning, data joins and merges, and data restriction processes occurring in tandem and sequentially. This logic within Alteryx, while robust and representative of careful consideration regarding the indicator calculation, may not be properly documented within or outside Alteryx. HSAG recommends that Salt Lake create a formalized document outlining the network adequacy indicator calculation steps, from beginning to end, to create a historical accounting of the steps taken and changes made over the years. This legacy document can serve as a reference guide for the unique processes and checks performed to ensure accuracy for better record keeping and infrastructure maintenance going forward.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Salt Lake's provider network and identified network inadequacies compared to DHHS' minimum time and distance standards. Regarding Salt Lake's provider network, HSAG recommended that Salt Lake assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Salt Lake should ensure that all providers are appropriately identified in future data submissions.

Salt Lake collapsed members' unique locations into ZIP-centroid locations using the U.S. Census Bureau datafile specific to the ZIP Code tabulation areas, which was only produced and updated every 10 years. The ZIP-centroid locations were population ZIP-centroid determined, meaning population density heavily skewed the "central" location of the ZIP Code. This approach could centrally locate members to areas that may be closer to business locations and could be miles away from a member's physical residential address. As a result, members may have been incorrectly assigned as having access to providers they may not have actually had access to when evaluated from their physical residential addresses. HSAG recommended that Optum continue to explore options that account for a member's physical residential address distance to a provider as compared to collapsing all members into a population ZIP-centroid location.

To address Salt Lake validating provider data within the myAvatar system retroactively when an encounter was rejected by the State, HSAG recommended that Salt Lake establish a proactive audit/validation process for provider data entered into the myAvatar system.

In response to HSAG's NAV recommendations, Salt Lake reported they were looking into options that would make it possible to calculate distance using members' physical residential address distance to a provider vs. collapsing all members into a population ZIP-centroid location.

Salt Lake did not respond to the recommendation of conducting ongoing assessments of its provider network or establishing a proactive audit/validation process for provider data entered into the myAvatar system.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that Salt Lake's intervention to address ZIP-centroid limitation will likely result in long-term improvements. As Salt Lake did not report any specific activities to address recommendations of conducting ongoing assessment of its provider network or establishing a proactive audit/validation process for provider data entered into the myAvatar system, HSAG cannot confirm that any ongoing interventions will likely result in long-term improvements.

Southwest Behavioral Health Center (Southwest)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Southwest's interpretation of data was accurate. Table 2-256 identifies HSAG's level of confidence for time/distance indicators.

Table 2-256—Southwest Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of four time/distance indicators for Southwest. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-257 displays the number of provider categories wherein Southwest met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Southwest in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-257—Compliance With Time/Distance Standards by Urbanicity—Southwest*

		Frontier		Rural		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)	Health Plan Percent Met (%)	HSAG Percent Met (%)	Health Plan Percent Met (%)	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Southwest's service area.

Opportunities for Improvement

HSAG identified no provider domains where Southwest failed to meet the time/distance standards at the statewide level.

Recommendations

Southwest reported the percentage of members with access to providers based on the areas where Southwest provides services and the general population of those counties. While this approach assesses the indicator as stated, it is not as rigorous as actually identifying how far Medicaid members must travel to reach providers. HSAG recommends that Southwest monitor member access through annual network adequacy assessments based on DHHS' expectations.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Southwest's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Southwest's provider network, HSAG recommended that Southwest assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Southwest should ensure all providers are appropriately identified in future data submissions.

Southwest reported that its 834 file processing was a manual upload process. Staff members performed daily and monthly eligibility verification and manually updated Axiom to reflect information received via 834 files. Southwest also discussed exploring options to automatically process and upload 834 files to Axiom; however, it indicated that there were no timeliness issues identified with the current process, and files were processed daily. HSAG encouraged Southwest to continue to explore system capabilities to implement an automated process for loading 834 files.

To address HSAG's NAV findings, Southwest reported that it will always look at expanding its network of providers. Southwest noted that it offers clinically appropriate telehealth services (e.g., behavioral health, certain specialties, and follow-up care) to the areas with limited physical access and believe these services will instantaneously reduce the effective travel time and distance for their member. Southwest reported that it has formally added the implementation of an automated 834 file processing and upload solution to Axiom to its IT roadmap for the upcoming fiscal year.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Wasatch Behavioral Health (Wasatch)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Wasatch's interpretation of data was accurate. Table 2-258 identifies HSAG's level of confidence for time/distance indicators.

Table 2-258—Wasatch Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of two time/distance indicators for Wasatch. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-259 displays the number of provider categories wherein Wasatch met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and Wasatch in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-259—Compliance With Time/Distance Standards by Urbanicity—Wasatch*

		Urban		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Wasatch's service area.

Opportunities for Improvement

HSAG identified no provider domains where Wasatch failed to meet the time/distance standards at the statewide level.

Recommendations

Wasatch collapsed members' unique locations into ZIP Code centroid locations using Google Maps. The ZIP Code centroid locations are geographic ZIP Code centroid determined, meaning population density does not skew the "central" location of the ZIP Code. This approach can centrally locate members to areas that could be miles away from a member's physical residential address. As a result, members may be incorrectly assigned as having access to providers they may not actually have access to when evaluated from their physical residential address. HSAG recommends that Wasatch continue to explore options that account for members' physical residential address distance to a provider as compared to collapsing all members into a geographic ZIP Code centroid location.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Wasatch's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Wasatch's provider network, HSAG recommended that Wasatch assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Wasatch should ensure all providers are appropriately identified in future data submissions.

During its calculations, Wasatch reported using the total number of members served instead of using the total member population. Therefore, the methods Wasatch selected were not appropriate for the State Medicaid and CHIP populations. Further, due to using the total number of members served instead of the total member population, Wasatch did not produce valid results—that is, Wasatch did not measure what it intended to measure, and Wasatch did not produce accurate results. Therefore, Wasatch's calculated values did not reflect the true values. HSAG recommended that Wasatch continue to monitor member access through annual network adequacy assessments based on the State's expectations. HSAG also recommended that Wasatch use the total member population instead of the total number of members served when calculating results. This would improve the methods to ensure that they are appropriate to the population. Further, it would improve the results to ensure that they are accurate and valid.

To address HSAG's NAV findings, Wasatch reported that the local behavioral health hospitals have not been willing to form contractual relationships with their health plan, but continue to serve their members and accept payment from them for those services. These hospitals include Utah Valley

Hospital, Aspen Grove Behavioral Hospital, Mountain View Hospital, St. Marks Hospital, Primary Children's Hospital (Lehi and SLC), Intermountain LDS Hospital, and McKay-Dee Hospital. All psychiatrists were listed as adult psychiatry providers, although they serve both adult and pediatric members. The same was the case with psychologists where all were listed as adult psychologists, although all of them serve adult and pediatric members. Wasatch does not employ any non-psychiatrist physicians, but does co-locate with Federally Qualified Health Center (FQHC) physical health clinics at two of their locations. Wasatch now has master's-level clinicians trained in serving SUD members at all of its family clinics. The error involving the use of members served instead of total members has been corrected in the 2025 NAV. Total members will be used in all future calculations.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Weber Human Services (Weber)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Weber's interpretation of data was accurate. Table 2-260 identifies HSAG's level of confidence for time/distance indicators.

Table 2-260—Weber Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of four time/distance indicators for Weber. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-261 displays the number of provider categories wherein Weber met the time/distance standards by urbanicity. Since most PMHPs are inherently regional, statewide results are not presented in the table. HSAG presented detailed current and speculative time/distance results to DHHS and the PMHP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-261—Compliance With Time/Distance Standards by Urbanicity—Weber*

		Rural		Urban		
PMHP	Number of Provider Categories	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	HSAG Percent Met (%)*	Health Plan Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
Behavioral Health Providers—All	1	100.0%	100.0%	100.0%	100.0%	
Behavioral Health Facilities—All	1	100.0%	100.0%	100.0%	100.0%	

*Analyses were restricted to counties and urbanicities within Weber's service area.

Opportunities for Improvement

HSAG identified no provider domains where Weber failed to meet the time/distance standards at the statewide level.

Recommendations

HSAG offers the following recommendations:

- HSAG observed that Weber continued to indicate that there were no specific required time frames for updating provider information if changes occurred prior to recredentialing. HSAG continues to recommend that Weber develop a process requiring provider updates within a specified time frame.
- Weber collapsed members' unique locations into ZIP Code centroid locations using Google Maps. The ZIP Code centroid locations are geographic ZIP Code centroid determined, meaning population density does not skew the "central" location of the ZIP Code. This approach can centrally locate members to areas that could be miles away from a member's physical residential address. As a result, members may be incorrectly assigned as having access to providers they may not actually have access to when evaluated from their physical residential address. HSAG recommends that Weber continue to explore options that account for members' physical residential address distance to a provider as compared to collapsing all members into a geographic ZIP Code centroid location.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Weber's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Weber's provider network, HSAG recommended that Weber assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Weber should ensure all providers are appropriately identified in future data submissions.

To address HSAG's NAV findings, Weber reported that when it evaluated the provider categories where it did not meet the time/distance standards, Weber determined that other provider categories provided the same covered service and the missing provider categories were not necessary to meet Weber's contractual obligations.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes these interventions will likely result in long-term improvements.

CHIP MCOs Providing Physical Health, Mental Health, and SUD Services

Healthy U CHIP

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Healthy U CHIP MCO's interpretation of data was accurate. Table 2-262 identifies HSAG's level of confidence for time/distance indicators.

Table 2-262—Healthy U CHIP Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 69 time/distance indicators for Healthy U CHIP MCO. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-263 displays the number of provider categories by provider domain wherein Healthy U CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Healthy CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-263—Compliance With Time/Distance Standards by Provider Domain—Healthy U CHIP

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Pediatric	17	11.8%	5.9%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	HSAG Percent Met (%)*	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	0.0%	0.0%	
Behavioral Health Providers—All	1	100.0%	100.0%	
Behavioral Health Facilities—All	1	11.8%	5.9%	

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-264 displays the provider domains and categories wherein Healthy U CHIP failed to meet the time/distance standards.

Table 2-264—Provider Categories That Failed to Meet Time/Distance Standards—Healthy U CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health Facilities—All	Behavioral Health—Facilities (Frontier)	
Specialist—Pediatric	Allergy & Immunology, Pediatric** (Frontier, Rural, Urban); Dermatology, Pediatric (Frontier, Rural, Urban); Endocrinology, Pediatric (Frontier, Rural, Urban); Gastroenterology, Pediatric (Frontier, Rural, Urban); General Surgery, Pediatric (Frontier, Rural, Urban); Infectious Disease, Pediatric (Frontier, Rural, Urban); Nephrology, Pediatric (Frontier, Rural, Urban); Neurology, Pediatric (Frontier, Rural, Urban); Oncology/Hematology, Pediatric (Frontier, Rural, Urban); Ophthalmology, Pediatric (Frontier, Rural, Urban); Otolaryngology, Pediatric (Frontier, Rural, Urban); Physical Medicine, Pediatric (Frontier, Rural, Urban); Pulmonology, Pediatric (Frontier, Rural, Urban); Rheumatology, Pediatric (Frontier, Rural, Urban); Urology, Pediatric (Frontier, Rural, Urban)	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

For the provider categories for which Healthy U CHIP did not meet the time/distance standard, HSAG recommends that Healthy U CHIP assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Healthy U CHIP should ensure all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Healthy U CHIP was launched July 1, 2024, and as such HSAG did not identify opportunities for improvement or recommendations related to NAV.

Molina Healthcare of Utah CHIP (Molina CHIP)

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Molina CHIP MCO's interpretation of data was accurate. Table 2-265 identifies HSAG's level of confidence for time/distance indicators.

Table 2-265—Molina CHIP Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 69 time/distance indicators for Molina CHIP. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-266 displays the number of provider categories by provider domain wherein Molina CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Molina CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-266—Compliance With Time/Distance Standards by Provider Domain—Molina CHIP

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Pediatric	17	17.6%	0.0%	
Hospitals	1	100.0%	100.0%	
Pharmacy	1	0.0%	0.0%	
Behavioral Health Providers—All	1	17.6%	0.0%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	HSAG Percent Met (%)*	
Behavioral Health Facilities—All	1	100.0%	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-267 displays the provider domains and categories wherein Molina CHIP failed to meet the time/distance standards.

Table 2-267—Provider Categories That Failed to Meet Time/Distance Standards—Molina CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Behavioral Health Facilities—All	Behavioral Health—Facilities (Frontier)	
Specialists—Pediatric	Allergy & Immunology, Pediatric (Frontier, Rural, Urban); Dermatology, Pediatric (Frontier, Rural, Urban); Endocrinology, Pediatric (Frontier, Urban); Gastroenterology, Pediatric (Frontier, Urban); General Surgery, Pediatric (Frontier, Urban); Infectious Disease, Pediatric (Frontier, Urban); Nephrology, Pediatric (Frontier, Urban); Oncology/Hematology, Pediatric (Frontier, Urban); Ophthalmology, Pediatric** (Frontier, Rural, Urban); Otolaryngology, Pediatric (Frontier, Rural, Urban); Physical Medicine, Pediatric (Frontier, Urban); Pulmonology, Pediatric (Frontier, Rural, Urban); Rheumatology, Pediatric (Frontier, Rural, Urban); Urology, Pediatric (Frontier, Urban)	

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

**No data were submitted for the provider category.

Recommendations

For the provider categories for which Molina CHIP did not meet the time/distance standard, HSAG recommends that Molina CHIP assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance

standard is due to data concerns, Molina CHIP should ensure all providers are appropriately identified in future data submissions.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Molina CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Molina CHIP's provider network, HSAG recommended that Molina CHIP assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Molina CHIP should ensure all providers are appropriately identified in future data submissions.

To address HSAG's NAV recommendations, Molina reported that its Network Contracting Team will continue to follow the State recommendations to develop the network on an ongoing monthly basis. For all identified provider gaps, Molina will monitor for new provider opportunities entering its service areas by using the Quest Analytics Tool, Physician & Hospital Compare, NPPES, State resources, and direct outreach. Molina CHIP stated that it will make assertive recruitment efforts and contract negotiations wherever necessary to close identified provider gaps. Where insufficient providers to meet adequacy standards are identified, Molina CHIP additionally stated that it will facilitate the appropriate provider specialty exception.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Select Health CHIP

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Select Health CHIP MCO's interpretation of data was accurate. Table 2-268 identifies HSAG's level of confidence for time/distance indicators.

Table 2-268—Select Health CHIP Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 69 time/distance indicators for Select Health CHIP. Of these indicators, 100 percent received a rating of *High Confidence*.

Select Health CHIP—Quality, Timeliness, and Access to Care—Network Adequacy

Strengths

Table 2-269 displays the number of provider categories by provider domain wherein Select Health CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Select Health CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-269—Compliance With Time/Distance Standards by Provider Domain—Select Health CHIP

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
PCP—Pediatric	1	100.0%	100.0%	
Prenatal Care and Women's Health Providers	1	100.0%	100.0%	
Specialists—Pediatric	17	5.9%	0.0%	
Hospitals	1	100.0%	0.0%	
Pharmacy	1	100.0%	100.0%	

Provider Domain	Number of Provider Categories	Statewide*		Impact: Quality, Access, and/or Timeliness
		HSAG Percent Met (%)*	HSAG Percent Met (%)*	
Behavioral Health Providers—All	1	100.0%	100.0%	🔑
Behavioral Health Facilities—All	1	100.0%	0.0%	🔑

* To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

Table 2-270 displays the provider domains and categories wherein Select Health CHIP failed to meet the time/distance standards.

Table 2-270—Provider Categories That Failed to Meet Time/Distance Standards—Select Health CHIP*

Provider Domain	Provider Category	Impact: Quality, Access, and/or Timeliness
Specialist—Pediatric	Allergy & Immunology, Pediatric (Frontier, Rural, Urban); Dermatology, Pediatric (Frontier, Rural, Urban); Endocrinology, Pediatric (Frontier); Gastroenterology, Pediatric (Frontier, Rural, Urban); General Surgery, Pediatric (Frontier, Rural, Urban); Infectious Disease, Pediatric (Frontier, Urban); Nephrology, Pediatric (Frontier, Urban); Neurology, Pediatric (Frontier); Oncology/Hematology, Pediatric (Frontier, Rural, Urban); Ophthalmology, Pediatric (Frontier, Rural, Urban); Orthopedic Surgery, Pediatric (Frontier, Urban); Otolaryngology, Pediatric (Frontier, Rural, Urban); Physical Medicine, Pediatric** (Frontier, Rural, Urban); Pulmonology, Pediatric (Frontier, Urban); Rheumatology, Pediatric (Frontier, Rural, Urban); Urology, Pediatric (Frontier, Rural, Urban)	🔑

*To meet the statewide time/distance standard for a provider category, health plans must meet the standard for each urbanicity (i.e., urban, rural, and frontier).

** No data were submitted for the provider category.

Recommendations

HSAG offers the following recommendations:

- For the provider categories for which Select Health CHIP did not meet the time/distance standard, HSAG recommends that Select Health CHIP assess whether this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CHIP should ensure all providers are appropriately identified in future data submissions.
- Select Health CC built Quest Analytics indicator calculations each time the time/distance analysis was run, which can lead to inconsistencies in reported member access. HSAG recommends that Select Health CC explore opportunities to standardize network indicator calculations to ensure consistent measurement of member access.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Select Health CHIP's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding Select Health CHIP's provider network, HSAG recommended that Select Health CHIP assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, Select Health CHIP should ensure all providers are appropriately identified in future data submissions.

Addressing that Select Health CHIP only had one individual trained and capable of accessing and developing reports using Quest Analytics, HSAG recommended that other staff members be cross-trained to support network adequacy activities to ensure business continuity in the development of its reports.

HSAG noted that Select Health CHIP's original submission used member data from 2021, which was updated upon request. While there were no substantial changes in the results between the two submissions, HSAG noted a reduction in the total member population, which was likely due to the unwinding. In addition, instead of accurately separating the population by adult, pediatric, and female groups, Select Health CHIP used the same total number of members in its calculations. Therefore, the methods Select Health CHIP selected were deemed not appropriate for the State Medicaid and CHIP populations.

Further, due to the member population not being accurately grouped by age and gender, Select Health CHIP did not produce valid nor accurate results—that is, Select Health CHIP did not measure what it intended to measure, and its values did not reflect the true values. HSAG recommended that Select Health CHIP continue to monitor member access through annual network adequacy assessments based on the State's expectations. HSAG also recommended that Select Health CHIP continue to use the most

updated member file for its network adequacy analyses. A final recommendation from HSAG was that Select Health CHIP group the member population into adult, pediatric, and female groups when calculating results. This would improve the methods to ensure that they were appropriate to the population. Further, it would improve the results to ensure that they were accurate and valid.

To address HSAG's NAV recommendations, Select Health CHIP reported it had:

- Cross-trained another individual to run Quest Analytics. This increases the number to three individuals who may be able to perform reporting, analysis and ongoing monitoring of network adequacy.
- Improved upon the recommendation to enhance member data by including specific details regarding gender and age to measure against the provider and facility specialty types. This has already been utilized this year and will be moving forward.
- Added the ability to look into claims data for pediatric specialty types that are not being reflected because the field types required are not mentioned in their data (i.e. Pediatric Allergy & Immunologist or Pediatric Rheumatologist) This may close gaps that Select Health considers to not be an access issue.
- Established a restructured NDSC to serve as a cross-functional forum to identify and resolve inter-departmental barriers. Enhancements include improved follow-up on actions items, strengthening feedback loops, and increased accountability. This committee continues to prioritize health plan recruitment and provider driven recruitment strategies to support growth and access. One of the key components to discuss is adequacy gaps, survey data, appeals and grievances, understanding if there are any patterns or outliers that have led to access shortages. If any are identified, Select Health CHIP will actively recruit and contract any practitioners or facilities to fill the gaps.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Medicaid PAHPs Providing Dental Services

MCNA

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if MCNA's interpretation of data was accurate. Table 2-271 identifies HSAG's level of confidence for time/distance indicators.

Table 2-271—MCNA Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of nine time/distance indicators for MCNA. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-272 displays the number of provider categories by provider domain wherein MCNA met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and MCNA in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-272—Compliance With Time/Distance Standards by Provider Domain—MCNA

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
All Dental Providers, including General Dentists	1	100.0%	100.0%	
General Dentists	1	100.0%	100.0%	
Pediatric Dentists	1	100.0%	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

HSAG identified no provider domains where MCNA failed to meet the time/distance standards at the statewide level.

Recommendations

No specific opportunities or recommendations were identified related to the data collection and management processes MCNA had in place to inform network adequacy standard and indicator calculations.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate MCNA's provider network and identified network inadequacies compared to DHHS' minimum time and distance network standards. Regarding MCNA's provider network, HSAG recommends that MCNA assess if this is due to a lack of providers available in the network, a lack of providers in the geographic area served, the inability to identify the providers in the data using the standard definitions, or other reasons. If the inability to meet the time/distance standard is due to data concerns, MCNA should ensure all providers are appropriately identified in future data submissions.

In response to HSAG's NAV recommendations, MCNA responded:

- MCNA has identified that this finding is a result of a lack of Pediatric Dentists in San Juan County. MCNA provides sufficient availability of dental services for the eligible population in these geographic service areas through the Primary Care General Dentists that serve its members and continues to receive claims for children being treated by General Dentists that treat both the adult and children's membership in this county. The Utah contract recognizes both General Dentists as well as Pediatric Dentists as primary care providers acting within the scope of their license providing comprehensive oral health care.
- MCNA recognizes San Juan County as a dental health professional shortage area and continues to invite all qualified dental providers to participate in the Utah network with particular attention given to monitoring any new providers to this area. In the event that a member in San Juan County requires to be treated by a Pediatric Dentist, MCNA will engage an out-of-network provider of the specialty type needed to agree via a Letter of Agreement to see the member on a case-by-case basis to ensure the member is receiving the care needed. The Network Development Team will continue recruitment efforts with any providers that move into this area and monitor any grievances related to network access to ensure all members are provided with the care that is needed.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will not likely result in long-term improvements.

Premier Access

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Premier Access' interpretation of data was accurate. Table 2-273 identifies HSAG's level of confidence for time/distance indicators.

Table 2-273—Premier Access Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of nine time/distance indicators for Premier Access. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-274 displays the number of provider categories by provider domain wherein Premier Access met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Premier Access in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-274—Compliance With Time/Distance Standards by Provider Domain—Premier Access

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
All Dental Providers, including General Dentists	1	100.0%	100.0%	🔑
General Dentists	1	100.0%	100.0%	🔑
Pediatric Dentists	1	100.0%	100.0%	🔑

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

HSAG identified no provider domains where Premier Access failed to meet the time/distance standards at the statewide level.

Recommendations

Although Premier Access added an additional layer of validation for manual data entry of provider data through internal audits, manual data entry can lead to errors. HSAG recommends that Premier Access explore opportunities to create an automated process for the transfer of provider data from Symplr Payor to Cadence.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Premier's provider network and identified that Premier Access conducted manual data entry for all provider network information with no internal audits in place to ensure data entry accuracy. HSAG recommended that Premier Access put a process in place to maintain data accuracy by frequently performing internal audits of a representative sample of updated provider records to reduce data entry errors and ensure provider data accuracy.

To address HSAG's NAV findings, Premier Access implemented a weekly audit of the full UT State Medicaid file, ensuring 100 percent of FQHC locations accurately reflected the appropriate National Provider Identifier 2 (NPI2) and Taxonomy Code. Additionally, Premier Access created a new staff position—Network Provider Information Quality Auditor and Trainer. Premier was actively interviewing candidates and expected to have this new position filled by the end of 2025. This Quality Auditor and Trainer is responsible for implementing a robust internal auditing process as well as standard operating procedures.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will not likely result in long-term improvements.

CHIP PAHPs Providing Dental Services

Premier Access CHIP

Results

Validation Ratings

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether network adequacy indicator results were valid, accurate, and reliable, and if Premier Access CHIP's interpretation of data was accurate. Table 2-275 identifies HSAG's level of confidence for time/distance indicators.

Table 2-275—Premier Access CHIP Validation Ratings

Network Adequacy Indicator Type	*High Confidence*	*Moderate Confidence*	*Low Confidence*	*No Confidence/ Significant Bias*
Time/Distance Indicators	100.0%	0.0%	0.0%	0.0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of nine time/distance indicators for Premier Access CHIP. Of these indicators, 100 percent received a rating of *High Confidence*.

Strengths, Opportunities, and Recommendations

Strengths

Table 2-276 displays the number of provider categories by provider domain wherein Premier Access CHIP met the time/distance standards at the statewide level. HSAG presented detailed current and speculative time/distance results to DHHS and Premier Access CHIP in an interactive Tableau dashboard filterable by urbanicity, county, and provider category.

Table 2-276—Compliance With Time/Distance Standards by Provider Domain—Premier Access CHIP

		Statewide*		
Provider Domain	Number of Provider Categories	HSAG Percent Met (%)*	HSAG Percent Met (%)*	Impact: Quality, Access, and/or Timeliness
All Dental Providers, including General Dentists	1	100.0%	100.0%	
General Dentists	1	100.0%	100.0%	
Pediatric Dentists	1	100.0%	100.0%	

*To meet the statewide time/distance standard for a provider category, health plans have to meet the standard for each urbanicity (i.e., urban, rural, and frontier).

Opportunities for Improvement

HSAG identified no provider domains where Premier Access CHIP failed to meet the time/distance standards at the statewide level.

Recommendations

Although Premier Access CHIP added an additional layer of validation for manual data entry of provider data through internal audits, manual data entry can lead to errors. HSAG recommends that Premier explore opportunities to create an automated process for the transfer of provider data from Symplr Payor to Cadence.

Assessment of Follow-Up on Last Year's Recommendations

Prior Year Recommendations and Health Plan Interventions

In CY 2024, HSAG conducted network capacity and geographic distribution analyses to evaluate Premier Access CHIP's provider network and identified that Premier Access CHIP conducted manual data entry for all provider network information with no internal audits in place to ensure data entry accuracy. HSAG recommended that Premier Access CHIP put a process in place to maintain data accuracy by frequently performing internal audits of a representative sample of updated provider records, to reduce data entry errors and ensure provider data accuracy.

To address HSAG's NAV findings, Premier Access CHIP implemented a weekly audit of the full UT State Medicaid file, ensuring 100 percent of FQHC locations accurately reflected the appropriate NPI2 and Taxonomy Code. Additionally, Premier created a new staff position, Network Provider Information Quality Auditor and Trainer. Premier was actively interviewing candidates and expected to have this new position filled by the end of 2025. This Quality Auditor and Trainer will be responsible for implementing a robust internal auditing process as well as standard operating procedures.

Assessment of Health Plans Approach to Addressing Prior Year Recommendations

HSAG recognizes that these interventions will likely result in long-term improvements.

Appendix A. Objectives and Methodology for External Quality Review by EQR Activity

Validation of Performance Improvement Projects

Objectives

The purpose of PIPs is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in both clinical and nonclinical areas. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a reasonable time. This structured method of assessing and improving health plan processes is expected to have a favorable effect on health outcomes and member satisfaction.

The primary objective of PIP validation is to determine the validity and reliability of a PIP through assessing a health plan's compliance with the requirements of 42 CFR §438.330(d)(2) including:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation is to ensure that DHHS and key stakeholders can have confidence that the health plan executed a methodologically sound improvement project, and any reported improvement is related to, and can be reasonably linked to, the QI strategies and activities the health plan conducted during the PIP.

Description of Data Obtained

DHHS required each health plan to conduct two PIPs during CY 2025. Each health plan chose its own clinical and nonclinical PIP topic. HSAG obtained the data needed to conduct the PIP validations from each health plan's CY 2025 PIP Submission Form. Within this form, health plans provided detailed information about each PIP as it related to the protocol activities and associated steps.

Each of the PIP submission forms included steps to be undertaken when conducting PIPs. The form presented instructions for documenting information related to each of the protocol steps. The health plans could also upload relevant supporting documentation with the PIP Submission Form. Each health plan completed the form for PIP activities and submitted it to HSAG for validation.

Methodology and Technical Methods of Data Collection

In its PIP evaluation and validation, HSAG used CMS' EQR Protocol 1 cited earlier in this report to evaluate the following components of the process:

- Evaluation of the technical structure of the PIP. This component ensures that the health plans design, conduct, and report PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., Aim statement, population, sampling methods, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Evaluation of the implementation of the PIP. Once a health plan designs a PIP, the health plan's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the health plans improve their rates through implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results.)

How Data Were Aggregated and Analyzed

HSAG obtained the information needed to conduct the PIP validation from the health plan's PIP Submission Form submitted in CY 2025. This form provided detailed information about the health plan's PIP related to the steps HSAG completed and evaluated for the CY 2025 validation cycle.

To monitor, assess, and validate PIPs, HSAG uses a standardized scoring methodology to rate a health plan's compliance with each of the nine steps listed in CMS EQR Protocol 1. With DHHS' input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. HSAG uses this tool to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected Performance Indicator(s)
- Step 6—Review the Data Collection Procedures
- Step 7—Review Data Analysis and Interpretation of PIP Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred

How Conclusions Were Drawn

HSAG evaluates each required step on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. To produce valid and reliable results, a PIP must receive a *Met* score for all critical elements.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation confidence ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the health plan adhered to acceptable methodology for all phases of the PIP and the second rating reflects HSAG's confidence with the achievement of statistically significant improvement in outcomes. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a Met validation score and the corresponding confidence level: *High Confidence, Moderate Confidence, Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

Overall Confidence That the PIP Achieved Significant Improvement

- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
  - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
  - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
  - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.

- *Low Confidence:* The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
- *No Confidence:* The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

While the focus of a health plan's PIP may have been to improve performance related to health care quality, timeliness, or access, PIP activities were designed to evaluate the validity and quality of a health plan's processes for conducting valid PIPs. Therefore, HSAG determined that all PIPs had potential to impact the quality domain of care. Additionally, a health plan's particular PIP also may have also been associated with the timeliness or access domains, depending on the specific PIP topic. HSAG therefore analyzed each health plan's performance in conducting PIPs across the three domains of care based on those associations and the potential impact on member outcomes related to the domains of care.

Validation of Performance Measures

Objectives

The primary objectives of the performance measure validation activity were to evaluate the accuracy of the performance measure rates calculated by the health plans and determine the extent to which the specific performance measures calculated by the health plans followed the technical specifications for each measure.

Description of Data Obtained

Medicaid ACOs, UMIC and CHIP MCOs, and Dental PAHPs

The ACOs, UMIC and CHIP MCOs, and dental PAHPs were required to calculate applicable HEDIS measures following the *HEDIS MY 2024 Technical Specifications*, undergo an NCQA HEDIS Compliance Audit[219] performed by an NCQA-certified auditor, and report the results of their HEDIS audit to DHHS. These health plans were also required to provide the HEDIS data, FARs, and a copy of the auditor's certification to DHHS. HSAG obtained the HEDIS FARs from DHHS and evaluated the FARs to assess the health plans' compliance with the NCQA HEDIS Compliance Audit standards.

[219] HEDIS Compliance Audit ™ is a trademark of NCQA.

PMHPs and HOME

The 11 PMHPs and HOME were required to calculate and report one measure, *Follow-Up After Hospitalization for Mental Illness*, which was a state-modified version of CMS core set measure *Follow-Up After Hospitalization for Mental Illness* measure. The measure was based on claims/encounter data and data from the organization's electronic health record system. DHHS required the PMHPs and HOME to maintain a data system that allowed for tracking, monitoring, calculating, and reporting this performance measure.

HSAG conducted validation activities for the 11 PMHPs and HOME to assess the accuracy of the reported performance measure rates and to determine the extent to which the calculated performance rates followed the measure specifications and reporting requirements. HSAG conducted on-site audits and reviewed the health plans' submitted documentation and performance measure rates.

Methodology and Technical Methods of Data Collection

Validation of Performance Measures

Upon completion of the NCQA HEDIS audit, the ACOs, UMIC plans, MCOs, and dental PAHPs submitted their FARs and final auditor-locked Interactive Data Submission System (IDSS) rate submissions to DHHS, which DHHS provided to HSAG.

For the PMHPs and HOME, HSAG conducted the following validation activities and utilized data collection methodology as outlined in CMS' EQR Protocol 2:

1. Conducted pre-virtual review activities including collecting and reviewing relevant documentation and rate review.
   - HSAG obtained a list of the indicators selected for validation as well as the indicator definitions from DHHS for the validation team to review.
   - HSAG prepared a documentation request for the PMHPs and HOME, which included the Information Systems Capabilities Assessment Tool (ISCAT). HSAG customized the ISCAT to collect data consistent with Utah's service delivery model and forwarded the ISCAT to each organization with a timeline for completion and instructions for submission. HSAG responded to organizations' ISCAT-related questions during the pre-virtual phase.
2. Conducted virtual site visits using a webinar format with each organization.
   - HSAG collected information using several methods, including interviews with key staff, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports.

3. Conducted post-virtual-site visit activities including compiling and analyzing findings, and reporting results to DHHS.

How Data Were Aggregated and Analyzed

HSAG reviewed and evaluated the HEDIS MY 2024 FARs for the ACOs, UMIC plans, MCOs, and dental PAHPs to assess health plan compliance with the following NCQA HEDIS Compliance Audit information system (IS) standards:

IS R – Data Management and Reporting

IS C – Clinical and Care Delivery Data

IS M – Medical Record Review Processes

IS A – Administrative Data

HSAG then analyzed each health plan's performance, identified strengths, and opportunities for improvement by reviewing the certified HEDIS rates in comparison to MY 2024 NCQA Quality Compass rates.

For the PMHPs and HOME, HSAG conducted the validation activities as outlined in CMS' EQR Protocol 2. The CMS protocol activities for validation of performance measures include aggregation and analysis of documentation submitted by the health plan including the ISCAT and supporting documentation, interviews with key staff during the virtual review, systems demonstrations during the virtual review, review of data output files, PSV of records used for denominator and numerator identification, observation of data processing, and review of data reports.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and access to care provided by Utah's Medicaid and CHIP health plans, HSAG categorized each of the HEDIS performance measures reported in one or more of the three domains of care (quality, timeliness, and access). HSAG then analyzed each health plan's performance in comparison to MY 2024 NCQA Quality Compass average rates to draw conclusions about the health plan's effectiveness in ensuring the quality, timeliness of, and access to care for its members.

Based on all validation activities with the PMHPs and HOME, HSAG determined results for each performance measure. As set forth in CMS' EQR Protocol 2, HSAG gave a validation finding of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported* (see Table A-1) to each performance measure. HSAG based each validation finding on how significant the errors were in each measure's evaluation elements, not by the number of elements determined to be noncompliant. For example, it was possible that a single error could result in a designation of *Do Not Report* if the impact of the error

biased the rate by more than 5 percentage points. Conversely, even if multiple errors were identified, if the errors had little or no impact on the rate, the indicator was given a designation of *Reportable*.

After completing the validation process, HSAG prepared a report of the PMV findings and recommendations for each PMHP and HOME. HSAG forwarded these reports to DHHS and the appropriate health plan. Finally, HSAG analyzed each health plan's performance based on measure rates and reviewed the rates in comparison to the statewide average. Section 2. Evaluation of Utah Medicaid and CHIP Health Plans contains information about the health plan-specific performance measure rates and validation status.

Table A-1—Designation Categories for Performance Indicators

Reportable (R)	Measure was compliant with the State's specifications.
Do Not Report (DNR)	The PMHP rate was materially biased and should not be reported.
Not Applicable (NA)	The PMHP was not required to report the measure.
Not Reported (NR)	The measure was not reported because the PMHP did not offer the required benefit.

Compliance Monitoring

Objectives

The objective of the compliance review activities is to determine the extent to which the health plan complies with the standards set forth at 42 CFR Part 438 and with State contract requirements. In addition, the compliance review process provides meaningful information to DHHS and the health plans regarding:

- The quality, timeliness, and access to health care furnished by the health plan.
- Corrective actions required and interventions needed to improve quality.
- Activities needed to enhance and sustain performance and processes.

Description of Data Obtained

During CY 2023 and CY 2024, HSAG conducted an assessment of the Utah health plans' compliance with Medicaid managed care regulations and State contract requirements, evaluating 13 managed care standards under 42 CFR §438 et seq. HSAG required that health plans complete a corrective action plan (CAP) to address requirements that were found to be out of compliance. HSAG then conducted a review of the implementation of each health plan's CAP.

Documents reviewed consisted of the following:

- HSAG's proprietary compliance monitoring tool with a portion completed by the health plan.
- A document request form outlining the compliance review process whereas health plans added high-level organizational and delegation information.
- Policies and procedures.
- Staff training materials.
- Key committee meeting minutes.
- Provider and member informational materials.
- Correspondence related to grievances, notice of adverse benefit determination (NABDs), and appeals.
- Initial credentialing and re-credentialing files

In addition, HSAG obtained data for assessing compliance with regulations through on-site interviews with key health plan staff members during site reviews.

During CY 2025, HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records, aligned with the Coverage and Authorization of Services and Grievance and Appeal System standards. HSAG required that health plans complete a CAP to address findings from the focused record review. HSAG then conducted a review of the implementation of each health plan's CAP.

Methodology and Technical Methods of Data Collection

To accomplish the stated objectives for the site reviews, for assessing each health plan's compliance with Medicaid and CHIP managed care regulations, HSAG collaborated with DHHS on the development of compliance monitoring tools and methods, document review and assessment processes, schedules, agendas, and scoring methodology. HSAG completed document review and interviews to assess all standards. Upon completion of each review, for each health plan, HSAG assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable* to each individual requirement reviewed and indicated where required corrective actions existed, if appropriate. Table A-2 presents the organization of the Medicaid managed care regulations into 13 standards reviewed during CY 2023 and CY 2024:

Table A-2—Compliance Standards and Review Years

Standard Number and Title	Regulations Included	CY 2023	CY 2024	CY 2025 (Focused Review)
Standard I—Enrollment and Disenrollment	438.3(d) 438.56	X		
Standard II—Member Rights and Confidentiality	438.100	X		

Standard Number and Title	Regulations Included	CY 2023	CY 2024	CY 2025 (Focused Review)
	438.224			
Standard III—Member Information	438.10		X	
Standard IV—Emergency and Poststabilization Services	438.114	X		
Standard V—Adequate Capacity	438.206 438.207		X	
Standard VI—Coordination and Continuity of Care	438.208		X	
Standard VII—Coverage and Authorization of Services	438.210	X		X
Standard VIII—Provider Selection and Program Integrity	438.214		X	
Standard IX—Subcontractual Relationships and Delegation	438.230		X	
Standard X—Practice Guidelines	438.236	X		
Standard XI—Health Information Systems	438.242		X	
Standard XII—QAPIP	438.330		X	
Standard XIII—Grievance and Appeal System	438.228 438.400 438.402 438.404 438.406 438.408 438.410 438.414 438.416 438.420 438.424	X		X

HSAG conducted compliance review activities consistent with CMS' EQR Protocol 3 cited earlier in this report. The CMS protocol for assessing health plan compliance with regulations includes five protocol activities. To conduct compliance review activities, HSAG:

1. Collaborated with DHHS on the development of the compliance monitoring tool.
   - Collaborated with DHHS to determine review and scoring methods and thresholds.
   - Collaborated with the health plans and DHHS to determine schedules, agendas, and to explain the compliance monitoring processes and address questions.
2. Collected and reviewed data and documents and performed a preliminary review.
3. Conducted an on-site review with each health plan's key personnel and subject matter experts.
4. Compiled and analyzed and the data and information collected.
5. Prepared a report that delineated findings and required corrective actions.
   - Submitted the health plan-specific draft reports to DHHS with a second draft to each health plan for review.

- Submitted the final health plan-specific reports and corrective action plan templates to the health plans and DHHS.

How Data Were Aggregated and Analyzed

HSAG assessed health plan compliance with the Medicaid managed care final rule, finalized November 9, 2020, through a proprietary compliance tool that itemized each of the regulations at 42 CFR Part 438, as noted in the Methodology and Technical Methods of Data Collection section of this report. Once the assessments were finalized, HSAG assigned scores (*Met*, *Partially Met*, *Not Met*, or *Not Applicable)* for each requirement and then assigned a point value, with *Met* equaling one point, *Partially Met* equaling one-half point, and *Not Met* equaling zero points. HSAG used this scoring methodology to determine scores for each requirement within the standards and then calculated a percent *Met* score for each standard. Finally, HSAG determined a weighted score for the entire assessment. With this information, HSAG was able to conduct analyses across standards; among health plan types (ACO, UMIC, CHIP, dental PAHP, and PMHP); and in the aggregate (statewide).

How Conclusions Were Drawn

HSAG assessed each requirement within the standards set forth at 42 CFR Part 438 and assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. To make conclusions regarding the domains of care (quality, timeliness, and access) provided by each health plan, HSAG determined the requirements within each standard that were associated with each domain. Each element may impact aspects of one or more of the domains of care. HSAG then analyzed each health plan's performance across the three domains of care based on those associations and potential impact on member outcomes related to the domains of care.

Validation of Network Adequacy

Objectives

Under the contract for EQR, DHHS requested that HSAG conduct NAV analyses including a network capacity analysis and a geographic network distribution analysis for Medicaid managed care and CHIP health plans during CY 2025.

Validation of network adequacy is a mandatory EQR activity described in Title 42 of the Code of Federal Regulations (42 CFR), Section 438.358(b)(1)(iv), and the Centers for Medicare & Medicaid Services (CMS) *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity,* February 2023

(CMS EQR Protocol 4).[220] As guided by CMS EQR Protocol 4, HSAG (1) validated the data and methods that the health plans used to assess network adequacy, (2) validated the results and generated a validation rating, and (3) reported the validation findings in the annual EQR technical report. As part of the analysis, HSAG refreshed the provider crosswalk developed in CY 2019 and updated in CY 2023, which the health plans used to classify providers into appropriate provider categories. HSAG calculated the time/distance and provider ratio results for each health plan and validated each health plan's compliance with access standards.

The purpose of the network adequacy validation activity was to validate the methods and results of the health plans in Utah. The data were reported as of June 1, 2025, and represent the methods and reporting processes used for the preceding 12 months.

Description of Data Obtained

The CY 2025 NAV analyses included all ordering, referring, and servicing practitioners; practice sites; and entities (e.g., health care facilities) contracted to provide care as of June 1, 2025, through one of Utah's Medicaid or CHIP managed care health plans.

Medicaid and CHIP Member Data Request

To complete the NAV analysis, HSAG obtained Medicaid and CHIP member eligibility, enrollment, and demographic information from DHHS. Key data elements requested included unique member identifier, gender, age, health plan in which the member is enrolled, and residential address as of June 1, 2025. Upon receiving the member data files from DHHS, HSAG conducted a preliminary review of the data to ensure compliance with HSAG's data requirements. HSAG collaborated with DHHS to resolve questions identified during the data review process.

Health Plan Data Request

- Provider Data Request: HSAG submitted a detailed data requirements document to the health plans to request information about providers actively enrolled as of June 1, 2025. HSAG supplied the health plans with the provider crosswalk that detailed the methods for classifying each provider category using provider type, specialty, taxonomy, and credentials. The health plans used the provider crosswalk to classify their providers to the appropriate provider categories. Key data elements requested included, but were not limited to, unique provider identifier, enrollment status with the health plans, provider category, provider type, provider specialty, and PCP indicator.

[220] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 17, 2025.

- Network Adequacy Assessment Results: HSAG also provided health plans with a template to submit their time/distance standard calculation results.

Information Systems Capabilities Assessment Tool (ISCAT) and Document Request Packet (DRP)

HSAG drafted and submitted for DHHS' review an ISCAT for the purpose of collecting information on and evaluating the capabilities of the health plans' IS infrastructure to monitor network standards in accordance with the requirements of CMS EQR Protocol 4. The ISCAT included a list of supplemental documentation requested, such as policies, procedures, and provider mapping documents. HSAG incorporated DHHS' feedback into the final version of the document and submitted this document for DHHS' reference.

Methodology and Technical Methods of Data Collection

Under the contract for EQR, DHHS requested that HSAG conduct NAV analyses including a network capacity analysis and a geographic network distribution analysis for the Medicaid and CHIP health plans during CY 2025. As part of the analysis, HSAG updated the provider crosswalk developed in CY 2019 and revised in CY 2023, which the health plans used to classify providers into appropriate provider categories. HSAG then calculated the time/distance and provider ratio results for each health plan and validated each health plan's compliance with access standards. Additionally, for provider types that did not meet the time/distance requirements, a saturation analysis was completed to determine the degree to which each health plan's provider network reflects available providers.

How Data were Aggregated and Analyzed

Network Capacity Analysis

HSAG calculated the provider ratio for the provider categories defined in the provider crosswalks for the health plans. Specifically, the provider ratio measures the number of providers by provider category (e.g., PCPs, cardiologists) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations.

Geographic Network Distribution Analysis

The second dimension of this study evaluated the geographic distribution of providers relative to the health plans' members. While the network capacity analysis identifies whether the network infrastructure is sufficient in both number of providers and variety of specialties, the geographic

network distribution analysis evaluates whether the provider locations in a health plan's provider network are proportional to the health plans' Medicaid and/or CHIP population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider specialties identified in the provider crosswalks:

- Percentage of members within predefined access standards:[221] A higher percentage of members meeting access standards indicates better geographic distribution of a health plan's providers in relation to its Medicaid or CHIP members.
- Average travel distance (in miles) and travel time[222] (in minutes) to the nearest one to three providers: A smaller distance or shorter travel time indicates greater accessibility to providers since individuals must travel fewer miles or minutes to access care.

HSAG used GeoAccess software to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to three providers for all provider categories identified in the provider crosswalks. All study results were stratified by health plan.

Provider Saturation Analysis

Based on the time/distance validation results, HSAG identified the provider categories for which each health plan failed to meet the established standard at the county level. For each time/distance standard in which a health plan did not meet the time/distance requirements, HSAG determined the extent to which deficiencies in the health plan provider network resulted from the failure to contract with available providers versus a lack of available providers for the provider type and/or geographic area. HSAG collaborated with DHHS to determine any limitations that should be applied when assessing potentially available providers. For example, HSAG worked with DHHS to determine if providers in adjacent counties should be included when determining potential network deficiencies.

[221] The percentage of members within predefined standards was calculated for provider categories with predefined access standards.

[222] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid or CHIP members; the shorter the average drive time, the more similar the distribution of providers is relative to members. Current drive times were estimated based on the following drive speeds: urban areas were estimated at a drive speed of 30 miles per hour, suburban areas were estimated at a drive speed of 45 miles per hour, and rural areas were estimated at a drive speed of 55 miles per hour.

Review of Information Systems Underlying Network Adequacy Monitoring

HSAG completed a desk review of the submitted ISCAT, followed by virtual interviews that included health plan network-related IS demonstrations and discussion of data management processes described in the ISCAT submission.

HSAG reviewed each health plan's ISCAT and supplemental documentation to understand the processes for maintaining and updating provider data, including how the health plan tracks providers over time, across multiple office locations, and through changes in participation in the health plan's network. HSAG assessed the ability of the health plan's IS to collect and report accurate data required for the calculation of network adequacy indicators. This involved understanding selected characteristics of the health plan's information technology (IT) system architecture, file structure, information flow, data processing procedures, and how these ensure the completeness and accuracy of data related to provider networks and network adequacy. HSAG thoroughly reviewed all documentation, noting issues, concerns, and items that needed clarification.

Validate Network Adequacy Data, Methods, and Results

HSAG assessed data and documentation from each health plan including, but not limited to, provider network data files or directories, member enrollment data files, and/or provider and member handbooks. HSAG assessed all data files used for network adequacy calculation at the indicator level for validity and completeness. HSAG required each health plan to submit its methodology for calculating each indicator in the scope of the validation. HSAG identified whether the required variables were present and required each health plan to submit documentation describing the steps the health plan takes for indicator calculation. HSAG assessed the health plan's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support health plan and State network adequacy monitoring. HSAG validated network adequacy reporting against state-defined indicators and against the most recent network adequacy reports to assess trending patterns and reasonability of reported indicator-level results, if available. HSAG assessed whether the results were valid, accurate, and reliable, and whether the health plan's interpretation of the data was accurate.

HSAG used software from Quest Analytics to calculate the travel time and physical distance between the addresses of specific members and the address of the nearest provider for all provider categories identified in the analysis. All study results were stratified by health plan, as well as by county. HSAG's results were compared to the results submitted by the health plans as an external point of validation.

Provide Validation Ratings for Network Adequacy Results Submitted by the Health Plans

HSAG used the CMS EQR Protocol 4 Worksheet 4.6 to guide it in a systematic assessment of the quality of health plan network adequacy data, methods, and results. The worksheet was completed for each network adequacy indicator for each health plan. The worksheet consists of 10 questions regarding

data collection procedures, 16 questions regarding network adequacy methods, and four questions regarding results. For each question, a "Yes" response indicates that the health plan met quality expectations, a "No" response indicates that the health plan fully or partially failed to meet expectations, and an "NA" response indicates that the question does not apply to the health plan or the specific indicator. For each indicator, HSAG calculated a validation score equal to the number of "Yes" responses divided by the total number of "Yes" and "No" responses. Based on where the score falls into ranges defined by CMS, the health plan received a rating for the indicator of *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*, as shown below in Table A-3.

Table A-3—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence/Significant Bias*

Aggregating and Analyzing Statewide Data

For each health plan, HSAG analyzed the results obtained from each EQR-related activity conducted in CY 2025. HSAG then analyzed the data to determine if common themes or patterns existed that would allow overall conclusions to be drawn or recommendations to be made about the quality or timeliness of, or access to care and services provided by each health plan as well as related to potential statewide improvement. To accomplish this analysis, HSAG used the following three step process:

1. HSAG analyzed the quantitative results obtained from each EQR-related activity, for each health plan, to identify strengths and weaknesses (opportunities for improvement) in each domain of care (quality and timeliness of, and access to care and services).
2. From the information collected, HSAG identified common themes and salient patterns that emerged for each domain of care and drew conclusions about the quality and timeliness of, and access to care and services furnished by the health plans.
3. From the analysis identifying common themes and patterns related to the domains of quality, timeliness, and access, HSAG evaluated the patterns and determined whether statewide recommendations may be appropriate.

How Conclusions Were Drawn

HSAG determined that results of network adequacy activities could provide information about health plan performance related to the quality and access domains of care. HSAG used analysis of the network data obtained to draw conclusions about Medicaid and CHIP member access to particular provider networks (e.g., primary, specialty, or behavioral health care) in specified geographic regions. The data also allowed HSAG to draw conclusions regarding the quality of the health plans' ability to track and monitor their respective provider networks.

Appendix B. Statewide Comparative Results

Statewide Strengths, Opportunities for Improvement, and Recommendations Across External Quality Review Activities

Statewide Strengths Related to All Activities

Across nearly all activities, the Utah Medicaid managed care health plans demonstrated a robust administrative foundation and moderate-to-high provider availability, including:

- Receiving *High Confidence* ratings for PIP validation rating 1 (adherence to PIP methodology) for ACOs, UMICs, and CHIP. This indicates that the health plans understand how to design and run PIPs.
- Demonstrating high performance in SUD treatment engagement and antidepressant medication management, particularly for UMICs and PMHPs.
- Consistently exceeding national averages in oral evaluation rates for children and adolescents for dental PAHPs.
- Showing a strong commitment to proper coverage and authorization processes for compliance monitoring, with the statewide average for NABD letter requirements remaining consistently high (at or above 90 percent).
- Demonstrating comprehensive provider networks, effectively ensuring that Medicaid and CHIP members had access to a broad range of services within mandated geographic time and distance standards across most health plans.

Statewide Opportunities Related to All Activities

The data revealed systemic gaps in clinical outcomes and member communication that persisted across different health plan types, including:

- Falling below the national average for *Breast Cancer Screening* across ACOs and UMICs.
- Exhibiting poor rates related to immunization status (specifically Combination 2 and Combination 3) and well-child visits in the first 15–30 months of life.
- Demonstrating insufficient benchmarks for follow-up after ED visits or hospitalizations for mental illness for UMICs and some PMHPs.
- Failing to meet federal readability and format requirements at 42 CFR §438.10(c) in member letters (denials, appeals, and grievances) for some health plans.

Statewide Recommendations Related to All Activities

For clinical and quality measures, HSAG recommends that health plans:

- Implement a statewide collaborative campaign for breast and cervical cancer screenings, potentially using mobile screening units or incentivized "screening days" to overcome geographic barriers.
- Enhance data-sharing between the State's immunization registry and health plan systems to identify and close vaccine gaps for children and adolescents in real time.
- Develop standardized transition-of-care protocols to ensure that when members are discharged from an ED or hospital for mental health, an appointment is scheduled within seven days before they leave the facility.

To improve compliance and operations, HSAG recommends that health plans:

- Develop strategies at the senior management level to ensure quality assurance pertaining to 42 CFR §438.10(c) compliance for critical member communication, focusing on developing member letters and ensuring they are written at an appropriate reading level to promote ease of understanding.
- For *Low Confidence* or *No Confidence* PIP ratings, request PIP design technical assistance to ensure future projects yield valid results.
- Proactively monitor provider turnover and appointment availability for high-demand specialties (e.g., child psychiatry and dermatology) to maintain NAV standards.

Validation of Performance Improvement Projects

For CY 2025, each health plan submitted two PIPs for validation: a clinical PIP and a nonclinical PIP.

ACO and UMIC Health Plans

Medicaid ACO Clinical PIPs

For the clinical PIPs, all four ACOs received a *High Confidence* rating for Validation Rating 1 (i.e., adherence to acceptable PIP methodology). Two ACOs received a *High Confidence* level and remaining two ACOs received a *Moderate Confidence* level for Validation Rating 2 (i.e., the PIP achieved significant improvement).

UMIC Clinical PIPs

For the clinical PIPs, all four UMIC plans received a *High Confidence* rating for Validation Rating 1. One UMIC plan received a *Moderate Confidence* level, and one UMIC plan received a *High Confidence* level for Validation Rating 2. For two UMIC plans, the PIP had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIP for Validation Rating 2.

Table B-1 lists the clinical PIP topics and validation scores for each ACO and UMIC health plan.

Table B-1—CY 2024 Medicaid ACO and UMIC Clinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Health Choice	*Well-Child Visits in the First 30 Months of Life*	94%	100%	*High Confidence*	100%	100%	*High Confidence*
Health Choice UMIC	*Adults' Access to Preventive/Ambulatory Health Services*	93%	100%	*High Confidence*	NA	NA	*NA*
Healthy U	*Improving Access to Well Visits in*	100%	100%	*High Confidence*	100%	100%	*High Confidence*

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	the First 15 and 30 Months of Life						
Healthy U Integrated	*Improving Adults' Access to Preventive/ Ambulatory Care Services*	92%	100%	*High Confidence*	NA	NA	*NA*
Molina	*Well-Child Visits in the First 30 Months of Life*	100%	100%	*High Confidence*	75%	100%	*Moderate Confidence*
Molina UMIC	*Follow-Up After Hospitalization for Mental Illness*	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Select Health CC	*Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members*	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
Select Health CC UMIC	*7-day Follow-Up After Hospitalization for Mental Illness for Medicaid Integration Members*	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Medicaid ACO Nonclinical PIPs

For the nonclinical PIPs, all four ACOs received a *High Confidence* rating for Validation Rating 1. The PIPs had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIPs for Validation Rating 2.

UMIC Nonclinical PIPs

For the nonclinical PIPs, all UMIC plans received a *High Confidence* rating for Validation Rating 1. The PIPs had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIPs for Validation Rating 2.

Table B-2 lists the nonclinical PIP topics and validation scores for each ACO and UMIC health plan.

Table B-2—CY 2024 Medicaid ACO and UMIC Nonclinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Health Choice	*Medicaid HRA Process Improvement*	100%	100%	*High Confidence*	*Not Assessed*		
Health Choice UMIC	*Medicaid HRA Process Improvement*	100%	100%	*High Confidence*	*Not Assessed*		
Healthy U	*Medicaid HRA Process Improvement*	92%	100%	*High Confidence*	*Not Assessed*		
Healthy U Integrated	*Medicaid HRA Process Improvement*	92%	100%	*High Confidence*	*Not Assessed*		
Molina	*Increasing Member Engagement and Satisfaction with Digital Channels*	100%	100%	*High Confidence*	*Not Assessed*		

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Molina UMIC	*Increasing Member Engagement and Satisfaction with Digital Channels*	100%	100%	*High Confidence*	*Not Assessed*		
Select Health CC	*Improving the Percentage of Select Health ACO Members Retaining Health Insurance When Identified for Redetermination*	100%	100%	*High Confidence*	*Not Assessed*		
Select Health CC UMIC	*Improving the Percentage of Select Health UMIC Members Retaining Health Insurance When Identified for Redetermination*	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

PMHPs

PMHP Clinical PIPs

For the clinical PIPs, 10 of the 11 PMHPs received a *High Confidence* rating, and one PMHP received a *No Confidence* rating for Validation Rating 1. Six PMHPs received a *High Confidence* level and one PMHP received a *No Confidence* level for Validation Rating 2. For four PMHPs, the PIPs had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIPs for Validation Rating 2.

Table B-3 lists the clinical PIP topics and validation scores for each PMHP.

Table B-3—CY 2024 PMHP Clinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Bear River	*YOQ/OQ*	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Central	*Improved Integrated Care*	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Davis	*Naloxone for Opioid Use Disorders*	100%	100%	*High Confidence*	*Not Assessed*		
Four Corners	*Improving the Completion of the SURE Survey*	95%	90%	*No Confidence*	0%	0%	*No Confidence*
Healthy U Behavioral	*Improving Follow-Up After Hospitalization for Mental Illness*	92%	100%	*High Confidence*	*Not Assessed*		
Northeastern	*Improve Monitoring of Selected Antipsychotic Medication Side*	100%	100%	*High Confidence*	100%	100%	*High Confidence*

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	Effects in Individuals Diagnosed with a Schizophrenia Spectrum Disorder						
Optum/Tooele	*Follow-Up After Hospitalization for Adults Aged 18–64*	100%	100%	*High Confidence*	*Not Assessed*		
Salt Lake	*Follow-Up After Hospitalization for Adults Aged 18–64*	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Southwest	*OQ/YOQ Outcome Suicide Ideation Questionnaire Project*	94%	100%	*Low Confidence*	*Not Assessed*		
Wasatch	*Increasing SURE Utilization in SUD*	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Weber	*Treating Anxiety and Depression with EBT*	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

PMHP Nonclinical PIPs

For the nonclinical PIPs, seven of the 11 PMHPs received a *High Confidence* level, one PMHP received *Moderate Confidence* level, two PMHPs received a *Low Confidence* level, and one PMHP received *No Confidence* level for Validation Rating 1. Two PMHPs received a *High Confidence* level for Validation Rating 2. For nine PMHPs, the PIPs had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIPs for Validation Rating 2.

Table B-4 lists the nonclinical PIP topics and validation scores for each PMHP.

Table B-4—CY 2024 PMHP Nonclinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Bear River	*No Shows*	86%	100%	*Moderate Confidence*	*Not Assessed*		
Central	*Screening for SDOH*	100%	100%	*High Confidence*	*Not Assessed*		
Davis	*Diagnosing Conflicts*	100%	100%	*High Confidence*	*100%*	*100%*	*High Confidence*
Four Corners	*Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care*	31%	38%	*No Confidence*	*Not Assessed*		
Healthy U Behavioral	*Medicaid HRA Process Improvement*	92%	100%	*High Confidence*	*Not Assessed*		
Northeastern	*Increasing Health-Related Social Needs Screenings*	100%	100%	*High Confidence*	*Not Assessed*		
Optum/Tooele	*Distribution of Provider Specific Results of*	94%	88%	*Low Confidence*	*Not Assessed*		

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	Member Satisfaction Surveys						
Salt Lake	*Distribution of Provider Specific Results of Member Satisfaction Surveys*	100%	100%	*High Confidence*	*Not Assessed*		
Southwest	*Increase Staff Level of Comfort Suicide Screening*	75%	78%	*Low Confidence*	*Not Assessed*		
Wasatch	*Increasing Social Supports in Substance Use Services*	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Weber	*Reducing Clinician Burnout*	94%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

HOME

HOME Clinical PIPs

For the clinical PIP, HOME received a *High Confidence* rating for Validation Rating 1. The PIP had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIP for Validation Rating 2.

Table B-5 lists the clinical PIP topic validation scores for HOME.

Table B-5—CY 2024 HOME Clinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
HOME	*Do Clinical Pharmacist led Interventions have an impact on Guideline Directed Statin Utilization in HOME population*	93%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

HOME Nonclinical PIPs

For the nonclinical PIP, HOME received a *No Confidence* rating for Validation Rating 1. The PIP had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIP for Validation Rating 2.

Table B-6 lists the clinical PIP topic and validation scores for HOME.

Table B-6—CY 2024 HOME Nonclinical PIP Rating Validation Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
HOME	*Implementation of Work Queue for Utilization Management*	44%	33%	*No Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

CHIP MCOs

CHIP MCO Clinical PIPs

For the clinical PIPs, both CHIP MCOs received a *High Confidence* level for Validation Rating 1. One CHIP MCO received a *Moderate Confidence* level for Validation Rating 2. One CHIP MCO PIP had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIP for Validation Rating 2.

Table B-7 lists the clinical PIP topics and validation scores for each CHIP MCO.

Table B-7—CY 2024 CHIP MCO Clinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Molina CHIP	*Immunizations for Adolescents*	100%	100%	*High Confidence*	*Not Assessed*		
Select Health CHIP	*Well-Child Visits for CHIP Members*	100%	100%	*High Confidence*	50%	100%	*Moderate Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

CHIP MCO Nonclinical PIPs

For the nonclinical PIPs, both CHIP MCOs received a *High Confidence* level for Validation Rating 1 (i.e., adherence to acceptable PIP methodology). The PIPs had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIPs for Validation Rating 2.

Table B-8 lists the nonclinical PIP topics and validation scores for each CHIP MCO.

Table B-8—CY 2024 CHIP MCO Nonclinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Molina CHIP	*Increasing Member*	100%	100%	*High Confidence*	*Not Assessed*		

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
	Engagement and Satisfaction with Digital Channels						
Select Health CHIP	*Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination*	100%	100%	*High Confidence*	*Not Assessed*		

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Medicaid and CHIP Dental PAHPs

Medicaid and CHIP Dental PAHP Clinical PIPs

For the clinical PIPs, each of the two Medicaid dental PAHPs and the CHIP dental PAHP received a *High Confidence* level for Validation Rating 1. One Medicaid dental PAHP received *High Confidence* level and one CHIP dental PAHP received *Moderate Confidence* level for Validation Rating 2. For one PAHP, the PIP had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIP for Validation Rating 2.

Table B-9 lists the clinical PIP topics and validation scores for each dental PAHP.

Table B-9—CY 2024 Dental PAHP Clinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
MCNA	*Increasing the Rate of Children Ages 1–4 Who Receive Twice Annual Fluoride*	100%	100%	*High Confidence*	*Not Assessed*		
Premier Access	*School Based Care for Medicaid Members*	94%	100%	*High Confidence*	100%	100%	*High Confidence*
Premier Access CHIP	*School Based Care for CHIP Members*	94%	100%	*High Confidence*	67%	100%	*Moderate Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Medicaid and CHIP Dental PAHP Nonclinical PIPs

For the nonclinical PIPs, all three dental PAHPs received a *High Confidence* level for Validation Rating 1. Two dental PAHPs received *No Confidence* level for Validation Rating 2. For one PAHP, the PIP had not progressed to the reporting remeasurement data phase; therefore, HSAG had not assessed the PIP for Validation Rating 2.

Table B-10 lists the nonclinical PIP topics and validation scores for each dental PAHP.

Table B-10—CY 2024 Dental PAHP Nonclinical PIP Validation Rating Scores and Status

Health Plan	PIP Topic	Validation Rating 1			Validation Rating 2		
		PIP Methodology Confidence Level			Significant Improvement Confidence Level		
		Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
MCNA	*Increasing the Rate of Providers Reporting Member No-shows Using CDT Codes*	100%	100%	*High Confidence*	*Not Assessed*		
Premier Access	*OHIF Completion for New Medicaid Members*	100%	100%	*High Confidence*	*33%*	*100%*	*No Confidence*
Premier Access CHIP	*OHIF Completion for New CHIP Members*	94%	100%	*High Confidence*	*33%*	*100%*	*No Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—HSAG calculated the percentage score by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—HSAG calculated the percentage score of critical elements *Met* by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Validation of Performance Measures

For a summary of statewide strengths, opportunities for improvement, and recommendations for performance measures, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Validation of Performance Measures.

ACOs

Validation Findings

The HEDIS compliance auditors determined that the IS and processes for all four ACOs were fully compliant with the applicable IS standards and reporting requirements for HEDIS MY 2024.

Performance Measure Results

All four ACOs met or exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*
- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Appropriate Treatment for Upper Respiratory Infection*
- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%*

Of the four ACOs, three met or exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%*
- *Controlling High Blood Pressure*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Use of Imaging Studies for Low Back Pain*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*

The following performance indicators demonstrated the most need for improvement, as all four ACOs fell below the MY 2024 NCQA Quality Compass average:

- *Breast Cancer Screening*
- *Immunizations for Adolescents—Combination 2*

In addition, three of the four ACOs fell below the MY 2024 NCQA Quality Compass average for the following performance indicator:

- *Childhood Immunization Status—Combination 3*
- *Eye Exam for Patients With Diabetes*
- *Prenatal and Postpartum Care—Postpartum Care*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—Total*

Based on performance measure outcomes:

- Three out of four ACOs exceeded the MY 2024 NCQA Quality Compass average for 9 of the 17 performance indicators (58.82 percent).
- Three out of the four ACOs fell below the MY 2024 NCQA Quality Compass average for seven of the 17 performance indicators (41.18 percent).

Table B-11 shows the ACOs' HEDIS MY 2024 results compared to the MY 2024 NCQA average rates using v to indicate performance that fell below the NCQA QC average.

Table B-11—ACOs' HEDIS MY 2024 Results

HEDIS Measure	Health Choice	Healthy U	Molina	Select Health CC	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services					
Total	78.00%	82.47%	82.10%	85.62%	77.83%
Antidepressant Medication Management					
Effective Acute Phase Treatment	72.48%	67.99%	69.72%	68.32%	64.05%
Appropriate Treatment for Upper Respiratory Infection					
Total	94.54%	94.69%	93.88%	94.58%	88.10%
Breast Cancer Screening					
Breast Cancer Screening	39.93%v	39.64%v	44.31%v	48.92%v	55.81%

HEDIS Measure	Health Choice	Healthy U	Molina	Select Health CC	MY 2024 NCQA Quality Compass Average
Cervical Cancer Screening					
Cervical Cancer Screening	56.93%	52.80%ᵛ	52.07%ᵛ	61.52%	56.91%
Childhood Immunization Status					
Combination 3	63.75%ᵛ	69.34%	59.85%ᵛ	61.56%ᵛ	66.18%
Glycemic Status Assessment for Patients With Diabetes					
Glycemic Status <8.0%	65.29%	68.13%	58.88%	68.62%	58.65%
*Glycemic Status >9.0%**	24.79%	23.60%	33.09%ᵛ	18.62%	32.66%
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	54.55%ᵛ	54.26%ᵛ	53.36%ᵛ	65.56%	56.06%
Controlling High Blood Pressure					
Controlling High Blood Pressure	76.67%	76.84%	52.31%ᵛ	78.03%	66.66%
Immunizations for Adolescents					
Combination 2	33.68%ᵛ	35.77%ᵛ	28.04%ᵛ	36.18%ᵛ	37.84%
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	90.68%	88.11%	71.34%ᵛ	95.20%	84.87%
Postpartum Care	79.93%ᵛ	78.96%ᵛ	73.43%ᵛ	86.46%	80.76%
Use of Imaging Studies for Low Back Pain					
Total	72.73%	71.83%	73.31%	68.73%ᵛ	70.71%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI percentile—Total	85.16%	86.60%	71.05%ᵛ	91.09%	80.87%
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	62.50%	49.26%ᵛ	49.90%ᵛ	57.81%ᵛ	61.92%
Child and Adolescent Well-Care Visits					
Total	45.27%ᵛ	48.70%ᵛ	49.58%ᵛ	55.68%	55.41%

ᵛ *Indicates the rate fell below the Quality Compass average.*
* *For this indicator, a lower rate indicates better performance.*

UMIC Plans

Validation Findings

The UMIC plans' HEDIS compliance auditors determined that the IS and processes for all 4 health plans were fully compliant with the applicable IS standards and reporting requirements for HEDIS MY 2024.

Performance Measure Results

All four UMIC plans exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Antidepressant Medication Management—Effective Acute Phase Treatment*
- *Follow-Up After ED Visit for Substance Use—7-Day Follow-Up*
- *Follow-Up After ED Visit for Substance Use—30-Day Follow-Up*
- *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment*

Of the four UMIC plans, three exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Controlling High Blood Pressure*
- *Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment*

The following performance indicators demonstrated the most need for improvement, as all four UMIC plans fell below the MY 2024 NCQA Quality Compass average:

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up*
- *Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up*
- *Use of Imaging Studies for Low Back Pain*

In addition, three of the four UMIC plans fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Adults' Access to Preventive/Ambulatory Health Services*

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up

Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up

Based on performance measure outcomes:

- Three out of four UMIC plans exceeded the MY 2024 NCQA Quality Compass average for six of the 20 performance indicators (30.00 percent).
- Three of the four UMIC plans fell below the MY 2024 NCQA Quality Compass average for nine of the 20 performance indicators (45.00 percent).

Table B-12 shows the UMIC plans' HEDIS MY 2024 results compared to the MY 2024 NCQA average rates using v to indicate performance that fell below the NCQA QC average.

Table B-12—UMIC Plans HEDIS MY 2024 Results

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	Select Health CC UMIC	MY 2024 NCQA Quality Compass Average
Adults' Access to Preventive/Ambulatory Health Services					
Total	65.86%v	71.22%v	70.18%v	80.74%	77.83%
Antidepressant Medication Management					
Effective Acute Phase Treatment	75.20%	72.92%	75.22%	66.41%	64.05%
Breast Cancer Screening					
Breast Cancer Screening	42.26%v	44.66%v	37.07%v	53.42%v	55.81%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	NA	NA	NA	NA	78.72%
Cervical Cancer Screening					
Cervical Cancer Screening	41.12%v	45.01%v	39.17%v	53.41%v	56.91%
Glycemic Status Assessment for Patients With Diabetes					
Glycemic Status <8.0%	58.49%v	67.40%	50.36%v	67.80%	58.65%
*Glycemic Status >9.0%**	33.42%v	24.33%	39.42%v	23.66%	32.66%

HEDIS Measure	Health Choice UMIC	Healthy U Integrated	Molina UMIC	Select Health CC UMIC	MY 2024 NCQA Quality Compass Average
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	47.44%ᵛ	48.66%ᵛ	56.20%	59.02%	56.06%
Controlling High Blood Pressure					
Controlling High Blood Pressure	71.11%	73.73%	51.34%ᵛ	74.93%	66.66%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.69%ᵛ	73.79%ᵛ	75.93%ᵛ	78.89%ᵛ	82.45%
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	NA	NA	NA	NA	73.25%
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—Total	32.18%ᵛ	33.00%ᵛ	38.18%ᵛ	40.31%ᵛ	42.57%
30-Day Follow-Up—Total	45.98%ᵛ	47.00%ᵛ	49.09%ᵛ	57.65%ᵛ	57.90%
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—Total	29.11%	31.10%	32.40%	33.79%	26.94%
30-Day Follow-Up—Total	40.38%	40.55%	45.20%	48.63%	38.95%
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	30.94%ᵛ	38.69%ᵛ	36.02%ᵛ	43.36%	40.70%
30-Day Follow-Up—Total	49.72%ᵛ	60.30%ᵛ	55.08%ᵛ	63.51%	61.25%
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total—Total	50.35%	48.51%	43.86%ᵛ	53.95%	46.09%
Engagement of SUD Treatment—Total—Total	16.55%	18.49%	17.70%	20.96%	15.97%
Use of Imaging Studies for Low Back Pain					
Total	68.09%ᵛ	70.00%ᵛ	66.06%ᵛ	65.96%ᵛ	70.71%

ᵛ *Indicates the rate fell below the Quality Compass average.*
NA indicates that the rate was not presented because the denominator was less than 30.
** For this indicator, a lower rate indicates better performance.*

PMHPs and HOME

Validation Finding

HSAG determined that the IS and processes of all 11 PMHPs and HOME were compliant with IS standards and that the performance indicators calculated by the PMHPs had a status of "Reportable" based on the reporting requirements for MY 2024 PMV.

Performance Measure Results

For MY 2024, the PMHPs and HOME calculated and reported the state-modified *Follow-Up After Hospitalization for Mental Illness* measure. This measure helps the PMHPs and HOME monitor and ensure that members receive timely follow-up outpatient services after a hospital discharge. Timely follow-up can help reduce the risk of rehospitalizations. Since the PMHPs and HOME used a State-modified version of the HEDIS specifications to report this measure, the results were not compared to NCQA's Quality Compass benchmarking data. In addition, with HOME being a unique health plan type, HOME's results for the *Follow-Up After Hospitalization for Mental Illness* measure could not be compared to the PMHPs' *Follow-Up After Hospitalization for Mental Illness* measure results. The PMHPs' results were compared to a calculated statewide PMHP average. HOME was not included in or compared to the statewide PMHP average.

Based on performance measure outcomes, seven PMHPs (Bear River, Central, Davis, Healthy U, Northeastern, Southwest, and Wasatch) exceeded the statewide PMHP average for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, while four PMHPs (Four Corners, Optum/Tooele, Salt Lake, and Weber) fell below the statewide PMHP average for both *Follow-Up After Hospitalization for Mental Illness* measure indicators.

HOME

Table B-13 presents the findings reported by HOME for the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* measure.

Table B-13—HOME MY 2024 *Follow-Up After Hospitalization for Mental Illness* Results

Indicator	HOME Rate
Follow-Up Within 7 Days	40.54%
Follow-Up Within 30 Day	83.78%

PMHPs

Table B-14 presents the findings reported by the PMHPs for the DHHS-Custom *Follow-Up After Hospitalization for Mental Illness* measure using ᵛ to indicate performance that fell below the statewide PMHP average.

Table B-14—PMHPs MY 2024 *Follow-Up After Hospitalization for Mental Illness* Results

PMHP	*Follow-Up Within 7 Days*	*Follow-Up Within 30 Days*
Statewide PMHP Average	**54.04%**	**70.04%**
Bear River	56.42%	72.07%
Central	73.77%	86.89%
Davis	65.00%	85.83%
Four Corners	48.39%ᵛ	51.61%ᵛ
Healthy U	62.50%	87.50%
Northeastern	70.97%	87.10%
Optum Tooele County	45.95%ᵛ	50.00%ᵛ
Salt Lake County	43.42%ᵛ	60.33%ᵛ
Southwest	54.79%	70.55%
Wasatch	69.79%	84.90%
Weber	48.23%ᵛ	68.79%ᵛ

ᵛ *Indicates the rate fell below the statewide PMHP average.*

CHIP MCOs

Validation Findings

The CHIP MCOs' HEDIS compliance auditors determined that the IS and processes of both health plans were compliant with the applicable IS standards and reporting requirements for HEDIS MY 2024.

Performance Measure Results

Both CHIP MCOs exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Appropriate Treatment for Upper Respiratory Infection*
- *Immunizations for Adolescents—Combination 2*

One CHIP MCO fell below the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Childhood Immunization Status—Combination 3*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months*
- *Child and Adolescent Well-Care Visits—Total*

Based on performance measure outcomes:

- Both CHIP MCOs exceeded the MY 2024 NCQA Quality Compass average for two of the six performance indicators (33.33 percent).
- One of the CHIP MCOs fell below the MY 2024 NCQA Quality Compass average for four of the six performance indicators (66.67 percent).

Table B-15 shows the CHIP MCOs' HEDIS MY 2024 results compared to the MY 2024 NCQA average rates using ᵛ to indicate performance that fell below the NCQA QC average. Quality Compass averages are not available for the CHIP population specifically; therefore, comparison of the CHIP MCO measure rates to these averages should be interpreted with caution.

Table B-15—CHIP MCO HEDIS MY 2024 Results

HEDIS Measure	Select Health CHIP	Molina CHIP	MY 2024 NCQA Quality Compass Average[1]
Appropriate Treatment for Upper Respiratory Infection			
Total	94.64%	92.36%	88.10%
Childhood Immunization Status			
Combination 3	75.14%	65.98%ᵛ	66.18%
Immunizations for Adolescents			
Combination 2	50.00%	40.56%	37.84%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI percentile—Total	89.18%	73.44%ᵛ	80.87%
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	71.17%	58.82%ᵛ	61.92%
Child and Adolescent Well-Care Visits			
3–11 Years	64.39%	58.61%ᵛ	62.45%

ᵛ *Indicates the rate fell below the Quality Compass average.*

[1] *NCQA Quality Compass Averages shown in table are not specific to CHIP population.*

Medicaid and CHIP Dental PAHPs

PAHPs

Validation Findings

The PAHPs' HEDIS compliance auditors determined that the IS and processes of both health plans were compliant with the applicable IS standards and reporting requirements for HEDIS MY 2024.

Performance Measure Results

Both PAHPs exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Oral Evaluation, Dental Services—0 to 2 Years*
- *Oral Evaluation, Dental Services—3 to 5 Years*
- *Oral Evaluation, Dental Services—6 to 14 Years*
- *Oral Evaluation, Dental Services—15 to 20 Years*
- *Oral Evaluation, Dental Services—Total*

Based on performance measure outcomes both PAHPs exceeded the MY 2024 NCQA Quality Compass average for five out of eight performance indicators (62.5 percent).

Table B-15 shows the PAHP's HEDIS MY 2024 results compared to the MY 2024 NCQA Quality Compass average rates.

Table B-16—PAHP's HEDIS MY 2024 Results

HEDIS Measure	Premier PAHP	MCNA PAHP	MY 2024 NCQA Quality Compass Average
Oral Evaluation, Dental Services			
0–2 Years	25.44%	33.46%	18.68%
3–5 Years	61.67%	59.67%	46.00%
6–14 Years	64.85%	62.80%	50.37%
15–20 Years	51.10%	48.29%	34.76%
Total	56.27%	55.70%	40.63%
Topical Fluoride for Children*			
1–2 Years	11.61%	11.19%	—

HEDIS Measure	Premier PAHP	MCNA PAHP	MY 2024 NCQA Quality Compass Average
3–4 Years	29.96%	27.99%	—

**NCQA Benchmarks are not available for this measure.*

PAHP CHIP

Validation Findings

The Premier Access CHIP HEDIS compliance auditors determined that the IS and processes for Premier Access CHIP were fully compliant with the applicable IS standards and reporting requirements for HEDIS MY 2024.

Performance Measure Results

Premier Access CHIP exceeded the MY 2024 NCQA Quality Compass average for the following performance indicators:

- *Oral Evaluation, Dental Services—0 to 2 Years*
- *Oral Evaluation, Dental Services—3 to 5 Years*
- *Oral Evaluation, Dental Services—6 to 14 Years*
- *Oral Evaluation, Dental Services—15 to 20 Years*
- *Oral Evaluation, Dental Services—Total*

Based on performance measure outcomes:

- Premier Access CHIP exceeded the MY 2024 NCQA Quality Compass average for five out of eight performance indicators (62.5 percent).

Table B-15 shows the Premier Access CHIP's HEDIS MY 2024 results compared to the MY 2024 NCQA Quality Compass average rates.

Table B-17—Premier Access CHIP HEDIS MY 2024 Results

HEDIS Measure	Premier Access CHIP PAHP MY 2024 Rate	MY 2024 NCQA Quality Compass Average[1]
Oral Evaluation, Dental Services		
0–2 Years	31.80%	18.68%

HEDIS Measure	Premier Access CHIP PAHP MY 2024 Rate	MY 2024 NCQA Quality Compass Average[1]
3–5 Years	61.98%	46.00%
6–14 Years	70.41%	50.37%
15–20 Years	61.05%	34.76%
Total	63.69%	40.63%
Topical Fluoride for Children*		
1–2 Years	12.66%	—
3–4 Years	28.52%	—
Total	21.33%	—

(–) Indicates NCQA Benchmarks are not available for this measure.
[1] NCQA Quality Compass Averages shown in table are not specific to CHIP population.

Assessment of Compliance With Medicaid Managed Care Regulations

Statewide Comparative Results

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for compliance activities, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Compliance Monitoring.

ACOs

For the CY 2023 and CY 2024 compliance monitoring reviews, HSAG conducted an assessment of the four Medicaid ACOs' compliance with Medicaid managed care regulations and State contract requirements, evaluating the requirements at 42 CFR §438, as indicated in Table A-2.

Table B-18 presents the standard scores and overall compliance scores for each Medicaid ACO. Comparative results for the standards reviewed can be found in the 2023 Utah External Quality Review Report of Results and 2024 Utah External Quality Review Report of Results.[223]

Table B-18—Statewide ACO Compliance Scores

Review Year	Standard	Health Choice	Healthy U	Molina	Select Health CC	Statewide Average
CY 2023	I—Enrollment and Disenrollment	100%	100%	93%	100%	**98%**

[223] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Review Year	Standard	Health Choice	Healthy U	Molina	Select Health CC	Statewide Average
CY 2023	II—Member Rights and Confidentiality	100%	100%	93%	93%	**97%**
CY 2024	III—Member Information	90%	93%	93%	88%	**91%**
CY 2023	IV—Emergency and Poststabilization Services	100%	100%	100%	86%	**97%**
CY 2024	V—Adequate Capacity	93%	96%	100%	89%	**95%**
CY 2024	VI—Coordination and Continuity of Care	69%	100%	94%	100%	**91%**
CY 2023	VII—Coverage and Authorization of Services	95%	100%	95%	100%	**98%**
CY 2024	VIII—Provider Selection and Program Integrity	87%	95%	100%	97%	**95%**
CY 2024	IX—Subcontractual Relationships and Delegation	50%	75%	100%	100%	**81%**
CY 2023	X—Practice Guidelines	100%	100%	100%	100%	**100%**
CY 2024	XI—Health Information Systems	100%	100%	100%	100%	**100%**
CY 2024	XII—QAPIP	92%	100%	100%	100%	**98%**
CY 2023	XIII—Grievance and Appeal System	96%	98%	98%	98%	**98%**
Total Weighted Score*		**90%**	**97%**	**97%**	**96%**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

For the CY 2025 compliance monitoring review, HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records aligned with individual requirements within the Coverage and Authorization of Services and Grievance and Appeal System standards. Table B-19 presents the focused review scores and overall scores for each Medicaid ACO.

Table B-19—Statewide ACO Focused Review Scores

Description	Health Choice	Healthy U	Molina	Select Health CC	Statewide Average
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	100%	100%	90%	80%	**93%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	88%	88%	100%	75%	**88%**

Description	Health Choice	Healthy U	Molina	Select Health CC	Statewide Average
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	83%	75%	88%	100%	**87%**
Total Weighted Score*	**85%**	**88%**	**93%**	**82%**	**87%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified trends when comparing the findings for the four ACOs based on the requirements reviewed within each standard area. The statewide average score was highest for Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials at 93 percent. Additionally, average scores for the requirements reviewed for all standards were above 85 percent.

For Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials, two ACOs (Health Choice and Healthy U) achieved full compliance with the requirements reviewed. Two ACOs (Molina and Select Health CC) had required corrective actions to improve the readability of notice of adverse benefit determinations to ensure the letters meet the language and format requirements of 42 CFR §438.10(c).

For Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals, one ACO (Molina) achieved full compliance with the requirements reviewed. Three ACOs (Health Choice, Healthy U, and Molina) had required corrective actions to improve the clarity, language, and format of appeal resolution letters to ensure the letters meet the language and format requirements of 42 CFR §438.10(c).

For Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances, one ACO (Select Health CC) achieved full compliance with the requirements reviewed. Three ACOs (Health Choice, Healthy U, and Molina) had required corrective actions related to grievance processes, such as ensuring grievance resolutions were effectively communicated to members and properly documented within the record.

UMIC Plans and HOME

For the CY 2023 and CY 2024 compliance monitoring reviews, HSAG conducted an assessment of the four UMIC plans' and HOME's compliance with Medicaid managed care regulations and State contract requirements, evaluating the requirements at 42 CFR §438, as indicated in Table A-2.

Table B-20 presents the standard scores and overall compliance scores for each Medicaid UMIC plan and HOME. Comparative results for the standards reviewed can be found in the 2023 Utah External Quality Review Report of Results and 2024 Utah External Quality Review Report of Results.[224]

Table B-20—Statewide UMIC & HOME Compliance Scores

Review Year	Standard	Health Choice UMIC	Healthy U Integrated	Molina UMIC	Select Health CC UMIC	HOME	Statewide Average
CY 2023	I—Enrollment and Disenrollment	100%	100%	93%	100%	100%	**99%**
CY 2023	II—Member Rights and Confidentiality	100%	100%	93%	93%	100%	**97%**
CY 2024	III—Member Information	90%	93%	95%	88%	92%	**92%**
CY 2023	IV—Emergency and Poststabilization Services	100%	100%	100%	86%	100%	**97%**
CY 2024	V—Adequate Capacity	93%	96%	100%	89%	93%	**94%**
CY 2024	VI—Coordination and Continuity of Care	69%	100%	94%	100%	100%	**93%**
CY 2023	VII—Coverage and Authorization of Services	95%	100%	95%	100%	100%	**98%**
CY 2024	VIII—Provider Selection and Program Integrity	84%	92%	100%	97%	97%	**94%**
CY 2024	IX—Subcontractual Relationships and Delegation	50%	75%	100%	100%	100%	**85%**
CY 2023	X—Practice Guidelines	100%	83%	100%	100%	83%	**93%**
CY 2024	XI—Health Information Systems	100%	100%	100%	100%	100%	**100%**
CY 2024	XII—QAPIP	92%	100%	100%	100%	100%	**98%**
CY 2023	XIII—Grievance and Appeal System	96%	98%	98%	98%	100%	**98%**
Total Weighted Score*		**90%**	**95%**	**98%**	**96%**	**97%**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

For the CY 2025 compliance monitoring review, HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records aligned with individual requirements within the Coverage and Authorization of Services and Grievance and Appeal System standards. Table B-21 presents the focused review scores and overall scores for each Medicaid UMIC plan and HOME.

[224] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf, Accessed on: Jan 5, 2026.

Table B-21—Statewide UMIC & HOME Focused Review Scores

Description	Health Choice UMIC	Healthy U Integrated	Molina UMIC	Select Health CC UMIC	HOME	Statewide Average
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	100%	100%	90%	80%	90%	**92%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	75%	90%	88%	92%	75%	**84%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	100%	75%	75%	100%	88%	**88%**
Total Weighted Score*	**92%**	**89%**	**85%**	**89%**	**85%**	**88%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified trends when comparing the findings for these five organizations based on the requirements reviewed within each standard area. The statewide average score was highest for Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials at 92 percent. Additionally, average scores for the requirements reviewed for all standards were at or above 84 percent.

For Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials, two ACOs (Health Choice UMIC and Healthy U) achieved full compliance with the requirements reviewed. Three MCOs (Molina UMIC, Select Health CC UMIC, and HOME) had required corrective actions to improve the readability of notice of adverse benefit determinations to ensure the notices meet the language and format requirements of 42 CFR §438.10(c).

For Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals, all five MCOs had required corrective actions. Four ACOs (Health Choice UMIC, Healthy U Integrated, and Molina UMIC, and HOME) had required corrective actions to improve the clarity, language, and format of appeal resolution letters to ensure the letters meet the language and format requirements of 42 CFR §438.10(c). Additionally, three ACOs (Health Choice UMIC, Select Health CC UMIC, and HOME) had required corrective actions related to processes for reviewing appeals, such as providing member acknowledgment and resolution and ensuring appeals are reviewed by appropriate individuals.

For Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances, two MCOs (Health Choice UMIC and Select Health CC UMIC) achieved full compliance with the requirements reviewed. Three ACOs (Healthy U Integrated, Molina UMIC, and HOME) had required corrective actions

related to processing grievances, such as ensuring grievance resolutions were effectively communicated to members and properly documented within the record.

PMHPs

For the CY 2023 and CY 2024 compliance monitoring reviews, HSAG conducted an assessment of the PMHPs' compliance with Medicaid managed care regulations and State contract requirements, evaluating the requirements at 42 CFR §438, as indicated in Table A-2.

Table B-22 presents the standard scores and overall compliance scores for each Medicaid PMHP. Comparative results for the standards reviewed can be found in the 2023 Utah External Quality Review Report of Results and 2024 Utah External Quality Review Report of Results.[225]

Table B-22—Statewide PMHP Compliance Scores

Review Year	Standard	Bear River	Central	Davis	Four Corners	Healthy U Behavioral	North-eastern	Optum Tooele	Salt Lake	South-west	Wasatch	Weber	State-wide Avg
CY 2023	I—Enrollment and Disenrollment	100%	100%	88%	100%	100%	100%	100%	100%	100%	100%	100%	**99%**
CY 2023	II—Member Rights and Confidentiality	86%	100%	93%	100%	100%	93%	93%	93%	86%	93%	86%	**93%**
CY 2024	III—Member Information	93%	90%	93%	83%	95%	95%	92%	90%	88%	90%	93%	**91%**
CY 2023	IV—Emergency and Poststabilization Services	95%	100%	86%	100%	100%	100%	100%	100%	91%	95%	100%	**97%**
CY 2024	V—Adequate Capacity	100%	96%	100%	71%	95%	96%	100%	100%	96%	100%	100%	**96%**
CY 2024	VI—Coordination and Continuity of Care	94%	100%	100%	100%	100%	100%	100%	100%	100%	94%	94%	**98%**
CY 2023	VII—Coverage and Authorization of Services	97%	100%	94%	100%	100%	100%	97%	97%	100%	97%	100%	**98%**
CY 2024	VIII—Provider Selection and Program Integrity	95%	95%	82%	97%	95%	97%	97%	97%	89%	87%	89%	**93%**
CY 2024	IX—Subcontractual	NA	NA	NA	NA	75%	NA	63%	100%	NA	NA	NA	**79%**

[225] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf, Accessed on: Jan 5, 2026.

Review Year	Standard	Bear River	Central	Davis	Four Corners	Healthy U Behavioral	North-eastern	Optum Tooele	Salt Lake	South-west	Wasatch	Weber	State-wide Avg
	Relationships and Delegation												
CY 2023	X—Practice Guidelines	100%	100%	83%	83%	83%	100%	100%	100%	100%	100%	100%	**95%**
CY 2024	XI—Health Information Systems	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**
CY 2024	XII—QAPIP	92%	92%	100%	83%	100%	100%	100%	100%	83%	83%	100%	**94%**
CY 2023	XIII—Grievance and Appeal System	100%	98%	100%	100%	98%	96%	100%	100%	100%	96%	95%	**98%**
Total Weighted Score*		**96%**	**98%**	**93%**	**93%**	**95%**	**98%**	**96%**	**98%**	**94%**	**95%**	**96%**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

For the CY 2025 compliance monitoring review, HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records aligned with individual requirements within the Coverage and Authorization of Services and Grievance and Appeal System standards. Table B-23 presents the focused review scores and overall scores for each PMHP.

Table B-23—Statewide PMHP Focused Review Scores

Description	Bear River	Central	Davis	Four Corners	Healthy U Behavioral	North-eastern	Optum Tooele	Salt Lake	South-west	Wasatch	Weber	State-wide Avg
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	NA	NA	80%	NA	NA	NA	92%	90%	NA	NA	100%	**91%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	100%	NA	100%	NA	100%	100%	83%	100%	NA	88%	100%	**96%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	83%	75%	88%	88%	100%	100%	100%	100%	63%	75%	100%	**88%**
Total Weighted Score*	**93%**	**75%**	**88%**	**88%**	**100%**	**100%**	**90%**	**96%**	**63%**	**81%**	**100%**	**89%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

Although the 11 PMHPs were spread across the State and continued to have different needs and challenges within their member populations and regional service areas, HSAG was able to identify trends by comparing findings across these 11 organizations based on the requirements reviewed within each standard area. The statewide average score was highest for Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals at 96 percent, and average scores for the requirements reviewed for all standards were at or above 88 percent. Further, three PMHPs (Healthy U Behavioral, Northeastern, and Weber) achieved full compliance across all standard areas reviewed.

For Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials, one PMHP (Weber) achieved full compliance with the requirements reviewed. Three PMHPs (Davis, Optum/Tooele, and Salt Lake) had required corrective actions regarding processing prior authorization denials, such as ensuring that requests for prior authorization are resolved in a timely manner ,and that the notices meet the language and format requirements of 42 CFR §438.10(c). Seven PMHPs (Bear River, Central, Four Corners, Healthy U Behavioral, Northeastern, Southwest, and Wasatch) did not report any denials for the period under review; therefore, the requirements were not applicable.

For Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals, six PMHPs (Bear River, Davis, Healthy U Behavioral, Northeastern, Salt Lake, and Weber) achieved full compliance with the requirements reviewed, indicating strong compliance with processing appeals. Two PMHPs (Optum/Tooele and Wasatch) had required corrective actions related to processing appeals, such as ensuring that appeals are resolved in a timely manner, and that appeal resolution letters are provided to all parties to the appeal and include required information. Three PMHPs (Central, Four Corners, and Southwest) did not report any appeals for the period under review; therefore, the requirements were not applicable.

For Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances, five PMHPs (Healthy U Behavioral, Northeastern, Optum/Tooele, Salt Lake, and Weber) achieved full compliance with the requirements reviewed. Six PMHPs (Bear River, Central, Davis, Four Corners, Southwest, and Wasatch) had required corrective actions related to processing grievances, including ensuring grievance resolutions were effectively communicated to members and properly documented within the record.

CHIP MCOs

For the CY 2023 and CY 2024 compliance monitoring reviews, HSAG conducted an assessment of the CHIP MCOs' compliance with Medicaid managed care regulations and State contract requirements, evaluating the requirements at 42 CFR §438, as indicated in Table A-2.Table B-24 provides the standard scores and overall compliance scores for each CHIP MCO. Comparative results for the standards

reviewed can be found in the 2023 Utah External Quality Review Report of Results and 2024 Utah External Quality Review Report of Results.[226]

Table B-24—Statewide CHIP Compliance Scores

Review Year	Standard	Molina CHIP	Select Health CHIP	Statewide Average
CY 2023	I—Enrollment and Disenrollment	93%	100%	**97%**
CY 2023	II—Member Rights and Confidentiality	93%	93%	**93%**
CY 2024	III—Member Information	95%	86%	**91%**
CY 2023	IV—Emergency and Poststabilization Services	100%	86%	**93%**
CY 2024	V—Adequate Capacity	93%	89%	**91%**
CY 2024	VI—Coordination and Continuity of Care	88%	100%	**94%**
CY 2023	VII—Coverage and Authorization of Services	95%	100%	**98%**
CY 2024	VIII—Provider Selection and Program Integrity	100%	97%	**99%**
CY 2024	IX—Subcontractual Relationships and Delegation	100%	100%	**100%**
CY 2023	X—Practice Guidelines	100%	100%	**100%**
CY 2024	XI—Health Information Systems	100%	100%	**100%**
CY 2024	XII—QAPIP	100%	100%	**100%**
CY 2023	XIII—Grievance and Appeal System	98%	98%	**98%**
Total Weighted Score*		**97%**	**96%**	**96%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

For the CY 2025 compliance monitoring review, HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records aligned with individual requirements within the Coverage and Authorization of Services and Grievance and Appeal System standards. Table B-25 presents the focused review scores and overall scores for each CHIP MCO.

Table B-25—Statewide CHIP Focused Review Scores

Description	Healthy U CHIP	Molina CHIP	Select Health CHIP	Statewide Average
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	100%	92%	90%	**94%**

[226] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf, Accessed on: Jan 5, 2026.

Description	Healthy U CHIP	Molina CHIP	Select Health CHIP	Statewide Average
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	88%	100%	92%	**93%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	67%	88%	100%	**85%**
Total Weighted Score*	**88%**	**93%**	**93%**	**91%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified commonalities when comparing the findings in the three CHIP MCOs based on the requirements reviewed within each standard area. The statewide average score was highest for Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials at 94 percent. Additionally, average scores for the requirements reviewed for all standards were at or above 85 percent.

For Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials, one CHIP MCO (Healthy U CHIP) achieved full compliance with the requirements reviewed. Two CHIP MCOs (Molina CHIP and Select Health CHIP) had required corrective actions to improve notice of adverse benefit determinations, such as ensuring the notices include State fair hearing requirements and meet the language and format requirements of 42 CFR §438.10(c).

For Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals, one CHIP MCO (Molina CHIP) achieved full compliance with the requirements reviewed. Two CHIP MCOs (Healthy U CHIP and Molina CHIP) had required corrective actions related to processing appeals, such as ensuring member notification was documented appropriated in the record and that resolution letters meet the language and format requirements of 42 CFR §438.10(c).

For Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances, one ACO (Select Health CHIP) achieved full compliance with the requirements reviewed. Two CHIP MCOs (Healthy U CHIP and Molina CHIP) had required corrective actions related to grievance processes, such as ensuring grievance resolutions were effectively communicated to members and properly documented within the record.

Medicaid and CHIP Dental PAHPs

For the CY 2023 and CY 2024 compliance reviews, HSAG conducted an assessment of the Medicaid and CHIP dental PAHPs' compliance with the State contract and Medicaid managed care regulations requirements at 42 CFR §438, as indicated in Table A-2.

Table B-26 provides the standard scores and overall compliance scores for the Medicaid and CHIP dental PAHPs. Comparative results for the standards reviewed can be found in the 2023 Utah External Quality Review Report of Results and 2024 Utah External Quality Review Report of Results.[227]

Table B-26—Statewide Dental PAHP Compliance Scores

Review Year	Standard	MCNA	Premier Medicaid	Premier CHIP	Statewide Average
CY 2023	I—Enrollment and Disenrollment	100%	100%	100%	**100%**
CY 2023	II—Member Rights and Confidentiality	100%	93%	93%	**95%**
CY 2024	III—Member Information	98%	95%	93%	**95%**
CY 2023	IV—Emergency and Poststabilization Services	100%	100%	100%	**100%**
CY 2024	V—Adequate Capacity	100%	88%	88%	**92%**
CY 2024	VI—Coordination and Continuity of Care	100%	100%	100%	**100%**
CY 2023	VII—Coverage and Authorization of Services	97%	91%	91%	**93%**
CY 2024	VIII—Provider Selection and Program Integrity	97%	71%	71%	**80%**
CY 2024	IX—Subcontractual Relationships and Delegation	100%	75%	75%	**83%**
CY 2023	X—Practice Guidelines	100%	100%	100%	**100%**
CY 2024	XI—Health Information Systems	100%	100%	100%	**100%**
CY 2024	XII—QAPIP	100%	100%	100%	**100%**
CY 2023	XIII—Grievance and Appeal System	100%	88%	88%	**92%**
Total Weighted Score*		**92%**	**99%**	**92%**	**95%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

For the CY 2025 compliance monitoring review, HSAG conducted a focused review of a sample of prior-authorization denial, appeal, and grievance records aligned with individual requirements within the Coverage and Authorization of Services and Grievance and Appeal System standards. Table B-27 presents the focused review scores and overall scores for each Medicaid and CHIP dental PAHP.

[227] Utah Department of Health and Human Services. Annual External Quality Review Report of Results. Available at: https://medicaid.utah.gov/Documents/pdfs/UT2024_EQR_TechRpt_F1.pdf. Accessed on: Jan 5, 2026.

Table B-27—Statewide Dental PAHP Focused Review Scores

Description	MCNA	Premier Access Medicaid	Premier Access CHIP	Statewide Average
Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials	100%	100%	100%	**100%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals	88%	100%	100%	**96%**
Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances	88%	100%	100%	**96%**
Total Weighted Score*	**92%**	**100%**	**100%**	**97%**

*HSAG obtained the weighted scores and overall weighted percentage by adding the number of requirements that received a score of *Met* to the weighted number of requirements (multiplied by 0.5) that received a score of *Partially Met*, then dividing this total by the total number of applicable requirements.

HSAG identified commonalities when comparing the findings for the three dental PAHPs based on the requirements reviewed within each standard area. The statewide average score was highest for Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials at 100 percent. Additionally, average scores for the requirements reviewed for all standards were at or above 96 percent.

For Standard VII—Coverage and Authorization of Services; Focused Record Review: Denials, all PAHPs achieved full compliance with the requirements reviewed, indicating strong compliance with processes for reviewing prior-authorization denials.

For Standard XIII—Grievance and Appeal System; Focused Record Review: Appeals and Standard XIII—Grievance and Appeal System; Focused Record Review: Grievances, two PAHPs (Premier Access Medicaid and Premier Access CHIP) achieved full compliance with the appeals and grievance requirements reviewed. One PAHP (MCNA) had required corrective actions related to ensuring appeal and grievance resolution letters clearly explain the resolution and meet the language and format requirements of 42 CFR §438.10(c).

Validation of Network Adequacy

Statewide Comparative Results

Table B-28 displays the number of provider categories meeting the time/distance standards by health plan statewide and by urbanicity. Health plans had to meet the standard for each urbanicity (i.e., urban, rural, and frontier) to meet the statewide time/distance standard for a provider category. UMIC plans operate only in urban areas. Since most PMHPs are inherently regional, statewide results are not presented for those regional health plans.

Overall, the Utah CY 2025 NAV results suggest that the health plans had comprehensive provider networks, with some opportunities for improvement in certain geographic areas and for certain provider categories (e.g., pediatric specialists). Utah's Medicaid and CHIP health plans have generally contracted with a variety of providers to ensure that Medicaid/CHIP members have access to a broad range of health care services within geographic time/distance standards.

For a breakdown of statewide strengths, opportunities for improvement, and recommendations for NAV, see Section 1. Executive Summary—Summary of Statewide Performance, Conclusions, and Recommendations Related to EQR Activities—Validation of Network Adequacy.

Table B-28—Compliance With Time/Distance Standards by Health Plan, Statewide, and Urbanicity

		Statewide		Frontier		Rural		Urban	
Health Plan	Number of Provider Categories	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard
ACOs									
Health Choice	39	92.3%	36	100.0%	39	100.0%	39	92.3%	36
Healthy U	39	82.1%	32	97.4%	38	82.1%	32	94.9%	37
Molina	39	84.6%	33	92.3%	36	84.6%	33	92.3%	36
Select Health CC	39	74.4%	29	97.4%	38	74.4%	29	97.4%	38
UMICs and HOME MCO									
HOME	38	94.7%	36	94.7%	36	94.7%	36	94.7%	36
Health Choice	23	100.0%	23	NA	NA	NA	NA	100.0%	23
Healthy U	23	100.0%	23	NA	NA	NA	NA	100.0%	23

		Statewide		Frontier		Rural		Urban	
Health Plan	Number of Provider Categories	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard	Percent Within Time Distance Standard (%)	Count Within Time Distance Standard
Molina	23	100.0%	23	NA	NA	NA	NA	100.0%	23
Select Health CC	23	100.0%	23	NA	NA	NA	NA	100.0%	23
CHIP MCOs									
Healthy U	23	30.4%	7	30.4%	7	34.8%	8	34.8%	8
Molina	23	34.8%	8	34.8%	8	73.9%	17	39.1%	9
Select Health	23	30.4%	7	30.4%	7	56.5%	13	39.1%	9
PMHPs									
Bear River	2	100.0%	2	100.0%	2	100.0%	2	NA	NA
Central	2	100.0%	2	100.0%	2	100.0%	2	NA	NA
Davis	2	100.0%	2	NA	NA	NA	NA	100.0%	2
Four Corners	2	50.0%	1	50.0%	1	100.0%	2	NA	NA
Healthy U Behavioral	2	100.0%	2	NA	NA	100.0%	2	NA	NA
Northeastern	2	100.0%	2	100.0%	2	NA	NA	NA	NA
Optum	2	100.0%	2	100.0%	2	NA	NA	NA	NA
Salt Lake	2	100.0%	2	NA	NA	NA	NA	100.0%	2
Southwest	2	100.0%	2	100.0%	2	100.0%	2	NA	NA
Wasatch	2	100.0%	2	NA	NA	NA	NA	100.0%	2
Weber	2	100.0%	2	NA	NA	100.0%	2	100.0%	2
Dental PAHPs									
MCNA	3	100.0%	3	100.0%	3	100.0%	3	100.0%	3
Premier	3	100.0%	3	100.0%	3	100.0%	3	100.0%	3
CHIP Dental PAHP									
Premier Access CHIP	3	100.0%	3	100.0%	3	100.0%	3	100.0%	3

NA refers to areas outside the serviced counties for each MCE.

Appendix C. Summary of PIP Interventions by Health Plan Type and PIP Topic

Table C-1 on the following page includes information about interventions each health plan implemented for PIP topics submitted for validation in CY 2025.

Table C-1—Health Plan Interventions by Health Plan Type and PIP Topic

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Medicaid ACOs Providing Physical Health Services			
Health Choice	*Well-Child Visits in the First 30 Months of Life*	1. Percentage of members with six or more well-child visits on different dates of service on or before the 15-month birthday. 2. Percentage of members with two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.	• Monthly distribution of comprehensive Well-Baby Packets to new plan members with infants. • Member outreach to remind parents of well-child visit gaps in care and answer questions related to well-child visits.
	Medicaid Health Risk Assessment (HRA) Process Improvement	Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	• Implementation of an embedded HRA webform on the health plan website for members to complete the electronic HRA form without the barrier of creating a member portal account or logging into the member portal. A QR code linking directly to the embedded HRA webform will be generated and printed on the paper HRA form that is mailed to new members. • Standardization of both paper and electronic HRA forms into a single version for adults and a single version for children.
Healthy U ACO	*Improving Access to Well Visits in the First 15 and 30 Months of Life*	1. The percentage of eligible members who received six or more well-child visits	• Development and distribution of Well Visit Record Card. • Development and Distribution of "Well-Baby Packet." • Phone outreach to parents by health plan staff.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		with a PCP by 15 months of age. 2. The percentage of eligible members who received two or more well-child visits with a PCP on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	
	Medicaid Health Risk Assessment (HRA) Process Improvement	Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the care management platform (MHK) within 90 days of enrollment.	• HRA Process Standardization and Automation. • Increase Options for Electronic Completion of the HRA: Create HRA embedded webform and QR Code.
Molina ACO	*Well-Child Visits in the First 30 Months of Life*	1. The percentage of members who had six or more well-child visits with a PCP during the first 15 months of life. 2. The percentage of members who had two or more well-child visits with a PCP between ages 15–30 months.	• Member outreach and incentive program for completing well-child visits. • Well Child Text Message Series. • Mail well-child tracker card to members. The card includes information on the importance of well-child visits and lists required visits/time frames with space to track visits. • Missing services lists are disseminated to providers who opt-in to pay-for-quality (P4Q) program, showing which members need well-child visits. Providers are offered a bonus for closing gaps.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Increasing Member Engagement and Satisfaction with Digital Channels	1. The percentage of members 18 years of age and older who opt in to text messaging during the measurement year 2. The percentage of members 18 years of age and older who register for the My Molina portal during the measurement year.	• Portal Training with Case Management Staff. • Relay Text Message Satisfaction Survey.
Select Health CC ACO	*Well-Child Visits in the First 30 Months of Life for Medicaid Legacy Members*	1. The percentage of eligible members who received six or more well-child visits with a primary care provider by 15 months of age. 2. The percentage of eligible members who received two or more well-child visits with a primary care provider on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday.	• Health plan mailed well-child visits (W30) tracking card to remind members to schedule a well-child visit. • Educate and Provide Access to W30 Gaps in Medicaid Enrollees' Data to QPP Providers. • W30 Monthly IVR Calls to Enrollees.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Improving the Percentage of Select Health Medicaid Legacy Members Retaining Health Insurance When Identified for Redetermination	Percent of Medicaid legacy members retaining health insurance when identified for redetermination.	Outreach to Medicaid Legacy Members Up for Redetermination.
Medicaid MCOs Providing Physical Health, Mental Health, and SUD Services			
Health Choice Utah Integrated	*Adults' Access to Preventive/Ambulatory Care Services*	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.	• Member Outreach—Telephonic • Member Outreach—Vendor SMS Campaign
	Medicaid Health Risk Assessment (HRA) Process Improvement	Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	• HRA Process Standardization and Automation • Increase Options for Electronic Completion of the HRA: Create HRA Embedded Webform and QR Code
Healthy U Integrated	*Improving Adults' Access to Preventive/Ambulatory Care Services*	The percentage of members 20 years of age and older who receive one or more ambulatory or preventive care visits during the measurement year.	• Member Outreach—Telephonic. • Member Outreach—Vendor SMS Campaign.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Medicaid Health Risk Assessment (HRA) Process Improvement	Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	• HRA Process Standardization and Automation. • Increase Options for Electronic Completion of the HRA: Create HRA embedded webform and QR Code.
Healthy Outcomes Medical Excellence (HOME)	*Do Clinical Pharmacist-Led Interventions have an Impact on Guideline-Directed Statin Utilization in the HOME Population*	Statin utilization among eligible HOME enrollees during the measurement year.	• Collaboration with PCP to address provider perceived barriers in prescribing statins: • The clinical pharmacist will collaborate with the PCP and make recommendations after reviewing the current medication regimen. • Patient education and outreach initiatives on the significance of adding statins: • The pharmacist will reach out to the qualifying population that is not on statin therapy to discuss both the benefits and side effects as well as their perceived apprehensions.
	*Implementation of Work Queue for Utilization Management**	The percentage of HOME enrollees who receive monthly supply deliveries from HOME vendors and had expired orders as reported by the vendors during the measurement period.**	Not Applicable.
	Follow Up After Hospitalization for Mental Illness	The percentage of discharges for members 6 years of age and	Partner with Molina UMIC Care Connections to offer members an opportunity to meet telephonically with a licensed clinical social

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Molina Healthcare of Utah UMIC		older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner.	worker (LCSW) and complete a follow-up visit within 30 days of hospitalization.
	Increasing Member Engagement and Satisfaction with Digital Channels	1. The percentage of members 18 years of age and older who opt in to text messaging. 2. The percentage of members 18 years of age and older who register for the My Molina portal.	• Portal Training with Case Management Staff. • Relay Text Message Satisfaction Survey.
SelectHealth CC UMIC	*7-Day Follow-Up After Hospitalization for Mental Illness for Medicaid Integrated Members*	Percentage of Medicaid Integrated members who were hospitalized for selected mental illness or intentional self-harm diagnoses and had a follow-up with a mental health practitioner within 7 days after discharge.	• Provide Behavioral Health (BH) services at home. • Intermountain BH Navigators member engagement : BH navigators visit BH unit members to schedule FUH appointments. Navigators also call members 24 hours after discharge for appointment reminder and assistance with any barriers to attending the appointment.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Improve the Percentage of Select Health Medicaid Integrated Members Retaining Health Insurance When Identified for Redetermination	1. Percent of Medicaid Integrated members retaining health insurance when identified for redetermination. 2. Percent of Medicaid Integrated Members Retaining Select Health Medicaid Integrated When Identified for Redetermination.	Outreach to Medicaid Integrated Members Up for Redetermination.
Medicaid PMHPs Providing Mental Health Services			
Bear River	*Outcome Questionnaires (OQ) or Youth Outcome Questionnaires (YOQ)*	1a. Frequency of OQ completed by each member in a year. 1b. Frequency of YOQ completed by each member in a year. 2a. Percentage of OQ reports reviewed by clinician within three days. 2b. Percentage of YOQ reports reviewed by clinician within three days.	• Staff reminders and training to review the OQ/YOQ within the required three-day period.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	No Shows	During the measurement period, allowing members to confirm through text messaging whether they will attend their appointment in fact reduces no shows.	Allow members to respond to appointment reminders to confirm their attendance or absence from the appointment.
Central	*Improved Integrated Care*	The percentage of open members aged 5 and older with a PCP documented in Central's electronic health record (EHR).	EHR form templates will be adapted to allow PCP names to be added easily by Central clinical and non-clinical staff.
	Screening for Social Determinants of Health (SDOH)	The percentage of members who received SDOH screening as part of the initial evaluation.	Educate Central staff to ensure that incoming members receive updated admission paperwork packets, which now include an SDOH screening form for client completion.
Davis	*Naloxone for Opioid Use Disorders*	The percentage of members 18 years and above who are diagnosed with opioid use disorder and possess Naloxone.	• Regular staff reminders and training to determine and prescribe Naloxone. • Outreach to those without Naloxone.
	Diagnosing Conflicts	The percentage of sampled health records that have incompatible diagnosing	• Clinician training on comorbidity, incompatibility, and ending/updating diagnoses in Credible. • Clinician case review of specific charts with diagnosing conflicts. • Monthly conflict notification to leadership.
Four Corners	*Improving the Completion of Substance Use Recovery Evaluator (SURE) Survey*	The percentage of completed SURE surveys.	Front office staff will be trained in the monthly meetings to administer the survey to the members that are enrolled in American Society of Addiction Medicine (ASAM) level of care.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Collecting Client Email to Improve Access to Client Portal to Improve Clinical Access and Care	Current members with email address.	Not Applicable.
Healthy U Behavioral	*Improving Follow-Up After Hospitalization*	1. Percentage of discharges for members 6 years of age and older who were hospitalized and who had a follow-up visit within 7 days of discharge. 2. Percentage of discharges for members 6 years of age and older who were hospitalized and who had a follow-up visit within 30 days of discharge.	Care Management Outreach to Discharge Facilities.
	Medicaid Health Risk Assessment (HRA) Process Improvement	Percentage of newly enrolled Medicaid members during the measurement year who had an HRA result documented in the health plan care management platform (MHK) within 90 days of enrollment.	• HRA Process Standardization and Automation. • Increase Options for Electronic Completion of the HRA: Create HRA embedded webform and QR Code.
Northeastern	*Improving Monitoring of Selected Antipsychotic Medication Side Effects in*	1. The percentage of eligible members who received annual Abnormal	• Training meetings with nurses and case managers two times a year.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Individuals Diagnosed with a Schizophrenia Spectrum Disorder	Involuntary Movement Scale (AIMS) administration. 2. The percentage of eligible members who received annual hemoglobin A1c (HbA1c) testing. 3. The percentage of eligible members who received annual lipid panel testing.	• Include an emailed population list provided by Administration two times a year. • Reminder to medical staff about practice standards regarding AIMS at measurement year midpoint. • Email the population list to nurses two times a year.
	Increasing Health-Related Social Needs Screenings	The percentage of served PMHP enrollees that have completed a HRSN screening during the six-month measurement periods.	• Policy Change: When members begin TCM services or have a service plan review, the client or case manager with the client completes HRSN screening. • Reminder/Training by email or in person twice a year on the purpose of HRSN, offering HRSN screening, and entering HRSN screening data. This will include TCM providers and support staff.
Optum/Tooele	*Follow-up After Hospitalization for a Mental Health Diagnosis in Adults Aged 18–64*	1. The percentage of discharges for which eligible members aged 18–64 years received at least one follow-up after hospitalization (FUH) service allowed by the Healthcare Effectiveness Data and Information Set (HEDIS®) within 7 days after discharge from inpatient	Not Applicable.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		hospitalization for treatment of mental illness. 2. The percentage of discharges for which eligible members aged 18–64 years who received at least one FUH service allowed by HEDIS® within 30 days after discharge from inpatient hospitalization for treatment of mental illness.	
	Distribution of Provider-Specific Results of Member Satisfaction Surveys	The percentage of Optum Toole County Outpatient Behavioral Health Network Providers with a provider-specific MHSIP submission ID who served ≥20 members during the calendar year immediately prior to the measurement period, met the anonymity threshold for survey responses gathered during the measurement period, and received provider-specific survey results.	• Increase the volume of providers with provider-specific MHSIP submission IDs. • Create reports with provider-specific MHSIP feedback. • Create a guidance document to assist providers in interpreting results.
Salt Lake	*Follow-Up After Hospitalization for a*	1. The percentage of eligible members aged 18–64 years who received at least one	• Create a Resource Guide of network providers and distribute to in and out-of-network inpatient facilities to guide discharge planning.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Mental Health Diagnosis in Adults Aged 18–64	behavioral health service within seven days after discharge from inpatient hospitalization for treatment of mental illness. 2. The percentage of eligible members aged 18–64 years who received at least one behavioral health service within 30 days after discharge from inpatient hospitalization for treatment of mental illness.	• Meet with in-network, inpatient facility leadership related to timely follow-up appointments. • Engage Care Navigator to outreach members and link to providers for needed follow-up treatment and supports. • Monitor care advocate responsibilities related to discharge planning.
	Distribution of Provider-Specific Results of Member Satisfaction Surveys (MHSIP)	The percentage of eligible Optum Salt Lake County Outpatient Mental Health Network Providers with a provider-specific MHSIP submission ID who met the anonymity threshold for response gathered during the measurement period, and received provider-specific survey results.	• Increase the volume of providers with provider-specific MHSIP submission IDs. • Create reports with provider-specific MHSIP feedback • Create a guidance document to assist providers in interpreting results.
Southwest	*OQ/YOQ Outcome Suicide Ideation Questionnaire Project*	The percentage of mental health (MH) survey instruments completed where members	Add the OQ link to progress notes in the EHR.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		answered "Almost Always" or "Frequently" for suicide ideation question 7 on the OQ instrument/survey and question 19 on the YOQ instrument/survey during the measurement period.	
	Increase Staff Level of Comfort Suicide Screening	The percentage of staff answering suicide screening comfort level survey questions with agree or strongly agree.	Train Program Managers and therapists on PIP Project alignment with Zero Suicide Grant funding.
Wasatch	*Increasing SURE Utilization in SUD*	The percentage of members diagnosed with a primary SUD who receive treatment at one of the eligible substance use treatment programs and who complete the SURE questionnaire each month.	• Trained staff on the importance of SURE administration. SUD division director and program managers will receive reports each month outlining the total number of administrations of SURE in SUD services. Progress toward the goal of improving administration of SURE will be discussed at least monthly at a meeting of Wasatch's executive team and program managers. • Increase access to the SURE questionnaires so that the members can take the questionnaire either 1) before arriving to their appointments, or 2) after arriving to their appointments but without relying on the clinic's front-end staff to manually administer the questionnaire.
	Increasing Social Supports in Substance Use Services	The proportion of members who have social supports at termination will increase over time after training staff in social supports.	Train staff at staff meetings on improving social supports.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
Weber	*Treating Anxiety and Depression with EBT*	Percent of members with an anxiety or depression diagnosis who are participating in the Unified Protocol.	Two clinical quality supervisors will be certified as supervisors/trainers in the Unified Protocol and twelve clinicians will be trained/certified in the Unified Protocol.
	Reducing Clinician Burnout	Percentage of eligible providers who scored average or higher for clinician burnout as measured by the ProQOL burnout scale during the measurement period.	Clinicians attending a self-care course.
CHIP MCOs Providing Both Physical Health and Mental Health Services			
Healthy U CHIP	*Child and Adolescent Well-Care Visits (WCV)*	Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Not Applicable.
	Medicaid Health Risk Assessment (HRA) Process Improvement	Percentage of newly enrolled Medicaid CHIP members during the measurement year who had an HRA result documented in the Healthy U CHIP care management platform (MHK) within 90 days of enrollment.	Not Applicable.
Molina CHIP	*Immunizations for Adolescents*	The percentage of adolescents 13 years of age who had one	• Member outreach, education, and incentive program. • Provider bonus program.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
		dose of meningococcal vaccine, one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.	
	Increasing Member Engagement and Satisfaction with Digital Channels	1. The percentage of members 18 years of age and older who opt in to text messaging. 2. The percentage of members 18 years of age and older who register for the My Molina portal.	• Portal Training with Case Management Staff. • Relay Text Message Satisfaction Survey.
Select Health CHIP	*Well-Child Visits for CHIP Members*	The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecology (OB/GYN) practitioner during the measurement year.	• WCV incentive to enrollees. • Educate and Provide WCV Gaps Data to QPP Providers.
	Improve the Percentage of Select Health Medicaid CHIP Members Retaining Health Insurance When	1. Percent of Medicaid CHIP Members Retaining Health Insurance When Identified for Redetermination.	Not Applicable.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
	Identified for Redetermination	2. Percent of Medicaid CHIP Members Retaining Select Health Medicaid CHIP When Identified for Redetermination.	
PAHPs Providing Medicaid Dental Services			
Premier Access	*School Based Care for Medicaid Members*	Percentage of Premier Access Medicaid members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	• Parent/guardian telephonic outreach.
	OHIF Completion for New Medicaid Members	OHIF completion rate: The percentage of members who complete an OHIF within 90 days of enrollment.	• Live agent reminder calls.
MCNA	*Increasing the Rate of Children Ages 1-4 Who Receive Twice Annual Fluoride*	The percentage of members 1–4 years of age who received at least two fluoride varnish applications during the measurement year.	• Targeted member outreach through fluoride outbound calls. • Targeted member outreach through fluoride text messages.
	Increasing the Rate of Providers Reporting Member No-shows Using CDT Codes	The percentage of providers reporting member no-shows using CDT code D9986.	• Targeted provider outreach through provider outreach calls. • Targeted provider outreach through provider webinars.

Health Plan Name	PIP Topic	Performance Indicator Descriptions	Interventions
PAHP Providing CHIP Dental Services			
Premier Access CHIP	*School Based Care for CHIP Members*	Percentage of Premier Access CHIP members 5–10 years of age residing in ZIP Codes 84044, 84106, 84117, 84118, 84119, 84120, 84123, or 84129 receiving any dental care in a school.	• Provider telephonic outreach to parent/guardian.
	OHIF Completion for New CHIP Members	OHIF completion rate: The percentage of members who complete an OHIF within 90 days of enrollment.	• Live agent reminder calls.

*This is a new nonclinical PIP topic that the health plan submitted for final validation (resubmission). The PIP topic continued from last year and submitted for initial validation this year, but did not demonstrate opportunity for improvement.

**The performance indicator, as documented by the health plan, was unclear. HSAG has rephrased the performance indicator for this report.

2027-2032 Renewal
Attachment 3

Pending 1115 Waiver Amendments

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

December 30, 2022

Chiquita-Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the Medicaid Reform 1115 Demonstration. This amendment seeks approval to allow individuals to provide Long Term Services and Supports (LTSS) to individuals with behaviorally complex conditions. One LTSS provider will be selected through a Request for Proposal process.

The State of Utah appreciates your consideration of this amendment request. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Reform 1115 Demonstration.

Respectfully,

Jennifer Strohecker (Dec 19, 2022 13:57 MST)

Jennifer Strohecker
State Medicaid Director
Director, Division of Integrated Healthcare

Utah Department of Health & Human Services

Utah's Medicaid Reform 1115 Demonstration

Amendment Request

Long Term Services and Supports for Behaviorally Complex Individuals

Demonstration Project No. **11-W-00145/8**
21-W-00054/8

Utah Department of
Health & Human
Services

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State of Utah

Section 1115 Demonstration Amendment

Long Term Services & Supports for Behaviorally Complex Individuals

Section I. Program Description and Objectives

Within the Medicaid population, there are individuals with behaviorally complex (BC) conditions that originate from a variety of complex medical, organic, cognitive, psychiatric and behavioral conditions. Individuals with BC conditions are a challenging population and present placement difficulties, especially when transitioning from inpatient to Long Term Services & Supports (LTSS) coverage and service options. Because limited options exist for individuals with BC conditions, transitions result in failed placements/discharges from inpatient facilities resulting in extended stays in higher levels of care than necessary. Examples include individuals discharged from the Utah State Hospital, or individuals discharged from a skilled nursing facility (SNF) who are later hospitalized but unable to return to a SNF due to significant behavioral issues. This amendment seeks approval from CMS to provide Long Term Services and Supports (LTSS) to individuals with behaviorally complex conditions. One LTSS provider will be selected through a Request for Proposal process.

Goals and Objectives

Under Section 1115 of the Social Security Act, States may implement "experimental, pilot or demonstration projects which, in the judgment of the Secretary [of Health and Human Services] is likely to assist in promoting the objectives of [Medicaid]". The State believes this demonstration is likely to promote the objectives of Medicaid by improving participant health outcomes and quality of life. Providing these services will make it possible for Medicaid eligible members with BC conditions to receive appropriate LTSS coverage and services that have not been previously available. The Utah State Legislature has appropriated funding to facilitate the transition of individuals with BC conditions from an inpatient setting to LTSS in NF's and home and community based settings. The State is seeking flexibility to offer treatment alternatives which promote integration and transition to home and community-based placements where individuals may otherwise be placed in inpatient psychiatric settings due to lack of less-restrictive options.

Operation and Proposed Timeline

The demonstration will operate statewide. The State intends to implement the proposed benefit as soon as possible after approval, but not before January 1, 2024. The State requests to operate the demonstration through June 30, 2027.

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will develop a plan for evaluating the hypothesis indicated below. Utah will identify validated performance measures that adequately assess the impact of these demonstrations to beneficiaries. The State will submit the evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this demonstration, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
This demonstration facilitates timely transition of members with BC conditions to receive LTSS through institutional and home and community-based services. Each placement represents an individual moving from a more restrictive setting, like an inpatient psychiatric setting, to a less restrictive setting of care.	● Number of individuals served under this demonstration	● MMIS Data Warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons.

Section II. Demonstration Eligibility

Medicaid eligible individuals eligible under this demonstration must meet the following requirement:

- Medicaid members who have one or more complex medical, organic, cognitive and psychiatric and/or behavioral conditions that result in difficulty finding appropriate LTSS options.

Projected Enrollment

The projected enrollment for the demonstration population is a maximum of 50 Medicaid members at a time.

Section III. Demonstration Benefits

If approved under this demonstration, qualified Medicaid members will be eligible to receive the following services:

- Ability to receive rehabilitative services in a skilled nursing facility with professionals who are licensed to provide care to individuals with substance use disorder, severe mental illness, or other behaviorally complex conditions.

Section IV. Delivery System

Services for Demonstration members will be provided initially through fee for service (FFS). At a future date, the State may continue delivery of these services through FFS or may transition delivery of these services to managed care under 1915(b) authority or by amendment to the Demonstration.

Section V. Delivery System

Eligible individuals will be enrolled in the demonstration as of the implementation date of this amendment.

Section VI. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality- Attachment 1 for the State's historical and projected expenditures for the requested period of the demonstration.

Below is the projected enrollment and expenditures for the remaining demonstration years.

	DY22 (SFY 24)	DY23 (SFY 25)	DY24 (SFY 26)	DY25(SFY 27)
Enrollment	50	50	50	50
Expenditures	$5,746,800	$6,034,100	$6,335,800	$6,652,600

Section VII. Proposed Waiver and Expenditure Authority

The State requests the following proposed waivers and expenditure authority to operate the demonstration.

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability	To enable the State to vary the amount, duration, and scope of services provided to individuals in the demonstration group.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for the population affected by this demonstration.

Expenditure Authority

The State requests expenditure authority to provide LTSS for individuals with BC conditions through institutional services.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing were advertised in the newspapers of widest circulation and sent to an electronic

mailing list. In addition, the abbreviated public was posted to the State's Medicaid website at **https://medicaid.utah.gov/1115-waiver.**

Two public hearings to take public comment on this request were held. The first public hearing was held on December 12, 2022 from 3:00 pm to 4:00 pm. The second public hearing was held on December 15, 2022, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting. Both public hearings were held via video and teleconferencing. The state received nine comments from individuals and agencies. This includes comments provided during both public hearings, email and online portal comments, and mailed comments. The State reviewed and considered all public comments received.

Commenters were generally in support of the amendment but had several concerns. One commenter was concerned with Utah's low funding rates. Two commenters were concerned with the amendment's broad eligibility requirements. Another commenter asked when Utah expects to implement the amendment and how long an individual would be served under the demonstration. The commenter also asked what the transition process (out of the facility and back into the community) would entail and if the state felt it was feasible to find a skilled nursing provider that is able to provide all of the necessary support in this setting. Several commenters expressed concern with these individuals being institutionalized and one was concerned that these individuals' civil rights would be violated. The commenter stated it was unclear why these individuals cannot be served in community based settings and wondered how other programs would interact with this demonstration. Another commenter stated the amendment is too general in its presentation for approval and recommended tabling the amendment for further review and discussion.

In response to these concerns, the state explained the demonstration is designed to be a short term placement and may include a rate structure where reimbursement is higher for the first 60 days, then decreases for longer stays. The intent of the funding is to build the capacity to serve these individuals in a lower level of care than an inpatient setting, which allows members to stabilize and transition back into the community. In regards to broad eligibility, the intent is to serve individuals by multiple specialists.

Public Comment

The public comment period was held November 24, 2022 through December 23, 2022.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the Utah Department of Health (UDOH) Intergovernmental Policy 01.19 Formal UDOH Tribal Consultation and Urban Indian Organization Conferment Process Policy https://healthnet.utah.gov/download/policies/edo-admin/01.19-Formal-UDOH-Tribal-Consultation-UIO-Conf-Policy.pdf , the State ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. The state notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, the state began the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on December 9, 2022 to present this demonstration amendment.

One commenter asked if this would be a statewide program. The state explained that it will be a sole source contract with a single facility but that members statewide could obtain services from the site.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, amendments they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

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Attachment 1

Compliance with Budget Neutrality Requirements

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Current Eligibles							
Pop Type:	**Medicaid**						
Eligible Member Months	0.0%	318,076	318,076	318,076	318,076	318,076	
PMPM Cost	5.3%	$ 1,293.75	$ 1,362.32	$ 1,434.52	$ 1,510.55	$ 1,590.61	
Total Expenditure		$ 411,511,221	$ 433,321,316	$ 456,287,346	$ 480,470,575	$ 505,935,516	$ 2,287,525,974
Demo Pop I - PCN Adults with Children							
Pop Type:	**Hypothetical**						
Eligible Member Months	5.9%						
PMPM Cost	5.3%						
Total Expenditure							$ -
Demo Pop III/V - UPP Adults with Children *							
Pop Type:	**Hypothetical**						
Eligible Member Months	34.9%	36,498	49,222	66,380	89,520	120,727	
PMPM Cost	5.3%	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults							
Pop Type:	**Medicaid**						
Eligible Member Months							
PMPM Cost							
Total Expenditure							$ -
Demo Pop III/V - UPP Childless Adults *							
Pop Type:	**Medicaid**						
Eligible Member Months	159	184	189	194	199	204	
PMPM Cost	68.45	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Dental - Aged							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	68,396	70,106	71,858	73,655	75,496	
PMPM Cost	5.3%	$ 35.90	$ 37.81	$ 39.81	$ 41.92	$ 41.92	
Total Expenditure		$ 2,455,608	$ 2,650,399	$ 2,860,641	$ 3,087,562	$ 3,164,751	$ 14,218,960
Dental - Blind/Disabled							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	393,600	393,600	393,600	393,600	393,600	
PMPM Cost	5.3%	$ 35.93	$ 37.83	$ 39.83	$ 41.95	$ 44.17	
Total Expenditure		$ 14,140,242	$ 14,889,675	$ 15,678,828	$ 16,509,805	$ 17,384,825	$ 78,603,375
Dental - Targeted Adults							
Pop Type:	**Expansion**						
Eligible Member Months		39,737	40,731	41,749	42,793	43,863	
PMPM Cost	5.3%	$ 43.51	$ 45.82	$ 48.24	$ 50.80	$ 53.49	
Total Expenditure		$ 1,728,934	$ 1,866,081	$ 2,014,108	$ 2,173,877	$ 2,346,320	$ 10,129,320
Employer Sponsored Insurance (ESI)							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	145,638	149,279	153,011	156,836	160,757	
PMPM Cost	4.7%	$ 264.70	$ 277.14	$ 290.17	$ 303.81	$ 318.08	
Total Expenditure		$ 38,550,492	$ 41,371,424	$ 44,398,778	$ 47,647,659	$ 51,134,277	$ 223,102,631
Expansion Parents <=100% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	365,958	375,106	384,484	394,096	403,949	
PMPM Cost	5.3%	$ 784.16	$ 825.72	$ 869.48	$ 915.56	$ 964.09	
Total Expenditure		$ 286,967,645	$ 309,731,354	$ 334,300,793	$ 360,819,204	$ 389,441,187	$ 1,681,260,182
Expansion Adults w/out Dependent Children <=100% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	431,799	442,594	453,658	465,000	476,625	
PMPM Cost	5.3%	$ 1,094.21	$ 1,152.20	$ 1,213.26	$ 1,277.57	$ 1,345.28	
Total Expenditure		$ 472,476,451	$ 509,955,646	$ 550,407,877	$ 594,068,982	$ 641,193,504	$ 2,768,102,461
Expansion Parents 101-133% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	5.25%	132,166	139,105	146,408	154,094	162,184	
PMPM Cost	5.3%	$ 766.98	$ 807.63	$ 850.43	$ 895.51	$ 942.97	
Total Expenditure		$ 101,368,614	$ 112,345,061	$ 124,510,065	$ 137,992,326	$ 152,934,480	$ 629,150,545
Expansion Adults w/out Dependent Children 101-133% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	5.25%	418,244	440,201	463,312	487,636	513,237	
PMPM Cost	5.3%	$ 1,075.02	$ 1,132.00	$ 1,191.99	$ 1,255.17	$ 1,321.69	
Total Expenditure		$ 449,621,028	$ 498,307,117	$ 552,265,058	$ 612,065,699	$ 678,341,703	$ 2,790,600,606

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Former Foster							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	10	10	10	10	10	
PMPM Cost	4.8%	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure		$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Housing Residential Support Services (HRSS)							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	33,508	34,346	35,205	36,085	36,987	
PMPM Cost	5.3%	$ 7,318.35	$ 7,706.22	$ 8,114.65	$ 8,544.73	$ 8,997.60	
Total Expenditure		$ 245,225,284	$ 264,677,760	$ 285,673,345	$ 308,334,383	$ 332,793,008	$ 1,436,703,800
Intense Stabilization Services (ISS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	5.3%	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure		$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment							
Pop Type:	**Hypothetical**						
Eligible Member Months	13.5%	162	184	209	237	269	
PMPM Cost	5.0%	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure		$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310
Medicaid for Justice-Involved Populations							
Pop Type:	**Hypothetical**						
Eligible Member Months	1.75%	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	3.0%	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure		$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	5.3%	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure		$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure		$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)							
Pop Type:	**Hypothetical**						
Eligible Member Months	6.9%	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	5.0%	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure		$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults		*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*					
Pop Type:	**Expansion**	*PMPM will increase due to adding the new managed care directed payments*					
Eligible Member Months	2.5%	180,918	185,441	190,077	194,828	199,699	
PMPM Cost	5.3%	$ 1,495.83	$ 1,575.11	$ 1,658.59	$ 1,746.50	$ 1,839.06	
Total Expenditure		$ 270,622,011	$ 292,089,289	$ 315,259,114	$ 340,267,965	$ 367,258,823	$ 1,585,497,203
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		600	600	600	600	
PMPM Cost	5.0%		$ 9,578.00	$ 10,056.90	$ 10,559.75	$ 11,087.73	
Total Expenditure			$ 5,746,800	$ 6,034,100	$ 6,335,800	$ 6,652,600	$ 24,769,300
Integrated Behavior Health Services							
Pop Type:	**Hypothetical**		*Starts 1/1/24*				
Eligible Member Months	0.0%		1,500	3,000	3,000	3,000	
PMPM Cost	5.0%		$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure			$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000

$ 17,675,902,312

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Current Eligibles						
Pop Type:						
Eligible Member Months	318,076	318,076	318,076	318,076	318,076	
PMPM Cost	$ 1,293.75	$ 1,362.32	$ 1,434.52	$ 1,510.55	$ 1,590.61	
Total Expenditure	$ 411,511,221	$ 433,321,316	$ 456,287,346	$ 480,470,575	$ 505,935,516	$ 2,287,525,974
Demo Pop I - PCN Adults w/Children						
Pop Type:						
Eligible Member Months	-	-	-	-	-	
PMPM Cost	-	-	-	-	-	
Total Expenditure	$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Adults with Children						
Pop Type:						
Eligible Member Months	$ 36,498	$ 49,222	$ 66,380	$ 89,520	$ 120,727	
PMPM Cost	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure	$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults						
Pop Type:						
Eligible Member Months	-	-	-	-	-	
PMPM Cost	$ -	$ -	$ -	$ -	$ -	
Total Expenditure	$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Childless Adults						
Pop Type:						
Eligible Member Months	$ 184	$ 189	$ 194	$ 199	$ 204	
PMPM Cost	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure	$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Dental - Aged						
Pop Type:						
Eligible Member Months	68,396	70,106	71,858	73,655	75,496	
PMPM Cost	$ 35.90	$ 37.81	$ 39.81	$ 41.92	$ 41.92	
Total Expenditure	$ 2,455,608	$ 2,650,399	$ 2,860,641	$ 3,087,562	$ 3,164,751	$ 14,218,960
Dental - Blind/Disabled						
Pop Type:						
Eligible Member Months	393,600	393,600	393,600	393,600	393,600	
PMPM Cost	$ 35.93	$ 37.83	$ 39.83	$ 41.95	$ 44.17	
Total Expenditure	$ 14,140,242	$ 14,889,675	$ 15,678,828	$ 16,509,805	$ 17,384,825	$ 78,603,375
Dental - Targeted Adults						
Pop Type:						
Eligible Member Months	39,737	40,731	41,749	42,793	43,863	
PMPM Cost	$ 43.51	$ 45.82	$ 48.24	$ 50.80	$ 53.49	
Total Expenditure	$ 1,728,934	$ 1,866,081	$ 2,014,108	$ 2,173,877	$ 2,346,320	$ 10,129,320
Employer Sponsored Insurance (ESI)						
Pop Type:						
Eligible Member Months	145,638	149,279	153,011	156,836	160,757	
PMPM Cost	$ 264.70	$ 277.14	$ 290.17	$ 303.81	$ 318.08	
Total Expenditure	$ 38,550,492	$ 41,371,424	$ 44,398,778	$ 47,647,659	$ 51,134,277	$ 223,102,631
Expansion Parents <=100% FPL						
Pop Type:						
Eligible Member Months	365,958	375,106	384,484	394,096	403,949	
PMPM Cost	$ 784.16	$ 825.72	$ 869.48	$ 915.56	$ 964.09	
Total Expenditure	$ 286,967,645	$ 309,731,354	$ 334,300,793	$ 360,819,204	$ 389,441,187	$ 1,681,260,182
Expansion Adults w/out Dependent Children <=100% FPL						
Pop Type:						
Eligible Member Months	431,799	442,594	453,658	465,000	476,625	
PMPM Cost	$ 1,094.21	$ 1,152.20	$ 1,213.26	$ 1,277.57	$ 1,345.28	
Total Expenditure	$ 472,476,451	$ 509,955,646	$ 550,407,877	$ 594,068,982	$ 641,193,504	$ 2,768,102,461

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Expansion Parents 101-133% FPL						
Pop Type:						
Eligible Member Months	132,166	139,105	146,408	154,094	162,184	
PMPM Cost	$ 766.98	$ 807.63	$ 850.43	$ 895.51	$ 942.97	
Total Expenditure	$ 101,368,614	$ 112,345,061	$ 124,510,065	$ 137,992,326	$ 152,934,480	$ 629,150,545
Expansion Adults w/out Dependent Children 101-133% FPL						
Pop Type:						
Eligible Member Months	418,244	440,201	463,312	487,636	513,237	
PMPM Cost	$ 1,075.02	$ 1,132.00	$ 1,191.99	$ 1,255.17	$ 1,321.69	
Total Expenditure	$ 449,621,028	$ 498,307,117	$ 552,265,058	$ 612,065,699	$ 678,341,703	$ 2,790,600,606
Former Foster Care						
Pop Type:						
Eligible Member Months	10	10	10	10	10	
PMPM Cost	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure	$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Housing Residential Support Services (HRSS)						
Pop Type:						
Eligible Member Months	33,508	34,346	35,205	36,085	36,987	
PMPM Cost	7,318	7,706	8,115	8,545	8,998	
Total Expenditure	$ 245,225,284	$ 264,677,780	$ 285,673,345	$ 308,334,383	$ 332,793,008	$ 1,436,703,800
Intense Stabilization Services (ISS)						
Pop Type:						
Eligible Member Months	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure	$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment						
Pop Type:						
Eligible Member Months	162	184	209	237	269	
PMPM Cost	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure	$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310
Medicaid for Justice-Involved Populations						
Pop Type:						
Eligible Member Months	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure	$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)						
Pop Type:						
Eligible Member Months	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure	$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)						
Pop Type:						
Eligible Member Months	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure	$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)						
Pop Type:						
Eligible Member Months	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure	$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults						
Pop Type:						
Eligible Member Months	180,918	185,441	190,077	194,828	199,699	
PMPM Cost	1,496	1,575	1,659	1,747	1,839	
Total Expenditure	$ 270,622,011	$ 292,089,289	$ 315,259,114	$ 340,267,965	$ 367,258,823	$ 1,585,497,203

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Withdrawal Management						
Pop Type:						
Eligible Member Months	4,018	4,018	4,018	4,018	4,018	
PMPM Cost	$ 850.85	$ 893.40	$ 938.07	$ 984.97	$ 1,034.22	
Total Expenditure	$ 3,418,520	$ 3,589,446	$ 3,768,918	$ 3,957,364	$ 4,155,233	$ 18,889,482
Long-Term Support Services (LTSS)						
Pop Type:						
Eligible Member Months	-	600	600	600	600	
PMPM Cost	-	9,578	10,057	10,560	11,088	
Total Expenditure	-	5,746,800	6,034,100	6,335,800	6,652,600	$ 24,769,300
Integrated Behavior Health Services						
Pop Type:		*Starts 1/1/24*				
Eligible Member Months	-	1,500	3,000	3,000	3,000	
PMPM Cost	$ -	$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure	$ -	$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000

$ 17,676,664,312

Attachment 2

Public Notice Requirements

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services

Public Body:

Medicaid Expansion Workgroup

Notice Information

Add Notice to Calendar

Notice Title:

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time:

December 12, 2022 03:00 PM

Event End Date & Time:

December 12, 2022 04:00 PM

14

Event Deadline Date & Time:

12/12/22 04:00 PM

Description/Agenda:

Integrated Behavioral Health Services and Long-Term Services and Supports for Behaviorally Complex Individuals Public Hearings

The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the amendments online, by email, or mail during the public comment period from November 24, 2022, to December 23, 2022.

Utah Medicaid is requesting authority to implement provisions of Senate Bill 41 'Behavioral Health Service Amendments', which passed during the 2022 Utah Legislative General Session. This amendment seeks approval from the Centers for Medicare & Medicaid Services (CMS) to allow individuals to receive existing state plan-covered physical and behavioral services through a contracted local mental health authority, which will be selected through a Request for Proposal process.

Utah Medicaid is also requesting authority to implement a second amendment to Utah's Medicaid Reform 1115 Demonstration. This amendment seeks approval from CMS to provide Long Term Services and Supports (LTSS) to individuals who have behaviorally complex conditions. One LTSS provider will be selected through a Request for Proposal process.

Public Hearings:
The Department will conduct two public hearings to discuss the demonstration amendments. The dates and times are listed below. Due to the COVID-19 public health emergency, both public hearings will be held via video and teleconferencing.

Monday, December 12, 2022, from 3:00 pm to 4:00 pm.
Video Conference: Google Meet Meeting meet.google.com/dtv-read-thf
Or join by phone: (US) +1 209-806-3237 PIN: 354 734 298 #

Thursday, December 15, 2022, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting
Video Conference: Google Meet Meeting meet.google.com/hdo-xdkn-yvt
Or join by phone: (US) +1 405-696-0719 PIN: 248 965 765 #

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or (801) 538-6241 by 5:00 p.m. on December 8, 2022.

Public Comment:

A copy of the public notice and proposed amendments are available online at:
https://medicaid.utah.gov/1115-waiver/ 15
The public may comment on the proposed amendment requests during the public comment period from

November 24, 2022, to December 23, 2022.

Comments may be submitted using the following methods:

Online: https://medicaid.utah.gov/1115-waiver/

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Notice of Special Accommodations (ADA):

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Laura Belgique at 801-538-6241.

Notice of Electronic or Telephone Participation:

Video Conference: Google Meet Meeting meet.google.com/dtv-read-thf Or join by phone: (US) +1 209-806-3237 PIN: 354 734 298 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

PBM-00005664

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

November 17, 2022 03:48 PM

Notice Last Edited On:

November 17, 2022 04:04 PM

Deadline Date:

December 12, 2022 04:00 PM

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PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services

Public Body:

Medicaid Expansion Workgroup

Notice Information

Add Notice to Calendar

Notice Title:

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time:

December 15, 2022 02:00 PM

Event End Date & Time:

December 15, 2022 04:00 PM

Event Deadline Date & Time:

12/15/22 04:00 PM

Description/Agenda:

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Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
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Attn: Laura Belgique

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Meeting Information

Meeting Location:

Video/Teleconferencing
Salt Lake City, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

PBM-00005664

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

November 17, 2022 04:02 PM

Notice Last Edited On:

November 17, 2022 04:02 PM

Deadline Date:

December 15, 2022 04:00 PM

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cdevashrayee@utah.gov

ACCOUNT NUMBER

8405

ACCOUNT NAME

DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE

801-538-6641

ORDER #

SLT0020265

CUSTOMER REFERENCE NUMBER

CAPTION

Integrated Behavioral Health Services and Long- Term Services and Supports for Behaviorally Complex Individuals Public Hearings The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration.

TOTAL COST

$235.40

Integrated Behavioral Health Services and Long- Term Services and Supports for Behaviorally Complex Individuals Public Hearings

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  - Or join by phone: (US) +1 209-806-323701 PIN: 354 736 298#
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  - Video Conference: Google Meet Meeting meet.google.com/hdc-sdkn-yat
  - Or join by phone: (US) +1 405-696-071901 PIN: 248 965 765#

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Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0020265

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF Integrated Behavioral Health Services and Long- Term Services and Supports for Behaviorally Complex Individuals Public Hearings The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 11/20/2022

DATE 11/24/2022

SIGNATURE Jordyn Gallegos

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 24th DAY OF NOVEMBER IN THE YEAR 2022

BY Jordyn Gallegos

LAREE WHITMER
NOTARY PUBLIC-STATE OF UTAH
COMMISSION# 715683
COMM. EXP. 12-09-2024

LaRee Whitmer
NOTARY PUBLIC SIGNATURE

23

Attachment 3

Medical Care Advisory Committee

Public Hearing

Utah Department of Health & Human Services
Integrated Healthcare

Medical Care Advisory Committee Agenda

Meeting: Medical Care Advisory Committee
Date: December 15, 2022
Start Time: 2:00 p.m.
End Time: 4:00 p.m.
Location: meet.google.com/hdo-xdkn-yvt (Google Chrome)
By Phone: 1-405-696-0719 PIN# 248 965 765#

Agenda Items

1.	Welcome • Approve Minutes for October 2022 MCAC* • Welcome New MCAC member: Dr. Jennifer Brinton ○ Provider Rep for Utah Physicians	Michael Hales	2:00 / 10 min
2.	California's CalAIM Initiative	Aaron Toyama	2:10 / 30 min
3.	Public Hearings – 1115 Demonstration Amendments** • S.B. 41 Integrated Behavioral Healthcare Services • Long Term Services and Supports for Behaviorally Complex Individuals	Laura Belgique / Members of the Public	2:40 / 10 min
4.	Director's Report	Jennifer Strohecker	2:50 / 15 min
5.	Governor's Budget Proposal	Eric Grant	3:05 / 10 min
6.	Discuss and Vote on the MCAC Bylaws*	Michael Hales	3:15 / 10 min
7.	Eligibility and Enrollment Discussion** • PHE Unwinding Update	Jeff Nelson	3:25 / 10 min
8.	Committee Member Updates	Committee Members	Time Remaining

* Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)
** Informational handout in the packet sent to committee members
***In accordance with the Open and Public Meetings Act Utah Code 52-4-207, the Chair of the MCAC committee has determined providing an anchor location for the MCAC meeting presents substantial risk to the health and safety of the attendees due to the COVID-19 pandemic. The MCAC meeting will be conducted remotely via electronic means only. The committee members and the public may attend via Google Meet or by calling in to the Google Meet session as listed on the meeting agenda. MCAC meetings will be held in an electronic format until further notice.

Next Meeting: January 19, 2023, from 2:00 p.m. – 4:00 p.m.
Please send meeting topics or other correspondence to Sharon Steigerwalt (ssteigerwalt@utah.gov)

Medical Care Advisory Committee

Minutes of December 15, 2022

Participants

Committee Members (via phone)

Michael Hales (Chair), Jennifer Marchant, Rachel Craig, Luis Rios, Muris Prses for Dale Ownby, Brian Monsen, Stephanie Burdick, Kim Dansie, Gina Tuttle, and Cassidy Matthew

Committee Members Absent

Lisa Heaton, Dr. Robert Baird, Nate Checketts, Dr. Jennifer Brinton, Alan Ormsby, Michael Jensen, and Davis Moore

DOH Staff (via phone)

Eric Grant, Brian Roach, Tracy Barkley, Laura Belgique, Emma Chacon, Dave Lewis, Matt Lund, Jennifer Meyer-Smart, Jeff Nelson, Michelle Smith, James Stamos, Jeremy Taylor, Greg Trollan, Kolbi Young, Sharon Steigerwalt, and Dorrie Reese

Guest (via phone)

Justin Allen, Ciriac Alvarez, Brittany Carver, Jill Chang, Clayton Nelson, Adam Cohen, William Cosgrove, Nate Crippes, Kaitlynn Drollinger, Jim Dunnigan, Kevin Eastman, Jeannie Edens, Russ Elbel, Julie Eqing, Ron Faerber, Melissa Garrett, Matt Hansen, Geoff Harding, Scott Horne, Ryan Jackson, Michelle Jenson, Vicki Jessup, Kristeen Jones, Rosemary Lesser, Jesse Liddell, Rebecca Martinez, Noah Miterko, Elise Napper, Joni Nebeker, Andrea Neilson, Andrew Riggle, Destiny Rockwood, Ken Schaecher, Randall Serr, Kristen Tiaden, Aaron Toyama, Ryan Westergard, Audry Wood, Todd Wood, Sheila Young, and Emily Zheutlin

California's CalAIM Initiative:

Aaron Toyama discussed California's CalAIM Initiative.
Aaron.toyama@dhcs.ca.gov
https://www.dhcs.ca.gov/calaim

The document which was presented is embedded in this document.

CalAIM Overview for Utah MCAC.pdf

Welcome New MCAC member: Dr. Jennifer Brinton:

Michael Hales welcomed new MCAC Member Dr. Jennifer Brinton-Provider Representative for Utah Physicians

Approval of Minutes:

Brian Monson made the motion to approve the October 20, 2022, MCAC minutes. Rachel Craig seconded that motion. The group unanimously agreed.

DRAFT

1115 Demonstration Waiver Public Hearings:

Laura Belgique discussed S.B 41: Integrated Behavioral Healthcare Services, and Long-Term Services & Supports Behaviorally Complex Individuals.

The documents which were presented are embedded in this document.

LTSS for BC Individuals Public Hea

SB41 Public Hearing Overview.pdf

Questions:

Andrew Riggle asked a couple of questions. 1.on the population eligibility for the behavioral complex amendment, who would be eligible for this, how would their eligibility be determined? 2. Would this be a contract with a single facility? 3. Is this a short-term placement? 3.1. How long would an individual be served under this program, and how would transition out of the facility be happening?

Brian Roach mentioned I will respond to each question individually. 2. Yes, the intent language in the funding would go in the RFP as a single entity. 3. It is designed to be somewhat short-term. However, we're not writing into the waiver any specific boundaries. We are envisioning a tiered rates structure for the first 60 days, then a lower rate for days after that with the goal to transition members to the community. 1. I think the intent is to require multiple specialties in a single setting, substance use disorder counselors, mental health counselors, psychologist, and psychiatrist. At this stage we are probably keeping it fairly broad for CMS authority and then later we would refine it a little bit when it comes to the contract setting.

Andrew Riggle asked there don't seem to be a lot of skilled nursing facilities that have staff or the expertise for folks with cognitive intellectual behavioral or psychological needs. Is it the states sense that you can find a provider in a skilled nursing who is able to provide all of the necessary support in a setting or how are the unique needs of this population going to be addressed in a skilled nursing environment?

Brian Roach mentioned the intent of the funding is to allow some capacity building by skilled nursing facility.

Ron Farber asked rebab verses long-term care our concern is if an individual is renting an apartment and goes to the hospital then is transferred to a LTSS facility. How long is rehab going to take place.

Brian Roach mentioned our New Choices Waiver does not have

Director's Report:

Brian Roach gave an update on Medicaid ARPA Funds, Medicaid Policies, SPAs, and Rules.

The document which was presented is embedded in this document.

MCAC Director's Office Updates- Dece

SPA's Rules:

The documents which were presented are embedded in this document

MCAC SPA Matrix 12-15-22.pdf

MCAC Rule Summary 12-15-22.pdf

DRAFT

Governor's Budget Proposal:

Eric Grant gave an update on the Governor's Budget Proposal.

The document which was presented is embedded in this document.

Governor's Budget Presentation.pdf

Questions:

Enrollment and Expansion Discussion:

Jeff Nelson gave an update on Public Health Emergency Unwinding.

The documents which were presented are embedded in this document

December 2022 MCAC PHE Report.pdf

Committee Member Updates:

Adjourn

Meeting was adjourned at 3:47pm. The next meeting is scheduled for January 20, 2022 at 2:00-4:00 p.m.

DRAFT

Attachment 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

12/9/2022
8:30 AM –11:30 AM

Utah Department of Health & Human Services
Salt Lake City, UT 84114
(801) 712-9346
Google Meeting Format Web Link:
https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
Call In: 1-414-909-6377
PIN: 211 599 534#

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
Note taker:	Dorrie Reese
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

8:30 AM	**UIHAB Meeting** Welcome & Introductions	Lorena Horse, Chairperson
8:40 AM	**Committee Updates & Discussion** • **UT Medicaid Eligibility Policy** • **Medicaid & CHIP State Plan Amendments (SPA) & Rules** • **DWS Medicaid Eligibility Operations** • **MCAC & CHIP Advisory Committees** • **Federal/State Policy Impacting I/T/U** ICWA Liaison Indian Health Liaison • **Data Reporting Updates** • **UT DHHS OAIANHFS Program Updates** Opioids & Tobacco Health Equity	 Jeff Nelson, UT Medicaid, Dir. BMEP Craig Devashrayee, UT Medicaid, BMEP Jessica Ware, AI/AN Elig. Spec., DWS Mike Jensen, UNHS & Courtney Muir, NWBSN Jeremy Taylor, IHFS Jamie Harvey, IHFS Melissa Zito, IHFS Alex Merrill, IHFS Hilary Makris, IHFS Kassie John, IHFS
09:45 AM	**Medicaid 1115 Waiver** • **Behavioral Health Integration** • **Community Based Waiver; LTS & BC**	Laurie Belgique & Michelle Smith Medicaid, Integrated Healthcare
10:15 AM	**Viral Hep C.**	Ethan Farnsworth, MPH, Pop. Health
10:45 AM	**BREAK 5 min**	
10:50 AM	**I/T/U updates:** Good News, Changes, Pressing Issue, Questions, Any Requests for Support, etc.	Open to UIHAB Reps.
11:15 AM	**Upcoming Annual UIHAB Retreat; Dates & Location**	Lorena Horse & Jeremy Taylor
11:30 AM	**ADJOURN** ***Next Mtg. January 13, 2023***	

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Utah Indian Health Advisory Board
Tribal Leadership Reporting Tool

DATE: _____

State Agency Updates & Discussions:

Medicaid State Plan Amendments (SPA) & Rules (see Matrices)

DWS Medicaid Eligibility

MCAC & CHIP Advisory Committees

Federal/State Policy Impacting I/T/U
- ICWA Liaison
- AI/AN Health Liaison

Data Updates

IHFS Program Updates
- Opioid/Tobacco
- Health Equity Grants

Agenda Item Updates

Medicaid 1115 Waivers: Behavior Health Integration and Long Term Services & Behaviorally Complex Individuals

Viral Hepatitis C :

I/T/U Updates:

Annual Retreat; Dates & Location:

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

December 30, 2022

Chiquita-Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the Medicaid Reform 1115 Demonstration. This amendment seeks approval to allow individuals to receive existing state plan covered physical and behavioral services in an integrated model through a contracted local mental health authority which will be selected through a Request for Proposal process.

The State of Utah appreciates your consideration of this amendment request. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Reform 1115 Demonstration.

Respectfully,

Jennifer Strohecker (Dec 19, 2022 13:55 MST)

Jennifer Strohecker
State Medicaid Director
Director, Division of Integrated Healthcare

Utah Department of Health & Human Services

Utah's Medicaid Reform 1115 Demonstration

Amendment Request

Integrated Behavioral Health Services

Demonstration Project No. **11-W-00145/8**
21-W-00054/8

State of Utah

Medicaid Reform 1115 Demonstration Amendment

Integrated Behavioral Health Services

Section I. Program Description and Objectives

During the 2022 General Session of the Utah State Legislature, Senate Bill 41 "Behavioral Health Services Amendments" was passed and signed into law by Governor Cox. This legislation requires the Utah Department of Health and Human Services, Division of Integrated Healthcare to seek 1115 Medicaid Reform Demonstration approval from the Centers for Medicare and Medicaid Services (CMS) to allow individuals to receive existing state plan covered physical and behavioral services in an integrated model through a contracted local mental health authority which will be selected through a Request for Proposal process.

Goals and Objectives

Under Section 1115 of the Social Security Act, States may implement "experimental, pilot or demonstration projects which, in the judgment of the Secretary [of Health and Human Services] is likely to assist in promoting the objectives of [Medicaid]". Within the Medicaid population, there are individuals that require the integration of both physical and behavioral healthcare services in order to receive necessary and effective delivery of care. Integrated approaches close gaps in care, improve overall care, provide a holistic member experience, and are cost effective. Providing integrated physical and behavioral healthcare services through a local mental health authority will make it possible for Medicaid eligible members to receive appropriate healthcare services that have not been previously available. The State believes this demonstration is likely to promote the objectives of Medicaid by improving participant health outcomes and quality of life.

Operation and Proposed Timeline

The demonstration will operate through the contracted local mental health authority selected through the Request for Proposal process. The State intends to implement the

proposed benefit as soon as possible after approval, but not before January 1, 2024. The State requests to operate the demonstration through June 30, 2027**.**

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will develop a plan for evaluating the hypothesis indicated below. Utah will identify validated performance measures that adequately assess the impact of these demonstrations to beneficiaries. The State will submit the evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this demonstration, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
This demonstration will increase the percent of individuals with a behavioral health condition receiving primary care services compared to a matched cohort receiving care in a non-integrated clinic model.	● Number of individuals served under this demonstration	● Data warehouse	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons.

Section II. Demonstration Eligibility

Medicaid eligible individuals eligible under this demonstration must meet the following requirement:

- Medicaid members who are served by the contracted local mental health authority who accesses services through the local mental health authority.

Projected Enrollment

The projected enrollment for the demonstration population is approximately 250 Medicaid members per year.

Section III. Demonstration Benefits

If approved under this demonstration, qualified Medicaid members will be eligible to receive the following services:

- Qualified Medicaid members will be eligible to receive existing state plan covered physical and behavioral services through the contracted local mental health authority.
- Individuals receiving mental health treatment will be able to receive primary care to prevent and treat conditions in an ambulatory environment.
- Integrated health delivery models address system fragmentation to better identify and manage co-occurring conditions, improved health outcomes, and lower costs of care compared to traditional models

Section IV. Delivery System

Services for Demonstration members will be provided through a contracted local mental health authority.

Section V. Delivery System

Eligible individuals will be enrolled in the demonstration as of the implementation date of this amendment.

Section VI. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality- Attachment 1 for the State's historical and projected expenditures for the requested period of the demonstration.

Below is the projected enrollment and expenditures for the remaining demonstration years.

	DY22 (SFY 24) (Jan-Jun 2024)	DY23 (SFY 25)	DY24 (SFY 26)	DY25(SFY 27)

Enrollment	250	250	250	250
Expenditures	$100,000	$200,000	$200,000	$200,000

Section VII. Proposed Waiver and Expenditure Authority

The State requests the following proposed waivers and expenditure authority to operate the demonstration.

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(1) - Statewideness	This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

Expenditure Authority

The State requests expenditure authority to provide Medicaid members appropriate and necessary integrated physical and behavioral healthcare services through a contracted local mental health authority.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing were advertised in the newspapers of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public was posted to the State's Medicaid website at **https://medicaid.utah.gov/1115-waiver.**

Two public hearings to take public comment on this request were held. The first public hearing was held on December 12, 2022 from 3:00 pm to 4:00 pm. The second public hearing was held on December 15, 2022, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting. Both public hearings were held via video and teleconferencing. The state received one comment in the MCAC meeting. The commenter

stated it seemed like a limited benefit and asked how extensive the primary care services would be and how it would overlay with the UMIC contracts. The commenter also expressed concern this may be confusing to members as well as providers. In response, the state explained we are not replacing our current UMIC delivery system, the services would be for primary care, and we will take any confusing information into advisement.

Public Comment

The public comment period was held November 24, 2022 through December 23, 2022.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the Utah Department of Health (UDOH) Intergovernmental Policy 01.19 Formal UDOH Tribal Consultation and Urban Indian Organization Conferment Process Policy https://healthnet.utah.gov/download/policies/edo-admin/01.19-Formal-UDOH-Tribal-Consultation-UIO-Conf-Policy.pdf, the State ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. The state notified the UDOH Indian Health Liaison of the waiver amendment. As a result of this notification, the state began the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on December 9, 2022 to present this demonstration amendment.

Three questions were received during the meeting. One commenter asked if the state was integrating the Indian Health Systems into the contracted local mental health. The state explained this is a pilot project and that a local mental health authority would be awarded through a Request for Proposal process. Another commenter asked if this is going to be expanded to the rest of the state if successful. The state explained there are currently no mechanisms to expand this project, but that could be evaluated in the future. The third question was in relation to the time frame and the state explained this pilot would go through the end of the demonstration period.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the

distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, amendments they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

Name and Title: Jennifer Strohecker, Medicaid Director, Division of Integrated Healthcare
Telephone Number: (801) 538-6689
Email Address: medicaiddirector@utah.gov

Attachment 1

Compliance with Budget Neutrality Requirements

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Current Eligibles							
Pop Type:	**Medicaid**						
Eligible Member Months	0.0%	318,076	318,076	318,076	318,076	318,076	
PMPM Cost	5.3%	$ 1,293.75	$ 1,362.32	$ 1,434.52	$ 1,510.55	$ 1,590.61	
Total Expenditure		$ 411,511,221	$ 433,321,316	$ 456,287,346	$ 480,470,575	$ 505,935,516	$ 2,287,525,974
Demo Pop I - PCN Adults with Children							
Pop Type:	**Hypothetical**						
Eligible Member Months	5.9%						
PMPM Cost	5.3%						
Total Expenditure							$ -
Demo Pop III/V - UPP Adults with Children *							
Pop Type:	**Hypothetical**						
Eligible Member Months	34.9%	36,498	49,222	66,380	89,520	120,727	
PMPM Cost	5.3%	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Dental - Blind/Disabled							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	393,600	393,600	393,600	393,600	393,600	
PMPM Cost	5.3%	$ 35.93	$ 37.83	$ 39.83	$ 41.95	$ 44.17	
Total Expenditure		$ 14,140,242	$ 14,889,675	$ 15,678,828	$ 16,509,805	$ 17,384,825	$ 78,603,375
Dental - Targeted Adults							
Pop Type:	**Expansion**						
Eligible Member Months		39,737	40,731	41,749	42,793	43,863	
PMPM Cost	5.3%	$ 43.51	$ 45.82	$ 48.24	$ 50.80	$ 53.49	
Total Expenditure		$ 1,728,934	$ 1,866,081	$ 2,014,108	$ 2,173,877	$ 2,346,320	$ 10,129,320
Employer Sponsored Insurance (ESI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months	2.5%	145,638	149,279	153,011	156,836	160,757	
PMPM Cost	4.7%	$ 264.70	$ 277.14	$ 290.17	$ 303.81	$ 318.08	
Total Expenditure		$ 38,550,492	$ 41,371,424	$ 44,398,778	$ 47,647,659	$ 51,134,277	$ 223,102,631
Expansion Parents <=100% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	365,958	375,106	384,484	394,096	403,949	
PMPM Cost	5.3%	$ 784.16	$ 825.72	$ 869.48	$ 915.56	$ 964.09	
Total Expenditure		$ 286,967,645	$ 309,731,354	$ 334,300,793	$ 360,819,204	$ 389,441,187	$ 1,681,260,182
Expansion Adults w/out Dependent Children <=100% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	431,799	442,594	453,658	465,000	476,625	
PMPM Cost	5.3%	$ 1,094.21	$ 1,152.20	$ 1,213.26	$ 1,277.57	$ 1,345.28	
Total Expenditure		$ 472,476,451	$ 509,955,646	$ 550,407,877	$ 594,068,982	$ 641,193,504	$ 2,768,102,461
Expansion Parents 101-133% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	5.25%	132,166	139,105	146,408	154,094	162,184	
PMPM Cost	5.3%	$ 766.98	$ 807.63	$ 850.43	$ 895.51	$ 942.97	
Total Expenditure		$ 101,368,614	$ 112,345,061	$ 124,510,065	$ 137,992,326	$ 152,934,480	$ 629,150,545
Expansion Adults w/out Dependent Children 101-133% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	5.25%	418,244	440,201	463,312	487,636	513,237	
PMPM Cost	5.3%	$ 1,075.02	$ 1,132.00	$ 1,191.99	$ 1,255.17	$ 1,321.69	
Total Expenditure		$ 449,621,028	$ 498,307,117	$ 552,265,058	$ 612,065,699	$ 678,341,703	$ 2,790,600,606

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Former Foster							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	10	10	10	10	10	
PMPM Cost	4.8%	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure		$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Housing Residential Support Services (HRSS)							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	33,508	34,346	35,205	36,085	36,987	
PMPM Cost	5.3%	$ 7,318.35	$ 7,706.22	$ 8,114.65	$ 8,544.73	$ 8,997.60	
Total Expenditure		$ 245,225,284	$ 264,677,780	$ 285,673,345	$ 308,334,383	$ 332,793,008	$ 1,436,703,800
Intense Stabilization Services (ISS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	5.3%	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure		$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment							
Pop Type:	**Hypothetical**						
Eligible Member Months	13.5%	162	184	209	237	269	
PMPM Cost	5.0%	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure		$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310
Medicaid for Justice-Involved Populations							
Pop Type:	**Hypothetical**						
Eligible Member Months	1.75%	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	3.0%	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure		$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	5.3%	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure		$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months	2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure		$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Long-Term Support Services (LTSS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		600	600	600	600	
PMPM Cost	5.0%		$ 9,578.00	$ 10,056.90	$ 10,559.75	$ 11,087.73	
Total Expenditure			$ 5,746,800	$ 6,034,100	$ 6,335,800	$ 6,652,600	$ 24,769,300
Integrated Behavior Health Services							
Pop Type:	**Hypothetical**		*Starts 1/1/24*				
Eligible Member Months	0.0%		1,500	3,000	3,000	3,000	
PMPM Cost	5.0%		$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure			$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000

$ 17,675,902,312

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Current Eligibles						
Pop Type:						
Eligible Member Months	318,076	318,076	318,076	318,076	318,076	
PMPM Cost	$ 1,293.75	$ 1,362.32	$ 1,434.52	$ 1,510.55	$ 1,590.61	
Total Expenditure	$ 411,511,221	$ 433,321,316	$ 456,287,346	$ 480,470,575	$ 505,935,516	$ 2,287,525,974
Demo Pop I - PCN Adults w/Children						
Pop Type:						
Eligible Member Months	-	-	-	-	-	
PMPM Cost	-	-	-	-	-	
Total Expenditure	$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Adults with Children						
Pop Type:						
Eligible Member Months	$ 36,498	$ 49,222	$ 66,380	$ 89,520	$ 120,727	
PMPM Cost	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure	$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults						
Pop Type:						
Eligible Member Months	-	-	-	-	-	
PMPM Cost	$ -	$ -	$ -	$ -	$ -	
Total Expenditure	$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Childless Adults						
Pop Type:						
Eligible Member Months	$ 184	$ 189	$ 194	$ 199	$ 204	
PMPM Cost	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure	$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Dental - Aged						
Pop Type:						
Eligible Member Months	68,396	70,106	71,858	73,655	75,496	
PMPM Cost	$ 35.90	$ 37.81	$ 39.81	$ 41.92	$ 41.92	
Total Expenditure	$ 2,455,608	$ 2,650,399	$ 2,860,641	$ 3,087,562	$ 3,164,751	$ 14,218,960
Dental - Blind/Disabled						
Pop Type:						
Eligible Member Months	393,600	393,600	393,600	393,600	393,600	
PMPM Cost	$ 35.93	$ 37.83	$ 39.83	$ 41.95	$ 44.17	
Total Expenditure	$ 14,140,242	$ 14,889,675	$ 15,678,828	$ 16,509,805	$ 17,384,825	$ 78,603,375
Dental - Targeted Adults						
Pop Type:						
Eligible Member Months	39,737	40,731	41,749	42,793	43,863	
PMPM Cost	$ 43.51	$ 45.82	$ 48.24	$ 50.80	$ 53.49	
Total Expenditure	$ 1,728,934	$ 1,866,081	$ 2,014,108	$ 2,173,877	$ 2,346,320	$ 10,129,320
Employer Sponsored Insurance (ESI)						
Pop Type:						
Eligible Member Months	145,638	149,279	153,011	156,836	160,757	
PMPM Cost	$ 264.70	$ 277.14	$ 290.17	$ 303.81	$ 318.08	
Total Expenditure	$ 38,550,492	$ 41,371,424	$ 44,398,778	$ 47,647,659	$ 51,134,277	$ 223,102,631
Expansion Parents <=100% FPL						
Pop Type:						
Eligible Member Months	365,958	375,106	384,484	394,096	403,949	
PMPM Cost	$ 784.16	$ 825.72	$ 869.48	$ 915.56	$ 964.09	
Total Expenditure	$ 286,967,645	$ 309,731,354	$ 334,300,793	$ 360,819,204	$ 389,441,187	$ 1,681,260,182
Expansion Adults w/out Dependent Children <=100% FPL						
Pop Type:						
Eligible Member Months	431,799	442,594	453,658	465,000	476,625	
PMPM Cost	$ 1,094.21	$ 1,152.20	$ 1,213.26	$ 1,277.57	$ 1,345.28	
Total Expenditure	$ 472,476,451	$ 509,955,646	$ 550,407,877	$ 594,068,982	$ 641,193,504	$ 2,768,102,461

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Expansion Parents 101-133% FPL						
Pop Type:						
Eligible Member Months	132,166	139,105	146,408	154,094	162,184	
PMPM Cost	$ 766.98	$ 807.63	$ 850.43	$ 895.51	$ 942.97	
Total Expenditure	$ 101,368,614	$ 112,345,061	$ 124,510,065	$ 137,992,326	$ 152,934,480	$ 629,150,545
Expansion Adults w/out Dependent Children 101-133% FPL						
Pop Type:						
Eligible Member Months	418,244	440,201	463,312	487,636	513,237	
PMPM Cost	$ 1,075.02	$ 1,132.00	$ 1,191.99	$ 1,255.17	$ 1,321.69	
Total Expenditure	$ 449,621,028	$ 498,307,117	$ 552,265,058	$ 612,065,699	$ 678,341,703	$ 2,790,600,606
Former Foster Care						
Pop Type:						
Eligible Member Months	10	10	10	10	10	
PMPM Cost	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure	$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Housing Residential Support Services (HRSS)						
Pop Type:						
Eligible Member Months	33,508	34,346	35,205	36,085	36,987	
PMPM Cost	7,318	7,706	8,115	8,545	8,998	
Total Expenditure	$ 245,225,284	$ 264,677,780	$ 285,673,345	$ 308,334,383	$ 332,793,008	$ 1,436,703,800
Intense Stabilization Services (ISS)						
Pop Type:						
Eligible Member Months	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure	$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment						
Pop Type:						
Eligible Member Months	162	184	209	237	269	
PMPM Cost	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure	$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310
Medicaid for Justice-Involved Populations						
Pop Type:						
Eligible Member Months	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure	$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)						
Pop Type:						
Eligible Member Months	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure	$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)						
Pop Type:						
Eligible Member Months	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure	$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)						
Pop Type:						
Eligible Member Months	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure	$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults						
Pop Type:						
Eligible Member Months	180,918	185,441	190,077	194,828	199,699	
PMPM Cost	1,496	1,575	1,659	1,747	1,839	
Total Expenditure	$ 270,622,011	$ 292,089,289	$ 315,259,114	$ 340,267,965	$ 367,258,823	$ 1,585,497,203

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Withdrawal Management						
Pop Type:						
Eligible Member Months	4,018	4,018	4,018	4,018	4,018	
PMPM Cost	$ 850.85	$ 893.40	$ 938.07	$ 984.97	$ 1,034.22	
Total Expenditure	$ 3,418,520	$ 3,589,446	$ 3,768,918	$ 3,957,364	$ 4,155,233	$ 18,889,482
Long-Term Support Services (LTSS)						
Pop Type:						
Eligible Member Months	-	600	600	600	600	
PMPM Cost	-	9,578	10,057	10,560	11,088	
Total Expenditure	-	5,746,800	6,034,100	6,335,800	6,652,600	$ 24,769,300
Integrated Behavior Health Services						
Pop Type:		*Starts 1/1/24*				
Eligible Member Months	-	1,500	3,000	3,000	3,000	
PMPM Cost	$ -	$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure	$ -	$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000

$ 17,676,664,312

Attachment 2

Public Notice Requirements

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services

Public Body:

Medicaid Expansion Workgroup

Notice Information

Add Notice to Calendar

Notice Title:

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time:

December 12, 2022 03:00 PM

Event End Date & Time:

December 12, 2022 04:00 PM

Description/Agenda:

Integrated Behavioral Health Services and Long-Term Services and Supports for Behaviorally Complex Individuals Public Hearings

The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the amendments online, by email, or mail during the public comment period from November 24, 2022, to December 23, 2022.

Utah Medicaid is requesting authority to implement provisions of Senate Bill 41 'Behavioral Health Services Amendments', which passed during the 2022 Utah Legislative General Session. This amendment seeks approval from the Centers for Medicare & Medicaid Services (CMS) to allow individuals to receive existing state plan-covered physical and behavioral services through a contracted local mental health authority, which will be selected through a Request for Proposal process.

Utah Medicaid is also requesting authority to implement a second amendment to Utah's Medicaid Reform 1115 Demonstration. This amendment seeks approval from CMS to provide Long Term Services and Supports (LTSS) to individuals who have behaviorally complex conditions. One LTSS provider will be selected through a Request for Proposal process.

Public Hearings:
The Department will conduct two public hearings to discuss the demonstration amendments. The dates and times are listed below. Due to the COVID-19 public health emergency, both public hearings will be held via video and teleconferencing.

Monday, December 12, 2022, from 3:00 pm to 4:00 pm.
Video Conference: Google Meet Meeting meet.google.com/dtv-read-thf
Or join by phone: (US) +1 209-806-3237 PIN: 354 734 298 #

Thursday, December 15, 2022, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting
Video Conference: Google Meet Meeting meet.google.com/hdo-xdkn-yvt
Or join by phone: (US) +1 405-696-0719 PIN: 248 965 765 #

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or (801) 538-6241 by 5:00 p.m. on December 8, 2022.

Public Comment:

A copy of the public notice and proposed amendments are available online at:
https://medicaid.utah.gov/1115-waiver/ 15
The public may comment on the proposed amendment requests during the public comment period from

November 24, 2022, to December 23, 2022.

Comments may be submitted using the following methods:

Online: https://medicaid.utah.gov/1115-waiver/

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Notice of Special Accommodations (ADA):

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Laura Belgique at 801-538-6241.

Notice of Electronic or Telephone Participation:

Video Conference: Google Meet Meeting meet.google.com/dtv-read-thf Or join by phone: (US) +1 209-806-3237 PIN: 354 734 298 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

PBM-00005664

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

November 17, 2022 03:48 PM

Notice Last Edited On:

November 17, 2022 04:04 PM

Deadline Date:

December 12, 2022 04:00 PM

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PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services

Public Body:

Medicaid Expansion Workgroup

Notice Information

Add Notice to Calendar

Notice Title:

Public Hearing on Amendments to Utah's Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time:

December 15, 2022 02:00 PM

Event End Date & Time:

December 15, 2022 04:00 PM

Event Deadline Date & Time:

12/15/22 04:00 PM

Description/Agenda:

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Or join by phone: (US) +1 209-806-3237 PIN: 354 734 298 #

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Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

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Meeting Information

Meeting Location:

Video/Teleconferencing
Salt Lake City, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

PBM-00005664

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

November 17, 2022 04:02 PM

Notice Last Edited On:

November 17, 2022 04:02 PM

Deadline Date:

December 15, 2022 04:00 PM

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SALT LAKE CITY, UT 84114
cdevashrayee@utah.gov

ACCOUNT NUMBER
8405

ACCOUNT NAME
DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE
801-538-6641

ORDER #
SLT0020265

CUSTOMER REFERENCE NUMBER

CAPTION
Integrated Behavioral Health Services and Long- Term Services and Supports for Behaviorally Complex Individuals Public Hearings The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration.

TOTAL COST
$235.40

Integrated Behavioral Health Services and Long- Term Services and Supports for Behaviorally Complex Individuals Public Hearings

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  - Or join by phone: (US) +1 209-806-32378 PIN: 354 734 298#
- Thursday, December 15, 2022, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting
  - Video Conference: Google Meet Meeting meet.google.com/hdc-ad-kk-yat
  - Or join by phone: (US) +1 405-696-07198 PIN: 248 965 765#

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Online: https://medicaid.utah.gov/1115-waiver/

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0020265

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF Integrated Behavioral Health Services and Long- Term Services and Supports for Behaviorally Complex Individuals Public Hearings The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 11/20/2022

DATE 11/24/2022

SIGNATURE Jordyn gallegos

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 24th DAY OF NOVEMBER IN THE YEAR 2022

BY Jordyn Gallegos

LAREE WHITMER
NOTARY PUBLIC-STATE OF UTAH
COMMISSION# 715683
COMM. EXP. 12-09-2024

LaRee Whitmer
NOTARY PUBLIC SIGNATURE

Attachment 3

Medical Care Advisory Committee

Public Hearing

Utah Department of Health & Human Services
Integrated Healthcare

Medical Care Advisory Committee Agenda

Meeting: Medical Care Advisory Committee
Date: December 15, 2022
Start Time: 2:00 p.m.
End Time: 4:00 p.m.
Location: meet.google.com/hdo-xdkn-yvt (Google Chrome)
By Phone: 1-405-696-0719 PIN# 248 965 765#

Agenda Items

1.	Welcome • Approve Minutes for October 2022 MCAC* • Welcome New MCAC member: Dr. Jennifer Brinton ○ Provider Rep for Utah Physicians	Michael Hales	2:00 / 10 min
2.	California's CalAIM Initiative	Aaron Toyama	2:10 / 30 min
3.	Public Hearings – 1115 Demonstration Amendments** • S.B. 41 Integrated Behavioral Healthcare Services • Long Term Services and Supports for Behaviorally Complex Individuals	Laura Belgique / Members of the Public	2:40 / 10 min
4.	Director's Report	Jennifer Strohecker	2:50 / 15 min
5.	Governor's Budget Proposal	Eric Grant	3:05 / 10 min
6.	Discuss and Vote on the MCAC Bylaws*	Michael Hales	3:15 / 10 min
7.	Eligibility and Enrollment Discussion** • PHE Unwinding Update	Jeff Nelson	3:25 / 10 min
8.	Committee Member Updates	Committee Members	Time Remaining

* Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)
** Informational handout in the packet sent to committee members
***In accordance with the Open and Public Meetings Act Utah Code 52-4-207, the Chair of the MCAC committee has determined providing an anchor location for the MCAC meeting presents substantial risk to the health and safety of the attendees due to the COVID-19 pandemic. The MCAC meeting will be conducted remotely via electronic means only. The committee members and the public may attend via Google Meet or by calling in to the Google Meet session as listed on the meeting agenda. MCAC meetings will be held in an electronic format until further notice.

Next Meeting: January 19, 2023, from 2:00 p.m. – 4:00 p.m.
Please send meeting topics or other correspondence to Sharon Steigerwalt (ssteigerwalt@utah.gov)

Medical Care Advisory Committee

Minutes of December 15, 2022

Participants

Committee Members (via phone)

Michael Hales (Chair), Jennifer Marchant, Rachel Craig, Luis Rios, Muris Prses for Dale Ownby, Brian Monsen, Stephanie Burdick, Kim Dansie, Gina Tuttle, and Cassidy Matthew

Committee Members Absent

Lisa Heaton, Dr. Robert Baird, Nate Checketts, Dr. Jennifer Brinton, Alan Ormsby, Michael Jensen, and Davis Moore

DOH Staff (via phone)

Eric Grant, Brian Roach, Tracy Barkley, Laura Belgique, Emma Chacon, Dave Lewis, Matt Lund, Jennifer Meyer-Smart, Jeff Nelson, Michelle Smith, James Stamos, Jeremy Taylor, Greg Trollan, Kolbi Young, Sharon Steigerwalt, and Dorrie Reese

Guest (via phone)

Justin Allen, Ciriac Alvarez, Brittany Carver, Jill Chang, Clayton Nelson, Adam Cohen, William Cosgrove, Nate Crippes, Kaitlynn Drollinger, Jim Dunnigan, Kevin Eastman, Jeannie Edens, Russ Elbel, Julie Eqing, Ron Faerber, Melissa Garrett, Matt Hansen, Geoff Harding, Scott Horne, Ryan Jackson, Michelle Jenson, Vicki Jessup, Kristeen Jones, Rosemary Lesser, Jesse Liddell, Rebecca Martinez, Noah Miterko, Elise Napper, Joni Nebeker, Andrea Neilson, Andrew Riggle, Destiny Rockwood, Ken Schaecher, Randall Serr, Kristen Tiaden, Aaron Toyama, Ryan Westergard, Audry Wood, Todd Wood, Sheila Young, and Emily Zheutlin

California's CalAIM Initiative:

Aaron Toyama discussed California's CalAIM Initiative.
Aaron.toyama@dhcs.ca.gov
https://www.dhcs.ca.gov/calaim

The document which was presented is embedded in this document.

CalAIM Overview for Utah MCAC.pdf

Welcome New MCAC member: Dr. Jennifer Brinton:

Michael Hales welcomed new MCAC Member Dr. Jennifer Brinton-Provider Representative for Utah Physicians

Approval of Minutes:

Brian Monson made the motion to approve the October 20, 2022, MCAC minutes. Rachel Craig seconded that motion. The group unanimously agreed.

DRAFT

1115 Demonstration Waiver Public Hearings:

Laura Belgique discussed S.B 41: Integrated Behavioral Healthcare Services, and Long-Term Services & Supports Behaviorally Complex Individuals.

The documents which were presented are embedded in this document.

LTSS for BC Individuals Public Hea

SB41 Public Hearing Overview.pdf

Questions:

Andrew Riggle asked a couple of questions. 1.on the population eligibility for the behavioral complex amendment, who would be eligible for this, how would their eligibility be determined? 2. Would this be a contract with a single facility? 3. Is this a short-term placement? 3.1. How long would an individual be served under this program, and how would transition out of the facility be happening?

Brian Roach mentioned I will respond to each question individually. 2. Yes, the intent language in the funding would go in the RFP as a single entity. 3. It is designed to be somewhat short-term. However, we're not writing into the waiver any specific boundaries. We are envisioning a tiered rates structure for the first 60 days, then a lower rate for days after that with the goal to transition members to the community. 1. I think the intent is to require multiple specialties in a single setting, substance use disorder counselors, mental health counselors, psychologist, and psychiatrist. At this stage we are probably keeping it fairly broad for CMS authority and then later we would refine it a little bit when it comes to the contract setting.

Andrew Riggle asked there don't seem to be a lot of skilled nursing facilities that have staff or the expertise for folks with cognitive intellectual behavioral or psychological needs. Is it the states sense that you can find a provider in a skilled nursing who is able to provide all of the necessary support in a setting or how are the unique needs of this population going to be addressed in a skilled nursing environment?

Brian Roach mentioned the intent of the funding is to allow some capacity building by skilled nursing facility.

Ron Farber asked rebab verses long-term care our concern is if an individual is renting an apartment and goes to the hospital then is transferred to a LTSS facility. How long is rehab going to take place.

Brian Roach mentioned our New Choices Waiver does not have

Director's Report:

Brian Roach gave an update on Medicaid ARPA Funds, Medicaid Policies, SPAs, and Rules.

The document which was presented is embedded in this document.

MCAC Director's Office Updates- Dece

SPA's Rules:

The documents which were presented are embedded in this document

MCAC SPA Matrix 12-15-22.pdf

MCAC Rule Summary 12-15-22.pdf

DRAFT

Governor's Budget Proposal:

Eric Grant gave an update on the Governor's Budget Proposal.

The document which was presented is embedded in this document.

Governor's Budget Presentation.pdf

Questions:

Enrollment and Expansion Discussion:

Jeff Nelson gave an update on Public Health Emergency Unwinding.

The documents which were presented are embedded in this document

December 2022 MCAC PHE Report.pd

Committee Member Updates:

Adjourn

Meeting was adjourned at 3:47pm. The next meeting is scheduled for January 20, 2022 at 2:00-4:00 p.m.

DRAFT

Attachment 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

12/9/2022
8:30 AM –11:30 AM

Utah Department of Health & Human Services
Salt Lake City, UT 84114
(801) 712-9346
Google Meeting Format Web Link:
https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
Call In: 1-414-909-6377
PIN: 211 599 534#

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
Note taker:	Dorrie Reese
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

Agenda topic

8:30 AM	**UIHAB Meeting** Welcome & Introductions	Lorena Horse, Chairperson
8:40 AM	**Committee Updates & Discussion** • **UT Medicaid Eligibility Policy** • **Medicaid & CHIP State Plan Amendments (SPA) & Rules** • **DWS Medicaid Eligibility Operations** • **MCAC & CHIP Advisory Committees** • **Federal/State Policy Impacting I/T/U** ICWA Liaison Indian Health Liaison • **Data Reporting Updates** • **UT DHHS OAIANHFS Program Updates** Opioids & Tobacco Health Equity	 Jeff Nelson, UT Medicaid, Dir. BMEP Craig Devashrayee, UT Medicaid, BMEP Jessica Ware, AI/AN Elig. Spec., DWS Mike Jensen, UNHS & Courtney Muir, NWBSN Jeremy Taylor, IHFS Jamie Harvey, IHFS Melissa Zito, IHFS Alex Merrill, IHFS Hilary Makris, IHFS Kassie John, IHFS
09:45 AM	**Medicaid 1115 Waiver** • **Behavioral Health Integration** • **Community Based Waiver; LTS & BC**	Laurie Belgique & Michelle Smith Medicaid, Integrated Healthcare
10:15 AM	**Viral Hep C.**	Ethan Farnsworth, MPH, Pop. Health
10:45 AM	**BREAK 5 min**	
10:50 AM	**I/T/U updates:** Good News, Changes, Pressing Issue, Questions, Any Requests for Support, etc.	Open to UIHAB Reps.
11:15 AM	**Upcoming Annual UIHAB Retreat; Dates & Location**	Lorena Horse & Jeremy Taylor
11:30 AM	**ADJOURN** ***Next Mtg. January 13, 2023***	

Utah Indian Health Advisory Board
Tribal Leadership Reporting Tool

DATE: _____

State Agency Updates & Discussions:

Medicaid State Plan Amendments (SPA) & Rules (see Matrices)

DWS Medicaid Eligibility

MCAC & CHIP Advisory Committees

Federal/State Policy Impacting I/T/U
- ICWA Liaison
- AI/AN Health Liaison

Data Updates

IHFS Program Updates
- Opioid/Tobacco
- Health Equity Grants

Agenda Item Updates

Medicaid 1115 Waivers: Behavior Health Integration and Long Term Services & Behaviorally Complex Individuals

Viral Hepatitis C :

I/T/U Updates:

Annual Retreat; Dates & Location:

State of Utah
SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

July 27, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

I am pleased to submit an amendment to the State of Utah's Medicaid Reform 1115 Demonstration. Approval of this amendment will allow the state to provide additional Medicaid services to fee-for-service enrolled members with qualified chronic health conditions.

The State of Utah appreciates your consideration of this amendment request. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Reform 1115 Demonstration.

Respectfully,

Jennifer Strohecker (Jul 11, 2023 15:30 MDT)

Jennifer Strohecker
Medicaid Director
Division of Integrated Healthcare

Utah's Medicaid Reform 1115 Demonstration

Amendment Request

Chronic Conditions Support

Demonstration Project No. **11-W-00145/8**
21-W-00054/8

Utah Department of Health & Human Services

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Section II. Demonstration Eligibility 3

Section III. Demonstration Benefits and Cost Sharing Requirements 3

Section IV. Delivery System 3

Section V. Implementation and Enrollment in Demonstration 3

Section VI. Demonstration Financing and Budget Neutrality 4

Section VII. Proposed Waivers and Expenditure Authority 4

Section VIII. Compliance with Public Notice and Tribal Consultation 4

Section IX. Demonstration Administration 6

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State of Utah

Section 1115 Demonstration Amendment

Chronic Conditions Support

Section I. Program Description and Objectives

During the 2023 General Session of the Utah State Legislature, Senate Bill 269, "Chronic Conditions Support Amendments", was passed. This legislation requires the Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) to seek 1115 Demonstration approval from the Centers for Medicare and Medicaid Services (CMS) to provide additional Medicaid services to fee for service enrolled individuals with qualified chronic health conditions. These services will be provided through a contracted provider which will be selected through a Request for Proposal process. These conditions include:

- diabetes
- high blood pressure
- congestive heart failure
- asthma
- obesity
- chronic obstructive pulmonary disease
- chronic kidney disease

Goals and Objectives

Six in ten Americans live with at least one chronic disease including heart disease and diabetes. These and other chronic diseases are the leading causes of death and disability in America, and they are also a leading driver of health care costs.[1] Low-income individuals are more likely to suffer from chronic disease and may be disproportionately burdened by the costs and associated social and economic consequences. [2] Many chronic conditions require continuous medical care. Without this care, serious complications can occur,

[1] Centers for Disease Control and Prevention. (2023, March 2). *Chronic disease center (NCCDPHP)*. Centers for Disease Control and Prevention. Retrieved March 14, 2023, from https://www.cdc.gov/chronicdisease/index.htm

[2] *Chronic disease in the United States: A worsening health and economic crisis*. AAF. Retrieved March 14, 2023, from https://www.americanactionforum.org/research/chronic-disease-in-the-united-states-a-worsening-health-and-economic-crisis/

further reducing quality of life and increasing costs. [3] The state believes this demonstration is likely to promote the objectives of Medicaid by improving participant health outcomes and quality of life, which will also lead to cost savings. Providing these services will make it possible for Medicaid eligible individuals with qualified chronic conditions to receive additional, appropriate services, and services that have not been previously utilized or available.

Operation and Proposed Timeline

The Demonstration will operate through the contracted provider selected by the state through the Request for Proposal process. The state intends to implement the Demonstration as soon as possible after approval. The state requests to operate the Demonstration for a three-year pilot program.

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the state will develop a plan for evaluating the hypotheses indicated below. Utah will identify validated performance measures that adequately assess the impact of the Demonstration to beneficiaries. The state will submit the evaluation plan to CMS for approval.

The state will conduct ongoing monitoring of this demonstration, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The following hypotheses will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
The implementation of the coordinated care program will lead to improved adherence to medications.	Comparison of medication adherence rates among participants. pre/post implementation.	Data warehouse	The independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons.
Participants will report having greater control of their health and	Health satisfaction survey	Survey	The independent evaluator will design quantitative and qualitative measures to include

[3] *Rural Health Information Hub*. Chronic Disease in Rural America Overview. (n.d.). Retrieved March 14, 2023, from https://www.ruralhealthinfo.org/topics/chronic-disease

report greater confidence in maintaining their health.			quasi-experimental comparisons.

Section II. Demonstration Eligibility

Individuals must meet all of the following eligibility criteria to qualify for additional services:

- Medicaid members who have been diagnosed as having a qualified condition and are not enrolled in an accountable care organization.

Projected Enrollment

The projected enrollment for the demonstration population is approximately 1,350 fee for service enrolled Medicaid members per year.

Section III. Demonstration Benefits and Cost Sharing Requirements

If approved under this demonstration, qualified Medicaid members will be eligible to receive the following services:

- A telemedicine platform for the member to use;
- An in-home initial visit to the member;
- Daily remote monitoring of the members qualified condition;
- All services in the member's language of choice;
- Individual peer monitoring and coaching for the member;
- Available access for the member to video-enabled consults and voice-enabled; consults 24 hours a day, seven days a week;
- In-home biometric monitoring devices to monitor the member's qualified condition; and
- At-home medication delivery to the member.

Cost sharing requirements will not differ from those provided under the state plan.

Section IV. Delivery System

Services for Demonstration individuals will be provided through fee for service. Services will be provided by a single entity under contract with the State.

Section V. Implementation and Enrollment in Demonstration

Eligible members will be enrolled in the Demonstration as of the implementation date of this amendment.

Section VI. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality Attachment 1 for the state's historical and projected expenditures for the requested period of the Demonstration.
Below is the projected enrollment and expenditures for each remaining demonstration year.

	DY23 (SFY 25) Jan-Jun	DY 24 (SFY 27) Jul-Jun	DY 25 (SFY 27) Jul-Jun	DY 26 (SFY 28) Jul-Dec
Enrollment	805	1,610	1,610	805
Expenditures	$1,738,800	$3,477,600	$3,477,600	$1,738,800

Section VII. Proposed Waiver and Expenditure Authority

The state requests the following proposed waivers and expenditure authorities to operate the Demonstration.

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability	To enable the state to provide benefit packages to the Demonstration population that differs from the state plan benefit package.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the state to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration.

Expenditure Authority

The state requests expenditure authority to provide additional Medicaid services to fee for service individuals in the state with certain qualified chronic health conditions.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing was advertised in the newspaper of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public notice was posted to the State's Medicaid website at **https://medicaid.utah.gov/1115-waiver.**

Two public hearings to take public comment on this request were held. The first public hearing was held on June 15, 2023, from 2:00 to 4:00 pm during the Medical Care Advisory Committee (MCAC) meeting. The second public hearing was held on June 26, 2023, from 4:00 to 5:00 pm. Both public hearings were held via video and teleconferencing.

Public Comment

The state accepted public comment during a 30-day public comment period, which was held June 7, 2023 through July 7, 2023. The state received comments from two individuals from the same agency. This included comments provided during both public hearings, email and online portal comments, and mailed comments. The state reviewed and considered all public comments received. A summary of the comments and state responses are outlined below.

Primary or secondary provider

One commenter asked if the patients would be in contact with their provider or if it would be a secondary provider.

Response:

The state explained that this would not necessarily remove them from provider choice outside their normal provider but would allow additional services/benefits beyond what is already covered.

Concerns with multiple aspects of the amendment

One commenter expressed concern with the following aspects of the amendment: concerns with the technical set up, questioning the ability of a single entity contract to: provide in-home initial visits and delivery medication to all members (specifically

duplicative or contraindicated prescriptions and deliveries for members, especially if medications are started or discontinued without a primary care provider's knowledge); being able to share information or medical records with the member's primary provider; have the most up to date information on the member's conditions. The commenter also stated that health centers would not be aware of any care that was provided, thereby disrupting continuity of care and that patient-provider relationships could be disrupted. Both commenters were concerned with equity of access, especially for members living in rural areas as they often lack broadband access. Lastly, the commenter believes that the request for proposal process is not truly competitive and that the state is already aware of what entity it will select.

Response:
The state agrees with the submitter on the importance of coordination of care and information sharing. The goal of the amendment is to enhance existing care, not replace it. Any implemented telehealth platform will have provisions for information sharing with primary care providers. The state acknowledges the submitter's concerns regarding the feasibility of one entity managing all services. The state assures that the chosen entity will be expected to demonstrate their capacity to fulfill these obligations across Utah. The state understands the submitter's concerns about patient safety in relation to medication management. It will be a requirement for the selected entity to coordinate effectively with a member's primary care provider to ensure safe and accurate medication delivery. The state shares the submitter's concerns about information sharing with primary providers. The state will require the selected entity to share patient information with primary providers in a manner consistent with HIPAA as part of their contractual obligations. The state is aligned with the submitter's concerns about equitable access to services. The selected entity will be required to demonstrate their ability to ensure accessibility across different regions and for members with varying technological capabilities. The state understands the submitter's concerns about potential disruption to patient-provider relationships. The state will consider making it a requirement for the selected entity to inquire about and respect these relationships. The state maintains its commitment to a transparent and competitive bidding process. The selection of the contracted entity will be based purely on the entity's ability to meet the program's requirements and objectives.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the DHHS Intergovernmental Policy 01.19 Formal DHHS Tribal Consultation and Urban Indian Organization Conferment Process Policy , the state ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. DIH has notified the DHHS Tribal Health Liaison of the waiver amendment. As a result of this notification, DIH began to engage in the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on June 9, 2023 to present this demonstration amendment. During this meeting, UIHAB made the motion to support this amendment.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

Name and Title: Jennifer Strohecker, Medicaid Director, Division of Integrated Healthcare
Telephone Number: (801) 538-6689
Email Address: jstrohecker@utah.gov

Attachment 1

Compliance with Budget Neutrality Requirements

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Current Eligibles							
Pop Type:	**Medicaid**						
Eligible Member Months	0.0%	318,076	318,076	318,076	318,076	318,076	
PMPM Cost	5.3%	$ 1,293.75	$ 1,362.32	$ 1,434.52	$ 1,510.55	$ 1,590.61	
Total Expenditure		$ 411,511,221	$ 433,321,316	$ 456,287,346	$ 480,470,575	$ 505,935,516	$ 2,287,525,974
Demo Pop I - PCN Adults with Children							
Pop Type:	**Hypothetical**						
Eligible Member Months	5.9%						
PMPM Cost	5.3%						
Total Expenditure							$ -
Demo Pop III/V - UPP Adults with Children *							
Pop Type:	**Hypothetical**						
Eligible Member Months	34.9%	36,498	49,222	66,380	89,520	120,727	
PMPM Cost	5.3%	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults							
Pop Type:	**Medicaid**						
Eligible Member Months							
PMPM Cost							
Total Expenditure							$ -
Demo Pop III/V - UPP Childless Adults *							
Pop Type:	**Medicaid**						
Eligible Member Months	159	184	189	194	199	204	
PMPM Cost	68.45	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Employer Sponsored Insurance (ESI)							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.5%	145,638	149,279	153,011	156,836	160,757	
PMPM Cost	4.7%	$ 264.70	$ 277.14	$ 290.17	$ 303.81	$ 318.08	
Total Expenditure		$ 38,550,492	$ 41,371,424	$ 44,398,778	$ 47,647,659	$ 51,134,277	$ 223,102,631
Expansion Parents <=100% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	365,958	375,106	384,484	394,096	403,949	
PMPM Cost	5.3%	$ 784.16	$ 825.72	$ 869.48	$ 915.56	$ 964.09	
Total Expenditure		$ 286,967,645	$ 309,731,354	$ 334,300,793	$ 360,819,204	$ 389,441,187	$ 1,681,260,182
Expansion Adults w/out Dependent Children <=100% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	431,799	442,594	453,658	465,000	476,625	
PMPM Cost	5.3%	$ 1,094.21	$ 1,152.20	$ 1,213.26	$ 1,277.57	$ 1,345.28	
Total Expenditure		$ 472,476,451	$ 509,955,646	$ 550,407,877	$ 594,068,982	$ 641,193,504	$ 2,768,102,461
Expansion Parents 101-133% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	5.25%	132,166	139,105	146,408	154,094	162,184	
PMPM Cost	5.3%	$ 766.98	$ 807.63	$ 850.43	$ 895.51	$ 942.97	
Total Expenditure		$ 101,368,614	$ 112,345,061	$ 124,510,065	$ 137,992,326	$ 152,934,480	$ 629,150,545
Expansion Adults w/out Dependent Children 101-133% FPL							
Pop Type:	**Expansion**						
Eligible Member Months	5.25%	418,244	440,201	463,312	487,636	513,237	
PMPM Cost	5.3%	$ 1,075.02	$ 1,132.00	$ 1,191.99	$ 1,255.17	$ 1,321.69	
Total Expenditure		$ 449,621,028	$ 498,307,117	$ 552,265,058	$ 612,085,699	$ 678,341,703	$ 2,790,600,606
Former Foster							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	10	10	10	10	10	
PMPM Cost	4.8%	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure		$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Housing Residential Support Services (HRSS)							
Pop Type:	**Expansion**						
Eligible Member Months	2.5%	33,508	34,346	35,205	36,085	36,987	
PMPM Cost	5.3%	$ 7,318.35	$ 7,706.22	$ 8,114.65	$ 8,544.73	$ 8,997.60	
Total Expenditure		$ 245,225,284	$ 264,677,780	$ 285,673,345	$ 308,334,383	$ 332,793,008	$ 1,436,703,800
Intense Stabilization Services (ISS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	5.3%	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure		$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment							
Pop Type:	**Hypothetical**						
Eligible Member Months	13.5%	162	184	209	237	269	
PMPM Cost	5.0%	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure		$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Medicaid for Justice-Involved Populations							
Pop Type:	Hypothetical						
Eligible Member Months	1.75%	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	3.0%	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure		$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)							
Pop Type:	Hypothetical						
Eligible Member Months	2.5%	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	5.3%	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure		$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)							
Pop Type:	Hypothetical						
Eligible Member Months	2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure		$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)							
Pop Type:	Hypothetical						
Eligible Member Months	6.9%	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	5.0%	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure		$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults		*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*					
Pop Type:	Expansion	*PMPM will increase due to adding the new managed care directed payments*					
Eligible Member Months	2.5%	180,918	185,441	190,077	194,828	199,699	
PMPM Cost	5.3%	$ 1,495.83	$ 1,575.11	$ 1,658.59	$ 1,746.50	$ 1,839.06	
Total Expenditure		$ 270,622,011	$ 292,089,289	$ 315,259,114	$ 340,267,965	$ 367,258,823	$ 1,585,497,203
Withdrawal Management							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%	4,018	4,018	4,018	4,018	4,018	
PMPM Cost	5.0%	$ 850.85	$ 893.40	$ 938.07	$ 984.97	$ 1,034.22	
Total Expenditure		$ 3,418,520	$ 3,589,446	$ 3,768,918	$ 3,957,364	$ 4,155,233	$ 18,889,482
Long-Term Support Services (LTSS)							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%		600	600	600	600	
PMPM Cost	5.0%		$ 9,578.00	$ 10,056.90	$ 10,559.75	$ 11,087.73	
Total Expenditure			$ 5,746,800	$ 6,034,100	$ 6,335,800	$ 6,652,600	$ 24,769,300
Integrated Behavior Health Services							
Pop Type:	Hypothetical		*Starts 1/1/24*				
Eligible Member Months	0.0%		1,500	3,000	3,000	3,000	
PMPM Cost	5.0%		$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure			$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000
Demo Pop VI - UPP for Children							
Pop Type:	Hypothetical		*Starts 1/1/24*				
Eligible Member Months	0.0%		1,775	3,523	3,523	3,523	
PMPM Cost	5.0%		$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure			$ 319,500	$ 634,140	$ 634,140	$ 634,140	$ 2,221,920
Dental Services for Medicaid-eligible Adults							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%		2,255,460	2,505,192	2,562,444	2,679,348	
PMPM Cost	0.0%		$ 32.19	$ 32.19	$ 32.19	$ 32.19	
Total Expenditure			$ 72,603,302	$ 80,642,218	$ 82,484,960	$ 86,248,288	$ 321,978,768
SB133 12-Month Extended Postpartum							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%		140,004	138,540	136,980	134,796	
PMPM Cost	4.5%		$ 1,072.13	$ 1,120.45	$ 1,170.87	$ 1,223.46	
Total Expenditure			$ 150,103,124	$ 155,227,571	$ 160,385,793	$ 164,917,386	$ 630,633,874
SB133 Family Planning Services							
Pop Type:	Hypothetical						
Eligible Member Months	1.6%		60,648	61,656	62,640	63,636	
PMPM Cost	1.2%		$ 21.60	$ 21.86	$ 22.13	$ 22.40	
Total Expenditure			$ 1,309,968	$ 1,348,051	$ 1,386,293	$ 1,425,154	$ 5,469,466
SB269 Chronic Conditions Support Amendment							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%		9,660	19,320	19,320	9,660	
PMPM Cost	0.0%		$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure			$ 1,738,800	$ 3,477,600	$ 3,477,600	$ 1,738,800	$ 10,432,800

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Current Eligibles						
Pop Type:						
Eligible Member Months	318,076	318,076	318,076	318,076	318,076	
PMPM Cost	$ 1,293.75	$ 1,362.32	$ 1,434.52	$ 1,510.55	$ 1,590.61	
Total Expenditure	$ 411,511,221	$ 433,321,316	$ 456,287,346	$ 480,470,575	$ 505,935,516	$ 2,287,525,974
Demo Pop I - PCN Adults w/Children						
Pop Type:						
Eligible Member Months	-	-	-	-	-	
PMPM Cost	-	-	-	-	-	
Total Expenditure	$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Adults with Children						
Pop Type:						
Eligible Member Months	$ 36,498	$ 49,222	$ 66,380	$ 89,520	$ 120,727	
PMPM Cost	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure	$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults						
Pop Type:						
Eligible Member Months	-	-	-	-	-	
PMPM Cost	$ -	$ -	$ -	$ -	$ -	
Total Expenditure	$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Childless Adults						
Pop Type:						
Eligible Member Months	$ 184	$ 189	$ 194	$ 199	$ 204	
PMPM Cost	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure	$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Employer Sponsored Insurance (ESI)						
Pop Type:						
Eligible Member Months	145,638	149,279	153,011	156,836	160,757	
PMPM Cost	$ 264.70	$ 277.14	$ 290.17	$ 303.81	$ 318.08	
Total Expenditure	$ 38,550,492	$ 41,371,424	$ 44,398,778	$ 47,647,659	$ 51,134,277	$ 223,102,631
Expansion Parents <=100% FPL						
Pop Type:						
Eligible Member Months	365,958	375,106	384,484	394,096	403,949	
PMPM Cost	$ 784.16	$ 825.72	$ 869.48	$ 915.56	$ 964.09	
Total Expenditure	$ 286,967,645	$ 309,731,354	$ 334,300,793	$ 360,819,204	$ 389,441,187	$ 1,681,260,182
Expansion Adults w/out Dependent Children <=100% FPL						
Pop Type:						
Eligible Member Months	431,799	442,594	453,658	465,000	476,625	
PMPM Cost	$ 1,094.21	$ 1,152.20	$ 1,213.26	$ 1,277.57	$ 1,345.28	
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Expansion Parents 101-133% FPL						
Pop Type:						
Eligible Member Months	132,166	139,105	146,408	154,094	162,184	
PMPM Cost	$ 766.98	$ 807.63	$ 850.43	$ 895.51	$ 942.97	
Total Expenditure	$ 101,368,614	$ 112,345,061	$ 124,510,065	$ 137,992,326	$ 152,934,480	$ 629,150,545
Expansion Adults w/out Dependent Children 101-133% FPL						
Pop Type:						
Eligible Member Months	418,244	440,201	463,312	487,636	513,237	
PMPM Cost	$ 1,075.02	$ 1,132.00	$ 1,191.99	$ 1,255.17	$ 1,321.69	
Total Expenditure	$ 449,621,028	$ 498,307,117	$ 552,265,058	$ 612,065,699	$ 678,341,703	$ 2,790,600,606
Former Foster Care						
Pop Type:						
Eligible Member Months	10	10	10	10	10	
PMPM Cost	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure	$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Housing Residential Support Services (HRSS)						
Pop Type:						
Eligible Member Months	33,508	34,346	35,205	36,085	36,987	
PMPM Cost	7,318	7,706	8,115	8,545	8,998	
Total Expenditure	$ 245,225,284	$ 264,677,780	$ 285,673,345	$ 308,334,383	$ 332,793,008	$ 1,436,703,800
Intense Stabilization Services (ISS)						
Pop Type:						
Eligible Member Months	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure	$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment						
Pop Type:						
Eligible Member Months	162	184	209	237	269	
PMPM Cost	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure	$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Medicaid for Justice-Involved Populations						
Pop Type:						
Eligible Member Months	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure	$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)						
Pop Type:						
Eligible Member Months	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure	$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)						
Pop Type:						
Eligible Member Months	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure	$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)						
Pop Type:						
Eligible Member Months	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure	$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults						
Pop Type:						
Eligible Member Months	180,918	185,441	190,077	194,828	199,699	
PMPM Cost	1,496	1,575	1,659	1,747	1,839	
Total Expenditure	$ 270,622,011	$ 292,089,289	$ 315,259,114	$ 340,267,965	$ 367,258,823	$ 1,585,497,203
Withdrawal Management						
Pop Type:						
Eligible Member Months	4,018	4,018	4,018	4,018	4,018	
PMPM Cost	$ 850.85	$ 893.40	$ 938.07	$ 984.97	$ 1,034.22	
Total Expenditure	$ 3,418,520	$ 3,589,446	$ 3,768,918	$ 3,957,364	$ 4,155,233	$ 18,889,482
Long-Term Support Services (LTSS)						
Pop Type:						
Eligible Member Months	-	600	600	600	600	
PMPM Cost	-	9,578	10,057	10,560	11,088	
Total Expenditure	-	5,746,800	6,034,100	6,335,800	6,652,600	$ 24,769,300
Integrated Behavior Health Services						
Pop Type:		*Starts 1/1/24*				
Eligible Member Months	-	1,500	3,000	3,000	3,000	
PMPM Cost	$ -	$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure	$ -	$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000
Demo Pop VI - UPP for Children						
Pop Type:		*Starts 1/1/24*				
Eligible Member Months	-	1,775	3,523	3,523	3,523	
PMPM Cost	$ -	$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure	$ -	$ 319,500	$ 634,140	$ 634,140	$ 634,140	$ 2,221,920
Dental Services for Medicaid-eligible Adults						
Pop Type:						
Eligible Member Months	-	2,255,460	2,505,192	2,562,444	2,679,348	
PMPM Cost	$ -	$ 32.19	$ 32.19	$ 32.19	$ 32.19	
Total Expenditure	$ -	$ 72,603,302	$ 80,642,218	$ 82,484,960	$ 86,248,288	$ 321,978,768
SB133 12-Month Extended Postpartum						
Pop Type:						
Eligible Member Months	-	140,004	138,540	136,980	134,796	
PMPM Cost	$ -	$ 1,072.13	$ 1,120.45	$ 1,170.87	$ 1,223.46	
Total Expenditure	$ -	$ 150,103,124	$ 155,227,571	$ 160,385,793	$ 164,917,386	$ 630,633,874
SB133 Family Planning Services						
Pop Type:						
Eligible Member Months	-	60,648	61,656	62,640	63,636	
PMPM Cost	$ -	$ 21.60	$ 21.86	$ 22.13	$ 22.40	
Total Expenditure	$ -	$ 1,309,968	$ 1,348,051	$ 1,386,293	$ 1,425,154	$ 5,469,466
SB269 Chronic Conditions Support Amendment						
Pop Type:						
Eligible Member Months	-	9,660	19,320	19,320	9,660	
PMPM Cost	$ -	$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure	$ -	$ 1,738,800	$ 3,477,600	$ 3,477,600	$ 1,738,800	$ 10,432,800

Attachment 2

Public Notice Requirements

Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Public Hearing on Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

Public Hearing on Medicaid Reform 1115 Demonstration

Notice Subject(s)

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time

June 15, 2023 02:00 PM

Event End Date & Time:

June 15, 2023 04:00 PM

Event Deadline Date & Time:

07/07/23 11:59 PM

Description/Agenda

Dental Services for Medicaid-eligible Adults,
Family Planning Services,
and Chronic Conditions Support
Public Hearings

The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss three amendments to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the amendments online, by email, or mail during the public comment period from June 7, 2023, through July 7, 2023.

Give Feedback

The Dental Services for Medicaid-eligible Adults amendment seeks authority from the Centers for Medicare & Medicaid Services (CMS) to provide dental services to Medicaid-eligible adults ages 21 and older who are not already eligible for dental services.

The Family Planning Services amendment seeks authority from CMS to provide family planning services to a specific population that is otherwise ineligible for Medicaid.

The Chronic Conditions Support amendment seeks authority from CMS to provide additional Medicaid services to individuals in rural areas of the state with qualified chronic health conditions.

Public Hearings:
The Department will conduct two public hearings to discuss the demonstration amendments. The dates and times are listed below. Both public hearings will be held via video and teleconferencing.

Thursday, June 15, 2023, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting

Video Conference: Google Meet Meeting meet.google.com/ppd-afmv-vnw

Or join by phone: (US) +1 401-552-4511 PIN: 955 386 753 #
Monday, June 26, 2023, from 4:00 pm to 5:00 pm.
Video Conference: Google Meet Meeting meet.google.com/vvm-yxkz-eah
Or join by phone: (US) +1 650-466-0974 PIN: 714 775 327 #

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by June 9, 2023, at 5:00 p.m.

Public Comment:
A copy of the public notice and proposed amendments are available online at:
https://medicaid.utah.gov/1115-waiver/
The public may comment on the proposed amendment requests during the public comment period from June 7, 2023, through July 7, 2023.
Comments may be submitted using the following methods:
Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

Notice of Special Accommodations (ADA):

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Jennifer Meyer-Smart at 1 (801)-538-6241.

Notice of Electronic or Telephone Participation:

Video Conference: Google Meet Meeting meet.google.com/ppd-afmv-vnw Or join by phone: (US) +1 401-552-4511 PIN: 955 386 753 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone

(801)538-6241

Notice Posting Details

Notice Posted On:

June 02, 2023 10:20 AM

Notice Last Edited On:

June 02, 2023 10:42 AM

Deadline Date:

July 7, 2023 11:59 PM

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Give Feedback

Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Public Hearing on Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services

Public Body:

Medicaid Expansion Workgroup

Notice Information

Add Notice to Calendar

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Public Hearing on Medicaid Reform 1115 Demonstration

Notice Subject(s)

Medicaid , Health Care

Notice Type(s):

Hearing

Give Feedback

Event Start Date & Time

June 26, 2023 04:00 PM

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June 26, 2023 05:00 PM

Event Deadline Date & Time:

07/07/23 11:59 PM

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Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

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Meeting Information

Meeting Location

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone

(801)538-6241

Notice Posting Details

Notice Posted On:

June 02, 2023 10:36 AM

Notice Last Edited On:

June 02, 2023 10:36 AM

Deadline Date:

July 7, 2023 11:59 PM

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cdevashrayee@utah.gov

ACCOUNT NUMBER
8405

ACCOUNT NAME
DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE
801-538-6641

ORDER #
SLT0023121

CUSTOMER REFERENCE NUMBER

CAPTION
Dental Services for Medicaid-eligible Adults, Family Planning Services, and Chronic Conditions Support Public Hearings The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss three amendments to Utah's Medicaid Reform 1115 Demonstration.

TOTAL COST
$224.60

Dental Services for Medicaid-eligible Adults, Family Planning Services, and Chronic Conditions Support Public Hearings

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- Or join by phone: (US) +1 401-552-4511 PIN: 955 386 753#
- **Monday, June 26, 2023**, from 4:00 pm to 5:00 pm.
- Video Conference: Google Meet Meeting meet.google.com/vvm-yauz-eah
- Or join by phone: (US) +1 650-466-09748 PIN: 714 775 327#

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Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0023121

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF Dental Services for Medicaid-eligible Adults, Family Planning Services, and Chronic Conditions Support Public Hearings The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss three amendments to Utah's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 06/04/2023

DATE 06/20/2023

SIGNATURE Jordyn gallegos

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 20th DAY OF JUNE IN THE YEAR 2023

BY Jordyn Gallegos

LAREE WHITMER
NOTARY PUBLIC-STATE OF UTAH
COMMISSION# 715683
COMM. EXP. 12-09-2024

LaRee Whitmer
NOTARY PUBLIC SIGNATURE

Attachment 3

Medical Care Advisory Committee

Public Hearing

Utah Department of Health & Human Services
Integrated Healthcare

Medical Care Advisory Committee Agenda

Meeting: Medical Care Advisory Committee
Date: June 15, 2023
Start Time: 2:00 p.m.
End Time: 4:00 p.m.
Location: https://meet.google.com/ppd-afmv-vnw (Google Chrome)
By Phone: 1-401-552-4511 PIN: 955 386 753#

Agenda Items

1.	Welcome
	• Approve Minutes for May 2023*
	• Requesting Nominations for 2 Appointments
	  ○ Consumer Representative for Beneficiaries
	  ○ Consumer Representative for Native American Communities
		Jennifer Marchant	2:00 / 5 min

2.	Committee Discussion and Vote on FY2025 Budget Recommendations	Jennifer Marchant & Committee Members	2:05 / 10 min
3.	Public Hearing for 1115 Demonstration Waiver Amendments • SB19: Dental Services for Medicaid-eligible Adults • SB133: Family Planning Services • SB269: Chronic Conditions Support	Laura Belgique	2:15 / 15 min
4.	Director's Report • PRISM Update • Two New CMS Proposed Rules	Jennifer Strohecker	2:30 / 20 min
5.	Unwinding Continuous Medicaid Eligibility Update**	Jeff Nelson	2:50 / 15 min
6.	UTA Pass Utilization	Brian Roach	3:05 / 15 min
7.	Committee Updates	Committee Members	3:20 / 5 min
8.	Voting Results for Priority Budget Recommendations	Sharon Steigerwalt	

* Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)
** Informational handout in the packet sent to committee members
***In accordance with the Open and Public Meetings Act Utah Code 52-4-207, the Chair of the MCAC committee has determined providing an anchor location for the MCAC meeting presents substantial risk to the health and safety of the attendees due to the COVID-19 pandemic. The MCAC meeting will be conducted remotely via electronic means only. The committee members and the public may attend via Google Meet or by calling in to the Google Meet session as listed on the meeting agenda. MCAC meetings will be held in an electronic format until further notice.

Next Meeting: July 20, 2023, from 2:00 p.m. – 4:00 p.m.
Please send meeting topics or other correspondence to Sharon Steigerwalt (ssteigerwalt@utah.gov)

Attachment 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

06/09/2023
8:30 AM – 11:00 AM
Utah Department of Health & Human Services
195 N 1950 W, Salt Lake City, UT 84116
Multi-State Agency Building (MASOB) Room 2082
(385) 227-2078
Google Meeting Format Web Link:
https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
Call In: 1-414-909-6377
PIN: 211 599 534#

Meeting called by:	UIHAB
Type of meeting:	Monthly UIHAB
Note taker:	Dorrie Reese
Please Review:	Medicaid Rules & SPA document(s), additional materials via presenters.

	Agenda topic	
8:30 AM	**UIHAB Meeting** Welcome & Introductions	Ed Napia, Chairperson
8:40 AM	**Committee Updates & Discussion** • **UT Medicaid Eligibility Policy** • **Medicaid & CHIP State Plan Amendments (SPA) & Rules** • **CHIP SPA**	Michelle Smith, Medicaid, Asst. Dir. BMEP Craig Devashrayee, Medicaid, BMEP Jenifer Wiser, Dental & CHIP Prg. Mgr
	• **DWS Medicaid Eligibility Operations** • **SNAP** • **MCAC Committee** • **CHIP Advisory Committee**	Jessica Ware, AI/AN Elig. Spec., DWS Paul Birkbeck, Snap Program Specialist Mike Jensen, UNHS Courtney Muir, NWBSN
	ICWA Liaison Tribal Health Liaison • **Data Reporting Updates** • **Program /Contracts/Grant Updates** • **UT DHHS OAIANHFS Program Updates** Opioids & Tobacco Health Equity	Jamie Harvey, IHFS Jeremy Taylor, IHFS Alex Merrill, IHFS Jeremy Taylor, IHFS Hilary Makris, IHFS Kassie John, IHFS
09:45 AM	**Medicaid 1115 Demonstration Amendments**	Laura Belgique, 1115 Demo. Pgr. Manager
10:15 AM	**Project Firstline Outreach (UDHHS)**	James Morales, Epidemiologist UDHHS Population Health
10:30 AM	**AUCH Presentation**	Melissa Zito, AUCH Tribal Liaison
10:50 AM	**I/T/U updates**	I/T/U
11:30 AM	**Other Business** **ADJOURN** ***Next Mtg. August 11, 2023***	

28

Utah Indian Health Advisory Board
Tribal Leadership Reporting Tool

DATE: _____

State Agency Updates & Discussions:

Medicaid State Plan Amendments (SPA) & Rules (see Matrices)

DWS Medicaid Eligibility

MCAC & CHIP Advisory Committees

Federal/State Policy Impacting I/T/U
- ICWA Liaison
- AI/AN Health Liaison

Data Updates

IHFS Program Updates
- Opioid/Tobacco
- Health Equity Grants

Agenda Item Updates

Medicaid: I/T/U Claims Submission Updates

Healthy Environments Active Living Program

I/T/U Updates: NWBSN, SJSP & SVBG

Section 105 (l) Leasing; IHS & BIA Facilities

UIHAB Meeting

June 9, 2023 (via phone)
8:30 a.m. – 11:00 a.m.

Participants: (via phone)

Hunter Timbimboo, *Northwestern Band of Shoshone Nation*
George Gover, *Northwestern band of Shoshone Nation*
Tyler Goddard, *Paiute Indian Tribe of Utah*
Ed Napa (Chair), *Skull Valley Band of Goshute*
Selwyn Whiteskunk, *Ute Mtn Ute*
Thomas Stephenson, *Ute Mtn Ute*
Mike Jensen, *Utah Navajo Health Systems*
Marquis Yazzie, *Navajo Area- IHS*
Hope Johnson, *PHX, IHS*
Tina Valencia, *PHX, IHS*

Guests:

Jessica Ware, *AI/AN Eligibility Specialist, DWS*
Paul Birkbeck, *SNAP Program Specialist, DWS*
Melissa Zito, *Tribal Liaison, AUCH*
Alan Pruhns, *AUCH*
Cyndi Gillaspie, *Technical Director, CMS*

DHHS Staff:

Michelle Smith, *Assistant Office Director, Office of Eligibility Policy, DHHS*
Craig Devashrayee, *Office of Eligibility Policy, DHHS*
Jennifer Wiser, *Office of Managed Healthcare, DHHS*
Laura Belgique, *Office of Eligibility Policy, DHHS*
Suzanne Puckett, *Health Policy & Authorization, DHHS*
Kirk Poulsen *Health Policy & Authorization, DHHS*
Justin Morales, *Office of Population Health, DHHS*
Sarah Rigby, *Office of Population Health, DHHS*
Jamie Harvey, *ICWA Liaison, Office of AI/AN Health Affairs, DHHS*
Jeremy Taylor, *Tribal Health Liaison, Office of AI/AN Health Affairs, DHHS*
Hilary Makris, *Opioid & Tobacco Health Program Coordinator, Office of AI/AN Health Affairs, DHHS*
Alex Merrill, *EPI, Office of AI/AN Health Affairs, DHHS*
Kassie John, *Health Equity Program Coordinator, Office of AI/AN Health Affairs, DHHS*
Dorrie Reese, *Recorder/Minutes, DIH Administrative Assistant, DHHS*

Welcome and Introductions:

UIHAB Chairperson welcomed everyone starting the meeting at 8:30 a.m.

Approval of Minutes:

The Oct 11, 2019, Nov 152019, Dec 13,2019, Jan 10, 2020, Mar 13,2020, Apr 10, 2020, May 8, 2020, Jun 12, 2020, Aug, 14, 2020, Sep 11, 2020, Oct 9, 2020, Nov 13, 2020, Dec 11, 2020, Jan 8, 2021, Feb 11, 2021, Feb 12, 2021, Mar 12, 2021, Apr 9, 2021, May 14, 2021, Jun 11, 2021, Aug 13, 2021, Sep 10, 2021, Oct 8, 2021, Nov 12, 2021, Dec 10, 2021, Jan 28, 2022, Mar 11, 2022, Apr 8, 2022, May 13, 2022, Jun 10, 2022, Aug 12, 2022, Sep 9, 2022, Oct 14, 2022, Nov 10, 2022, Dec 9, 2022, Jan 13, 2023, Feb 10, 2023, Mar 10, 2023, Apr 14, 2023, and May 12, 2023 UIHAB minutes will be approved at a later UIHAB meeting.

Medicaid Eligibility Policy:

Michelle Smith gave an update on PHE Unwinding- Ended: May 11, 2023
https://jobs.utah.gov/mycase-app/ui/home
https://medicaid.utah.gov/unwinding/

Medicaid & CHIP State Plan Amendments (SPA) & Rules:

Craig Devashrayee gave an update.

The documents which were presented are embedded in this document.

SPA MATRIX 6-9-23-1.pdf

UIHAB MATRIX 6-9-23.pdf

Dental SPA:

Jennifer Wiser gave an update.

The documents which were presented are embedded in this document.

SB19_ Adult Dental Public Hearing Overvi

SB19 Adult Dental Amendment FINAL.pd

DWS Medicaid Eligibility:

Jessica Ware gave an update on DWS Medicaid Eligibility Unwinding. Paul Birkbeck gave update on SNAP.

Ozzy Escarate:

Ozzy Escarate gave an update in the Office of AI/AN Health Affairs

Data Reporting:

Alex Merrill gave an update on data reporting.

2023 AI-AN Health Status Report_Jun 9 2

DHHS OAIANHFS Program Updates:

Kassie John gave an update on Health Equity.
kassiejohn@utah.gov

IHFS Health Equity Updates _ UIHAB June

Hilary Makris gave an update on Opioids and Tobacco.
hmakris@utah.gov

Jamie Harvie:

Jamie Harvie gave an update on ICWA.

Medicaid 1115 Demonstration Amendments:

Laura Belgique discussed Medicaid 1115 Demonstration Amendment.

The documents which were presented are embedded in this document.

SB 133_ Family Planning Public Hearir

SB 133 Family Planning Services Am

SB269 Chronic Conditions Support Pi

SB269_ Chronic Conditions Support A

Motion:

The Utah Indian Health Advisory Board made the motion to support these amendments.
Representatives: SKBG, UNHS, PITU, and Ute Mtn Ute Tribe.

Project Firstline Outreach:

Justin Morales gave an update.

The document which was presented is embedded in this document.

UIHAB Presentation Project Firstline.pdf

AUCH Presentation:

Melissa Zito gave an update.

The documents which were presented are embedded in this document.

AUCH Affiliate Handbook 2023-24.pı

UIHAB Ex Summary AUCH.pdf

I/T/U Updates:

Ed Napia: Skull Valley Band of Goshute
Tyler Goddard: Paiute Indian Tribe of Utah
Hunter Timbimboo: Northwestern Band of Shoshone Nation
Mike Jensen: Utah Navajo Health Systems
Thomas Stephenson: Ute Mountain Ute Tribe
Selwyn Whiteskunk: Ute Mountain Ute Tribe
Hope Johnson: PHX, IHS

Adjourn:

The meeting ended at 10:50. Tyler Goddard made that motion to adjourn the meeting. Hunter Timbimboo seconded that motion. The next meeting: August 11, 2023 @ 8:30 a.m. (Hybrid)

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

NATE CHECKETTS
Deputy Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

November 25, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Brooks-LaSure:

I am pleased to submit an amendment to the State of Utah's Special Terms and Conditions for the Medicaid Reform 1115 Demonstration. Approval of this amendment will allow the state to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to Medicaid enrollees who are members of an American Indian or Alaskan Native (AI/AN) tribe

The State of Utah appreciates your consideration of this amendment request. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Reform 1115 Demonstration.

Respectfully,

Jennifer Strohecker (Nov 22, 2024 10:31 MST)
Jennifer Strohecker
Director, Division of Integrated Healthcare

Cannon Bldg.: 288 North 1460 West, Salt Lake City, Utah 84116
telephone: (801) 538-6689| web: medicaid.utah.gov/

Utah's Medicaid Reform 1115 Demonstration

Amendment Request

NATIVE AMERICAN HEALTH AMENDMENTS

Demonstration Project No. **11-W-00145/8**
21-W-00054/8

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State of Utah

Section 1115 Demonstration Amendment

Native American Health Amendments

Section I. Program Description

During the 2024 General Session of the Utah State Legislature, Senate Bill 181 "Native American Health Amendments" was passed and signed into law. This legislation directs the Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH), to seek 1115 Demonstration approval from the Centers for Medicare and Medicaid Services (CMS), to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to Medicaid enrollees who are members of an American Indian or Alaskan Native (AI/AN) tribe.

Background

The World Health Organization defines traditional healing as the sum of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, used in the maintenance of health and the prevention, diagnosis, improvement or treatment of physical and mental illness[4]. Traditional healing embodies a holistic approach and considers health as the sum of a person's physical, spiritual, emotional and intellectual well-being[5]. Traditional healing services are a fundamental element of AI/AN health that helps individuals achieve wellness and healing for a specific physical or mental ailment or affliction and restores emotional balance. Traditional healing services have been a part of the AI/AN traditions of the eight tribal nations that reside in the state of Utah.

The Indian Health Care Improvement Act (U.S.Code Title 25 Chapter 18) contains several sections noting the acceptance and respect for these services and specifically incorporating them into various preventative service categories, including behavioral health services and treatment. In addition, federal officials have called for Medicaid to improve its ability to provide culturally competent services to AI/AN beneficiaries and many Tribes have incorporated traditional healing services into their health care delivery. While Congress

[4] World Health Organization. *Traditional Medicine.* https://www.who.int/news-room/questions-and-answers/item/traditional-medicine. Published August 2023. Accessed August 28, 2024.

[5] Li R. Indigenous identity and traditional medicine: Pharmacy at the crossroads. Can Pharm J (Ott). 2017 Aug 10;150(5):279-281. doi: 10.1177/1715163517725020. PMID: 28894496; PMCID: PMC5582679.

granted the Indian Health Service the ability to bill Medicaid, traditional healing services are not currently a Medicaid covered service[6]. The incorporation of a Medicaid traditional healing services benefit will further enhance delivery of culturally appropriate AI/AN health care.

Goals and Objectives

The primary objective of the Native American Health Amendment is to provide culturally appropriate options for AI/AN members to maintain and sustain health and wellness through traditional healing services made available at, in, or as part of services offered by qualified entities as defined in Section IV that provide or arrange traditional healing services. By providing these services in a complimentary fashion with physician-led healthcare teams and other licensed professionals, members can achieve wellness and healing for specific physical, mental, holistic and emotional ailments or afflictions, and restore emotional balance and one's relationship to the environment, and aid care coordination.
Specific goals include:

- Provide culturally appropriate options for AI/AN members to maintain and sustain physical, mental, holistic and emotional health and wellness through traditional healing services.
- Provide an integrated service delivery by combining Western medicine with traditional healing services.
- Incorporate traditional healing services into various preventative service categories including behavioral health services and treatment.

Operation and Proposed Timeline

The Demonstration will operate statewide. The State intends to implement the proposed benefit within 90 days of approval. The State requests to operate the Demonstration through the end of the current approval period, which is June 30, 2027.

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will develop a plan for evaluating the hypotheses indicated below. These hypotheses will be analyzed for the overall demonstration population as well as key subpopulations (e.g., by sex, age, race and ethnicity, primary language, disability status, and geography). The State will identify validated performance measures that adequately assess the impact of the Demonstration on these populations. The State will submit the evaluation plan to CMS for approval.

---

[6] American Medical Association. *Report on the Council on Medical Services.* https://www.ama-assn.org/system/files/a24-cms03.pdf. Published 2024. Accessed August 21, 2024.

The State will conduct ongoing monitoring of this demonstration and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The following hypotheses will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
Participants will have increased access to culturally appropriate services, including traditional healing services.	Participants will have increased utilization of traditional healing.	Administrative claims data.	The independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons.

Section II. Demonstration Eligibility

Individuals eligible under this demonstration must be Medicaid eligible individuals who are members of an AI/AN tribe. Acceptable documents to verify AI/AN tribe members include:

- Tribal Identification/Enrollment Card with number/tribal census document issued by a federally recognized tribe indicating the individual's affiliation with the tribe.
- Certificate of Degree of Indian or Alaska Native Blood (CDIB) signed by the Bureau of Indian Affairs (BIA), or another document from BIA recognizing the person as American Indian/Alaskan Native.
- Tribal court documents containing identifying information such as name and the date of birth.
- Indian Health Services (IHS) document indicating the individual is eligible for IHS services as an American Indian/Alaskan Native. (Such documents must have identifying information about the individual. IE, name and date of birth.)

AI/AN Descendent

- Documents of ascendent (parent or grandparent) that verifies status as member of federally recognized AI/AN tribe.
- Provider document: Birth certificate, tribal court document or IHS fact sheet showing lineal descent from ascendant to descendant.

Projected Enrollment

The projected enrollment for individuals in this demonstration population is 3,300.

Section III. Demonstration Benefits and Cost Sharing Requirements

Eligible individuals will receive culturally appropriate healing methods for physical, mental, holistic and emotional healing. Traditional healing services must be included in the member's care plan in order to be deemed medically necessary.

AI/AN individuals enrolled in the Demonstration are subject to cost sharing exemptions of section 5006 of the American Recovery Reinvestment Act of 2009, and are not required to pay premiums or cost sharing for services received through the Indian health care system.

Section IV. Delivery System

Services for Demonstration individuals will be reimbursed through fee for service. Traditional healing services must be part of a comprehensive plan of health care that includes specific individualized goals. The covered traditional services, limitations, and exclusions shall be described by a Qualified Entity (working with each tribe they primarily serve) seeking to participate in this program. A Qualified Entity means any of the following:

- an Indian Health Service facility;
- a tribal health program designated under the Indian Self-Determination and Education assistance Act, Pub. L. No. 93-638;
- an Urban Indian organization as defined in 25 U.S.C. Sect. 1603; or
- a facility operated by a person that contracts with an Urban Indian organization.

It is recognized that the training and qualifications of traditional healing providers may vary widely depending on the tribe. For this reason, the array of services provided by traditional healers shall be in accordance with an individual tribe's established and accepted traditional healing services as identified by the Qualifying Entity. A facility or clinic governing body may serve as the Qualifying Entity or the tribe(s) served by the facility may choose to designate another governing body as its Qualifying Entity to define what constitutes as a traditional healing service. In addition, the Qualifying Entity will be responsible for identifying the type of practitioner, including educational or cultural requirements traditional healing providers must possess.

Section V. Implementation and Enrollment in Demonstration

Eligible individuals will be enrolled in the Demonstration as of the implementation date of this amendment. The state intends to implement the coverage as soon as possible after approval.

Section VI. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality- Attachment 1 for the state's historical and projected expenditures for the requested period of the Demonstration.
Below is the projected enrollment for eligible adults in this demonstration and expenditures for each remaining demonstration year.

	DY22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)
Enrollment	3,300	3,300	3,300	3,300
Expenditures	$7,664,300	$7,664,300	$7,664,300	$7,664,300

Section VII. Proposed Waiver and Expenditure Authority

The State requests the following proposed waivers and expenditure authority to operate the Demonstration.

Waiver and Expenditure Authority	Reason and Use of Waiver
Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)	To the extent necessary to enable the State to reimburse for traditional healing services for AI/AN members provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program.
Expenditure authority for services not covered under Section 1905 of the Social Security Act	To the extent necessary to enable the State to claim FFP for the cost of traditional healing services provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program and receive 100 percent FMAP.

Expenditure Authority

The State is seeking waiver authority to reimburse traditional healing services provided in, at, or as part of services offered by Qualified Entities. The State is seeking to claim FFP for these services when provided by Qualified Entities at the 100 percent Federal Medical Assistance Percentage (FMAP) pursuant to Sections 1903(a)(1) and 1905(b) of the Act. When delivered by an Indian Health Service facility or a tribal health program, reimbursement will

be equivalent to the All-Inclusive Rate. Otherwise, it will be a rate developed using a prospective payment system (PPS).

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing was advertised in the newspaper of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public notice was posted to the State's Medicaid website at https://medicaid.utah.gov/1115-waiver.

Two public hearings to take public comment on this request were held. The first public hearing was held on October 17, 2024, from 2:00 to 4:00 pm during the Medical Care Advisory Committee (MCAC) meeting. The second public hearing was held on October 21, 2024, from 4:00 to 5:00 pm. Both public hearings were held via video and teleconferencing.

Public Comment

The public comment period was held October 9, 2024, through November 9, 2024. The original dates for the public comment period were October 9, 2024 through November 8, 2024. Due to technical difficulties, the 30 day public comment period was extended through November 9, 2024. Other than through UIHAB and Tribal Consultation, no comments were received.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the DHHS Intergovernmental Policy 01.19 Formal DHHS Tribal Consultation and Urban Indian Organization Conferment Process Policy , the state ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. DIH notified the DHHS Tribal Health Liaison of the waiver amendment. As a result of this notification, DIH began to engage in the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on September 13, 2024 to present this demonstration amendment. During this meeting, the following comment and response was made:

Reimbursement vs. providing services

One commenter was concerned with the language in the amendment draft specific to providing services not being in alignment with the language in the Senate bill. The

commenter explained that the services are to be provided by the Tribes who would then receive reimbursement and that this was not clear in the amendment.

Response: The State explained the language could be revised to clarify that services will be provided by the Tribes and then reimbursed by Medicaid. The State subsequently changed the language to align with the commenter's suggestions.

During the November 8, 2024 UIHAB meeting, the State presented the Tribal Consultation discussion and response items outlined in the table below. No comments or feedback were received.

In accordance with CMS requirements and Utah's Tribal Consultation and Urban Indian Organization Conferment Process Policy, a Dear Tribal Letter, which included an invitation for consultation, was distributed on September 23, 2024 to all of Utah's Eight Federally Recognized Tribes and UIO. The 1115 Medicaid Waiver Tribal Consultation occurred via a hybrid in-person and videoconference on October 8, 2024. Attendees included Federally Recognized Tribes, Indian Health Service partners and Urban Indian Organization.

At Tribal Consultation, DHHS reviewed the amendment draft. DHHS provided an opportunity for Tribes to ask any questions they had about any aspect of the Waiver amendment application, which had been sent out to the Tribes with the Dear Tribal Leader Letter in advance.

Summary of discussion and response:

Discussion	Response
<u>Definition of Qualified Entities:</u> The Tribes recommend adding other non-tribal facilities and clinics to the list of qualified entities. The Tribes also requested clarification on what constitutes an Urban Indian "organization."	The Senate Bill 181 language is specific to prohibiting non-tribal facilities and clinics as qualified entities under this Demonstration. Therefore, no changes can be made. The language also includes the "organization" description and can therefore cannot be changed.
<u>Adding midlevel, licensed providers to those who can administer services:</u>	The State agreed and will add "other licensed professionals" in the amendment

The Tribes explained that not all services are led through physicians. Other licensed professionals provide services as well and should be included in the description of who can provide services under this Demonstration.	description of who can be part of the healthcare team.
<u>Adding "spiritual" as a component of health and wellness needs:</u> In addition to physical, mental and emotional, the Tribes explained the spiritual component of healing is very important and needs to be added as a health and wellness element throughout the amendment application.	The State appreciates the suggestion and has decided to use "holistic" as an alternate word.
<u>Concerns with administering a Health Satisfaction Survey as an evaluation method:</u> The Tribes expressed concern with the invasiveness of administering a health satisfaction survey to members who receive services and suggested finding alternate methods to evaluate the effectiveness of the Demonstration. The Tribes emphasized the importance of data sovereignty and their concerns with who is going to use and distribute the data. They also expressed the importance of providing the evaluator the background necessary to understand and respect the AI/AN members.	The State proposed aligning the proposed evaluation method with New Mexico's simple hypothesis which involves using administrative claims data as opposed to a survey. The State therefore revised the survey description in the evaluation section of the amendment. The State indicated they will continue to consult with the Tribes on the evaluation methods as they are developed.
<u>Adding additional detail to eligibility criteria:</u> The Tribes expressed the need to add detail to the description of what	The State added Medicaid policy's list of acceptable eligibility documents to the amendment application.

documents can be used to verify who is a member of an AI/AN tribe.	
<u>Projected Enrollment number</u> The Tribes asked what methodology was used to come up with a projected enrollment number.	The State explained the methodology and that this number is a projection and not a cap.
<u>Delivery System:</u> The Tribes inquired on what billing codes will be used in the delivery system.	The State indicated they will consult with the Tribes when developing billing codes and that this will take place after the Demonstration has been approved.
<u>Referral Process</u> The Tribes inquired on how the referral process will work. For example, will the State require a referral by a physician or other licensed healthcare practitioner before reimbursing for traditional healing?	The State indicated they will consult with the Tribes when developing any necessary referral processes and that this will take place after the Demonstration has been approved. The State also explained that the state does not intend to restrict referral pathways to a certain way, nor will they limit services.
<u>Expenditure Authority</u> The Tribes asked if recent expenditure authority policy will change the reimbursement rate.	The State explained that the existing reimbursement methodology for IHS, Tribal 638, and Urban Indian facilities will continue and that the current rates would only change if there are changes to federal regulation.
<u>Overall comment: Federal Involvement in Traditional Healing:</u> The Tribes expressed their concerns with allowing the government to have involvement in their traditional healing practices. They must ensure they can always provide the support needed to heal their people in traditional ways. This is an expensive process and they need Medicaid involvement in order to continue their practices and support necessary resources. They feel they should never have to open their doors to do this but understand the reasoning and are willing to partner with the government in order to protect and move forward. However, doing it in a respectful way is critical. The patient and their perspective is always highly considered and this will be a critical component of the Demonstration. Traditional healing would have never been discussed in the past due to previous restrictions and regulations but it is important to now discuss and can utilize	

the 1115 Waiver to help with these discussions. Traditional healing is a way of life and how they have been able to remain healthy.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

Name and Title: Jennifer Strohecker, Medicaid Director, Division of Integrated Healthcare
Telephone Number: (801) 538-6689
Email Address: jstrohecker@utah.gov

Attachment 1

Compliance with Budget Neutrality Requirements

Waiver Year	DY21	DY22	DY23	DY24	DY25
With Waiver	0	0	$7,664,300	$7,664,300	$7,664,300
Without Waiver	0	0	$7,664,300	$7,664,300	$7,664,300

Attachment 2

Public Notice Requirements

Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Amendment to Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

Amendment to Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Meeting

Event Start Date & Time:

October 17, 2024 02:00 PM

Event End Date & Time:

October 17, 2024 04:00 PM

Event Deadline Date & Time:

10/17/24 04:00 PM

Description/Agenda:

Native American Health Amendments Public Hearing

The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss an amendment to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the amendment online, by email, or mail during the public comment period from October 9, 2024, through November 8, 2024.

Utah Medicaid is requesting authority from the Centers for Medicare and Medicaid Services to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to Medicaid enrollees who are members of an American Indian or Alaskan Native tribe.

Give Feedback

Public Hearings:

The Department will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below. Both public hearings will be held via video and teleconferencing.

Thursday, October 17, 2024, from 2:00 to 4:00 pm, during the Medical Care Advisory Committee (MCAC) meeting.
Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #
Monday, October 21, 2024, from 4:00 pm to 5:00 pm.
Video Conference: Google Meet Meeting meet.google.com/hen-avwv-ove
Or join by phone: (US) +1 323-920-8881 PIN: 503 950 427 #

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by October 10, 2024.

Public Comment:

A copy of the public notice and proposed amendment is available online at: https://medicaid.utah.gov/1115-waiver/

The public may comment on the proposed amendment request during the public comment period from October 9, 2024, through November 8, 2024.

Comments may be submitted using the following methods:

Online: https://medicaid.utah.gov/1115-waiver/

Email: Medicaid1115waiver@utah.gov

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

Notice of Special Accommodations (ADA):

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Laura Belgique at 1 (801) 538-6241.

Notice of Electronic or Telephone Participation:

Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
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Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

October 02, 2024 11:44 AM

Notice Last Edited On:

October 02, 2024 12:03 PM

Deadline Date:

October 17, 2024 04:00 PM

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Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Amendment to Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

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Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Meeting, Hearing

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October 21, 2024 04:00 PM

Event End Date & Time:

October 21, 2024 05:00 PM

Event Deadline Date & Time:

10/21/24 05:00 PM

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Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

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Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

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October 02, 2024 11:54 AM

Notice Last Edited On:

October 02, 2024 12:34 PM

Deadline Date:

October 21, 2024 05:00 PM

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CRAIG DEVASHRAYEE
PO BOX 143102
SALT LAKE CITY, UT 84114
cdevashrayee@utah.gov

ACCOUNT NUMBER

8405

ACCOUNT NAME

DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE

801-538-6641

ORDER #

SLT0029691

CUSTOMER REFERENCE NUMBER

CAPTION

Native American Health Amendments Public Hearing
The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss an amendment to Utah's Medicaid Reform 1115 Demonstration.

TOTAL COST

$195.80

Native American Health Amendments Public Hearing

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- Video Conference: Google Meet Meeting **meet.google.com/hen-nvwy-ove**
- Or join by phone: (US) +1 323-920-8881 PIN: ┌ 503 950 427#

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at **lbelgique@utah.gov** or 1 (801) 538-6241 by October 10, 2024.

Public Comment:

A copy of the public notice and proposed amendment is available online at: **https://medicaid.utah.gov/1115-waiver/**

The public may comment on the proposed amendment request during the public comment period from October 9, 2024, through November 8, 2024.

Comments may be submitted using the following methods:

Online: **https://medicaid.utah.gov/1115-waiver/**

Email: **Medicaid1115waiver@utah.gov**

Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0029691

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF Native American Health Amendments Public Hearing The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss an amendment to Utah's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 10/06/2024

DATE 10/11/2024

SIGNATURE

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 11th DAY OF OCTOBER IN THE YEAR 2024

BY Doug Ryle

NOTARY PUBLIC SIGNATURE

Attachment 3

Medical Care Advisory Committee

Public Hearing

Utah Department of Health & Human Services
Integrated Healthcare

Medical Care Advisory Committee Agenda

Meeting: Medical Care Advisory Committee
Date: October 17, 2024
Start Time: 2:00 p.m.
End Time: 4:00 p.m.
Location: meet.google.com/ieq-jggb-pec Google Chrome)
By Phone: 1-513-818-1049 PIN# 510 813 429#

Agenda Items

1.	Welcome • Approve Minutes for September 2024* • Thank you, Dr. Baird, for your service to the MCAC • Welcome Dr. Scott Folkman, dental community • Welcome Joey Ulrich, business community • Accepting nominations for Local Health Departments representative	Rachel Craig	2:00 / 10 min
2.	Public Hearing: 1115 Waiver Amendment for SB 181 Native American Health Amendments	Laura Belgique	2:10 / 10 min
3.	MAC and BAC discussion for the changes to the bylaws • Vote to adopt will occur in the November meeting • Accepting nominations for the BAC	Rachel Craig	2:20 / 10 min
4.	EPSDT Overview of CMS Requirements	Jim Stamos	2:30 / 10 min
5.	Notices Workgroup Quarterly Report	Workgroup Member	2:40 / 15 min
6.	Eligibility and Enrollment Update	Michelle Smith	2:55 / 10 min
7.	Media Campaign	Kolbi Young	3:05 / 10 min
8.	Post-unwinding data analysis and strategy	Brian Roach	3:15 / 15 min
9.	Director's Report • Upcoming policy changes	Jennifer Strohecker	3:30 / 20 min
10.	Committee Member Updates	Committee Members	3:50 / 5 min

* Action Item - MCAC Members must be present to vote (substitutes are not allowed to vote)

Next Meeting: November 21, 2024, from 2:00 p.m. – 4:00 p.m.

Please send meeting topics or other correspondence to Sharon Steigerwalt (ssteigerwalt@utah.gov)

Attachment 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

UIHAB - September 09/13/2024 8:30 AM –11:00 AM	**Join via Google Meeting:** https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
In person: 195 N 1950 W, Salt Lake City, UT 84116. Multi-State Agency Building **Room 2082** DHHS side (385) 227-2078	**Join via Phone:** 1-(414)-909-6377 PIN: 211 599 534

Agenda

Time	Topic	Presenter
8:30 am	Welcome and Introductions Roll Call	Shawn Begay, Chairperson
8:45 am	**Committee Updates**	
	UT Medicaid Eligibility Policy	Michelle Smith (DHHS)
	Medicaid and CHIP State Plan Amendments	Craig Devashrayee (DHHS)
	DWS Medicaid Eligibility Operations	Jessica Ware (DWS)
	SNAP	Frank Vega (DWS)
	MCAC Committee	Michael Jensen (UNHS)
	CHIP Advisory Committee	TBD
9:30 am	**Office of AI/AN Health and Family Services Updates**	
	Data Reporting Updates	Alex Merrill (IHFS)
	Program Manager Updates	Hilary Makris (IHFS)
	IHFS Opioids and Tobacco	Kassie John (IHFS)
	ICWA Liaison	Jamie Harvey (IHFS)
	Tribal Health Liaison	Jeremy Taylor (IHFS)

Time	Topic	Presenter
10:00 am	Traditional Health Waiver	Laura Belgique, DHHS Brian Roach, DHHS
10:30 am	November full scale exercise - Earthquake	Mindy Colling, DHHS
10:45am	AUCH - Partner Spotlight	Melissa Zito, AUCH
11:00 am	I/T/U Updates	I/T/U partners
11:25 am	Other Business	All
11:30 am	Adjourn	

Next UIHAB Meeting will be October 11, 2024

Hosted by:
Urban Indian Center of Salt Lake
120 W 1300 S St, Salt Lake City, UT 84115

Facilitated by: Utah Department of Health and Human Services Office of AI/AN Health & Family Services
Note Taker: Dorrie Reese (All meetings are recorded)

Utah Indian Health Advisory Board (UIHAB) Meeting

11/08/2024 8:30 AM –11:00 AM	**Join via Google Meeting:** https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
In person: 195 N 1950 W, Salt Lake City, UT 84116. Multi-State Agency Building **Room 2082** DHHS side (385) 227-2078	**Join via Phone:** 1-(414)-909-6377 PIN: 211 599 534

Agenda

Time	Topic	Presenter
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8:45 am	**Committee Updates**	
	UT Medicaid Eligibility Policy	Michelle Smith (DHHS)
	Medicaid and CHIP State Plan Amendments	Craig Devashrayee (DHHS)
	DWS Medicaid Eligibility Operations	Jessica Ware (DWS)
	SNAP	Frank Vega (DWS)
	MCAC Committee	Michael Jensen (UNHS)
	CHIP Advisory Committee	TBD (Nomination)
9:30 am	**Office of AI/AN Health and Family Services Updates**	
	Data Reporting Updates	Alex Merrill (IHFS)
	IHFS Opioids and Tobacco	Hilary Makris (IHFS)
	Health Equity	Kassie John (IHFS)
	ICWA Liaison	Jamie Harvey (IHFS)
	Tribal Health Liaison/ Program Updates	Jeremy Taylor (IHFS)

Time	Topic	Presenter
10:00 am	Traditional Healing Waiver	Brian Roach (DHHS)
10:30 am	HAN (Health Alert Network)	Michelle Hale (DHHS)
10:45 am	I/T/U Updates	I/T/U partners
11:00 am	Other Business	All
	Adjourn	

Next UIHAB Meeting will be December 13, 2024

Hosted by:
Utah Department of Health and Human Services
195 N 1950 W, Salt Lake City, UT 84116
Multi-State Agency Building (MASOB)
(385) 227-2078

Facilitated by: Utah Department of Health and Human Services Office of AI/AN Health & Family Services
Note Taker: Dorrie Reese (All meetings are recorded)

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

June 30, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Oz:

I am pleased to submit two amendments to the State of Utah's Medicaid Reform 1115 Demonstration. With the first amendment, the State is requesting authority to provide wraparound Medicaid services for qualified individuals who have minimum essential healthcare coverage and have a disability. With the second amendment, the State is requesting approval to shift all Medicaid dental services for children under age 21 and pregnant/postpartum women from managed care to a fee for service (FFS) model in partnership with the University of Utah School of Dentistry (UUSOD) and their associated statewide provider network.

The State of Utah appreciates your consideration of these amendment requests. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Reform 1115 Demonstration.

Respectfully,

Jennifer Strohecker (Jun 27, 2025 12:26 MDT)

Jennifer Strohecker
Medicaid Director
Division of Integrated Healthcare

Utah Department of Health & Human Services

Utah's Medicaid Reform 1115 Demonstration

Amendment Request

Amendments: Disability Wraparound Coverage and Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

Demonstration Project No. **11-W-00145/8**
21-W-00054/8

Utah Department of Health & Human Services

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- Section III. Demonstration Benefits and Cost Sharing Requirements 4
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- Section V. Implementation and Enrollment in Demonstration 5
- Section VI. Demonstration Financing and Budget Neutrality 5
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State of Utah

Section 1115 Demonstration Amendment

Amendments: Disability Wraparound Coverage and Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

Section I. Program Descriptions and Objectives

Disability Wraparound Coverage

During the 2025 General Session of the Utah State Legislature, House Bill 310 "Disability Coverage Amendments" was passed and signed into law by Governor Cox. This legislation requires the Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) to seek 1115 Demonstration approval from the Centers for Medicare and Medicaid Services (CMS) to provide wraparound Medicaid services for qualified individuals who have minimum essential healthcare coverage and have a disability. These wraparound services would cover benefits available under Medicaid but not provided by the individual's minimum essential coverage. With this amendment, the State is requesting authority to provide these wraparound services.

Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

The State also seeks authority to transition the dental benefit delivery system for children and pregnant/postpartum women. Appropriations SB0002 item 138 "Shift Medicaid Dental All to University of Utah" was passed and signed into law by Governor Cox during the 2025 General Session of the Utah State Legislature. This legislation requires the Utah Department of Health and Human Services (DHHS), Division of Integrated Healthcare (DIH) to seek 1115 Demonstration approval from CMS to shift all Medicaid dental services for children under age 21 and pregnant/postpartum women from managed care to a fee for service (FFS) model in partnership with the University of Utah School of Dentistry (UUSOD) and their associated statewide provider network. The State is currently authorized to provide dental services to all Medicaid eligible adults who are 21 years of age or older. These benefits are reimbursed through FFS by the State to the University of Utah School of Dentistry and its associated statewide network of dental providers. Dental services for

children and pregnant/postpartum women are currently provided through dental managed care plans as authorized under a 1915 (b) amendment. With this amendment, the State is requesting authority to change the Medicaid dental benefit delivery system for children and pregnant/postpartum women.

The state would like to add these populations to the existing Dental Services Demonstration which was approved on January 8, 2025.

Goals and Objectives

Under Section 1115 of the Social Security Act, States may implement "experimental, pilot or demonstration projects which, in the judgment of the Secretary [of Health and Human Services] is likely to assist in promoting the objectives of [Medicaid]". The State believes the provisions requested in this proposal are likely to promote the following goals and objectives:

- Improve beneficiary health outcomes and quality of life;
- Provide continuity of coverage for individuals eligible under the demonstration;
- Improve access to services across the continuum of care;
- Improving oral health outcomes

This demonstration will allow the State to test the effectiveness of policy that is designed to improve health outcomes of demonstration individuals.

Operation and Proposed Timeline

These Demonstrations will operate statewide. The State requests to operate the Demonstrations through the end of the current approval period, which is June 30, 2027.

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will develop a plan for evaluating the hypotheses indicated below. The State will identify validated performance measures that adequately assess the impact of the demonstrations to beneficiaries. The State will submit the evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this demonstration, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
Disability Wraparound Coverage			
Beneficiaries will report improved satisfaction and access to services under the demonstration.	-Beneficiary satisfaction score -Reported access to care	Beneficiary survey	The independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons. The evaluation will include subpopulation comparisons to measure disparities.
Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration			
Individuals in the demonstration will have increased utilization of preventive dental care and decreased utilization of emergency dental services.	- Utilization of preventive dental services -Utilization of emergency dental services	Claims data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

Section II. Demonstration Eligibility:

Disability Wraparound Coverage
Individuals eligible under this demonstration must: • be disabled as described in 41 U.S.C. Sec. 1382c; • have been enrolled in Medicaid within the previous 12 months; • be enrolled in minimum essential healthcare coverage other than Medicaid; • not meet the income or asset requirements for enrollment in Medicaid; • have a household income that is between 250% and 800% of the federal poverty level (FPL); and

• meet the resource requirements. The State will follow the Medicaid Work Incentive program resource requirements outlined in the state plan, with the exception of the resource limit which, with approval of this waiver, will be a maximum of $125,000. Participation in the Disability Wraparound Coverage demonstration is subject to an enrollment cap based on available state funding. The State may close new enrollment in order to stay within state appropriations.
Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration
Individuals eligible under this demonstration must be pregnant women (including postpartum) or children enrolled in Medicaid.

Projected Enrollment

The projected enrollment for individuals in the Disability Wraparound Coverage demonstration population is 30.

The projected enrollment for individuals who are pregnant, in their postpartum period, or a child on Medicaid is approximately 200,000.

Section III. Demonstration Benefits and Cost Sharing Requirements

Disability Wraparound Coverage

Qualified individuals will receive wraparound services which include services covered by Medicaid but not covered by the individual's minimum essential healthcare coverage. Qualified individuals must share costs based on a sliding scale established by the State. The sliding scale will be based on income in relation to the FPL and will be used to determine the percentage of the cost of a wraparound service that a qualified individual is required to pay. Individuals with a household income greater than 400% of the FPL will be required to pay a minimum of 10% of the service costs, not to exceed $1,500 per month. Payments toward minimum essential healthcare coverage premiums will be counted toward meeting the individual's monthly cost-sharing responsibility. The State will establish income categories, cost sharing rules, and provide 12 months of continuous enrollment for members.

Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

There are no changes to the dental benefits provided to eligible individuals under this amendment. Individuals will continue to receive state plan dental benefits.

Cost sharing requirements will align with those provided under the state plan.

Section IV. Delivery System

Disability Wraparound Coverage

Wrap-around benefits provided by Medicaid will be delivered through FFS.

Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

The Department will deliver services through a fee for service payment model, with services provided by the UUSOD and their associated statewide provider network. The UUSOD currently provides dental services to Adult Medicaid members, as authorized by the State's 1115 Demonstration Waiver.

Section V. Implementation and Enrollment in Demonstration

Eligible individuals will be enrolled in these Demonstrations as of the implementation date of this amendment. The State intends to implement Disability Wraparound Coverage as soon as possible after approval. The State also intends to implement the Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration as soon as possible after approval but no sooner than July 2026.

Section VI. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality- Attachment 1 for the state's historical and projected expenditures for the requested period of the Demonstration.
Below is the projected enrollment for eligible adults in this demonstration and expenditures for each remaining demonstration year.

Disability Wraparound Coverage	**DY 25 (SFY 27)**
Enrollment	30
Expenditures	$118,747

Dental Services Demonstration	DY 25 (SFY 27)
Enrollment	200,097*
Expenditures	$56,461,030*

* Enrollment and expenditures included for the Dental Services Demonstration starting July 1, 2026.

Section VII. Proposed Waiver and Expenditure Authority

The State requests the following proposed waivers and expenditure authority to operate the Demonstration.

Disability Wraparound Coverage	Reason and Use of Waiver
Section 1902(a)(14) Cost Sharing Requirements	To permit individuals affected by this demonstration, whose benefits are limited to wraparound coverage, to have cost sharing requirements.
Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability	To enable the State to vary the amount, duration, and scope of services provided to individuals in the demonstration group.
Section 1902(a)(10)(A)- Eligibility Requirements	To permit the State to cap enrollment for individuals eligible under the Disability Wraparound Coverage demonstration group.
Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration	**Reason and Use of Waiver**
Section 1902(a)(10)(B)- Amount, Duration, and Scope of Services and Comparability	To enable the State to vary the amount, duration, and scope of services provided to individuals in the demonstration group.
Section 1902(a)(23)(A)- Freedom of Choice	To enable the State to restrict freedom of choice of providers for the population affected by this demonstration.

Expenditure Authority

Disability Wraparound Coverage

The state requests expenditure authority to provide wraparound Medicaid services for qualified individuals who have private health insurance and have a disability.

Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

The State requests expenditure authority to provide state plan dental benefits to all eligible individuals through the UUSOD and its associated statewide network of dental providers.

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing were advertised in the newspaper of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public notice was posted to the State's Medicaid website at **https://medicaid.utah.gov/1115-waiver.**

Two public hearings to take public comment on this request were held. The first public hearing was held on April 17, 2025, from 2:00 pm to 4:00 pm during the Medicaid Advisory Committee (MAC) meeting. The second public hearing was held on April 21, 2025, from 4:00 pm to 5:00 pm. Both public hearings were held via video and teleconferencing.

Public Comment

The state accepted public comment during a 30-day public comment period, which was held April 8, 2025 through May 8. 2025. Two comments were received. One commenter asked if the plan for dental services would be statewide, and to clarify the funding model. The State explained that this is a FFS model and the services would continue to be available statewide through associated providers with the UUSOD. The second commenter explained that under the Medicaid Work Incentive (MWI) program, he qualified as his own household and asked if the same would be true with the disability wraparound coverage. He also asked if the State had details on the proposed cost-sharing components. The State explained that the same MWI household size determination would be used and that specifics on the sliding scale amounts have not yet been developed.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the DHHS Intergovernmental Policy 01.19 Formal DHHS Tribal

Consultation and Urban Indian Organization Conferment Process Policy , the state ensures that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. DIH has notified the DHHS Tribal Health Liaison of the waiver amendment. As a result of this notification, DIH began to engage in the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on April 11, 2025 to present this demonstration amendment. No comments were received.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

Name and Title: Jennifer Strohecker, Medicaid Director, Division of Integrated Healthcare
Telephone Number: (801) 538-6689
Email Address: jstrohecker@utah.gov

Attachment 1

Compliance with Budget Neutrality Requirements

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

APPROVED MEGS

ELIGIBILITY GROUP	DY 15	TREND RATE	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Current Eligibles								
Pop Type:	**Medicaid**							
Eligible Member Months	377,866	0.0%	479,104	196,941				
PMPM Cost	$ 949.03	5.3%	$694.83	$810.29	Pop. Ended 12/31/23			
Total Expenditure			$347,560,796	$145,816,589				$ 493,377,385
Adult Expansion Population				*Assumes higher PMPM from Mid-Course Correction then trended forward at 4.7%*			*Community Engagement: Assumes start date of 7/1/2026*	
Pop Type:	**Expansion**							
Eligible Member Months			1,537,011	1,082,920	1,019,071	958,987	902,445	
PMPM Cost		4.7%	$ 651.40	$ 837.96	$ 877.34	$ 918.58	$ 961.75	
Total Expenditure			$ 1,001,208,965	$ 907,443,643	$ 894,075,982	$ 880,905,241	$ 867,928,521	$ 4,551,562,353
Employer Sponsored Insurance (ESI)								
Pop Type:	**Expansion**							
Eligible Member Months			11,310	9,192	8,650	8,140	7,660	
PMPM Cost		5.3%	$ 266.22	$ 280.33	$ 295.19	$ 310.83	$ 327.31	
Total Expenditure			$ 3,010,948.00	$ 2,576,793.00	$2,553,384.00	$ 2,530,186.00	$2,507,200.00	$ 13,178,511
Targeted Adults								
Pop Type:	**Expansion**							
Eligible Member Months			120,464	89,798	84,504	79,521	74,833	
PMPM Cost		5.5%	$1,177.22	$1,242.97	$1,310.28	$1,382.35	$1,458.38	
Total Expenditure			$141,812,630.00	$111,616,220.00	$110,723,259.00	$109,926,107.00	$109,134,388.00	$ 583,212,604
Dental - Targeted Adults								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	36,000	36,000	36,000			
PMPM Cost	5.0%	5.3%	$ 40.57	$ 42.72	$ 44.98			
Total Expenditure			$ 1,460,520	$ 1,537,328	$ 1,619,438			$ 4,617,885
Dental - Blind & Disabled Adults								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	512,840	488,825	465,935			
PMPM Cost	5.0%	4.8%	$ 21.08	$ 22.09	$ 23.15			
Total Expenditure			$ 10,810,667	$ 10,799,050	$ 10,787,445			$ 32,397,162
Dental - Aged								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	116,313	119,226	122,211			
PMPM Cost	5.0%	3.4%	$ 34.00	$ 35.16	$ 36.36			
Total Expenditure			$ 3,954,656	$ 4,191,985	$ 4,443,609			$ 12,590,250
Dental Services for Medicaid-eligible Adults					*Assumes start date of April 1, 2025*		*Dental Services Network starts*	
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies			544,014	2,236,774	2,401,169	
PMPM Cost	5.0%	5.9%			$ 19.64	$ 20.80	$ 23.51	
Total Expenditure					$ 10,684,438	$ 46,522,127	$ 56,461,030	$ 113,667,596
Former Foster Care Youth from Another State								
Pop Type:	**Hypothetical**							
Eligible Member Months		0.0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 1,679.32	$ 1,766.64	$ 1,858.51	$ 1,955.15	$ 2,056.82	
Total Expenditure			$ 16,793	$ 17,666	$ 18,585	$ 19,552	$ 20,568	$ 93,164
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	49,527	52,940	56,587	60,486	64,654	
PMPM Cost		5.2%	$ 4,468.94	$ 4,701.32	$ 4,945.79	$ 5,202.97	$ 5,473.52	
Total Expenditure			$ 221,334,672	$ 248,886,774	$ 279,868,973	$ 314,707,781	$ 353,883,200	$ 1,418,681,400
Serious Mental Illness (SMI)								
Pop Type:	**Hypothetical**							
Eligible Member Months		2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost		5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure			$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Intense Stabilization Services (ISS)								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost		5.3%	$2,501.79	$2,606.87	$2,716.35	$2,830.44	$2,949.32	
Total Expenditure			$ 3,602,578	$ 3,753,886	$ 3,911,549	$ 4,075,834	$ 4,247,019	$ 19,590,866
ESI/COBRA								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	5,541	5,096	5,096	5,096	5,096	
PMPM Cost		5.3%	$247.15	$260.00	$273.52	$287.75	$302.71	
Total Expenditure			$ 1,369,458	$ 1,324,969	$ 1,393,868	$ 1,466,349	$ 1,542,599	$ 7,097,242
Housing Related Services and Supports (HRSS)								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	32,691	32,691	32,691			
PMPM Cost		5.3%	$7,318.35	$7,706.22	$8,114.65			
Total Expenditure			$239,244,179.85	$251,924,121.38	###########			$ 756,444,401

Health Related Social Needs (HRSN) Non-Medical Transportation (NMT)								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%				59,076	59,076	
PMPM Cost		5.3%				$8.58	$9.02	
Total Expenditure						$ 506,760	$ 533,111	$ 1,039,871
Fertility Treatment for Individuals Diagnosed with Cancer – Male								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		59	125	128	131	
PMPM Cost		5.3%		$500.00	$526.50	$554.40	$583.79	
Total Expenditure				$ 29,500	$ 65,813	$ 70,964	$ 76,476	$ 242,752
Fertility Treatment for Individuals Diagnosed with Cancer – Female								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		60	125	128	131	
PMPM Cost		5.3%		$9,375.00	$10,042.46	$10,574.71	$11,135.17	
Total Expenditure				$ 562,500	$ 1,255,308	$ 1,353,563	$ 1,458,707	$ 4,630,078
Cryopreservation								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		119	250	256	262	
PMPM Cost		5.3%		$500.00	$526.50	$554.40	$583.79	
Total Expenditure				$ 59,500	$ 131,625	$ 141,928	$ 152,952	$ 486,005
In-Vitro Fertilization and Genetic Testing Services								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%			209	237	269	
PMPM Cost		5.3%			$7,421.38	$7,814.71	$8,228.89	
Total Expenditure					$ 1,551,376	$ 1,854,005	$ 2,215,668	$ 5,621,050
Reentry								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%			41,159	41,880	42,613	
PMPM Cost		5.3%			$1,028.19	$1,086.80	$1,148.74	
Total Expenditure					$42,319,669.92	$45,514,699.19	$48,950,945.20	$ 136,785,314
Reentry Non-Services								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%						
PMPM Cost		5.3%						
Total Expenditure					$2,847,829.00	$4,271,743.50	$4,271,743.50	$ 11,391,316
HRSN Services								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%						
PMPM Cost		5.3%						
Total Expenditure						$94,157,357.00	$94,157,357.00	$ 188,314,714
HRSN Infrastructure								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%						
PMPM Cost		5.3%						
Total Expenditure					$4,150,000.00	$16,600,000.00	$12,450,000.00	$ 33,200,000
UNDER TITLE XXI AUTHORITY								
Demo Pop VI - UPP for Children								
Pop Type:	**Expansion**			*Starts MY24*				
Eligible Member Months		2.5%		1,775	3,523	3,523	3,523	
PMPM Cost		5.3%		$190.00	$190.00	$190.00	$190.00	
Total Expenditure				$ 337,250	$ 669,370	$ 669,370	$ 669,370	$ 2,345,360
PENDING APPROVAL BY CMS								
Long-Term Support Services (LTSS)								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		600	600	600	600	
PMPM Cost		5.3%		$9,578.00	$10,056.90	$10,559.75	$11,087.73	
Total Expenditure				$5,746,800.00	$6,034,100.00	$6,335,800.00	$6,652,600.00	$ 24,769,300
Integrated Behavior Health Services								
Pop Type:	**Expansion**			*Starts MY24*				
Eligible Member Months		2.5%		1,500	3,000	3,000	3,000	
PMPM Cost		5.3%		$66.67	$70.00	$73.50	$77.18	
Total Expenditure				$100,000.00	$210,000.00	$220,500.00	$231,500.00	$ 762,000
SB133 Family Planning Services								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		60,648	61,656	62,640	63,636	
PMPM Cost		5.3%		$21.60	$21.86	$22.13	$22.40	
Total Expenditure				$ 1,309,968	$ 1,348,051	$ 1,386,293	$ 1,425,154	$ 5,469,466
SB269 Chronic Conditions Support Amendment								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		9,660	19,320	19,320	9,660	
PMPM Cost		5.3%		$180.00	$180.00	$180.00	$180.00	
Total Expenditure				$ 1,738,800	$ 3,477,600	$ 3,477,600	$ 1,738,800	$ 10,432,800
SB181 Native American Health Amendments								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%		-	3,300	3,300	3,300	
PMPM Cost		5.3%		$0.00	$2,322.52	$2,322.52	$2,322.52	
Total Expenditure				$ -	$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 22,992,900
Disability Wraparound Coverage								
Pop Type:	**Expansion**							
Eligible Member Months		0.0%					360	
PMPM Cost		0.0%					$329.00	
Total Expenditure							$ 118,440	$ 118,440
Pregnant Women and 12-Month Extended Postpartum								
Pop Type:	**Expansion**							
Eligible Member Months		0.0%				167,904	165,660	
PMPM Cost		0.0%				$792.93	$797.45	
Total Expenditure						133,136,680	132,106,106	$ 265,242,786

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

APPROVED MEGS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	24)	25)	26)	27)	DY21-25 TOTAL WOW
Current Eligibles		*Assumes higher PMPM from Mid-Course.*	*Assumes higher PMPM from Mid-Course.*				
Pop Type:	**Medicaid**						
Eligible Member Months	0.0%	479,104	196,941				
PMPM Cost	5.3%	$ 694.83	$810.29	Pop. Ended 12/31/23			
Total Expenditure		$ 347,560,796	$ 145,816,589				$ 493,377,385
Adult Expansion Population			*PMPM from Mid-Course Correction then trended forward at 4.7%*			*Community Engagement: Assumes start date of 7/1/2026*	
Pop Type:	**Expansion**						
Eligible Member Months		1,537,011	1,082,920	1,019,071	958,987	902,445	
PMPM Cost	4.7%	$ 651.40	$ 837.96	$ 877.34	$ 918.58	$ 961.75	
Total Expenditure		$ 1,001,208,965	$ 907,443,643	$ 894,075,982	$ 880,905,241	$ 867,928,521	$ 4,551,562,353
Employer Sponsored Insurance (ESI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months		11,310	9,192	8,650	8,140	7,660	
PMPM Cost	5.3%	$266.22	$280.33	$295.19	$310.83	$327.31	
Total Expenditure		$ 3,010,948	$ 2,576,793	$ 2,553,384	$ 2,530,186	$ 2,507,200	$ 13,178,511
Targeted Adults		*Member months will increase when the criteria is expanded to include victims of domestic violence and individuals with court ordered treatment.*					
Pop Type:	**Expansion**	*PMPM will increase due to adding the new managed care directed payments*					
Eligible Member Months		120,464	89,798	84,504	79,521	74,833	
PMPM Cost	5.5%	$1,177.22	$1,242.97	$1,310.28	$1,382.35	$1,458.38	
Total Expenditure		$141,812,630	$111,616,220	$110,723,259	$109,926,107	$109,134,388	$ 583,212,604
Dental - Targeted Adults							
Pop Type:	**Hypothetical**						
Eligible Member Months	varies	36,000	36,000	36,000			
PMPM Cost	5.3%	$ 40.57	$ 42.72	$ 44.98			
Total Expenditure		$ 1,460,520	$ 1,537,928	$ 1,619,438			$ 4,617,885
Dental - Blind & Disabled Adults							
Pop Type:	**Hypothetical**						
Eligible Member Months	varies	512,840	488,825	465,935			
PMPM Cost	4.8%	$ 21.08	$ 22.09	$ 23.15			
Total Expenditure		$ 10,810,667	$ 10,799,050	$ 10,787,445			$ 32,397,162
Dental - Aged							
Pop Type:	**Hypothetical**						
Eligible Member Months	varies	116,313	119,226	122,211			
PMPM Cost	3.4%	$ 34.00	$ 35.16	$ 36.36			
Total Expenditure		$ 3,954,656	$ 4,191,985	$ 4,443,609			$ 12,590,250
Dental Services for Medicaid-eligible Adults				*date of April 1, 2025*		*Dental Services Network starts*	
Pop Type:	**Hypothetical**						
Eligible Member Months	varies			544,014	2,236,774	2,401,169	
PMPM Cost	5.9%			$ 19.64	$ 20.80	$ 23.51	
Total Expenditure				$ 10,684,438	$ 46,522,127	$ 56,461,030	$ 113,667,596
Former Foster Care Youth from Another State							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	10	10	10	10	10	
PMPM Cost	5.2%	$ 1,679.32	$ 1,766.64	$ 1,858.51	$ 1,955.15	$ 2,056.82	
Total Expenditure		$ 16,793	$ 17,666	$ 18,585	$ 19,552	$ 20,568	$ 93,164
Substance Use Disorder (SUD)							
Pop Type:	**Hypothetical**						
Eligible Member Months	6.9%	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	5.2%	$ 4,468.94	$ 4,701.32	$ 4,945.79	$ 5,202.97	$ 5,473.52	
Total Expenditure		$ 221,334,672	$ 248,886,774	$ 279,868,973	$ 314,707,781	$ 353,883,200	$ 1,418,681,400
Serious Mental Illness (SMI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months	2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure		$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Intense Stabilization Services (ISS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	4.2%	$2,501.79	$2,606.87	$2,716.35	$2,830.44	$2,949.32	
Total Expenditure		$ 3,602,578	$ 3,753,886	$ 3,911,549	$ 4,075,834	$ 4,247,019	$ 19,590,866
ESI/COBRA							
Pop Type:	**Medicaid**						
Eligible Member Months (Includes ESI/COBRA & ESI Childless Adults)		5,541	5,096	5,096	5,096	5,096	
PMPM Cost	5.2%	$ 247.15	$ 260.00	$ 273.52	$ 287.75	$ 302.71	
Total Expenditure		$ 1,369,458	$ 1,324,969	$ 1,393,868	$ 1,466,349	$ 1,542,599	$ 7,097,242
Housing Related Services and Supports (HRSS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%	32,691	32,691	32,691			
PMPM Cost	5.3%	$7,318.35	$7,706.22	$8,114.65			
Total Expenditure		$ 239,244,180	$ 251,924,121	$ 265,276,100			$ 756,444,401

Health Related Social Needs (HRSN) Non-Medical Transportation (NMT)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%				59,076	59,076	
PMPM Cost	5.2%				$ 8.58	$ 9.02	
Total Expenditure					$ 506,760	$ 533,111	$ 1,039,871

Fertility Treatment for Individuals Diagnosed with Cancer – Male							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		59	125	128	131	
PMPM Cost	5.3%		$500.00	$526.50	$554.40	$583.79	
Total Expenditure			$ 29,500	$ 65,813	$ 70,964	$ 76,476	$ 242,752

Fertility Treatment for Individuals Diagnosed with Cancer – Female							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		60	125	128	131	
PMPM Cost	5.3%		$9,375.00	$10,042.46	$10,574.71	$11,135.17	
Total Expenditure			$ 562,500	$ 1,255,308	$ 1,353,563	$ 1,458,707	$ 4,630,078

Cryopreservation							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		119	250	256	262	
PMPM Cost	5.3%		$500.00	$526.50	$554.40	$583.79	
Total Expenditure			$ 59,500	$ 131,625	$ 141,928	$ 152,952	$ 486,005

In-Vitro Fertilization and Genetic Testing Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	13.5%			209	237	269	
PMPM Cost	5.0%			$ 7,421.38	$ 7,814.71	$ 8,228.89	
Total Expenditure				$ 1,551,376	$ 1,854,005	$ 2,215,668	$ 5,621,050

Reentry							
Pop Type:	**Hypothetical**						
Eligible Member Months	1.75%			41,159	41,880	42,613	
PMPM Cost	5.7%			$1,028.19	$1,086.80	$1,148.74	
Total Expenditure				$ 42,319,670	$ 45,514,699	$ 48,950,945	$ 136,785,314

Reentry Non-Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%						
PMPM Cost	0.0%						
Total Expenditure				$ 2,847,829	$ 4,271,744	$ 4,271,744	$ 11,391,316

HRSN Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%						
PMPM Cost	N/A						
Total Expenditure					$ 94,157,357	$ 94,157,357	$ 188,314,714

HRSN Infrastructure							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%						
PMPM Cost	N/A						
Total Expenditure				$ 4,150,000	$ 16,600,000	$ 12,450,000	$ 33,200,000

UNDER TITLE XX1 AUTHORITY

Demo Pop VI - UPP for Children							
Pop Type:	**Hypothetical**		*Starts MY2*				
Eligible Member Months	0.0%		1,775	3,523	3,523	3,523	
PMPM Cost	0.0%		$ 190.00	$ 190.00	$ 190.00	$ 190.00	
Total Expenditure			$ 337,250	$ 669,370	$ 669,370	$ 669,370	$ 2,345,360

PENDING APPROVAL BY CMS

Long-Term Support Services (LTSS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		600	600	600	600	
PMPM Cost	5.0%		$ 9,578.00	$ 10,056.90	$ 10,559.75	$ 11,087.73	
Total Expenditure			$ 5,746,800	$ 6,034,100	$ 6,335,800	$ 6,652,600	$ 24,769,300

Integrated Behavior Health Services							
Pop Type:	**Hypothetical**		*Starts MY2*				
Eligible Member Months	0.0%		1,500	3,000	3,000	3,000	
PMPM Cost	5.0%		$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure			$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000

SB133 Family Planning Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	1.6%		60,648	61,656	62,640	63,636	
PMPM Cost	1.2%		$ 21.60	$ 21.86	$ 22.13	$ 22.40	
Total Expenditure			$ 1,309,968	$ 1,348,051	$ 1,386,293	$ 1,425,154	$ 5,469,466

SB269 Chronic Conditions Support Amendment							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		9,660	19,320	19,320	9,660	
PMPM Cost	0.0%		$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure			$ 1,738,800	$ 3,477,600	$ 3,477,600	$ 1,738,800	$ 10,432,800

SB181 Native American Health Amendments							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%			3,300	3,300	3,300	
PMPM Cost	0.0%			$ 2,322.52	$ 2,322.52	$ 2,322.52	
Total Expenditure				$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 22,992,900

Disability Wraparound Coverage							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%					360	
PMPM Cost	0.0%					$329.00	
Total Expenditure						$ 118,440	$ 118,440

Pregnant Women and 12-Month Extended Postpartum							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%				167,904	165,660	
PMPM Cost	0.0%				$792.93	$797.45	
Total Expenditure					$ 133,136,680	$ 132,106,106	$ 265,242,786

Attachment 2

Public Notice Requirements

Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Amendments to Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

Amendments to Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Meeting

Event Start Date & Time:

April 17, 2025 02:00 PM

Event End Date & Time:

April 17, 2025 04:00 PM

Event Deadline Date & Time:

04/17/25 04:00 PM

Description/Agenda:

Disability Wraparound Coverage and Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

The Utah Department of Health & Human Services, Division of Integrated Healthcare, will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comments regarding the amendment online, by email, or mail during the public comment period from April 8, 2025, through May 8, 2025.

Utah Medicaid is requesting authority from the Centers for Medicare & Medicaid Services (CMS) to provide wraparound Medicaid services for qualified individuals who have minimum essential healthcare coverage and have a disability. These wraparound services would cover benefits available under Medicaid but not provided by the individual's minimum essential coverage.

Utah Medicaid also seeks authority to transition the dental benefit delivery system for children and pregnant/postpartum women. Dental services for children and pregnant/postpartum women are currently provided through the dental managed care plans as authorized under a 1915(b) amendment. With approval of this amendment, dental benefits will be provided through the University of Utah School of Dentistry and its associated statewide network of dental providers.

Public Hearings:

The Department will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below. Both public hearings will be held via video and teleconferencing.

Thursday, April 17, 2025, from 2:00 to 4:00 pm, during the Medicaid Advisory Committee (MAC) meeting.

Give Feedback

Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #
Monday, April 21, 2025, from 4:00 pm to 5:00 pm.
Video Conference: Google Meet Meeting meet.google.com/ddt-hhfk-aps
Or join by phone: (US) +1 317-659-0155 PIN: 875 965 289 #

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by April 10, 2025.

Public Comment:

A copy of the public notice and proposed amendment is available online at:
https://medicaid.utah.gov/1115-waiver/
The public may comment on the proposed amendment request during the public comment period from April 8, 2025, through May 8, 2025.
Comments may be submitted using the following methods:
Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

Notice of Special Accommodations (ADA):

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Laura Belgique at 1 (801) 538-6241.

Notice of Electronic or Telephone Participation:

meet.google.com/ieq-jggb-pec Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116

Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 02, 2025 11:06 AM

Notice Last Edited On:

April 02, 2025 11:11 AM

Deadline Date:

April 17, 2025 04:00 PM

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username@example.com

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Give Feedback

Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Amendments to Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

Amendments to Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Meeting

Event Start Date & Time:

April 21, 2025 04:00 PM

Event End Date & Time:

April 21, 2025 05:00 PM

Event Deadline Date & Time:

04/21/25 05:00 PM

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Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #
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Or join by phone: (US) +1 317-659-0155 PIN: 875 965 289 #

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Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

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Notice of Electronic or Telephone Participation:

meet.google.com/ddt-hhfk-aps Or join by phone: (US) +1 317-659-0155 PIN: 875 965 289 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 02, 2025 11:30 AM

Notice Last Edited On:

April 02, 2025 11:30 AM

Deadline Date:

April 21, 2025 05:00 PM

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The Salt Lake Tribune

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DIVISION OF MEDICAID AND HEALTH FINANCING CRAIG DEVASHRAYEE PO BOX 143102 SALT LAKE CITY, UT 84114 cdevashrayee@utah.gov

ACCOUNT NUMBER
8405

ACCOUNT NAME
DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE
801-538-6641

ORDER #
SLT0032293

CUSTOMER REFERENCE NUMBER

CAPTION
Disability Wraparound Coverage and Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration The Utah Department of Health & Human Services, Division of Integrated Healthcare, will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration.

TOTAL COST
$221.00

Disability Wraparound Coverage and Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration

The Utah Department of Health & Human Services, Division of Integrated Healthcare, will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comments regarding the amendment online, by email, or mail during the public comment period from April 8, 2025, through May 8, 2025.

Utah Medicaid is requesting authority from the Centers for Medicare & Medicaid Services (CMS) to provide wraparound Medicaid services for qualified individuals who have minimum essential healthcare coverage and have a disability. These wraparound services would cover benefits available under Medicaid but not provided by the individual's minimum essential coverage.

Utah Medicaid also seeks authority to transition the dental benefit delivery system for children and pregnant/postpartum women. Dental services for children and pregnant/postpartum women are currently provided through the dental managed care plans as authorized under a 1915(b) amendment. With approval of this amendment, dental benefits will be provided through the University of Utah School of Dentistry and its associated statewide network of dental providers.

Public Hearings:

The Department will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below. Both public hearings will be held via video and teleconferencing.

- Thursday, April 17, 2025, from 2:00 to 4:00 pm, during the Medicaid Advisory Committee (MAC) meeting.
- Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
- Or join by phone: (US) +1 513-818-1049 PIN: ⌈ 510 813 429#
- Monday, April 21, 2025, from 4:00 pm to 5:00 pm.
- Video Conference: Google Meet Meeting meet.google.com/ddt-hhfk-aps
- Or join by phone: ⌈ (US) +1 317-659-0155 PIN: ⌈ 875 965 289#

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by April 10, 2025.

Public Comment:

A copy of the public notice and proposed amendment is available online at: https://medicaid.utah.gov/1115-waiver/

The public may comment on the proposed amendment request during the public comment period from April 8, 2025, through May 8, 2025.

Comments may be submitted using the following methods:

Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

SLT0032293

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF Disability Wraparound Coverage and Inclusion of Children and Pregnant/Postpartum Women in the Dental Services Demonstration The Utah Department of Health & Human Services, Division of Integrated Healthcare, will hold public hearings to discuss two amendments to Utah's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 04/05/2025, 04/06/2025

DATE 04/09/2025

SIGNATURE

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 9th DAY OF APRIL IN THE YEAR 2025

BY Doug Ryle

LAREE WHITMER
Notary Public
State of Utah
My Commission Expires December 9, 2028
Commission Number 740391

NOTARY PUBLIC SIGNATURE

Attachment 3

Medical Care Advisory Committee

Public Hearing

Utah Department of Health & Human Services
Integrated Healthcare

Medicaid Advisory Committee Agenda

Meeting: Medicaid Advisory Committee
Date: April 17, 2025
Start Time: 2:00 p.m.
End Time: 4:00 p.m.
Location: meet.google.com/ieq-jggb-pec Google Chrome)
By Phone: 1-513-818-1049 PIN# 510 813 429#

Agenda Items

1.	Welcome • Approve Minutes for March 2025*	Rachel Craig	2:00 / 5 min
2.	1115 Waiver Amendments Public Hearing • Disability wraparound coverage • Inclusion of Children and Pregnant/Postpartum Women in Dental Services	Laura Belgique	2:05 / 15 min
3.	Federal Reform Updates	Jennifer Strohecker	2:20 / 40 min
4.	Eligibility and Enrollment Update	Michelle Smith	3:00 / 10 min
5.	Director's Report • Upcoming policy changes	Jennifer Strohecker	3:10 / 20 min
6.	MAC meeting request process	Rachel Craig	3:30 / 5 min
7.	Committee member updates	Committee Members	3:35 / 5 min

* Action Item - MAC Members must be present to vote (substitutes are not allowed to vote)

Next Meeting: May 15, 2025, from 4:00 p.m. – 6:00 p.m.
Budget Recommendations Meeting
Email ssteigerwalt@utah.gov to sign up to present

Please send meeting topics or other correspondence to Sharon Steigerwalt (ssteigerwalt@utah.gov)

Attachment 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

4/11/2025 8:30 AM –11:00 AM	Join via Google Meeting: https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
In person: Four Points Health Cedar City Clinic, 376 Paiute Dr, Cedar City, UT 84721	Join via Phone: 1-(414)-909-6377 PIN: 211 599 534

Time	Agenda Topic	Presenter
8:30 am	Welcome and Introductions and Roll Call	LaTosha Mayo, Chairperson
8:45 am	Committee Updates	
	UT Medicaid Eligibility Policy	Michelle Smith (DHHS)
	UT Medicaid Policy Update	Jim Stamos (DHHS)
	Medicaid and CHIP State Plan Amendments	Craig Devashrayee (DHHS)
	Medicaid 1115 Wavier	Laura Belgique (DHHS)
	DWS Medicaid Eligibility Operations	Jessica Ware (DWS)
	SNAP	Frank Vega (DWS)
	MCAC Committee	Michael Jensen (UNHS)
	CHIP Advisory Committee	Rachel Greymountain
9:30 am	Office of AI/AN Health and Family Services Updates	
	Data Reporting Updates	Alex Merrill (IHFS)
	Program Updates	Hilary Makris (IHFS)
	IHFS Opioids and Tobacco	Kassie John (IHFS)
	ICWA Liaison	Jamie Harvey (IHFS)
	Tribal Health Liaison	Jeremy Taylor (IHFS)

Time	Topic	Presenter
10:00 am	PHEP 2025 grant	Andrea Skewes
10:10 am	Measles DHHS Update	Amelia Salmanson (DHHS)
10:30 am	I/T/U Partner Spotlight	LaTosha Mayo
11:00 am	I/T/U Updates	I/T/U partners
	Lunch and tour	

Next UIHAB Meeting will be May 9, 2025

Hosted by:
CTGR - TBD

Facilitated by: Utah Department of Health and Human Services Office of AI/AN Health & Family Services
Note Taker: Dorrie Reese (All meetings are recorded)

UIHAB Meeting

Apr 11, 2025 (Hybrid)
8:30 a.m. – 11:00 a.m.

Participants: (Hybrid)

Lorena Horse, *Confederated Tribes of the Goshute*
Michelle Richards, *Northwestern Band of Shoshone Nation*
Amy Faatoafe, *Skull Valley Band of Goshute*
Craig Sandoval, *Urban Indian Center of Salt Lake*
Matt Poss, *Urban Indian Center of Salt Lake*
Tracie Tso, *Utah Division of Indian Affairs*
Maurice James, *Ute & Ouray/IHS*
Clarissa Friday, *Ute & Ouray/HIS*
Tyler Deines, *CMS*
Barbara Prehmus, *CMS*

Guests:

Jessica Ware, *AI/AN Eligibility Specialist, DWS*
Natalie Barfuss for Frank Vega, *AI/AN SNAP Specialist, DWS*

DHHS Staff:

Brian Roach, *Assistant Division Director, Division of Integrated Healthcare, DHHS*
Michelle Smith, *Office Director, Office of Eligibility Policy, DHHS*
Jim Stamos, *Office Director, Office of Healthcare Policy and Authorization, DHHS*
Laura Belgique, *Office of Eligibility Policy, DHHS*
Craig Devashrayee, *Office of Reimbursement Coordinated Care & Audit, DHHS*
Andrea Skewes, *Office of Emergency Medical Services & Preparedness, DHHS*
Tonya Merton, *Office of Emergency Medical Services & Preparedness, DHHS*
Amelia Salmanson, *Office of Communicable Disease, DHHS*
Jeremy Taylor, *Tribal Health Liaison, Office of AI/AN Health Affairs, DHHS*
Alex Merrill, *EPI, Office of AI/AN Health Affairs, DHHS*
Jamie Harvey, *ICWA, Office of AI/AN Health Affairs, DHHS*
Dorrie Reese, *Recorder/Minutes, DIH Administrative Assistant, DHHS*

Welcome and Introductions:

The UIHAB Chairperson welcomed everyone starting the meeting at 8:30 a.m.

Approval of Minutes:

The Oct 11, 2019, Nov 15, 2019, Dec 13,2019, Jan 10, 2020, Mar 13,2020, Apr 10, 2020, May 8, 2020, Jun 12, 2020, Aug, 14, 2020, Sep 11, 2020, Oct 9, 2020, Nov 13, 2020, Dec 11, 2020, Jan, 21, 2021, , Feb 12, 2021, Mar 12, 2021, Apr 9, 2021, May 14, 2021, Jun 11, 2021, Aug 13, 2021, Sep 10, 2021, Oct 8, 2021, Nov 12, 2021, Dec 10, 2021, Jan 28, 2022, Mar 11, 2022, Apr 8, 2022, May 13, 2022, Jun 10, 2022, Aug 12, 2022, Sep 9, 2022, Oct 14, 2022, Nov 10, 2022, Dec 9, 2022, Jan 13, 2023, Feb 10, 2023, Mar 10, 2023, Apr 14, 2023, May 12, 2023, June 9, 2023, Aug 11, 2023, Sep 8, 2023, Oct 13, 2023, Nov 9, 2023, Dec 9, 2023, Jan 12, 2024, Mar 8, 2024, Apr 12, 2024, May 10, 2024, Jun 14, 2024, Aug 9, 2024, Sep 13, 2024, Oct 11, 2024, Nov 8, 2024, Dec 13, 2024, Jan 10, 2025, and Mar 14, 2025 UIHAB minutes will be approved at a later UIHAB meeting.

DRAFT

Medicaid Eligibility Policy:

Michelle Smith gave an update.
michellesmith@utah.gov
https://medicaid-documents.dhhs.utah.gov/Medicaid Enrollment Report
https://medicaid.utah.gov/eligibility-data/
https://medicaid.utah.gov/mcac/

Medicaid Policy Update:

Jim Stamos gave an update.

The document which was presented is embedded in this document.

Updated April 2025 Director's Report.doc

Medicaid 1115 Waiver:

Laura Belgique gave an update.
https://medicaid.utah.gov/1115-waiver/
Medicaid1115waiver@utah.gov
Comment end date: May 8, 2025

The documents which were presented are embedded in this document.

Public Hearing Overview_ Disability W

Amendments_ Disability Wraparounc

DWS Medicaid Eligibility:

Jessica Ware gave an update on DWS Medicaid Eligibility Unwinding.

AIT quarterly report 2024 CY.xlsx

AIT quarterly report 2024 q4.xlsx

Medicaid and CHIP State Plan Amendments:

Craig Devashrayee gave an update.

The documents which were presented are embedded in this document.

UIHAB MATRIX 4-11-25.pdf

SPA MATRIX 4-11-25.pdf

DRAFT

DWS Medicaid SNAP:

Natalie Barfuss for Frank Vega gave an update on SNAP.
nbarfuss@utah.gov

The documents which were presented are embedded in this document.

NAVAJO How do I get SUN Bucks (1).pdf
NAVAJO Utah SUN Bucks for CEP_Provisic
NAVAJO Utah SUN Bucks for National Sch
How do I get SUN Bucks infographic (4).p
Utah SUN Bucks for CEP_Provision 1, 2, 3
Utah SUN Bucks for National School Lunch

MAC & CHIP Advisory Committees:

Rachel Greymountain gave an update on January 16, 2025, CHIPAC meeting.

The next MAC meeting is scheduled for April 17, 2025, at 2:00 -4:00pm.
The next CHIPAC meeting is scheduled for April 17, 2025, at 1:00-1:55 pm

Data Reporting:

Alex Merrill gave an update.

ICWA Liasion:

Jamie Harvey gave an update.

DHHS Advisory Opinion 02252025.pdf
NICWA 2025 Summaries of Pres Ex

Tribal Health Liaison:

Jeremy Taylor gave an update.

- Traditional Healing Waiver: Tyler Deines CMS w/follow up on this
- I/T/U Trainings: Barbara Prehmus CMS mentioned that at this time they do not have dates for these meetings.
- Tribal Liaison -Emergency Preparedness: Anna Boynton: Apr 17th-Statewide Shakeout

Here is the form for requesting PPE supplies, each link contains a different set of supplies. (pictures included in the links)
https://docs.google.com/forms/d/e/1FAIpQLSevmTTEsVHUbWvX20AYzPPFxX5SMweGZcqTytjx4GzZhm207Q/viewform
https://docs.google.com/forms/d/e/1FAIpQLSc7ce56y_JLoTGndE2vfgiIRljpn9D8vOccJh9xhlivKC41Lw/viewform

Any questions, please email to claytonsweeney@utah.gov or call at 801-656-8042 to begin the order process.

All items will call only, and would need to be picked up at Pick up address: **1865 South 4490 West SLC Utah 84104**
Hours of Operations are **Monday- Friday 7am- 3pm** (EXCEPT for state observed holidays)

PHEP 2025 Grant:

Andrea Skewes gave an update.
https://forms.gle/mNeP4v2YyeS4TNEk6

The document which was presented is embedded in this document.

UIHAB 4.11.2025

DRAFT

Measles DHHS Update:

Amelia Salmanson gave an update.

The document which was presented is embedded in this document.

Measles update (1).pdf

I/T/U Updates:

- Lorena Horse: Confederated Tribes of Goshute Reservation
- Michelle Richards: Northwestern Band of Shoshone Nation
- Shawn Begay: Utah Navajo Health Systems
- Craig Sandoval: Urban Indian Center of Salt Lake
- Tracie Tso: Utah Division of Indian Affairs

I/T/U Spotlight:

Amelia Salmanson gave an update.

The document which was presented is embedded in this document.

FPH Spotlight PowerPoint_Amelia Sa

Adjourn:

The meeting ended at 11:19. Shawn Begay made that motion to adjourn the meeting. Lorena Horse seconded that motion.

The next meeting: May 9, 2025 @ 8:30 a.m. (Hybrid)
Sacred Circle Healthcare
660 South 200 East, Suite 250
Salt Lake City

DRAFT

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

Department of Health & Human Services

TRACY S. GRUBER
Executive Director

NATE CHECKETTS
Deputy Director

DR. MICHELLE HOFMANN
Executive Medical Director

DAVID LITVACK
Deputy Director

NATE WINTERS
Deputy Director

July 3, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Administrator Oz:

I am pleased to submit an amendment to the State of Utah's Medicaid Reform 1115 Demonstration. With this amendment, the State is requesting authority to implement a Community Engagement work requirement for the Adult Expansion Medicaid demonstration group which is currently authorized under the State's 1115 Demonstration. The Community Engagement requirement would apply to Adult Expansion Medicaid members who are able to participate in the requirement, are not already participating in other work or training activities, and do not meet an exemption or do not demonstrate good cause.

The State of Utah appreciates your consideration of this amendment request. We look forward to the continued guidance and support from CMS in administering Utah's Medicaid Reform 1115 Demonstration.

Respectfully,

Jennifer Strohecker (Jul 3, 2025 13:07 MDT)

Jennifer Strohecker
Medicaid Director
Division of Integrated Healthcare

Utah's Medicaid Reform 1115 Demonstration

Amendment Request

COMMUNITY ENGAGEMENT

Demonstration Project No. **11-W-00145/8**
21-W-00054/8

Utah Department of Health & Human Services

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State of Utah

Section 1115 Demonstration Amendment

Community Engagement

Background

On December 23, 2019, the Centers for Medicare and Medicaid Services (CMS) authorized the Utah Department of Health and Human Services (DHHS) authority to implement a full Medicaid expansion in the State. The expansion extends Medicaid eligibility to Utah adults whose annual income is up to 133% of the federal poverty level. The State also requires newly eligible adults to enroll in their employer-sponsored health plan if one is available. Medicaid will then cover the member's monthly premium and other out-of-pocket expenses like copays and deductibles. In addition, the Medicaid expansion approval included a Community Engagement (CE) requirement. CE required some expansion members to participate and report completion of specified work-related activities as a condition of continued Medicaid eligibility. This requirement went into effect January 1, 2020 but was suspended on April 1, 2020 due to the COVID-19 Public Health Emergency. In August 2021, CMS required that the community engagement requirement be removed from Utah's 1115 before they would renew it. Because the requirement was suspended and later removed before it was fully operationalized, there was no impact on Medicaid members.

The State recognizes the connection between employment and health and proposes to reinstitute the CE requirement to:

- increase an individual's health and wellbeing through incentivizing work and community engagement;
- increase their sense of purpose;
- help build a healthy lifestyle; and
- increase employment and wage earnings of able-bodied adults, while focusing funding on the State's neediest individuals.

Section 1. Program Description and Objectives

With this amendment, the State is requesting authority to implement a CE requirement for the Adult Expansion Medicaid (AEM) demonstration group which is currently authorized

under the State's 1115 Demonstration. The State is not requesting authority to implement a CE requirement for the Targeted Adult Medicaid demonstration group. The State will align closely with Utah's work requirements and activities of the Supplemental Nutrition Assistance Program (SNAP) program work activities to ensure consistency and reduce complexity for those members required to participate.

Community Engagement through a Self Sufficiency Requirement

With this waiver amendment, the State proposes to administer the CE requirement for individuals eligible for the AEM demonstration group. The CE requirement applies to AEM members who do not meet an exemption and do not demonstrate good cause, as outlined in the sections below. Details on additional requirements including participation, suspension and closure due to non-participation, regaining eligibility, reasonable modifications, member supports, and impacts to members are also outlined below.

1. Community Engagement Exemptions

The State recognizes that not all members may be able to participate in the CE requirement, or they may already be participating in other work or training activities that meet the goals of the Demonstration. Therefore, the State will exempt certain members from the requirement, as approved under the State's 1115 Demonstration. The exemptions are largely aligned with federal SNAP exemptions. The exemptions are:

A. Age 60 or older;
B. Pregnant or within the twelve month postpartum period;
C. Physically or mentally unable to meet the requirements;
D. A parent or other member of the household with the responsibility to care for a dependent child age 13 and under;
E. Responsible for the care of a person with a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act ;
F. A member of a federally recognized tribe;
G. Has applied for and is awaiting an eligibility determination for unemployment insurance benefits, or is currently receiving unemployment insurance benefits, and has registered for work at the Department of Workforce Services (DWS). Appealing an unemployment insurance decision is also an exemption;
H. Participating regularly in a Substance Use Disorder (SUD) treatment program, including intensive outpatient treatment;
I. Enrolled at least half time in any school (including, but not limited to, college or university) or vocational training or apprenticeship program;

J. Participating in refugee employment services offered by the State, which may include vocational training and apprenticeship programs, case management, and employment planning;
K. State Family Employment Program (FEP) recipients who are working with an employment counselor;
L. A member cooperating with SNAP employment requirements;
M. Working a total of 80 hours a month or working and earning at least federal minimum wage times 80 hours a month;
N. A combination of education, community service, and employment to reach a total of 80 hours in a month.
O. A justice involved member incarcerated or in the first three months after release from incarceration;
P. A member on probation or parole who is required to complete court ordered activities such as work release, drug court etc.
Q. Veterans with rated disabilities
R. Foster youth and former foster youth under the age of 26

A member can claim an exemption at any time. Members meeting at least one of the above listed exemptions will not be required to complete the CE participation requirement within the 12-month certification period in which the exemption is claimed in order to maintain continued coverage. To verify exemptions, the State will maximize the use of available data sources and other mechanisms before requiring members or applicants to provide proof.

2. Community Engagement Participation

Members who do not meet an exemption or do not demonstrate good cause will be referred for participation on the first of the month following approval for AEM. This will be month one of the three month participation period. This is the same participation period used for the SNAP program. Members will be required to complete participation requirements within the three-month period. Once they have met the requirement, they will be eligible for the remainder of their eligibility period. Eligibility periods are 12 months. The member must complete participation requirements every 12 months to continue to receive Medicaid.

Members who do not meet an exemption, or who do not demonstrate good cause must complete the following participation activities. Members must engage for three consecutive months within a twelve month period or until they qualify for an exemption:

A. Register for work through the state system.
B. Complete an evaluation of employment training needs.

C. Complete the job training modules as determined to be relevant to the member through the assessment of employment training needs.
D. Apply for employment with at least 48 potential employers.

Activities will be completed through the DWS, using the same online evaluation, training, and search resources offered to Utah SNAP recipients.

3. Suspension and Closure due to Non-participation

- Failure to comply with the CE requirements by the end of the three month participation period will result in suspension of eligibility for a three month period unless good cause is demonstrated, or the member meets an exemption.
- If a member completes all activities within the suspension period, the member will regain eligibility back to the start of the suspension period without having to reapply.
- If a member fails to participate, they will lose eligibility at the end of the three month suspension period. The period of ineligibility continues through the end of the member's current certification period unless requirements are completed as detailed in Section 4.

4. Regaining Eligibility

- Members who lose eligibility may become eligible again by completing all required activities or by demonstrating good cause or meeting an exemption.
- After completing all required participation activities, the individual must reapply for Medicaid. Benefits will be effective the first day of the month in which they reapply.
- If the individual meets the qualifications for an exemption or demonstrates good cause for the earlier non-compliance, or becomes eligible for Medicaid under an eligibility category that is not subject to the CE requirement, the individual can re-enroll with consideration for retroactive coverage.

5. Good Cause for Not Participating

The State will waive loss of eligibility if a member demonstrates good cause for failure to participate in the CE requirement. The good cause will exempt the member as long as the good cause reason exists. Good cause reasons include, but are not limited to:

A. The member or an immediate family member who was living in the home with the member experiences a hospitalization or temporary illness;
B. The member experiences the birth, or death of a family member living with the member;
C. The member experiences a natural disaster and therefore was unable to meet the requirement;

D. The member has a family emergency or other life-changing event (e.g. divorce or domestic violence);
E. The member is not able to participate due to a lack of internet access or transportation;
F. Living in a county in which the unemployment rate is greater than 150% of the national average. ;
G. The member is the primary caretaker of a child age 6 or older and is unable to meet the requirement due to childcare responsibilities.

To verify good cause, the State will maximize the use of available data sources and other mechanisms before requiring members or applicants to provide proof.

6. Reasonable Modifications

The State will provide reasonable modifications related to meeting the CE requirement for members with disabilities protected by the ADA, Section 504, or Section 1557, when necessary, to enable them to have an equal opportunity to participate in, and benefit from, the program. The State will also provide reasonable modifications for program requirements and procedures, including but not limited to, assistance with demonstrating eligibility for an exemption from CE requirements on the basis of disability; demonstrating good cause; appealing disenrollment; documenting CE activities and other documentation requirements; understanding notices and program rules related to CE requirements; navigating ADA compliant web sites as required by 42 CFR 435.1200(f); and other types of reasonable modifications. Reasonable modifications must include exemptions from participation where a member is unable to participate for disability-related reasons, and the provision of support services necessary to participate is unavailable, where participation is otherwise possible with supports.

7. Member Supports

The State will assist members in meeting the CE requirement through outreach. This outreach will reinforce the participation requirements and the member support available to complete them.

Additional support from the State may include non-Medicaid assistance with transportation, childcare, language access services, sending text message reminders and other supports; and connect members with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act with services to enable them to participate. Members can also utilize the DWS employment

counselors to assist in understanding employment resources and helping to successfully meet CE requirements.

The state is seeking federal match for these member supports.

8. Impact to Members

The State estimates approximately 89.5% percent of AEM members will meet an exemption to CE participation. Among members who do not meet an exemption or do not demonstrate good cause, the State projects that approximately 50% will comply with the CE requirements.

Goals and Objectives

Under Section 1115 of the Social Security Act, states may implement "experimental, pilot or demonstration projects which, in the judgment of the Secretary [of Health and Human Services] is likely to assist in promoting the objectives of [Medicaid]". The State believes the provisions requested in this proposal are likely to promote the Medicaid goal of Improving participant health outcomes and quality of life. The State realizes the benefit of providing affordable healthcare coverage to those involved in employment and other employment-related activities for both the member and the community. This demonstration will allow the State to test the effectiveness of policy that is designed to promote member's financial independence by encouraging members to obtain or sustain employment.

Operation and Proposed Timeline

The demonstration will operate statewide. The State intends to implement the proposed benefit as soon as possible after approval, but will require at least 6 months for operational readiness. The State requests to operate the demonstration through June 30, 2027.

Demonstration Impact to Medicaid and CHIP

The requirement is an eligibility restriction on the AEM demonstration group. Any new applicant will be required to meet the participation requirements or meet an exemption or demonstrate good cause. Any person presently enrolled in AEM will be required to participate or be determined exempt at the beginning of their next certification period. This requirement will not impact CHIP or traditional Medicaid.

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will develop a plan for evaluating the hypotheses indicated below. The State will identify validated performance measures that adequately assess the impact of the demonstrations to members. The State will submit the evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this demonstration, and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The following hypothesis will be tested during the approval period:

Hypothesis	Anticipated Measure(s)	Data Sources	Evaluation Approach
The community engagement requirement will encourage skills development through an evaluation of job search readiness and the completion of employment related training workshops. In addition, by increasing the member's job skills and encouraging job search activities, the community engagement requirement will promote gainful employment.	• Number of trainings completed/ ended • Number of job searches • Number of job registrations • Amount of earned income	eREP & UWORKS system data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons.
Community engagement requirements that promote engagement with the employment process will improve the health outcomes of Medicaid members subject to the requirements, compared to Medicaid members not	• Number of non-emergent ED visits • Number of inpatient stays • Number of well-care visits	Claims/encounter data	Independent evaluator will design quantitative and qualitative measures to include quasi-experimental comparisons

subject to the requirements.			

Section II. Demonstration Eligibility

Adult Expansion Medicaid
Individuals must meet the following requirements in order to qualify for AEM: 1. The individual must be a US citizen or qualified non-citizen. 2. The individual must be age 19 through 64 years old. 3. The individual must meet residency requirements. 4. Meet other non-financial requirements. 5. The individual's household income must be at or below 133% of the Federal Poverty Level. 6. The individual with access to qualified Employer Sponsored Insurance, must enroll or remain enrolled in their current qualified health insurance plan.

Projected Enrollment

The projected annual enrollment for members in this demonstration population is 75,200.

Section III. Demonstration Benefits and Cost Sharing Requirements

There are no changes to the benefits provided to eligible individuals under this amendment. Individuals will continue to receive state plan benefits. Cost sharing requirements will not differ from those provided under the state plan.

Section IV. Delivery System and Payment Rates for Services

Services for the AEM group will be provided through fee-for-service (FFS) during the month of application and potentially the following month depending on the date of approval. In addition, AEM members that live in non-mandatory managed care counties will receive services through the FFS network if they choose not to enroll in a managed care plan. FFS reimbursement rates for physical health and behavioral health services will be the same as State Plan provider payment rates.

AEM members living in mandatory managed care counties will be enrolled in managed care no later than the second month after they are approved for Medicaid Expansion. In addition, in Utah's five largest counties, members in the AEM group will be enrolled in integrated plans that provide access to both physical health and behavioral health services

through a single managed care plan. In the remaining counties, members will be enrolled in a pre-paid mental health plan for their behavioral health services.

Section V. Implementation and Enrollment in Demonstration

Members currently enrolled in the AEM group under Utah's 1115 Demonstration waiver will remain as the AEM group under the new demonstration.

The State will provide members with official notices about when CE requirements will commence, specific activities that will satisfy the requirements, how to complete the activities, and supports that are available to assist members in meeting the requirements. Members will also be notified of the timeframe in which they have to complete these activities. This notice will be sent upon approval and renewal of AEM, if the individual does not appear to meet an exemption or demonstrate good cause.

Section VI. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality- Attachment 1 for the State's historical and projected expenditures for the requested period of the demonstration.

Below are the projected enrollment and expenditures for the remaining demonstration year:

Enrollment	DY25(SFY 27) Community Engagement anticipated start date: 7/1/26
AEM	75,204

Expenditures	DY25(SFY 27) Community Engagement anticipated start date: 7/1/26
AEM	$867,928,521

Section VII. Proposed Waiver and Expenditure Authority

The State requests the following proposed waivers and expenditure authorities to operate the Demonstration.

Waiver and Expenditure Authority	**Reason and Use of Waiver**

Section 1902(a)(10)(B)-Comparability of amount, duration and scope of service	To enable the State to provide additional benefits to AEM members compared to the benefits available to members eligible under the State Plan that are not affected by the Demonstration.
Section 1902(a)(8) and (a)(10)-Eligibility and Provision of Medical Assistance	To the extent necessary to enable the State to suspend eligibility for, and not make medical assistance available to members subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the member is exempted, or demonstrates good cause, as described in the STCs. To the extent necessary to enable the State to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs.
Section 1902(a)(10)(A)(i)(VIII) and 1902(a)(17) Compatibility of Eligibility Requirements	To the extent necessary to enable Utah to require work, training, and/or engagement as a condition to qualify for and maintain eligibility for the eligibility category defined in 1902(a)(10)(A)(i)(VIII).

Expenditure Authority

The State is requesting expenditure authority for expenditures for services delivered to the Adult Expansion population with federal financial participation pursuant to 42 U.S.C. Section 1396d(y).

Section VIII. Compliance with Public Notice and Tribal Consultation

Public Notice Process

Public notice of the State's request for this demonstration amendment, and notice of public hearing were advertised in the newspapers of widest circulation and sent to an electronic mailing list. In addition, the abbreviated public notice was posted to the State's Medicaid website at **https://medicaid.utah.gov/1115-waiver.**

The State originally scheduled two public hearings. Due to a public comment request provided after the May 14, 2025 public hearing, the State added a third public hearing, held on Tuesday, May 27, 2025 as indicated below, and extended the public comment period from April 22, 2025 through May 22, 2025, to April 22, 2025 through June 2, 2025.

Three public hearings to take public comment were held as indicated below:

- Friday, May 2, 2025, from 12:30 pm to 2:00 pm.
  - In person: Multi-Agency State Office Building 195 N 1950 W, Salt Lake City, Utah Room 1020 A-B-C
  - Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
  - Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#
- Wednesday, May 14, 2025, from 4:00 pm to 6:00 pm.
  - In person: Multi-Agency State Office Building 195 N 1950 W, Salt Lake City, Utah Room 1020 A-B-C
  - Video Conference: Google Meet Meeting meet.google.com/env-pmts-caw
  - Or join by phone: (US) +1 262-546-6218 PIN: 431 053 232#
- Tuesday, May 27, 2025, from 4:00 pm to 5:00 pm.
  - In person: Dr. Martha Hughes Cannon Building, 288 N 1460 W, Salt Lake City, UT 84116, room 125
  - Video Conference: Google Meet Meeting meet.google.com/srp-oieh-qaz
  - Or join by phone: (US)+1 321-586-0614 PIN: 800 715 753#

Public Comment

The original public comment period was from April 22, 2025, through May 22, 2025, but was extended through June 2, 2025. The State received 260 public comments during the public comment period. This includes comments provided during the three public hearings, email and online portal comments, and mailed comments. The State reviewed and considered all public comments received during the public notice period. Summarized comments and the State's responses are included in Attachment 3.

In response to the comments, the State made the following changes to its application:

- Removed the research information included in the background section of the amendment.
- Modified several exemptions.
- Modified two reasons for good cause.
- Using available data sources and other mechanisms before requiring members or applicants to provide proof of meeting an exemption or good cause.
- Seeking federal match for member supports.

Tribal Consultation

In accordance with the Utah Medicaid State Plan, and section 1902(a)(73) of the Social Security Act and the DHHS Intergovernmental Policy 01.19 Formal DHHS Tribal Consultation and Urban Indian Organization Conferment Process Policy , the State ensures

that a meaningful consultation process occurs in a timely manner on program decisions or policy impacting Indian Tribes and the Urban Indian Organization (UIO) in the State of Utah. DIH has notified the DHHS Tribal Health Liaison of the waiver amendment. As a result of this notification, DIH began to engage in the tribal consultation process by attending the Utah Indian Health Advisory Board (UIHAB) meeting on May 9, 2025, to present this demonstration amendment.

Tribal Consultation & Conferment Policy Process

In the event that a grant, project, policy, waiver renewal or amendment is requested, the Office of AI/AN Health Affairs is contacted. If the request is within the 90 days of submission, the Office's AI/AN Health Liaison will provide an opportunity for presentation to the Utah Indian Health Advisory Board (UIHAB) Tribal and UIO representatives. The Liaison will request an executive summary of the materials to be included in the distribution of the meeting agenda and materials to the UIHAB representatives and Tribal leadership. The information is disseminated to the UIHAB representatives and leadership at least 10 days prior to the meeting for review. During the UIHAB meeting, presenters will address any questions or concerns raised by the representatives. If the UIHAB representatives provide resolutions to or are in agreement with the changes, they will make a motion to pass or support by a majority. If additional Consultation is required, the UIHAB will inform the presenters of that need at that time. If a Tribal or UIO representative would like to have the presentation provided to their leadership, they can also make a formal request at that time. The Office of AI/AN Health Affairs will coordinate with the presenter and the UIHAB representatives or the Tribe or UIO to schedule an additional Consultation or Conferment meeting on the issue(s) or concern(s) raised.

Section IX. Demonstration Administration

Name and Title: Jennifer Strohecker, Medicaid Director, Division of Integrated Healthcare
Telephone Number: (801) 538-6689
Email Address: medicaiddirector@utah.gov

Attachment 1

Compliance with Budget Neutrality Requirements

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Current Eligibles							
Pop Type:	Medicaid						
Eligible Member Months	0.0%	479,104	196,941	Pop. Ended 12/31/23			
PMPM Cost	5.3%	$ 628.81	$ 649.69				
Total Expenditure		$ 347,560,796	$ 145,816,589				$ 493,377,385
Demo Pop I - PCN Adults with Children							
Pop Type:	Hypothetical						
Eligible Member Months	5.9%						
PMPM Cost	5.3%						
Total Expenditure							$ -
Demo Pop III/V - UPP Adults with Children *							
Pop Type:	Hypothetical						
Eligible Member Months	34.9%	36,498	49,222	66,380	89,520	120,727	
PMPM Cost	0.0%	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults							
Pop Type:	Medicaid						
Eligible Member Months							
PMPM Cost							
Total Expenditure							$ -
Demo Pop III/V - UPP Childless Adults *							
Pop Type:	Medicaid						
Eligible Member Months	159	184	189	194	199	204	
PMPM Cost	$ 68.45	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure		$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Employer Sponsored Insurance (ESI)							
Pop Type:	Hypothetical						
Eligible Member Months		11,310	9,192	8,650	8,140	7,660	
PMPM Cost	5.3%	$266.22	$280.33	$295.19	$310.83	$327.31	
Total Expenditure		$ 3,010,948	$ 2,576,793	$ 2,553,384	$ 2,530,186	$ 2,507,200	$ 13,178,511
Adult Expansion Population		*Assumes higher PMPM from Mid-Course Correction then trended forward at 4.7%*				*Community Engagement: Assumes start date of 7/1/2026*	
Pop Type:	Expansion						
Eligible Member Months		1,537,011	1,082,920	1,019,071	958,987	902,445	
PMPM Cost	4.7%	$ 651.40	$ 837.96	$ 877.34	$ 918.58	$ 961.75	
Total Expenditure		$ 1,001,208,965	$ 907,443,643	$ 894,075,982	$ 880,905,241	$ 867,928,521	$ 4,551,562,353
Former Foster							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%	10	10	10	10	10	
PMPM Cost	4.8%	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure		$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Intense Stabilization Services (ISS)							
Pop Type:	Hypothetical						
Eligible Member Months	0.0%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost	5.3%	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure		$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment							
Pop Type:	Hypothetical						
Eligible Member Months	13.5%	162	184	209	237	269	
PMPM Cost	5.0%	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure		$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310
Medicaid for Justice-Involved Populations							
Pop Type:	Hypothetical						
Eligible Member Months	1.75%	39,756	40,451	41,159	41,880	42,613	
PMPM Cost	3.0%	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure		$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)							
Pop Type:	Hypothetical						
Eligible Member Months	2.5%	11,043	11,319	11,602	11,892	12,190	
PMPM Cost	5.3%	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.67	$ 17,630.03	
Total Expenditure		$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	DY21-25 TOTAL WOW
Serious Mental Illness (SMI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months	2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost	5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure		$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)							
Pop Type:	**Hypothetical**						
Eligible Member Months	6.9%	49,527	52,940	56,587	60,486	64,654	
PMPM Cost	5.0%	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure		$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults		*Member months will increase when the criteria is expanded to include victims of*					
Pop Type:	**Expansion**	*PMPM will increase due to adding the new managed care directed payments*					
Eligible Member Months		120,464	89,798	84,504	79,521	74,833	
PMPM Cost	5.5%	$1,177.22	$1,242.97	$1,310.28	$1,382.35	$1,458.38	
Total Expenditure		$141,812,630	$111,616,220	$110,723,259	$109,926,107	$109,134,388	$ 583,212,604
Long-Term Support Services (LTSS)							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		600	600	600	600	
PMPM Cost	5.0%		$ 9,578.00	$ 10,056.90	$ 10,559.75	$ 11,087.73	
Total Expenditure			$ 5,746,800	$ 6,034,100	$ 6,335,800	$ 6,652,600	$ 24,769,300
Integrated Behavior Health Services							
Pop Type:	**Hypothetical**		*Starts 1/1/24*				
Eligible Member Months	0.0%		1,500	3,000	3,000	3,000	
PMPM Cost	5.0%		$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure			$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000
Demo Pop VI - UPP for Children							
Pop Type:	**Hypothetical**		*Starts 1/1/24*				
Eligible Member Months	0.0%		1,775	3,523	3,523	3,523	
PMPM Cost	0.0%		$ 190.00	$ 190.00	$ 190.00	$ 190.00	
Total Expenditure			$ 337,250	$ 669,370	$ 669,370	$ 669,370	$ 2,345,360
IVF and Genetic Testing							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		5	20	20	20	
PMPM Cost	5.3%		$ 7,421.38	$ 7,814.71	$ 8,228.89	$ 8,665.02	
Total Expenditure			$ 37,107	$ 156,294	$ 164,578	$ 173,300	$ 531,280
Oncofertility							
Pop Type:	**Hypothetical**						
Eligible Member Months	2.4%	119	244	250	256	262	
PMPM Cost	3.0%	$ 7,485.29	$ 7,700.82	$ 7,927.20	$ 8,164.84	$ 8,414.50	
Total Expenditure		$ 890,750	$ 1,879,000	$ 1,981,800	$ 2,090,200	$ 2,204,600	$ 9,046,350
Dental Services for Medicaid-eligible Adults							
Pop Type:	**Hypothetical**						
Eligible Member Months	varies		2,255,460	2,505,192	2,562,444	2,679,348	
PMPM Cost	0.0%		$ 32.19	$ 32.19	$ 32.19	$ 32.19	
Total Expenditure			$ 72,603,302	$ 80,642,218	$ 82,484,960	$ 86,248,288	$ 321,978,768
SB133 12-Month Extended Postpartum							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		140,004	138,540	136,980	134,796	
PMPM Cost	4.5%		$ 1,072.13	$ 1,120.45	$ 1,170.87	$ 1,223.46	
Total Expenditure			$ 150,103,124	$ 155,227,571	$ 160,385,793	$ 164,917,386	$ 630,633,874
SB133 Family Planning Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	1.6%		60,648	61,656	62,640	63,636	
PMPM Cost	1.2%		$ 21.60	$ 21.86	$ 22.13	$ 22.40	
Total Expenditure			$ 1,309,968	$ 1,348,051	$ 1,386,293	$ 1,425,154	$ 5,469,466
SB269 Chronic Conditions Support Amendment							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%		9,660	19,320	19,320	9,660	
PMPM Cost	0.0%		$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure			$ 1,738,800	$ 3,477,600	$ 3,477,600	$ 1,738,800	$ 10,432,800

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Current Eligibles								
Pop Type:	**Medicaid**							
Eligible Member Months	377,866	0.0%	479,104	196,941				
PMPM Cost	$ 949.03	5.3%	$ 1,293.75	$ 1,362.32				
Total Expenditure			$ 619,841,397	$ 268,296,675				$ 888,138,072
Demo Pop I - PCN Adults w/Children								
Pop Type:	**Hypothetical**							
Eligible Member Months	104,836	5.9%	-	-	-	-	-	
PMPM Cost	$ 46.18	5.3%	-	-	-	-	-	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Adults with Children								
Pop Type:	**Hypothetical**							
Eligible Member Months	6,067	34.9%	$ 36,498	$ 49,222	$ 66,380	$ 89,520	$ 120,727	
PMPM Cost	$ 150.08	0.0%	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure			$ 14,182,519	$ 19,126,545	$ 25,794,059	$ 34,785,867	$ 46,912,221	$ 140,801,211
Demo Pop I - PCN Childless Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	70,097	4.9%	-	-	-	-	-	
PMPM Cost	$ 48.97	5.3%	$ -	$ -	$ -	$ -	$ -	
Total Expenditure			$ -	$ -	$ -	$ -	$ -	$ -
Demo Pop III/V - UPP Childless Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	159	4.9%	$ 184	$ 189	$ 194	$ 199	$ 204	
PMPM Cost	$ 68.45	5.3%	$ 388.58	$ 388.58	$ 388.58	$ 388.58	$ 388.58	
Total Expenditure			$ 71,651	$ 73,442	$ 75,278	$ 77,160	$ 79,089	$ 376,620
Employer Sponsored Insurance (ESI)								
Pop Type:	**Expansion**							
Eligible Member Months			11,310	9,192	8,650	8,140	7,660	
PMPM Cost		5.3%	$ 266.22	$ 280.33	$ 295.19	$ 310.83	$ 327.31	
Total Expenditure			$ 3,010,948	$ 2,576,793	$ 2,553,394	$ 2,530,156	$ 2,507,195	$ 13,178,486
Adult Expansion Population			*Assumes higher PMPM from Mid-Course Correction then trended forward at 4.7%*			*Community Engagement: Assumes start date of 7/1/2026*		
Pop Type:	**Expansion**							
Eligible Member Months			1,537,011	1,082,920	1,019,071	958,987	902,445	
PMPM Cost		4.7%	$ 651.40	$ 837.98	$ 877.34	$ 918.58	$ 961.75	
Total Expenditure			$ 1,001,208,965	$ 907,443,643	$ 894,075,982	$ 880,905,241	$ 867,928,521	$ 4,551,562,353
Former Foster Care								
Pop Type:	**Hypothetical**							
Eligible Member Months		0.0%	10	10	10	10	10	
PMPM Cost		4.8%	$ 1,252.63	$ 1,312.76	$ 1,375.77	$ 1,441.81	$ 1,511.01	
Total Expenditure			$ 12,526	$ 13,128	$ 13,758	$ 14,418	$ 15,110	$ 68,940
Intense Stabilization Services (ISS)								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	1,440	1,440	1,440	1,440	1,440	
PMPM Cost		5.3%	$2,328.50	$2,451.91	$2,581.86	$2,718.70	$2,862.79	
Total Expenditure			$ 3,353,038	$ 3,530,749	$ 3,717,879	$ 3,914,927	$ 4,122,418	$ 18,639,012
In-Vitro Fertilization (IVF) Treatment								
Pop Type:	**Hypothetical**							
Eligible Member Months		13.5%	162	184	209	237	269	
PMPM Cost		5.0%	$ 20,588.98	$ 21,620.64	$ 22,703.99	$ 23,841.63	$ 25,036.27	
Total Expenditure			$ 3,341,461	$ 3,982,315	$ 4,746,077	$ 5,656,320	$ 6,741,137	$ 24,467,310
Medicaid for Justice-Involved Populations								
Pop Type:	**Hypothetical**							
Eligible Member Months		1.8%	39,756	40,451	41,159	41,880	42,613	
PMPM Cost		3.0%	$ 551.67	$ 568.22	$ 585.26	$ 602.82	$ 620.91	
Total Expenditure			$ 21,931,981	$ 22,985,264	$ 24,089,131	$ 25,246,012	$ 26,458,452	$ 120,710,839
Mental Health Institutions for Mental Disease (IMD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		2.5%	11,043	11,319	11,602	11,892	12,190	
PMPM Cost		5.3%	$ 14,339.69	$ 15,099.69	$ 15,899.97	$ 16,742.87	$ 17,630.03	
Total Expenditure			$ 158,356,552	$ 170,918,185	$ 184,476,270	$ 199,109,850	$ 214,904,239	$ 927,765,096
Serious Mental Illness (SMI)								
Pop Type:	**Hypothetical**							
Eligible Member Months		2.5%	17,688	18,130	18,583	19,048	19,524	
PMPM Cost		5.3%	$ 14,998.85	$ 15,793.79	$ 16,630.86	$ 17,512.30	$ 18,440.45	
Total Expenditure			$ 265,296,529	$ 286,341,176	$ 309,055,190	$ 333,570,993	$ 360,031,512	$ 1,554,295,400
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		6.9%	49,527	52,940	56,587	60,486	64,654	
PMPM Cost		5.0%	$ 4,239.75	$ 4,451.74	$ 4,674.33	$ 4,908.05	$ 5,153.45	
Total Expenditure			$ 209,983,503	$ 235,674,067	$ 264,507,781	$ 296,869,197	$ 333,189,497	$ 1,340,224,045
Targeted Adults								
Pop Type:	**Expansion**							
Eligible Member Months			120,464	89,798	84,504	79,521	74,833	
PMPM Cost		5.5%	1,177	1,243	1,310	1,382	1,458	
Total Expenditure			$ 141,812,630	$ 111,616,220	$ 110,723,901	$ 109,925,854	$ 109,134,951	$ 583,213,556
Long-Term Support Services (LTSS)								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	0.0%	-	600	600	600	600	
PMPM Cost	5.0%	0.0%	-	9,578	10,057	10,560	11,088	

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 15	DEMO TREND RATE	DY 21 (SFY 23)	DY 22 (SFY 24)	DY 23 (SFY 25)	DY 24 (SFY 26)	DY 25 (SFY 27)	TOTAL WW
Total Expenditure			-	5,746,800	6,034,100	6,335,800	6,652,600	$ 24,769,300
Integrated Behavior Health Services								
Pop Type:	**Hypothetical**			*Starts 1/1/24*				
Eligible Member Months	0.0%	0.0%	-	1,500	3,000	3,000	3,000	
PMPM Cost	5.0%	0.0%	$ -	$ 66.67	$ 70.00	$ 73.50	$ 77.18	
Total Expenditure			$ -	$ 100,000	$ 210,000	$ 220,500	$ 231,500	$ 762,000
Demo Pop VI - UPP for Children								
Pop Type:	**Hypothetical**			*Starts 1/1/24*				
Eligible Member Months	0.0%	0.0%	-	1,775	3,523	3,523	3,523	
PMPM Cost	0.0%	0.0%	$ -	$ 190.00	$ 190.00	$ 190.00	$ 190.00	
Total Expenditure			$ -	$ 337,250	$ 669,370	$ 669,370	$ 669,370	$ 2,345,360
IVF and Genetic Testing								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	0.0%	-	5	20	20	20	
PMPM Cost	5.0%	5.3%	$ -	$ 7,421.38	$ 7,814.71	$ 8,228.89	$ 8,665.02	
Total Expenditure			$ -	$ 37,107	$ 156,294	$ 164,578	$ 173,300	$ 531,280
Oncofertility								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	2.4%	119	244	250	256	262	
PMPM Cost	5.0%	3.0%	$ 7,485.29	$ 7,700.82	$ 7,927.20	$ 8,164.84	$ 8,414.50	
Total Expenditure			$ 890,750	$ 1,879,000	$ 1,981,800	$ 2,090,200	$ 2,204,600	$ 9,046,350
Dental Services for Medicaid-eligible Adults								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	-	2,255,460	2,505,192	2,562,444	2,679,348	
PMPM Cost	5.0%	0.0%	$ -	$ 32.19	$ 32.19	$ 32.19	$ 32.19	
Total Expenditure			$ -	$ 72,603,302	$ 80,642,218	$ 82,484,960	$ 86,248,288	$ 321,978,768
SB133 12-Month Extended Postpartum								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	-	140,004	138,540	136,980	134,796	
PMPM Cost	5.0%	4.5%	$ -	$ 1,072.13	$ 1,120.45	$ 1,170.87	$ 1,223.46	
Total Expenditure			$ -	$ 150,103,124	$ 155,227,571	$ 160,385,793	$ 164,917,386	$ 630,633,874
					-1%	-1%	-2%	
SB133 Family Planning Services								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	1.6%	-	60,648	61,656	62,640	63,636	
PMPM Cost	5.0%	1.2%	$ -	$ 21.60	$ 21.86	$ 22.13	$ 22.40	
Total Expenditure			$ -	$ 1,309,968	$ 1,348,051	$ 1,386,293	$ 1,425,154	$ 5,469,466
SB269 Chronic Conditions Support Amendment								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	-	9,660	19,320	19,320	9,660	
PMPM Cost	0.0%	0.0%	$ -	$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure			$ -	$ 1,738,800	$ 3,477,600	$ 3,477,600	$ 1,738,800	$ 10,432,800
SB181 Native American Health Amendments								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	varies	-		3,300	3,300	3,300	
PMPM Cost	5.0%	0.0%	$ -	Not approved	$ 2,322.52	$ 2,322.52	$ 2,322.52	
Total Expenditure			$ -		$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 22,992,900
Health Related Social Needs (HRSN) excluding transportation								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	0.0%	-		-	-	-	
PMPM Cost	0.0%	0.0%	$ -	Not approved	$ -	$ -	$ -	
Total Expenditure		0.0%	$ -		$ -	$ 94,157,357	$ 94,157,357	$ 188,314,713
Health Related Social Needs (HRSN) transporation only								
Pop Type:	**Hypothetical**							
Eligible Member Months	0.0%	0.0%	-		-	59,076	59,076	
PMPM Cost	0.0%	0.0%	$ -	-	$ -	$ 8.58	$ 8.58	
Total Expenditure		0.0%	$ -		$ -	$ 506,760	$ 506,760	$ 1,013,520

Attachment 2

Public Notice Requirements

Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Utah Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

Utah Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time:

May 2, 2025 12:30 PM

Event End Date & Time:

May 2, 2025 02:00 PM

Event Deadline Date & Time:

05/02/25 02:00 PM

Description/Agenda:

Community Engagement Public Hearing

The Utah Department of Health & Human Services, Division of Integrated Healthcare will hold public hearings to discuss an amendment to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comments regarding the amendment online, by email, or mail during the public comment period from April 22, 2025, through May 22, 2025.

Utah Medicaid is requesting authority from the Centers for Medicare & Medicaid Services to implement a Community Engagement (CE) work requirement for the Adult Expansion Medicaid (AEM) demonstration group, which is currently authorized under the State's 1115 Demonstration. The CE requirement applies to AEM members who can participate in the CE requirement, are not already participating in other work or training activities, and do not meet an exemption or do not demonstrate good cause.

Give Feedback

Public Hearings:

The Department will conduct two public hearings to discuss the demonstration amendment. The dates and times are listed below.

- Friday, May 2, 2025, from 12:30 pm to 2:00 pm.
  - In person: Multi-Agency State Office Building 195 N 1950 W, Salt Lake City, Utah Room 1020 A-B-C
    Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
    Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #
    Wednesday, May 14, 2025, from 4:00 pm to 5:00 pm.
  Video Conference: Google Meet Meeting meet.google.com/env-pmts-caw
  Or join by phone: (US) +1 262-546-6218 PIN: 431 053 232 #

Individuals requiring an accommodation to fully participate in either meeting may contact

Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by April 28, 2025.

Public Comment:

A copy of the public notice and proposed amendment is available online at: https://medicaid.utah.gov/1115-waiver/

The public may comment on the proposed amendment request during the public comment period from April 22, 2025, through May 22, 2025.

Comments may be submitted using the following methods:

Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health & Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Give Feedback

Notice of Special Accommodations (ADA):

In compliance with the Americans with Disabilities Act, individuals needing special accommodations (including auxiliary communicative aids and services) during this meeting should notify Laura Belgique at 1 (801) 538-6241.

Notice of Electronic or Telephone Participation:

Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429 #

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 24, 2025 03:26 PM

Notice Last Edited On:

April 24, 2025 03:57 PM

Deadline Date:

May 2, 2025 02:00 PM

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Utah Medicaid Reform 1115 Demonstration

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Notice Information

Add Notice to Calendar

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Utah Medicaid Reform 1115 Demonstration

Notice Subject(s):

Medicaid , Health Care

Notice Type(s):

Hearing

Event Start Date & Time:

May 14, 2025 04:00 PM

Event End Date & Time:

May 14, 2025 05:00 PM

Event Deadline Date & Time:

05/14/25 05:00 PM

Description/Agenda:

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Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

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Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 24, 2025 03:34 PM

Notice Last Edited On:

April 24, 2025 03:50 PM

Deadline Date:

May 14, 2025 05:00 PM

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Support

PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Utah Medicaid Reform 1115 Demonstration

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

Give Feedback

Notice Information

Add Notice to Calendar

Notice Title:

Utah Medicaid Reform 1115 Demonstration

Notice Type(s):

Notice

Event Start Date & Time:

May 27, 2025 04:00 PM

Event End Date & Time:

May 27, 2025 05:00 PM

Event Deadline Date & Time:

05/27/25 05:00 PM

Description/Agenda:

PUBLIC NOTICE
Utah's Medicaid Reform 1115 Demonstration
Community Engagement Public Hearing

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Video Conference: Google Meet Meeting meet.google.com/env-pmts-caw
Or join by phone: (US) +1 262-546-6218 PIN: 431 053 232 #
Tuesday, May 27, 2025, from 4:00 pm to 5:00 pm.

In person: Dr. Martha Hughes Cannon Building, 288 N 1460 W, Salt Lake City, UT 84116, Room 125

Video Conference: Google Meet Meeting meet.google.com/srp-oieh-qaz
Or join by phone: (US) +1 321-586-0614 PIN: 800 715 753#

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by May 26, 2025.

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Mail: Utah Department of Health & Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

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Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

May 21, 2025 04:02 PM

Notice Last Edited On:

May 21, 2025 04:02 PM

Deadline Date:

May 27, 2025 05:00 PM

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The Salt Lake Tribune

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TELEPHONE
801-538-6641

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CAPTION
PUBLIC NOTICE Utah's Medicaid Reform 1115 Demonstration Community Engagement Public Hearing The Utah Department of Health & Human Services, Division of Integrated Healthcare will hold public hearings to discuss an amendment to Utah's Medicaid Reform 1115 Demonstration.

TOTAL COST
$231.80

PUBLIC NOTICE
Utah's Medicaid Reform 1115 Demonstration Community Engagement Public Hearing

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- Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#

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Mail: Utah Department of Health & Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0033072

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF PUBLIC NOTICE Utah's Medicaid Reform 1115 Demonstration Community Engagement Public Hearing The Utah Department of Health & Human Services, Division of Integrated Healthcare will hold public hearings to discuss an amendment to Utah's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 05/25/2025

DATE 05/30/2025

SIGNATURE

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 30th DAY OF MAY IN THE YEAR 2025

BY Doug Ryle

LAREE WHITMER
Notary Public
State of Utah
My Commission Expires December 9, 2028
Commission Number 740391

LaRee Whitmer
NOTARY PUBLIC SIGNATURE

PUBLIC NOTICE
Utah's Medicaid Reform 1115 Demonstration
Community Engagement Public Hearing

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Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Attachment 3

Public Comments and State Responses

CE Public comments and responses

General comments

Many commenters generally opposed the community engagement (CE) requirement. Several commenters stated that able bodied Medicaid members are already working and that placing work requirements on the broader population of Medicaid adults not working is unnecessary, punitive and counterproductive. Other commenters stated CE is unlikely to promote employment in a meaningful way, that tying health coverage to employment harms families and could lead to loss of care and homelessness. A few other commenters stated that the proposed process for compliance verification, including tracking job applications, monitoring exemption status, and handling appeals, is not clearly outlined. Another commenter stated the amendment fails to address how data will be integrated across Medicaid and workforce systems to ensure accuracy.

> **Response:** The State appreciates the thoughtful feedback provided through public comment. While some commenters expressed concern that the CE requirements may not promote meaningful employment, the State's design attempts to align with the Supplemental Nutrition Assistance Program (SNAP) work requirement, where many operational and exemption pathways already exist. The State acknowledges the risks identified and intends to mitigate them as much as possible by strengthening member supports and maximizing use of available data sources. The goal of the CE requirement is to increase employment since studies show associations between employment and improved health outcomes, including physical and mental health.[7] The State has added additional detail regarding its intent to maximize available data sources in the verification process.

Barriers to compliance

Many commenters stated there are significant barriers to compliance which will affect the poorest, sickest, least-educated and more vulnerable members including those experiencing homelessness, disability, mental illness, people of color, individuals with physical challenges as well as those with cancer, members receiving supportive housing, members with chronic conditions, and justice involved members. Several commenters stated CE only adds administrative burden that will cut off benefits and that the process of

[7] Silver SR, Li J, Quay B. Employment status, unemployment duration, and health-related metrics among US adults of prime working age: Behavioral Risk Factor Surveillance System, 2018-2019. Am J Ind Med. 2022 Jan;65(1):59-71. doi: 10.1002/ajim.23308. Epub 2021 Nov 8. PMID: 34748231; PMCID: PMC8678322.

documenting and providing compliance is complex and stressful for members who are already facing many other obstacles and burdens. Examples of barriers include lack of reliable transportation, unaffordable childcare, limited internet access, unstable housing, undiagnosed physical or mental health conditions, caregiving obligations, limited job opportunities in their area, lack of devices (computer, wifi), and lack of email addresses. Other examples include not being able to successfully navigate the Department of Workforce Services (DWS) system, difficulty getting third party verifications from employers and providers, not having the support to meet these burdens, and not receiving or understanding the requirements. One commenter stated that aligning Medicaid with SNAP is not only administratively unsound, but will likely replicate access barriers already experienced by families. Another commenter stated that the requirements will disproportionately harm the State's rural and frontier communities. Several other commenters noted many that employers prohibit more than 29 hours of work per week so they do not have to provide insurance and exemptions will be difficult for those with shift work and seasonal schedules.

Response: The State acknowledges that members may face barriers to meeting CE requirements and is committed to designing a program that will actively reduce those burdens wherever possible. In designing its approach, the State has aligned with SNAP to streamline compliance and avoid duplicative reporting. The State is committed to maximizing available electronic data sources to limit the member reporting burden. The State will also implement a range of supports that assist members in navigating the CE requirement. Additional support from the State may include Medicaid-related assistance with transportation, childcare, language access services, sending text message reminders and other supports; and connect members with disabilities as defined in the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act with services to enable them to participate. Members can claim a good cause exception due to lack of internet access or transportation. Members living in a county in which the unemployment rate is greater than 150% of the national average can also claim a good cause exception. Where self-reporting is necessary, the State's intent is to capture attestation in a manner that supports accurate and streamlined reporting while reducing complexity for members. Members can also utilize the DWS employment centers to assist in understanding employment resources and helping to successfully meet CE requirements. Recognizing the need and concern with barriers, the State is seeking federal match for navigation supports.

Cost concerns

Many commenters expressed concern with associated costs and stated the administrative systems and overhead required to track compliance, process exemptions, and manage increased churn and appeals can consume millions of taxpayer dollars and will far exceed the cost of healthcare. One commenter stated the administrative cost is not considered in the amendment and not adequately funding this will set members up for failure. A few commenters stated the State will see an increase in uncompensated care costs, resulting in a greater strain on the safety-net hospitals and clinics and an increase in emergency room visits. One commenter referred to a Government Accountability Office (GAO) study of work reporting requirements which estimated that the administrative costs could be up to $272 million and that in Georgia, the state spent over $86 million within a year of implementing the Georgia Pathways to Coverage Program, despite the low enrollment, and it is estimated that 90% of this was for administrative and consulting costs.

> **Response**: The State's alignment with SNAP provides a strong foundation for implementing a CE requirement within Medicaid. State's usage of existing systems, interfaces, established workflows and usage of online processes helps control administrative cost. Existing infrastructure at DWS (e.g., systems for job assessment, training, and employment tracking) will be leveraged to reduce the need for entirely new systems. This approach helps contain administrative costs compared to states that developed stand-alone CE systems from scratch. However, the State acknowledges that additional administrative resources may be needed to fully support members, including the development of new data connections, navigation supports, and mechanisms to capture streamlined attestations. The State is actively assessing these needs and will pursue opportunities, including federal match funding, to ensure successful implementation of CE requirements.

Unrealistic requirements

Many commenters stated that the requirements to apply for 48 jobs within 3 months or work 30 hours per week are unrealistic and would be a significant burden for members who are already employed. One commenter suggested a reduction to 24 applications for those with no employment and 12 for members with part time or irregular work. Another commenter suggested reducing the required weekly hours to 20. One commenter stated the requirements detract from meaningful job searching and that the State should be focusing on quality job searching as opposed to quantity.

> **Response**: The State is using SNAP as the standard for proposing the CE requirements. The State reinforces that exemptions exist for members that meet these requirements. However, in light of public comment, the State has modified the proposed exemption criteria for employment from 30 hours per week to at least

80 hours per month or working and earning at least federal minimum wage times 80 hours a month. This modification also better aligns with the federal proposal for CE.

Consequences of coverage loss

Many commenters stated CE will result in coverage loss which will reduce access to care, disrupt access to critical and lifesaving services, and lead to disease, distress, homelessness, emergency visits, overdose, worsened health outcomes, incarceration, mental health hospitalization and death. One commenter stated the loss of coverage can make it difficult for members to find or maintain employment. Another commenter stated that the community health centers will struggle financially to accommodate an increase in uninsured patients. A few other commenters stated that work requirements do not improve health outcomes or increase employment; instead, they risk cutting off access to essential care for those who need it most and that the policy in practice will harm the very people it is meant to help. One commenter stated that while the State would reinstate coverage after 3 months when beneficiaries are found to be in compliance, the proposed amendment does not indicate whether services received during the suspended period would be retroactively covered and if not, could leave low-income families facing medical debt incurred during this time.

Response: The State recognizes concerns about potential coverage disruptions and has included numerous exemptions for vulnerable populations. Members who are physically unable to work will be exempt. The State will maximize available data sources to limit the reporting burden for members who meet an exemption. The State intends to provide member support for members in order to help them navigate the requirements. For individuals who become compliant during a suspension period, eligibility will be retroactively reinstated to the beginning of the suspension period without having to reapply.

Create evidence based programs

Many commenters suggested that the State create programs that will help members become more self-sufficient, including strategies and employment services that support beneficiaries holistically, such as strengthening connections to voluntary employment and training programs, addressing social determinants of health like housing and transportation, and ensuring robust access to physical and behavioral healthcare. One commenter suggested a program with incentives for helping members get a better job

while another stated that resources should be aimed at helping members find work that comports with their abilities and subsequently supporting them in that work.

> **Response:** The State will continue to provide employment supportive services through DWS and provide high quality healthcare services to all enrolled members. The State is committed to active engagement with our federal partners to broaden the scope of employment support services that are billable under the Medicaid benefit. Likewise, the State will actively coordinate with existing community services to build robust employment support services for Medicaid members.

CE undermines the objectives of Medicaid

Many commenters discussed the purpose of Medicaid is to provide access to healthcare for low-income individuals and families, and that the CE approach is counter productive to that and likely to exacerbate health disparities and hardships. One commenter stated that Medicaid is a healthcare program and not a workforce program while another stated that for many, stable health coverage is a prerequisite for, not a result of, stable employment. Another commenter addressed one of the hypotheses included in the amendment, stating that it is difficult to logically see the link between employment and improved health outcomes not being from healthcare coverage but instead from interacting with the "employment process" and that this fails to address the fundamental purpose of Medicaid spelled out in Gresham v. Azar: "…covering health costs' through the provision of free or low-cost health coverage."

> **Response:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations. The State is seeking a waiver to demonstrate that employment is a social determinant of health and can contribute to improved health outcomes for Medicaid members.

Research and experience from other states demonstrates ineffectiveness

Many commenters discussed that research and experiences from other states that have attempted similar work requirements often leads to substantial coverage losses among eligible individuals without significantly increasing employment or improving health outcomes, and are prohibitively expensive. Instead, studies show work requirements do not meet objectives, but rather decrease mental health and promote the burden of red

tape. In addition, prior attempts to impose work requirements have shown that even those who are working or otherwise exempt from work requirements can be disenrolled due to the high paperwork burden required to prove those exemptions to the State. One commenter stated that the State is misrepresenting the research included in the amendment and that there is no evidence that work requirements lead to positive outcomes. Several commenters discussed Arkansas' work requirements, indicating that studies determined there to be an association of significant Medicaid coverage loss, but no corresponding increase in employment and that the U.S. Court of Appeals for the D.C. Circuit ruled that CMS's approval of Arkansas' work requirement was "arbitrary and capricious." In addition, one commenter stated that the amendment acknowledges that the previous CE requirement, implemented briefly in 2020, was suspended and removed before it could be fully operationalized or evaluated. Therefore, there is no State-specific evidence to suggest this policy will achieve its stated goals. In addition, one commenter stated that the State's own Office of the Legislative Auditor General found in a 2023 audit that DWS programs do not make a meaningful difference in helping people find stable employment.

> **Response:** The State's proposal differs from other states in its impact to members. The State recognizes the data produced by other state programs and believes that our proposal has meaningful differences in its design. The State is structuring its CE requirements to be similar to SNAP requirements in order to align with an existing model. Individuals who are meeting the SNAP requirement or who are already exempt under the SNAP requirement will meet the Medicaid CE requirements. Finally, due to the simplicity of the State's CE requirement and the options for exemption or hardship, the State's estimates on the impact on enrollment may differ from those estimated by other states. The State is committed to maximizing available data sources to limit the reporting burden for members who meet an exemption. The State intends to provide member support for members subject to the CE requirement in order to help them navigate the requirement.

Lack of State staff needed to operationalize

A few commenters stated that DWS does not have enough staff or employment centers to adequately operationalize CE and that there is no mention of hiring additional staff to manage the increased workload. One commenter stated that DWS is already challenged to meet its existing obligations to the public and the State will need to invest significant money to meet the additional administrative burden of implementing CE. Another commenter stated that recent experience with DWS suggests that they may not be ready to manage this additional burden without additional staff as they are currently not meeting

call wait times, and that during Medicaid unwinding, the call wait time and volumes increased substantially, and staff were overwhelmed by the number of cases assigned to them, resulting in delays to questions and complaints being resolved. Without an increase in staff, the commenter does not believe that DWS can process exemption requests for the over 67,000 Medicaid expansion members who should qualify for one, nor would they be able to adequately support the approximately 7,500 Medicaid expansion members who would be subject to the work requirement.

> **Response:** The State acknowledges the importance of sufficient staffing and resources to implement CE effectively. DWS is committed to ensuring adequate staffing levels to manage the implementation and maintenance of CE.

Opposed to proposed federal requirements

Three commenters expressed opposition to the proposed federal requirements, noting that accelerating biannual redeterminations and limiting retroactive Medicaid coverage will only deepen coverage interruptions and hardship, leading to worse health outcomes and higher public costs through emergency care, hospitalization, or homelessness.

> **Response:** The State is only reviewing and responding to public comments related to the State's CE amendment proposal.

Request for additional exemptions

Twenty two comments requesting additional exemptions were received. Examples include those experiencing homelessness, caregivers (including grandparents, parents and guardians of children under 19), those with serious and chronic health conditions including HIV, cancer patients, mental health treatment), those who volunteer, students in postgraduate programs, pregnancy, changing the 60 years of age exemption to 50, and ensuring the exemption for American Indian and Alaska Native people is implemented in a way that is inclusive of all American Indian and Alaska Native beneficiaries including those who receive care at all Indian Health Service (IHS), Tribal, and UIO facilities, and those who live off Tribal lands and receive health care services at UIOs. In addition, one commenter stated the exemption description in the amendment is not clear (including how exemptions will be verified) and can cause confusion and subsequent non-compliance, and that it is also unclear how CE will address fluctuating disability status.

> **Response:** Based on public feedback, the State has revised several exemptions. New exemptions include parents of a dependent child 13 years or younger, veterans with rated disabilities, and former foster care youth under the age of 26. Additionally, the CE requirement has been modified to allow for working 80 hours per month or working and earning at least federal minimum wage times 80 hours a

month. For justice involved members, the State is also modifying the time period exemption from six months after release from incarceration to three months.

The State appreciates the comment to ensure that the exemption for American Indian and Alaska Native (AI/AN) people will be implemented in a way that is inclusive of all AI/AN beneficiaries. The State met with the UIHAB on May 9, 2025, to discuss the CE amendment. The State has robust processes in place to work closely with the AI/AN community to include a specialized team at DWS that provides outreach and support.

As stated in the amendment, a member can claim an exemption at any time. Members meeting at least one exemption will not be required to complete the CE participation requirement within the 12-month certification period in which the exemption is claimed in order to maintain continued coverage.

Supportive comments

The State received three comments supporting the proposed amendment. One commenter stated that Medicaid members need to be nudged into better, productive lives. Two additional commenters stated that members who abuse Medicaid should be held accountable or removed from Medicaid.

Response: The State appreciates the range of perspectives shared through public comment.

Attachment 4

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

5/9/2025 8:30 AM –11:00 AM	Join via Google Meeting: https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
In person: 660 S 200 E, SLC, UT 8411. Sacred Circle Healthcare: Salt Lake City Main Clinic (4th floor)	Join via Phone: 1-(414)-909-6377 PIN: 211 599 534

Time	Agenda Topic	Presenter
8:30 am	Welcome and Introductions and Roll Call	LaTosha Mayo, Chairperson
8:45 am	Committee Updates	
	UT Medicaid Eligibility Policy	Gina Boren (DHHS)
	UT Medicaid Policy Update	Jim Stamos (DHHS)
	Medicaid and CHIP State Plan Amendments	Craig Devashrayee (DHHS)
	Medicaid 1115 Wavier	Laura Belgique (DHHS)
	DWS Medicaid Eligibility Operations	Jessica Ware (DWS)
	SNAP	Frank Vega (DWS)
	MCAC Committee	Michael Jensen (UNHS)
	CHIP Advisory Committee	Rachel Greymountain
9:30 am	Office of AI/AN Health and Family Services Updates	
	Data Reporting Updates	Alex Merrill (IHFS)
	Program Manager Updates	Hilary Makris (DHHS)
	Tobacco & Opioid Updates	Kassie John (DHHS)
	ICWA Liaison	Jamie Harvey (IHFS)
	Tribal Health Liaison	Jeremy Taylor (IHFS)

Time	Topic	Presenter
10:00 am	UIHAB Priorities	IHFS Team
10:15 am	I/T/U Partner Spotlight	Lorena Horse
10:45 am	I/T/U Updates	I/T/U partners
11:00 am	Adjourn	
	Lunch and tour	

Next UIHAB Meeting will be June 13, 2025

Hosted by:

SKVB - TBD

Facilitated by: Utah Department of Health and Human Services Office of AI/AN Health & Family Services
Note Taker: Dorrie Reese (All meetings are recorded)

UIHAB Meeting

May 9, 2025 (Hybrid)
8:30 a.m. – 11:00 a.m.

Participants: (Hybrid)

Lorena Horse, *Confederated Tribes of the Goshute*
Rachel Greymountain, *Confederated Tribes of the Goshute*
Josh Anderson, *Confederated Tribes of the Goshute*
LaTosha Mayo (Chair), *Paiute Indian Tribe of Utah*
Shawn Begay, *Utah Navajo Health Systems*
Craig Sandoval, *Urban Indian Center of Salt Lake*
Matt Poss, *Urban Indian Center of Salt Lake*
Tracie Tso, *Utah Division of Indian Affairs*
Maurice James, *Ute & Ouray, IHS*
MaryLynn Old Coyote, *Ute & Ouray, IHS*
Hope Johnson, *PHX, IHS*
Tyler Deines, *CMS*
Barbara Prehmus, *CMS*

Guests:

Jessica Ware, *AI/AN Eligibility Specialist, DWS*
Frank Vega, *SNAP Specialist, DWS*

DHHS Staff:

Jennifer Strohecker, *State Medicaid Director, Division of Integrated Healthcare, DHHS*
Brian Roach, *Assistant Division Director, Division of Integrated Healthcare, DHHS*
Gina Boren, *Assistant Office Director, Office of Eligibility Policy, DHHS*
Craig Devashrayee, *Office of Reimbursement Coordinated Care & Audit, DHHS*
Jim Stamos, *Office Director, Office of Health Policy & Authorization, DHHS*
Laura Belgique, *Office of Eligibility Policy, DHHS*
Jeremy Taylor, *Tribal Health Liaison, Office of AI/AN Health Affairs, DHHS*
Alex Merrill, *EPI, Office of AI/AN Health Affairs, DHHS*
Kassie John, *Opioid & Tobacco Health Program Coordinator, Office of AI/AN Health Affairs, DHHS*
Dorrie Reese, *Recorder/Minutes, DIH Administrative Assistant, DHHS*

Welcome and Introductions:

The UIHAB Chairperson welcomed everyone starting the meeting at 8:30 a.m.

Approval of Minutes:

The Oct 11, 2019, Nov 15, 2019, Dec 13,2019, Jan 10, 2020, Mar 13,2020, A2025,0, 2020, May 8, 2020, Jun 12, 2020, Aug, 14, 2020, Sep 11, 2020, Oct 9, 2020, Nov 13, 2020, Dec 11, 2020, Jan, 21, 2021, , Feb 12, 2021, Mar 12, 2021, Apr 9, 2021, May 14, 2021, Jun 11, 2021, Aug 13, 2021, Sep 10, 2021, Oct 8, 2021, Nov 12, 2021, Dec 10, 2021, Jan 28, 2022, Mar 11, 2022, Apr 8, 2022, May 13, 2022, Jun 10, 2022, Aug 12, 2022, Sep 9, 2022, Oct 14, 2022, Nov 10, 2022, Dec 9, 2022, Jan 13, 2023, Feb 10, 2023, Mar 10, 2023, Apr 14, 2023, May 12, 2023, June 9, 2023, Aug 11, 2023, Sep 8, 2023, Oct 13, 2023, Nov 9, 2023, Dec 9, 2023, Jan 12, 2024, Mar 8, 2024, Apr 12, 2024, May 10, 2024, Jun 14, 2024, Aug 9, 2024, Sep 13, 2024, Oct 11, 2024, Nov 8, 2024, Dec 13, 2024, Jan 10, 2025, Mar 14, 2025, Apr 11, 2025 UIHAB minutes will be approved at a later UIHAB meeting.

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Medicaid Eligibility Policy:

Gina Boren gave an update.
https://medicaid.utah.gov/administration-publications/

Policy Updates:

Jim Stamos gave an update.
dmhfmedicalpolicy@utah.gov

Medicaid and CHIP State Plan Amendments:

Craig Devashrayee gave an update.

The documents which were presented are embedded in this document.

UIHAB MATRIX 5-9-25-1.pdf

SPA MATRIX 5-9-25-1.pdf

Medicaid 1115 Waiver:

Jennifer Strohecker and Laura Belgique gave an update.
https://medicaid.utah.gov/1115-waiver/
https://medicaid-documents.dhhs.utah.gov/Community Engagement Amendment.pdf

DWS Medicaid Eligibility/SNAP:

Jessica Ware gave an update on DWS Medicaid Eligibility Unwinding.

Frank Vega gave an update on SNAP.

SNAP-ebtlockunlock.pdf

MAC & CHIP Advisory Committees:

The next MAC meeting is scheduled for May 15, 2025, at 4:00 -6:00pm.
The next CHIPAC meeting is scheduled for July 17, 2025, at 1:00-1:55 pm

Data Reporting:

Alex Merrill gave an update.

IHFS Opioids and Tobacco Updates:

Kassie John gave an update.
kassiejohn@utah.gov

Please share in this chat which of the following your organization uses to engage and inform your service population: - Good Health TV - Newsletter - Social Media (Facebook, Instagram, Twitter) - Webpage - Email - Text messages
Substance Misuse Survey: Please fill out this form before the end of May 2025:
https://forms.gle/JmgetkYK1JMcpntx6

Traditional Tobacco Pamphlet.pdf

UIHAB Priorities:

Lorena Horse mentioned that Consultation claims and billings formal requests go through Jeremy Taylor at jeremytaylor@utah.gov

Tribal Health Liaison:

Jeremy Taylor gave an update.

CDC Measles Response Briefing for

Sacred Circle Presentation:

Lorena Horse gave an update.
https://sacredcircle.com/about-us/

Sacred Circle Healthcare.pdf

I/T/U Updates:

- Shawn Begay: Utah Navajo Health Systems
- LaTosha Mayo: Paiute Indian Tribe
- Hope Johnson: PHX, IHS

IHS PHX area UIHAB updates May 2025.pd

- Jeremy Taylor: AI/AN: Made the announcement that the UIHAB has a vacant Vice Chair position available. If anyone is interested to please email Jeremy at jeremytaylor@utah.gov

Adjourn:

The meeting ended at 11:35. Lorena Horse made that motion to adjourn the meeting. Craig Sandoval seconded that motion.

The next meeting: Jun 13, 2025 @ 8:30 a.m. (Hybrid)
Skull Valley Band of Goshute
TBD

2027-2032 Renewal
Attachment 4

Budget Neutrality Requirements

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

APPROVED MEGS

ELIGIBILITY GROUP	TREND RATE 1	DEMONSTRATION YEARS (DY) DY 26 (SFY 28)	DY 27 (SFY 29)	DY 28 (SFY 30)	DY 29 (SFY 31)	DY 30 (SFY 32)	DY21-25 TOTAL WOW
Adult Expansion Population							
Pop Type:	**Expansion**						
Eligible Member Months		1,006,224	1,006,224	1,006,224	1,006,224	1,006,224	
PMPM Cost	4.7%	$ 861.63	$ 902.13	$ 944.53	$ 988.92	$ 1,035.40	
Total Expenditure		$ 866,991,427	$ 907,740,024	$ 950,403,805	$ 995,072,784	$ 1,041,841,205	$ 4,762,049,244
Employer Sponsored Insurance (ESI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months		6,819	6,780	6,780	6,780	6,780	
PMPM Cost	5.3%	$338.34	$356.27	$375.15	$395.04	$415.97	
Total Expenditure		$ 2,307,137	$ 2,415,520	$ 2,543,543	$ 2,678,351	$ 2,820,303	$ 12,764,853
ESI Adultsw/ or w/o Children							
Pop Type:	**Expansion**						
Eligible Member Months		2,515	2,506	2,477	2,443	2,411	
PMPM Cost	5.3%	$318.74	$335.64	$353.43	$372.16	$391.88	
Total Expenditure		$801,639	$841,105	$875,434	$909,179	$944,825	$ 4,372,182
Dental Services							
Pop Type:	**Hypothetical**						
Eligible Member Months		3,904,781	3,904,776	3,904,776	3,904,776	3,904,776	
PMPM Cost	5.9%	$ 35.52	$ 37.61	$ 39.83	$ 42.18	$ 44.67	
Total Expenditure		$ 138,693,370	$ 146,876,090	$ 155,541,780	$ 164,718,745	$ 174,437,151	$ 780,267,135
Former Foster Care Youth from Another State							
Pop Type:	**Hypothetical**						
Eligible Member Months		168	168	168	168	168	
PMPM Cost	5.2%	$ 2,163.77	$ 2,276.29	$ 2,394.66	$ 2,519.18	$ 2,650.18	
Total Expenditure		$ 363,514	$ 382,417	$ 402,303	$ 423,222	$ 445,230	$ 2,016,686
Substance Use Disorder (SUD)							
Pop Type:	**Hypothetical**						
Eligible Member Months		9,684	9,684	9,684	9,684	9,684	
PMPM Cost	5.2%	$ 7,953.33	$ 8,366.90	$ 8,801.98	$ 9,259.69	$ 9,741.19	
Total Expenditure		$ 77,020,048	$ 81,025,090	$ 85,238,395	$ 89,670,791	$ 94,333,673	$ 427,287,997
Serious Mental Illness (SMI)							
Pop Type:	**Hypothetical**						
Eligibile Member Months		2,927	2,916	2,916	2,916	2,916	
PMPM Cost	5.3%	$ 19,375.78	$ 20,402.70	$ 21,484.04	$ 22,622.69	$ 23,821.70	
Total Expenditure		$ 56,712,906	$ 59,494,260	$ 62,647,456	$ 65,967,771	$ 69,464,063	$ 314,286,455
Health Related Social Needs (HRSN) Non-Medical Transportation (NMT)							
Pop Type:	**Hypothetical**						
Eligible Member Months		612	730	730	730	674	
PMPM Cost	5.2%	$ 9.78	10.29	10.83	11.39	11.98	
Total Expenditure		$ 5,988	$ 7,513	$ 7,904	$ 8,315	$ 8,076	$ 37,797
Fertility Treatment for Individuals Diagnosed with Cancer – Male							
Pop Type:	**Hypothetical**						
Eligible Member Months		12	12	12	12	12	
PMPM Cost	5.3%	$ 789.81	$831.67	$875.75	$922.17	$971.04	
Total Expenditure		$ 9,478	$ 9,980	$ 10,509	$ 11,066	$ 11,652	$ 43,208
Fertility Treatment for Individuals Diagnosed with Cancer – Female							
Pop Type:	**Hypothetical**						
Eligible Member Months		24	24	24	24	24	
PMPM Cost	5.3%	$ 11,725.33	$12,346.78	$13,001.16	$13,690.22	$14,415.80	
Total Expenditure		$ 281,408	$ 296,323	$ 312,028	$ 328,565	$ 345,979	$ 1,282,895
Cryopreservation							
Pop Type:	**Hypothetical**						
Eligible Member Months		262	262	262	262	262	
PMPM Cost	5.3%	$ 614.73	$647.31	$681.62	$717.74	$755.79	
Total Expenditure		$ 161,059	$ 169,596	$ 178,584	$ 188,049	$ 198,016	$ 734,245

In-Vitro Fertilization and Genetic Testing Services							
Pop Type:	**Hypothetical**						
Eligible Member Months		144	144	144	144	144	
PMPM Cost	5.0%	$ 9,099.20	$ 9,555.14	$ 10,033.92	$ 10,536.69	$ 11,064.66	
Total Expenditure		$ 1,310,285	$ 1,375,940	$ 1,444,884	$ 1,517,284	$ 1,593,311	$ 7,241,703

Reentry							
Pop Type:	**Hypothetical**						
Eligible Member Months		276	276	276	276	276	
PMPM Cost	5.3%	$ 1,209.62	$ 1,273.73	$ 1,341.24	$ 1,412.33	$ 1,487.18	
Total Expenditure		$ 333,856	$ 351,550	$ 370,183	$ 389,802	$ 410,462	$ 1,855,853

SB133 Family Planning Services							
Pop Type:	**Hypothetical**						
Eligible Member Months		63,828	63,828	63,828	63,828	63,828	
PMPM Cost	5.3%	$ 48.75	$ 51.34	$ 54.06	$ 56.92	$ 59.94	
Total Expenditure		$ 3,111,864	$ 3,276,793	$ 3,450,463	$ 3,633,337	$ 3,825,904	$ 17,298,361

Pregnant Women and 12-Month Extended Postpartum							
Pop Type:	**Hypothetical**						
Eligible Member Months		89,928	89,928	89,928	89,928	89,928	
PMPM Cost	5.3%	$ 912.98	$ 961.37	$ 1,012.32	$ 1,065.98	$ 1,122.47	
Total Expenditure		$ 82,102,698	$ 86,454,141	$ 91,036,211	$ 95,861,130	$ 100,941,770	$ 456,395,951

Reentry Non-Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%						
PMPM Cost	0.0%						
Total Expenditure		$ 4,271,744	$ 4,271,744	$ 4,271,744	$ 4,271,744	$ 4,271,744	$ 21,358,718

HRSN Services							
Pop Type:	**Hypothetical**						
Eligible Member Months	0.0%						
PMPM Cost	N/A						
Total Expenditure		$ 94,157,357	$ 94,157,357	$ 94,157,357	$ 94,157,357	$ 94,157,357	$ 470,786,785

HRSN Infrastructure							
Pop Type:	**Hypothetical**						
Eligible Member Months	AVERAGE						
PMPM Cost	N/A						
Total Expenditure		$ 12,450,000	$ 12,450,000	$ 12,450,000	$ 12,450,000	$ 12,450,000	$ 62,250,000

PENDING APPROVAL BY CMS

Long-Term Support Services (LTSS)							
Pop Type:							
Eligible Member Months		600	600	600	600	600	
PMPM Cost	5%	$ 11,642.12	$ 12,224.22	$ 12,835.43	$ 13,477.21	$ 14,151.07	
Total Expenditure		$ 6,985,270	$ 7,334,533	$ 7,701,300	$ 8,086,300	$ 8,490,600	$ 38,598,003

Integrated Behavior Health Services							
Pop Type:							
Eligible Member Months		3,000	3,000	3,000	3,000	3,000	
PMPM Cost	5%	$ 81.04	$ 85.09	$ 89.35	$ 93.81	$ 98.50	
Total Expenditure		$ 243,100	$ 255,300	$ 268,000	$ 281,400	$ 295,500	$ 1,343,300

SB269 Chronic Conditions Support Amendment							
Pop Type:							
Eligible Member Months		19,320	19,320	19,320	19,320	19,320	
PMPM Cost		$ 180.00	$ 180.00	$ 180.00	$ 180.00	$ 180.00	
Total Expenditure		$ 3,477,600	$ 3,477,600	$ 3,477,600	$ 3,477,600	$ 3,477,600	$ 17,388,000

SB181 Native American Health Amendments							
Pop Type:							
Eligible Member Months		3,300	3,300	3,300	3,300	3,300	
PMPM Cost		$ 2,322.52	$ 2,322.52	$ 2,322.52	$ 2,322.52	$ 2,322.52	
Total Expenditure		$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 38,321,500

Disability Wraparound Coverage							
Pop Type:							
Eligible Member Months		360	360	360	360	360	
PMPM Cost		$329.00	$329.00	$329.00	$329.00	$329.00	
Total Expenditure		$ 118,440	$ 118,440	$ 118,440	$ 118,440	$ 118,440	$ 592,200

Community Engagement Population							
Pop Type:							
Eligible Member Months		1,006,224	1,006,224	1,006,224	1,006,224	1,006,224	
PMPM Cost	4.7%	$ 861.63	$ 902.13	$ 944.53	$ 988.92	$ 1,035.40	
Total Expenditure		$ 866,991,427	$ 907,740,024	$ 950,403,805	$ 995,072,784	$ 1,041,841,205	$ 4,762,049,244

DEMONSTRATION WITH WAIVER (WW ALL) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

APPROVED MEGS

ELIGIBILITY GROUP		DEMO TREND RATE	DY 26 (SFY 28)	DY 27 (SFY 29)	DY 28 (SFY 30)	DY 29 (SFY 31)	DY 30 (SFY 32)	TOTAL WW
Adult Expansion Population								
Pop Type:	**Expansion**							
Eligible Member Months			1,006,224	1,006,224	1,006,224	1,006,224	1,006,224	
PMPM Cost		4.7%	$ 861.63	$ 902.13	$ 944.53	$ 988.92	$ 1,035.40	
Total Expenditure			$ 866,991,427	$ 907,740,024	$ 950,403,805	$ 995,072,784	$ 1,041,841,205	$ 4,762,049,244
Employer Sponsored Insurance (ESI)								
Pop Type:	**Expansion**							
Eligible Member Months			6,819	6,780	6,780	6,780	6,780	
PMPM Cost		5.3%	$ 338.34	$ 356.27	$ 375.15	$ 395.04	$ 415.97	
Total Expenditure			$ 2,307,136.57	$ 2,415,520.23	$ 2,543,542.80	$ 2,678,350.57	$ 2,820,303.15	$ 12,764,853
ESI Adultsw/ or w/o Children								
Pop Type:	**Expansion**							
Eligible Member Months			2,515	2,506	2,477	2,443	2,411	
PMPM Cost		5.3%	$318.74	$335.64	$353.43	$372.16	$391.88	
Total Expenditure			$801,638.90	$841,105.03	$875,434.26	$909,178.95	$944,825.24	$ 4,372,182
Dental Services								
Pop Type:	**Hypothetical**							
Eligible Member Months			3,904,781	3,904,776	3,904,776	3,904,776	3,904,776	
PMPM Cost		5.9%	$ 35.52	$ 37.61	$ 39.83	$ 42.18	$ 44.67	
Total Expenditure			$ 138,693,370	$ 146,876,090	$ 155,541,780	$ 164,718,745	$ 174,437,151	$ 780,267,135
Former Foster Care Youth from Another State								
Pop Type:	**Hypothetical**							
Eligible Member Months		0.0%	168	168	168	168	168	
PMPM Cost		4.8%	$ 2,163.77	$ 2,276.29	$ 2,394.66	$ 2,519.18	$ 2,650.18	
Total Expenditure			$ 363,514	$ 382,417	$ 402,303	$ 423,222	$ 445,230	$ 2,016,686
Substance Use Disorder (SUD)								
Pop Type:	**Hypothetical**							
Eligible Member Months		0.0%	9,684	9,684	9,684	9,684	9,684	
PMPM Cost		5.2%	$ 7,953.33	$ 8,366.90	$ 8,801.98	$ 9,259.69	$ 9,741.19	
Total Expenditure			$ 77,020,048	$ 81,025,090	$ 85,238,395	$ 89,670,791	$ 94,333,673	$ 427,287,997
Serious Mental Illness (SMI)								
Pop Type:	**Hypothetical**							
Eligible Member Months		2.5%	2,927	2,916	2,916	2,916	2,916	
PMPM Cost		5.3%	$ 19,375.78	$ 20,402.70	$ 21,484.04	$ 22,622.69	$ 23,821.70	
Total Expenditure			$ 56,712,906	$ 59,494,260	$ 62,647,456	$ 65,967,771	$ 69,464,063	$ 314,286,455
Health Related Social Needs (HRSN) Non-Medical Transportation (NMT)								
Pop Type:	**Expansion**							
Eligible Member Months			612	730	730	730	674	
PMPM Cost		5.3%	$9.78	$10.29	$10.83	$11.39	$11.98	
Total Expenditure			$5,987.56	$7,513.41	$7,904.11	$8,315.12	$8,076.47	$ 37,797
Fertility Treatment for Individuals Diagnosed with Cancer – Male								
Pop Type:	**Expansion**							
Eligible Member Months			12	12	12	12	12	
PMPM Cost		5.3%	$789.81	$831.67	$875.75	$922.17	$971.04	
Total Expenditure			$ 9,478	$ 9,980	$ 10,509	$ 11,066	$ 11,652	$ 43,208
Fertility Treatment for Individuals Diagnosed with Cancer – Female								
Pop Type:	**Expansion**							
Eligible Member Months			24	24	24	24	24	
PMPM Cost		5.3%	$11,725.33	$12,346.78	$13,001.16	$13,690.22	$14,415.80	
Total Expenditure			$ 281,408	$ 296,323	$ 312,028	$ 328,565	$ 345,979	$ 1,564,303
Cryopreservation								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%	262	262	262	262	262	
PMPM Cost		5.3%	$614.73	$647.31	$681.62	$717.74	$755.79	
Total Expenditure			$ 161,059	$ 169,596	$ 178,584	$ 188,049	$ 198,016	$ 895,304

In-Vitro Fertilization and Genetic Testing Services								
Pop Type:	**Expansion**							
Eligible Member Months			144	144	144	144	144	
PMPM Cost		5.3%	$9,099.20	$9,555.14	$10,033.92	$10,536.69	$11,064.66	
Total Expenditure			$ 1,310,285	$ 1,375,940	$ 1,444,884	$ 1,517,284	$ 1,593,311	$ 7,241,703
Reentry								
Pop Type:	**Expansion**							
Eligible Member Months			276	276	276	276	276	
PMPM Cost		5.3%	$1,209.62	$1,273.73	$1,341.24	$1,412.33	$1,487.18	
Total Expenditure			$ 333,856	$ 351,550	$ 370,183	$ 389,802	$ 410,462	$ 1,855,853
SB133 Family Planning Services								
Pop Type:	**Expansion**							
Eligible Member Months			63,828	63,828	63,828	63,828	63,828	
PMPM Cost		5.3%	$48.75	$51.34	$54.06	$56.92	$59.94	
Total Expenditure			$ 3,111,864	$ 3,276,793	$ 3,450,463	$ 3,633,337	$ 3,825,904	$ 17,298,361
Pregnant Women and 12-Month Extended Postpartum								
Pop Type:	**Expansion**							
Eligible Member Months			89,928	89,928	89,928	89,928	89,928	
PMPM Cost		5.3%	$912.98	$961.37	$1,012.32	$1,065.98	$1,122.47	
Total Expenditure			$ 82,102,698	$ 86,454,141	$ 91,036,211	$ 95,861,130	$ 100,941,770	$ 456,395,951
Reentry Non-Services								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%						
PMPM Cost		5.3%						
Total Expenditure			$4,271,743.50	$4,271,743.50	$4,271,743.50	$4,271,743.50	$4,271,743.50	$ 21,358,718
HRSN Services								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%						
PMPM Cost		5.3%						
Total Expenditure			$94,157,357.00	$94,157,357.00	$94,157,357.00	$94,157,357.00	$94,157,357.00	$ 470,786,785
HRSN Infrastructure								
Pop Type:	**Expansion**							
Eligible Member Months		2.5%						
PMPM Cost		5.3%						
Total Expenditure			$12,450,000.00	$12,450,000.00	$12,450,000.00	$12,450,000.00	$12,450,000.00	$ 62,250,000

PENDING APPROVAL BY CMS

Long-Term Support Services (LTSS)								
Pop Type:								
Eligible Member Months			600	600	600	600	600	
PMPM Cost		5%	$11,642.12	$12,224.22	$12,835.43	$13,477.21	$14,151.07	
Total Expenditure			$ 6,985,270	$ 7,334,533	$ 7,701,260	$ 8,086,323	$ 8,490,639	$ 38,598,026
Integrated Behavior Health Services								
Pop Type:								
Eligible Member Months			3,000	3,000	3,000	3,000	3,000	
PMPM Cost		5%	$81.04	$85.09	$89.35	$93.81	$98.50	
Total Expenditure			$ 243,117	$ 255,273	$ 268,036	$ 281,438	$ 295,510	$ 1,343,375
SB269 Chronic Conditions Support Amendment								
Pop Type:								
Eligible Member Months			19,320	19,320	19,320	19,320	19,320	
PMPM Cost			$180.00	$180.00	$180.00	$180.00	$180.00	
Total Expenditure			$ 3,477,600	$ 3,477,600	$ 3,477,600	$ 3,477,600	$ 3,477,600	$ 17,388,000
SB181 Native American Health Amendments								
Pop Type:								
Eligible Member Months			3,300	3,300	3,300	3,300	3,300	
PMPM Cost			$2,322.52	$2,322.52	$2,322.52	$2,322.52	$2,322.52	
Total Expenditure			$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 7,664,300	$ 38,321,500
Disability Wraparound Coverage								
Pop Type:								
Eligible Member Months			360	360	360	360	360	
PMPM Cost			$329.00	$329.00	$329.00	$329.00	$329.00	
Total Expenditure			$ 118,440	$ 118,440	$ 118,440	$ 118,440	$ 118,440	$ 592,200
Community Engagement Population								
Pop Type:								
Eligible Member Months			1,006,224	1,006,224	1,006,224	1,006,224	1,006,224	
PMPM Cost		4.7%	$861.63	$902.13	$944.53	$988.92	$1,035.40	
Total Expenditure			$ 866,991,427	$ 907,740,024	$ 950,403,805	$ 995,072,784	$ 1,041,841,205	$ 4,762,049,244

SAVINGS NEUTRALITY TEST - Last Five Years of Actuals/Projected for current and last demostration year

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Current Eligibles	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 328,086,416	$ 149,735,936				$ 477,822,352
ELIGIBLE MEMBER MONTHS	478,945	196,919				675,864
PMPM COST	$ 685.02	$ 760.39				
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-54.36%				
ELIGIBLE MEMBER MONTHS		-58.88%				
PMPM COST		11.00%				

Adult Expansion Population	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 956,795,765	$ 937,920,392	$ 748,268,466	$ 842,191,278	$ 893,909,254	$ 4,379,085,155
ELIGIBLE MEMBER MONTHS	1,536,401	1,082,063	898,279	916,595	926,185	
PMPM COST	$ 622.75	$ 866.79	$ 833.00	$ 918.83	$ 965.15	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-1.97%	-20.22%	12.55%	6.14%	-1.69%
ELIGIBLE MEMBER MONTHS		-29.57%	-16.98%	2.04%	1.05%	-11.89%
PMPM COST		39.19%	-3.90%	10.30%	5.04%	11.58%

Mandatory ESI for Adult Expansion	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 2,263,589	$ 2,451,476	$ 1,949,620	$ 1,885,213	$ 2,142,331	$ 10,692,229
ELIGIBLE MEMBER MONTHS	11,323	9,218	8,108	8,190	8,864	
PMPM COST	$ 199.91	$ 265.94	$ 240.46	$ 230.18	$ 241.69	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		8.30%	-20.47%	-3.30%	13.64%	-1.37%
ELIGIBLE MEMBER MONTHS		-18.59%	-12.04%	1.01%	8.23%	-5.94%
PMPM COST		33.03%	-9.58%	-4.27%	5.00%	4.86%

Targeted Adults	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 86,522,660	$ 95,918,025	$ 118,972,928	$ 125,189,424	$ 135,810,589	$ 562,413,626
ELIGIBLE MEMBER MONTHS	120,327	89,687	79,309	82,399	85,133	
PMPM COST	$ 719.06	$ 1,069.48	$ 1,500.12	$ 1,519.31	$ 1,595.28	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		10.86%	24.04%	5.23%	8.48%	11.93%
ELIGIBLE MEMBER MONTHS		-25.46%	-11.57%	3.90%	3.32%	-8.29%
PMPM COST		48.73%	40.27%	1.28%	5.00%	22.04%

Dental - Targeted Adults	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 952,801	$ 1,804,450	$ 2,093,969	$ 25,352		$ -
ELIGIBLE MEMBER MONTHS	18,256	13,329	7,995			
PMPM COST	$ 52.19	$ 135.38	$ 261.91			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		89.38%	16.04%			
ELIGIBLE MEMBER MONTHS		-26.99%	-40.02%			
PMPM COST		159.39%	93.47%			

Dental - Blind & Disabled Adults	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 13,227,385	$ 12,908,678	$ 9,913,044			$ 36,049,107
ELIGIBLE MEMBER MONTHS	554,401	490,131	350,239			
PMPM COST	$ 23.86	$ 26.34	$ 28.30			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-2.41%	-23.21%			
ELIGIBLE MEMBER MONTHS		-11.59%	-28.54%			
PMPM COST		10.39%	7.47%			

Dental - Aged	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 2,176,694	$ 1,859,020	$ 1,501,636	$ 238,113		$ 5,775,463
ELIGIBLE MEMBER MONTHS	150,131	121,548	84,929			
PMPM COST	$ 14.50	$ 15.29	$ 17.68			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-14.59%	-19.22%			
ELIGIBLE MEMBER MONTHS		-19.04%	-30.13%			
PMPM COST		5.49%	15.60%			

Dental Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES			$ 16,561,570	$ 68,098,713	$ 159,400,507	$ 244,060,790
ELIGIBLE MEMBER MONTHS			439,539	1,744,540	3,888,576	
PMPM COST			$ 37.68	$ 39.04	$ 40.99	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				311.19%	134.07%	
ELIGIBLE MEMBER MONTHS				296.90%	122.90%	
PMPM COST				3.60%	5.01%	

Former Foster Care Youth from Another State	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 186,709	$ 207,250	$ 368,364	$ 315,411	$ 331,182	$ 1,408,916
ELIGIBLE MEMBER MONTHS	170	201	231	181	180	
PMPM COST	$ 1,098.29	$ 1,031.09	$ 1,594.65	$ 1,742.60	$ 1,839.90	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		11.00%	77.74%	-14.38%	5.00%	15.41%
ELIGIBLE MEMBER MONTHS		18.24%	14.93%	-21.65%	-0.55%	1.44%
PMPM COST		-6.12%	54.66%	9.28%	5.58%	13.77%

SUD	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 39,571,201	$ 55,422,813	$ 64,306,835	$ 65,722,712	$ 66,818,922	$ 291,842,483
ELIGIBLE MEMBER MONTHS	9,117	10,336	10,619	10,336	10,008	
PMPM COST	$ 4,340.38	$ 5,362.11	$ 6,055.83	$ 6,358.62	$ 6,676.55	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		40.06%	16.03%	2.20%	1.67%	13.99%
ELIGIBLE MEMBER MONTHS		13.37%	2.74%	-2.67%	-3.17%	2.36%
PMPM COST		23.54%	12.94%	5.00%	5.00%	11.37%

SMI	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 10,446,565	$ 29,906,004	$ 34,856,622	$ 34,768,551	$ 32,720,636	$ 142,698,378
ELIGIBLE MEMBER MONTHS	1,339	4,004	3,938	3,741	3,353	
PMPM COST	$ 7,801.77	$ 7,469.03	$ 8,851.35	$ 9,293.92	$ 9,758.61	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		186.28%	16.55%	-0.25%	-5.89%	33.03%
ELIGIBLE MEMBER MONTHS		199.03%	-1.65%	-5.00%	-10.37%	25.79%
PMPM COST		-4.26%	18.51%	5.00%	5.00%	5.75%

Intensive Support Service	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 18,420	$ 36,053	$ 1,949	$ 16,567		$ 72,989
ELIGIBLE MEMBER MONTHS	52	50	2			
PMPM COST	$ 354.23	$ 721.06	$ 974.50			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		95.73%	-94.59%	750.03%		
ELIGIBLE MEMBER MONTHS		-3.85%	-96.00%	-100.00%		
PMPM COST		103.56%	35.15%			

ESI/COBRA	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 347,797	$ 340,076	$ 470,758	$ 449,174	$ 469,683	$ 2,077,488
ELIGIBLE MEMBER MONTHS	2,191	2,372	2,662	2,419	2,409	
PMPM COST	$ 158.74	$ 143.37	$ 176.84	$ 185.69	$ 194.97	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-2.22%	38.43%	-4.58%	4.57%	7.80%
ELIGIBLE MEMBER MONTHS		8.26%	12.23%	-9.13%	-0.41%	2.40%
PMPM COST		-9.68%	23.35%	5.00%	5.00%	5.27%

HRSS	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 54,634	$ (25,786)	$ 1,361,352			$ 1,390,200
ELIGIBLE MEMBER MONTHS	61	537	2,714			
PMPM COST	$ 895.64	$ (48.02)	$ 501.60			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-147.20%	-5379.42%			
ELIGIBLE MEMBER MONTHS		780.33%	405.40%			
PMPM COST		-105.36%	-1144.60%			

HRSN NMT	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ (9,396)	$ 223	$ (9,173)
ELIGIBLE MEMBER MONTHS				14	24	
PMPM COST				$ (671.14)	$ 9.29	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE					-102.37%	
ELIGIBLE MEMBER MONTHS					71.43%	
PMPM COST					-101.38%	

Fertility Treatment for Individuals Diagnosed with Cancer - Male	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES			$ 4,256	$ 6,703	$ 14,077	$ 25,036
ELIGIBLE MEMBER MONTHS			4	6	12	
PMPM COST			$ 1,064.00	$ 1,117.20	$ 1,173.06	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				57.50%	110.00%	
ELIGIBLE MEMBER MONTHS				50.00%	100.00%	
PMPM COST				5.00%	5.00%	

Fertility Treatment for Individuals Diagnosed with Cancer - Female	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES			$ 6,462	$ 27,140	$ 56,995	$ 90,597
ELIGIBLE MEMBER MONTHS			3	12	24	
PMPM COST			$ 2,154.00	$ 2,261.70	$ 2,374.79	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				320.00%	110.00%	
ELIGIBLE MEMBER MONTHS				300.00%	100.00%	
PMPM COST				5.00%	5.00%	

Cryopreservation	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES					$ 5,838	$ 5,838
ELIGIBLE MEMBER MONTHS			-	-	10	
PMPM COST					$ 583.79	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE						
ELIGIBLE MEMBER MONTHS						
PMPM COST						

In Vitro Fertilization and Genetic Testing Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES		$ 1,712	$ 41,776	$ 110,169	$ 125,872	$ 279,530
ELIGIBLE MEMBER MONTHS			84	213	234	
PMPM COST			$ 497.33	$ 517.23	$ 537.92	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				163.71%	14.25%	
ELIGIBLE MEMBER MONTHS				153.57%	9.86%	
PMPM COST				4.00%	4.00%	

Family Planning Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES					$ 2,948,569	$ 2,948,569
ELIGIBLE MEMBER MONTHS					63,684	
PMPM COST					$ 46.30	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE						
ELIGIBLE MEMBER MONTHS						
PMPM COST						

2027-2032 Renewal
Attachment 5

Public Notice Requirements

Utah Department of Health & Human Services

Full Public Notice

Utah's Medicaid Reform 1115 Demonstration

July 1, 2027-June 30, 2032, Renewal

The Utah Department of Health and Human Services is requesting a five-year renewal of Utah's Medicaid Reform 1115 Demonstration under Section 1115 of the Social Security Act. Utah's existing Demonstration is currently approved through June 30, 2027. With this application, Utah is seeking a renewal period from July 1, 2027, through June 30, 2032. This 1115 Demonstration renewal requests authority to continue to operate as currently approved, with minimal changes.

Section I. Overview of Current Program Features to Continue under the Demonstration Renewal

With this renewal, Utah is requesting to continue all currently approved demonstration populations and components below, with the exception of Targeted Adult Medicaid (TAM). Utah is requesting to end TAM on June 30, 2027.

A description of the currently approved demonstration populations, including eligibility requirements, is detailed below:

- Adult Expansion -comprised of adults, ages 19 through 64 who are U.S. citizens/qualified non-citizens, are residents of Utah, and have household income at or below 133 percent of the FPL. To remain eligible for Medicaid, beneficiaries in this eligibility group who have access to ESI are required to enroll in a qualified ESI plan, as defined by the state.
- Current Eligible CHIP Children -premium subsidies for children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children are eligible for the CHIP, but the children's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving CHIP direct coverage. There is no enrollment cap applied to this population. These children can opt back into direct coverage at any time.
- Demonstration Population III - premium subsidies for working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.
- Demonstration Population V - premium subsidies for adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent

of FPL, are U.S. citizens or qualified non- citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).

- Demonstration Population VI -premium subsidies for children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child. These children can opt into direct coverage at any time. There is no enrollment cap applied to this population. Demonstration Population VI is subdivided into two groups:
    - COBRA-Eligible Children: A child that meets the definition of a targeted low-income child eligible under Title XXI who is eligible and able to enroll in COBRA continuation coverage based on any qualifying event. These children are eligible for CHIP, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of COBRA continuation of coverage instead of receiving CHIP direct coverage.
    - COBRA Continuation Children: A child that meets the definition of a targeted low-income child except for receipt of continuation coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272, and who elect to receive such premium subsidies.
- Dental Services- All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women receive dental benefits that are defined in the Utah Medicaid Provider Manual, Dental, Oral Maxillofacial, and Orthodontia Services.
- Employer Sponsored Insurance (ESI) - Individuals who are eligible for Adult Expansion, and have access to an ESI plan, are required to purchase such plans. The State will reimburse the eligible individual for the health insurance premium amount for that individual. Failure to enroll in, and purchase, the insurance plan will result in ineligibility for Medicaid.
- Extended Postpartum Coverage - comprised of women who are eligible for Medicaid during their pregnancy. Coverage is extended for individuals from the end of the state plan 60-day postpartum period to the end of the 12th month following the end of their pregnancy. To be eligible for continuous extended postpartum coverage, individuals must be enrolled in any Medicaid eligibility group while pregnant (including during a period of retroactive eligibility). Individuals who are eligible for extended postpartum coverage will remain enrolled continuously within their eligibility group regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination, or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period.
- The Family Planning and Family Planning Related population -provides family planning services and family planning related services to individuals age 18 or older with a household income at or below 185 percent of the Federal Poverty Level (FPL) who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP) and are not in a public institution.

- Fertility Preservation for Individuals Diagnosed with Cancer -Fertility preservation services are available for beneficiaries undergoing gonadotoxic cancer treatments, or other medically necessary treatment, that is expected to render them permanently infertile. Cost sharing requirements for this benefit will not differ from those under the state plan. Reimbursement for cryopreservation storage is covered as a single payment for five years. Additional 5-year storage increments may only be requested for members that retain eligibility.
- Former Foster Care Youth from Another State -defined as individuals under age 26, who were in foster care under the responsibility of a state other than Utah or a tribe in such other state when they turned 18 (or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act), were ever enrolled in Medicaid, are now applying for Medicaid in Utah, and are not otherwise eligible for Medicaid. Beginning January 1, 2023, the Former Foster Care Youth from Another State population will include individuals who otherwise meet the definition and turned age 18 on December 31, 2022, or earlier. Individuals who turn age 18 on January 1, 2023, or later, and who qualify as a Former Foster Care Youth, will be eligible under the state plan.
- Health Related Social Needs - Provides health related social needs coverage for eligible members in the Adult Expansion and Targeted Adult Medicaid demonstration populations who have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate. Medical appropriateness must be based on clinical and health-related social risk factors. Services include the following HRSN housing interventions: housing supports without room and board (i.e., pre-tenancy navigation services, one-time transition and moving costs other than rent, and tenancy and sustaining services), home remediations, home/environmental accessibility modifications, episodic housing interventions with clinical services with room and board (i.e., short-term recuperative care and short-term post-transition housing) limited to a clinically appropriate amount of time, and room and board-only supports (i.e., short term rental assistance) limited to a clinically appropriate amount of time.
- In Vitro Fertilization and Genetic Testing for Qualified Conditions -Provides in vitro fertilization services and genetic testing services for eligible individuals between the ages of 18 and 35 and who have a familial medical history or be in an ethnic group that has a high risk of one or more of the following medical conditions: cystic fibrosis, morquio syndrome, myotonic dystrophy, sickle cell anemia, or spinal muscular atrophy.
- Reentry Pre-Release Services -Provides limited coverage of targeted services for certain individuals who are inmates in state prisons, county jails, or juvenile justice facilities for up to 90 days prior to the individual's expected release date. To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid or as determined pursuant to an application filed before or during incarceration and must have an expected release date no later than 90 days. Covered services include, but are not limited to, intensive case management, Medication-Assisted Treatment (MAT) services for all types of Substance Use Disorders (SUD), a 30-day supply of prescription medication upon release, lab and radiology services, targeted outpatient services, diagnosis and treatment of physical and behavioral health conditions, and screening for housing related services.
- Serious Mental Illness Services in an institution for mental diseases (IMD)- Provides authority for Medicaid recipients, age 21 through 64, to receive SMI services in IMD treatment settings.

- Substance Use Disorder Services in an IMD- provides authority for Medicaid recipients to receive opioid use disorder (OUD)/substance use disorder (SUD) treatment services provided in a residential or inpatient treatment setting that qualifies as an IMD.
- Targeted Adult Medicaid -comprised of adults, ages 19-64, with incomes at zero percent of the FPL (effectively five percent of the FPL with the five percent disregard) and no dependent children, who meet one of the following additional criteria:
    - Be chronically homeless, defined as:
        - An individual who has been continuously homeless for at least 12 months or on at least four separate occasions in the last three years (totaling at least 12 months); and has a diagnosable substance use disorder, serious mental illness, developmental disability, posttraumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
        - An individual living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter for a total of six months within a 12-month period; and has a diagnosable substance use disorder or serious mental health disorder. At the option of the state, these criteria may be expanded to include individuals with a diagnosable developmental disability, post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability;
        - An individual who is a victim of domestic violence who is living or residing in a place not meant for human habitation, a safe haven or in an emergency shelter; or
        - An individual currently living in supportive housing who has previously met the definition of chronically homeless.
    - Involved in the criminal justice system and in need of substance use or mental health treatment, defined as:
        - An individual who has complied with and substantially completed a substance use disorder treatment program while they were incarcerated in jail or prison, including Tribal jails;
        - An individual who is court ordered to receive substance abuse or mental health treatment by a district court or Tribal court;
        - An individual on probation or parole with serious mental illness and/or serious substance use disorder;
        - An individual discharged from the Utah State Hospital who was admitted to the civil unit of the hospital in connection with a criminal charge, or admitted to the forensic unit due to a criminal offense with which the individual was charged or of which the individual was convicted; or
        - An individual involved with a Drug Court or Mental Health Court, including Tribal courts, related to a criminal charge or conviction.
    - Needing substance use or mental health treatment, defined as:
        - An individual receiving General Assistance from the Department of Workforce Services (DWS), who has been diagnosed with a substance use or mental health disorder; or

        - An individual recently discharged from the Utah State Hospital who was civilly committed.
- The state proposes to continue to mandatorily enroll the Adult Expansion Population into UMIC managed care organizations (MCO) for delivery of their physical and behavioral health services in the five urban counties in the state (Davis, Salt Lake, Utah, Washington, and Weber). The state also mandatorily enrolls members of the Adult Expansion Population in an ACO and a PMHP or FFS, for beneficiaries residing in the remaining eight counties (Box Elder, Cache, Iron, Morgan, Rich, Summit, Tooele, and Wasatch) in which beneficiaries are not enrolled into UMIC

Section II. Proposed Changes to Current Demonstration

The state requests the following changes to the current demonstration for the identified demonstration populations or components.

Targeted Adult Medicaid

The state is requesting the following changes to the 1115 Demonstration STCs related to the TAM population.

The state is requesting to end TAM on June 30, 2027. If approved, TAM Members will transition to Adult Expansion effective July 1, 2027.

Utah's Premium Partnership for Health Insurance (UPP)- Demonstration Populations III, V, VI, and Current Eligible CHIP Children

The state is requesting the following changes to the 1115 Demonstration STCs related to the UPP populations:

1. Combining the four UPP demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population. The state is requesting this change to simplify reporting, because the overall group population has remained relatively small, and because the state considers these to be one population for administration purposes.

Removal of Supportive Living Services (mental health services in residential treatment settings) from Behavioral Health Benefits.

The state is requesting the removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion Population. This is because these services were moved into the State Plan on November 7, 2024.

Pending Demonstration Amendments

At this time, the state has several demonstration amendment requests pending a decision from CMS. These amendments can be found on the state's 1115 Demonstration website at https://medicaid.utah.gov/1115-waiver/. The state requests that these amendments be considered in addition to the demonstration renewal, with the hope of gaining approval for these amendments

prior to the approval of the full demonstration renewal. A brief overview of the amendments is contained below.

Chronic Conditions Support

On July 27, 2023, the state submitted an amendment as a result of Senate Bill 269, "Chronic Conditions Support Amendments" which passed during the 2023 General Session of the Utah State Legislature. This amendment requests the authority to provide additional Medicaid services to fee for service enrolled individuals with qualified chronic health conditions.

Community Engagement

On July 3, 2025, the state submitted a Community Engagement Amendment. This amendment requests the authority to implement a community engagement work requirement for the Adult Expansion Population. This requirement would apply to Adult Expansion members who are able to participate in the requirement, are not already participating in other work or training activities, and do not meet an exemption or do not demonstrate good cause.

Disability Wraparound Coverage

On June 30, 2025, the state submitted an amendment as a result of House Bill 310, "Disability Coverage Amendments" which passed during the 2025 General Session of the Utah State Legislature. This amendment requests authority to provide wraparound Medicaid services for qualified individuals who have private health insurance and have a disability. This would include services covered by Medicaid and not by private health insurance.

Integrated Behavioral Health Services

On December 30, 2022, the state submitted an amendment as a result of Senate Bill 41, "Behavioral Health Services Amendments" which passed during the 2022 General Session of the Utah State Legislature. This amendment requests authority to allow individuals to receive existing state plan covered physical and behavioral services in an integrated model through a contracted local mental health authority.

Long Term Services and Supports for Behaviorally Complex Individuals

On December 30, 2022, the state submitted an amendment seeking approval to provide Long Term Services and Supports (LTSS) to individuals with behaviorally complex conditions through a contracted LTSS provider.

Native American Health Amendments

On November 25, 2024, the state submitted an amendment seeking approval to reimburse for traditional healing services provided by a traditional healing provider in an eligible facility to Medicaid enrollees who are members of an American Indian or Alaskan Native (AI/AN) tribe.

Other amendments

At this time the state is not requesting action on the following 1115 Demonstration amendments as part of the renewal. However, the state is not withdrawing these amendment requests at this time.

- Fallback Plan
- Per Capita Cap

Section III. Demonstration Goals, Objectives and Evaluation

Since the initial approval in 2002, Utah has received CMS authority to implement many additional programs and benefits through its 1115 Demonstration.

With these additions, Utah's primary objectives have expanded. Utah's demonstration strives to do the following:

- Provide health care coverage for low-income Utahns eligible under the demonstration who would not otherwise have access to, or be able to afford, health care coverage;
- Improve beneficiary health outcomes and quality of life;
- Lower the uninsured rate of low income Utahns;
- Provide continuity of coverage for individuals eligible under the demonstration;
- Increase access to primary care;
- Reduce uncompensated care provided by Utah hospitals;
- Reduce barriers to health care and housing, an important social determinant of health;
- Increase the utilization of preventive dental services, while reducing emergency dental procedure costs;
- Improve access to services across the continuum of care;
- Provide for better care coordination for individuals transitioning to community-based care;
- Reduce the utilization of emergency departments and inpatient hospital settings for treatment where utilization is preventable or medically inappropriate;
- Reduce the overdose death rate; and
- Improve access to fertility preservation services for Medicaid eligible individuals diagnosed with cancer, as well as access to in vitro fertilization (IVF) services for individuals diagnosed with certain genetic disorders.

Future goals for the 1115 Demonstration:

- Enhancing care for vulnerable populations, including justice-involved individuals.
- Increasing access to medication-assisted treatment.
- Increase access to family planning services.

Demonstration Evaluation

To determine if Utah's 1115 Demonstration is meeting its intended goals and objectives, the state has contracted with an independent evaluator to conduct an evaluation of the demonstration. This evaluator is Public Consulting Group, Inc. (PCG). PCG is responsible for conducting an evaluation of the following demonstration populations:

- Adult Expansion, including the ESI component
- Demonstration Populations III, V, VI and Current Eligible CHIP children
- Dental Services
- Extended Postpartum Coverage
- Family Planning Services

- Former Foster Care Youth from Another State
- Fertility Preservation for Individuals Diagnosed with Cancer
- HRSN (includes HRSS)
- In Vitro Fertilization and Genetic Testing
- Reentry
- SMI
- SUD
- Targeted Adult Medicaid
- UMIC

PCG will also be including the following demonstrations, no longer in the demonstration, in the Interim and Summative Reports:

- Intensive Stabilization Services
- Current Eligibles

The evaluations have been designed by the independent evaluator to meet the STCs of Utah's 1115 Demonstration. The evaluations will test the specific hypotheses and performance measures as identified by the evaluation designs for the demonstration populations.

Demonstration Hypotheses

Utah proposes the following research hypotheses and design approach for Utah's demonstration renewal. The hypotheses below are consistent with those already approved in the evaluation designs. The state is not requesting any changes at this time.

Table 1: Demonstration Objectives and Proposed Hypotheses

Objectives	Proposed Hypotheses	Potential Approaches/Data Sources
Low-income UT residents		
Provide health care coverage for low-income Utahns eligible who would not otherwise have access to or be able to afford healthcare coverage.	The demonstration overall will improve access to coverage and engagement in health care for low-income UT residents.	Behavioral Risk Factor Surveillance System (BRFSS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) Custom Member Survey Claims Data
Adult Expansion/UMIC/Dental		
Improve healthcare access and engagement for the AEM population.	The demonstration will improve healthcare access and engagement for the Adult Expansion population.	Claims Data Pre-Dental Expansion Baseline Custom Member Survey

Targeted Adults/TAM Dental		
Improve healthcare access and engagement for the TAM population.	By providing coverage through the Targeted Adult Medicaid demonstration, healthcare access and engagement will improve for this population.	Claims Data
Health Related Social Needs		
The HRSN demonstration will mitigate housing and transportation needs, increase continuity of behavioral health treatment, and improve health outcomes for eligible members.	The HRSN Services demonstration will effectively mitigate members' housing and transportation needs, lead to more appropriate service utilization and improved physical and mental health outcomes.	Administrative Data American Community Survey Area Health Resources File Case Records Claims Data Participant Interviews Administrative: Maintenance of Effort section of Annual Monitoring Reports Key Informant Interviews
SUD and SMI		
Behavioral Health coverage for residential and inpatient services provided to members in IMDs will lead to a reduction in inpatient stays, ED utilization, and rate of unplanned readmission among recipients, resulting in cost decrease or stabilization. Coverage will also lessen unmet need and increase engagement in treatment to reduce overdose deaths in the long-term.	The SMI and SUD demonstrations increased access to appropriate treatment.	Claims Data National Survey on Drug Use and Health (NSDUH) Administrative Data
Greater utilization of non-hospital, non-residential services will lead to greater reductions in inpatient stays, ED utilization, and overdose deaths in the long-term.	The SMI and SUD demonstrations stabilized or reduced cost of care for these populations.	Claims
UPP/ESI, Former Foster Care Youth from Another State,		

Fertility and Genetic Testing Services		
Utilization of the services provided to these populations will increase and total cost of care will decrease.	The demonstration delivered coverage/ services appropriately to individuals in the smaller demonstration populations.	Claims Monitoring Reports
Reentry		
The demonstration will enhance cross-system collaboration between the correctional and community-based services systems, that enrollment and redetermination support will improve continuity of coverage, and that coverage of pre-release and reentry services will improve engagement in high quality care, reduce unnecessary acute care utilization, and ultimately improve health outcomes for the Reentry population.	The Reentry Benefit will enhance cross-system communication and coordination between correctional and community services.	Beneficiary Interviews Case Manager Interviews Correctional System Staff Interviews Community-based Providers Interviews
	The Reentry Benefit will improve pre-release service provision during the covered period and continuity of coverage for the reentry population.	Claims/administrative Carceral Facility Readiness Assessment and Key Informant Interviews Beneficiary Interviews Carceral Facility Administrative Data Medicaid Administrative Data: Eligibility and Enrollment
	The Reentry Benefit's 90-day pre-release coverage period ("the coverage timeline") will support effective program implementation.	Carceral Facility Administrative Data Beneficiary Interviews State and Correctional System Staff Interviews
	The Reentry Benefit will improve engagement in health care and social services, reduce acute care utilization, and improve health outcomes for the reentry population post-release.	Claims Beneficiary Interviews Case Manager Interviews Vital Statistics
Family Planning Services		
Effectively implement a fiscally sustainable family planning demonstration.	Hypothesis 1: The family planning demonstration will be effectively implemented.	Qualitative Analysis • Interviews with state Medicaid agency staff • Interviews with health plan

		staff or providers Quantitative Analysis • State-administered beneficiary survey • Medicaid administrative data • Monitoring reports
	Hypothesis 2: The family planning demonstration will improve the fiscal sustainability of the Utah Medicaid program.	Qualitative Analysis • Interviews with state Medicaid agency staff Quantitative Analysis • State-administered data
Enhance awareness of family planning demonstrations and improve participation in programs and access to family planning and other family planning demonstration-covered services among demonstration beneficiaries.	Hypothesis 3: The family planning demonstration will maintain or increase beneficiary participation in family planning programs, including awareness of and access to family planning services.	Quantitative Analysis • State-administered beneficiary survey • Medicaid administrative data
Increase the effective use of family planning services or other family planning demonstration-covered services among demonstration beneficiaries.	Hypothesis 4: The ongoing access to family planning services through the demonstration will maintain or increase the use of these services among beneficiaries.	Quantitative Analysis • Medicaid administrative data
Extended Postpartum		
Improve maternal and infant health outcomes, particularly focusing on reducing unintended pregnancies.	Hypothesis 5: The ongoing provision of family planning services, family planning-related services, and other demonstration-covered services will lead to improvements in maternal and infant health outcomes.	Quantitative Analysis • State-administered beneficiary survey • Medicaid administrative data • Vital statistics data

Dental Services for Medicaid-Eligible Children and Pregnant or Postpartum Women		
Increase the utilization of dental services.	Hypothesis 6: The provision of dental services will increase utilization among Medicaid-eligible children and pregnant or postpartum women.	Quantitative Analysis • State-administered beneficiary survey • Medicaid administrative data

Section IV. Benefits, Delivery System, Cost Sharing and Eligibility Requirements

The state intends to continue to provide demonstration benefits per the delivery systems outlined below.

Table 2: Demonstration Benefits, Delivery System and Eligibility Requirements

Demonstration Populations	Benefits	Delivery System	Eligibility Requirements
Adults and Adult Children in Demonstration Populations III and V	Individuals in this eligibility category are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	The sole benefit provided to persons eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the employee's, individual's, or family's share of the monthly premium cost of qualifying insurance plans.	Demonstration Population III: Working adults, age 19 through 64, their spouses, and their children who are ages 19 through 26, with countable gross family incomes above 133 percent of the FPL up to and including 200 percent of the FPL, who are U.S. citizens/qualified non-citizen, are residents of Utah, are not otherwise eligible for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and participate in an approved ESI plan where the employee's cost to participate in the plan is at least five percent of the household's countable income.

			Demonstration Population V: Adults age 19 through 64 with countable gross family income above 133 percent of the FPL up to and including 200 percent of FPL, are U.S. citizens or qualified non-citizen, are resident(s) of Utah, do not qualify for Medicaid, Medicare, or Veterans benefits, have no other health insurance, and would otherwise be eligible as a member of Demonstration Population III (except that the eligible individual or custodial parent/caretaker is able to enroll in COBRA continuation coverage based on any qualifying event rather than a qualifying ESI plan, and that COBRA-eligibles are not subject to the requirement that an employer subsidize at least 50 percent of the premium cost for the employee's health coverage).
Children in Demonstration (Current Eligible CHIP Children and Demonstration Populations VI)	Individuals in this eligibility category are eligible to receive premium assistance (through ESI or COBRA) in paying the employee's, individual's, or family's share of the	The primary benefit provided to children eligible for premium subsidies (through ESI or COBRA coverage) is assistance in paying the child's share of the employee's, individual's, or family's share of the	Children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child.

	monthly premium cost of qualifying insurance plans.	monthly premium cost of qualifying insurance plans.	
Adult Expansion	• Expansion adults will receive state plan benefits • Expansion adults also receive benefits that are the equivalent of (b)(3) services under the state's 1915(b) PMHP waiver, which include psychoeducational services, personal services, respite care	• Benefits are provided through UMIC in five counties. • Adult Expansion individuals in eight additional counties are enrolled in an Accountable Care Organization (ACO) for their physical health services and in a Prepaid Mental Health Plan (PMHP) for their behavioral health services. Adult Expansion individuals in the remaining 16 counties receive their physical health services on a FFS basis and are enrolled in a PMHP for their behavioral health services.	Adults age 19-64 who have household income up to 133 percent of the FPL.
Dental Benefits	Dental benefits that are defined in the Utah Medicaid Provider Manual, Dental, Oral Maxillofacial, and Orthodontia Services. Cost sharing requirements for this benefit will not differ from those under the state plan.	Benefits are provided through a fee-for-service delivery system and are delivered through the University of Utah School of Dentistry and their associated statewide provider network.	All adults who are enrolled in Medicaid, as well as Medicaid-eligible children and pregnant and postpartum women.

Employer Sponsored Insurance	Individuals in the Adult Expansion Population will be reimbursed for the full amount of the individual's share of the monthly premium cost of the qualified ESI plan.	• Individuals will receive services through the delivery systems provided by their respective qualified plan. • Wrap-around benefits will be provided through a fee-for-service delivery system.	Individuals in the Adult Expansion Population
Extended Postpartum Coverage	Individuals enrolled in this eligibility category will receive full Medicaid state plan benefits.	• Benefits are delivered through the individual's applicable delivery system (ACO, PMHP, UMIC, or FFS).	Provides twelve months of coverage to pregnant women following the end of a pregnancy.
Family Planning Services	• Comprehensive family planning preventive visits. • FDA-approved methods of contraception. • Screening for sexually transmitted infection (STI) or sexually transmitted disease (STD) during a family planning visit, Pap smears, and pelvic exams. • Drugs, supplies, or devices related to family planning services. • Contraceptive management, patient education,	Benefits are provided through a fee-for-service delivery system.	Women and men age 18 and older who have a household income at or below 185 of the FPL. Must be a U.S. Citizen or qualified non-citizen, a resident of Utah and not in a public institution, and be ineligible for coverage under any other Medicaid program.

	and counseling. • Sterilization procedures and devices, the office visits or physical exams related to and necessary for sterilization or long-acting reversible contraception, laboratory testing necessary to complete a sterilization or long-acting reversible contraception insertion, and approved prescription medication to treat anxiety and pain in relation to the sterilization procedure. • Treatment of STIs/STDs, except for HIV/AIDS and hepatitis, when the STI/STD is identified/diagnosed during a screen pursuant to a routine or periodic family planning visit. A follow-up visit or encounter for the treatments, such as drugs and subsequent follow-up visits to rescreen for STIs/STDs based on the Centers for		

	Disease Control and Prevention guidelines, may be covered. • STI/STD diagnosis and treatment pursuant to a family planning visit, such as contraceptive counseling. • FDA-approved vaccination for Human Papillomavirus (HPV).		
Fertility Treatment for Individuals Diagnosed with Cancer	Eligible beneficiaries can receive the following services once per lifetime: • Collection and storage of eggs and sperm. • Preimplantation genetic testing prior to cryopreservation storage. • Cryopreservation storage, which is covered as a single payment for a five-year period. Cost sharing requirements for this benefit will not differ from those under the state plan.	Benefits will be provided through a fee-for-service delivery system.	Medicaid eligible individuals diagnosed by a physician as having an active cancer diagnosis requiring treatment that may cause a substantial risk of sterility or iatrogenic infertility.
Former Foster Care Youth from Another State	Individuals enrolled in this eligibility category will receive full Medicaid state plan benefits.	Benefits are delivered through the individual's applicable delivery system (ACO, PMHP, UMIC, or FFS).	An individual aged 18-26 who were in foster care under state custody on or after their 18th birthday and received Medicaid at some point during the foster care period in which they turned age 18.

Health Related Social Needs	The following services may be covered: Housing Interventions, including: ● Housing supports without room and board, including: ○ Pre-tenancy navigation services (e.g., finding and securing housing). ○ One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household. Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. ○ Tenancy and sustaining services (e.g., eviction prevention, tenant rights education). ● Home remediations that	Benefits will be provided through a fee-for-service delivery system.	Individuals eligible for Adult Expansion or Targeted Adult Medicaid.

	are medically necessary. ● Home/environmental accessibility modifications. ● Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including: ○ Short-term recuperative care, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care. ○ Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing		

	monitoring of the individual's condition by clinicians is not required. ● Room and board-only supports (also referred to as "rent-only" supports or interventions), limited to a clinically appropriate amount of time, including: ○ Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment. Cost sharing requirements for this benefit will not differ from those under the state plan.		
In Vitro Fertilization and Genetic Testing	The following services may be covered: ● Genetic testing services. ● Preimplantation genetic testing to test embryos for genetic disorders prior to transfer to	Benefits will be provided through a fee-for-service delivery system.	An individual must be age 18 through 35, diagnosed by a physician as having a generic trait associated with a qualified condition including cystic fibrosis, spinal muscular atrophy, Morquio Syndrome, Myotonic dystrophy, or

	the uterus. In vitro fertilization services, up to three cycles per lifetime. Cost sharing requirements for this benefit will not differ from those under the state plan.		Sickle cell anemia and intends to get pregnant with a partner who has been diagnosed by a physician as having a generic trait associated with the same qualified condition as the individual.
Reentry	The following services may be covered: ● Case management to assess and address physical and behavioral health needs, and health-related social needs. ● MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies. ● A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility. ● Physical and behavioral health clinical consultation services, as	Benefits will be provided through a fee-for-service delivery system.	An individual must be a qualified inmate which is defined as an individual who is incarcerated in a correctional facility with 90 days or fewer remaining before release and meets eligibility requirements for Medicaid.

	clinically appropriate, to diagnose health conditions, provide treatment, and support prerelease case managers' development of a post-release treatment plan and discharge planning. ● Diagnostic services, including laboratory and radiology services, and treatment services. ● Prescribed drugs and medication administration. ● Family planning services and supplies. ● Services provided by community health workers. ● Peer support services. ● Treatment for Hepatitis C. ● Medical equipment and supplies and/or medical equipment provided upon release. Cost sharing requirements for this benefit will not differ from those under the state plan.		
SMI IMD	Individuals will receive state plan	Benefits are delivered through the individual's	Individuals ages 21 through 64 who receive

	services, including mental health treatment services. provided in residential and inpatient treatment settings that qualify as an IMD.	applicable delivery system (PMHP, UMIC, or FFS).	treatment for a SMI, and who are short-term residents in facilities that meet the definition of an IMD.
SUD IMD	Individuals will receive state plan services, including SUD treatment services provided in residential treatment settings that qualify as an IMD.	Benefits are delivered through the individual's applicable delivery system (PMHP, UMIC, or FFS).	Medicaid eligible individuals receiving SUD residential treatment in an IMD.

Cost Sharing

Cost sharing requirements for individuals under this demonstration are as defined in the Medicaid state plan, with two exceptions:

- Individuals receiving premium assistance under the UPP program (Demonstration populations III, V, VI and current eligible CHIP children) will have cost sharing requirements set by their qualified ESI or COBRA plan.
- American Indian/Alaska Natives enrolled in the demonstration are exempt from cost sharing requirements under section 5006 of the American Recovery Reinvestment Act of 2009.

Section V. Annual Enrollment and Expenditures

The table below indicates the projected demonstration enrollees for each demonstration year (DY). Enrollees are expressed in terms of member months.

Table 3: Annual Enrollment

Enrollment	DY26	DY27	DY28	DY29	DY30
ESI Adults w/ or w/o Children	2,515	2,506	2,477	2,443	2,411
Reentry Services	276	276	276	276	276
HRSN	612	730	730	730	674

Non-Medical Transportation					
Adult Expansion	1,006,224	1,006,224	1,006,224	1,006,224	1,006,224
Dental Benefits	3,904,781	3,904,776	3,904,776	3,904,776	3,904,776
Employer Sponsored Insurance	6,819	6,780	6,780	6,780	6,780
Cryopreservation	262	262	262	262	262
Family Planning Services	63,828	63,828	63,828	63,828	63,828
Fertility Treatment for Individuals Diagnosed with Cancer-Female	24	24	24	24	24
Fertility Treatment for Individuals Diagnosed with Cancer-Male	12	12	12	12	12
Former Foster Care Youth from Another State	168	168	168	168	168
In Vitro Fertilization and Genetic Testing	144	144	144	144	144
SMI IMD	2,927	2,916	2,916	2,916	2,916
SUD IMD	9,684	9,684	9,684	9,684	9,684

Pending Amendments					
Chronic Conditions Support	19,320	19,320	19,320	19,320	19,320
Community Engagement	1,006,224	1,006,224	1,006,224	1,006,224	1,006,224
Disability Wraparound Coverage	360	360	360	360	360
Integrated Behavioral Health Services	3,000	3,000	3,000	3,000	3,000
Long Term Services and Supports for Behaviorally Complex Individuals	600	600	600	600	600
Native American Health Amendments	3,300	3,300	3,300	3,300	3,300

SAVINGS NEUTRALITY TEST - Last Five Years of Actuals/Projected for current and last demostration year

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Current Eligibles	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 328,086,416	$ 149,735,936				$ 477,822,352
ELIGIBLE MEMBER MONTHS	478,945	196,919				675,864
PMPM COST	$ 685.02	$ 760.39				
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		-54.36%				
ELIGIBLE MEMBER MONTHS		-58.88%				
PMPM COST		11.00%				

Adult Expansion Population	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 956,795,765	$ 937,920,392	$ 748,268,466	$ 842,191,278	$ 893,909,254	$ 4,379,085,155
ELIGIBLE MEMBER MONTHS	1,536,401	1,082,063	898,279	916,595	926,185	
PMPM COST	$ 622.75	$ 866.79	$ 833.00	$ 918.83	$ 965.15	
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		-1.97%	-20.22%	12.55%	6.14%	-1.69%
ELIGIBLE MEMBER MONTHS		-29.57%	-16.98%	2.04%	1.05%	-11.89%
PMPM COST		39.19%	-3.90%	10.30%	5.04%	11.58%

Mandatory ESI for Adult Expansion	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 2,263,589	$ 2,451,476	$ 1,949,620	$ 1,885,213	$ 2,142,331	$ 10,692,229
ELIGIBLE MEMBER MONTHS	11,323	9,218	8,108	8,190	8,864	
PMPM COST	$ 199.91	$ 265.94	$ 240.46	$ 230.18	$ 241.69	
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		8.30%	-20.47%	-3.30%	13.64%	-1.37%
ELIGIBLE MEMBER MONTHS		-18.59%	-12.04%	1.01%	8.23%	-5.94%
PMPM COST		33.03%	-9.58%	-4.27%	5.00%	4.86%

Targeted Adults	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 86,522,660	$ 95,918,025	$ 118,972,928	$ 125,189,424	$ 135,810,589	$ 562,413,626
ELIGIBLE MEMBER MONTHS	120,327	89,687	79,309	82,399	85,133	
PMPM COST	$ 719.06	$ 1,069.48	$ 1,500.12	$ 1,519.31	$ 1,595.28	
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		10.86%	24.04%	5.23%	8.48%	11.93%
ELIGIBLE MEMBER MONTHS		-25.46%	-11.57%	3.90%	3.32%	-8.29%
PMPM COST		48.73%	40.27%	1.28%	5.00%	22.04%

Dental - Targeted Adults	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 952,801	$ 1,804,450	$ 2,093,969	$ 25,352		$ -
ELIGIBLE MEMBER MONTHS	18,256	13,329	7,995			
PMPM COST	$ 52.19	$ 135.38	$ 261.91			
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		89.38%	16.04%			
ELIGIBLE MEMBER MONTHS		-26.99%	-40.02%			
PMPM COST		159.39%	93.47%			

Dental - Blind & Disabled Adults	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 13,227,385	$ 12,908,678	$ 9,913,044			$ 36,049,107
ELIGIBLE MEMBER MONTHS	554,401	490,131	350,239			
PMPM COST	$ 23.86	$ 26.34	$ 28.30			
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		-2.41%	-23.21%			
ELIGIBLE MEMBER MONTHS		-11.59%	-28.54%			
PMPM COST		10.39%	7.47%			

Dental - Aged	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 2,176,694	$ 1,859,020	$ 1,501,636	$ 238,113		$ 5,775,463
ELIGIBLE MEMBER MONTHS	150,131	121,548	84,929			
PMPM COST	$ 14.50	$ 15.29	$ 17.68			
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE		-14.59%	-19.22%			
ELIGIBLE MEMBER MONTHS		-19.04%	-30.13%			
PMPM COST		5.49%	15.60%			

Dental Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES			$ 16,561,570	$ 68,098,713	$ 159,400,507	$ 244,060,790
ELIGIBLE MEMBER MONTHS			439,539	1,744,540	3,888,576	
PMPM COST			$ 37.68	$ 39.04	$ 40.99	
TREND RATES						5-YEAR AVERAGE
			ANNUAL CHANGE			
TOTAL EXPENDITURE				311.19%	134.07%	
ELIGIBLE MEMBER MONTHS				296.90%	122.90%	
PMPM COST				3.60%	5.01%	

Former Foster Care Youth from Another State	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 186,709	$ 207,250	$ 368,364	$ 315,411	$ 331,182	$ 1,408,916
ELIGIBLE MEMBER MONTHS	170	201	231	181	180	
PMPM COST	$ 1,098.29	$ 1,031.09	$ 1,594.65	$ 1,742.60	$ 1,839.90	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		11.00%	77.74%	-14.38%	5.00%	15.41%
ELIGIBLE MEMBER MONTHS		18.24%	14.93%	-21.65%	-0.55%	1.44%
PMPM COST		-6.12%	54.66%	9.28%	5.58%	13.77%

SUD	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 39,571,201	$ 55,422,813	$ 64,306,835	$ 65,722,712	$ 66,818,922	$ 291,842,483
ELIGIBLE MEMBER MONTHS	9,117	10,336	10,619	10,336	10,008	
PMPM COST	$ 4,340.38	$ 5,362.11	$ 6,055.83	$ 6,358.62	$ 6,676.55	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		40.06%	16.03%	2.20%	1.67%	13.99%
ELIGIBLE MEMBER MONTHS		13.37%	2.74%	-2.67%	-3.17%	2.36%
PMPM COST		23.54%	12.94%	5.00%	5.00%	11.37%

SMI	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 10,446,565	$ 29,906,004	$ 34,856,622	$ 34,768,551	$ 32,720,636	$ 142,698,378
ELIGIBLE MEMBER MONTHS	1,339	4,004	3,938	3,741	3,353	
PMPM COST	$ 7,801.77	$ 7,469.03	$ 8,851.35	$ 9,293.92	$ 9,758.61	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		186.28%	16.55%	-0.25%	-5.89%	33.03%
ELIGIBLE MEMBER MONTHS		199.03%	-1.65%	-5.00%	-10.37%	25.79%
PMPM COST		-4.26%	18.51%	5.00%	5.00%	5.75%

Intensive Support Service	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 18,420	$ 36,053	$ 1,949	$ 16,567		$ 72,989
ELIGIBLE MEMBER MONTHS	52	50	2			
PMPM COST	$ 354.23	$ 721.06	$ 974.50			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		95.73%	-94.59%	750.03%		
ELIGIBLE MEMBER MONTHS		-3.85%	-96.00%	-100.00%		
PMPM COST		103.56%	35.15%			

ESI/COBRA	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 347,797	$ 340,076	$ 470,758	$ 449,174	$ 469,683	$ 2,077,488
ELIGIBLE MEMBER MONTHS	2,191	2,372	2,662	2,419	2,409	
PMPM COST	$ 158.74	$ 143.37	$ 176.84	$ 185.69	$ 194.97	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-2.22%	38.43%	-4.58%	4.57%	7.80%
ELIGIBLE MEMBER MONTHS		8.26%	12.23%	-9.13%	-0.41%	2.40%
PMPM COST		-9.68%	23.35%	5.00%	5.00%	5.27%

HRSS	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES	$ 54,634	$ (25,786)	$ 1,361,352			$ 1,390,200
ELIGIBLE MEMBER MONTHS	61	537	2,714			
PMPM COST	$ 895.64	$ (48.02)	$ 501.60			
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		-147.20%	-5379.42%			
ELIGIBLE MEMBER MONTHS		780.33%	405.40%			
PMPM COST		-105.36%	-1144.60%			

HRSN NMT	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ (9,396)	$ 223	$ (9,173)
ELIGIBLE MEMBER MONTHS				14	24	
PMPM COST				$ (671.14)	$ 9.29	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE					-102.37%	
ELIGIBLE MEMBER MONTHS					71.43%	
PMPM COST					-101.38%	

Fertility Treatment for Individuals Diagnosed with Cancer - Male	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES			$ 4,256	$ 6,703	$ 14,077	$ 25,036
ELIGIBLE MEMBER MONTHS			4	6	12	
PMPM COST			$ 1,064.00	$ 1,117.20	$ 1,173.06	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				57.50%	110.00%	
ELIGIBLE MEMBER MONTHS				50.00%	100.00%	
PMPM COST				5.00%	5.00%	

Fertility Treatment for Individuals Diagnosed with Cancer - Female	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES			$ 6,462	$ 27,140	$ 56,995	$ 90,597
ELIGIBLE MEMBER MONTHS			3	12	24	
PMPM COST			$ 2,154.00	$ 2,261.70	$ 2,374.79	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				320.00%	110.00%	
ELIGIBLE MEMBER MONTHS				300.00%	100.00%	
PMPM COST				5.00%	5.00%	

Cryopreservation	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES					$ 5,838	$ 5,838
ELIGIBLE MEMBER MONTHS			-	-	10	
PMPM COST					$ 583.79	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE						
ELIGIBLE MEMBER MONTHS						
PMPM COST						

In Vitro Fertilization and Genetic Testing Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES		$ 1,712	$ 41,776	$ 110,169	$ 125,872	$ 279,530
ELIGIBLE MEMBER MONTHS			84	213	234	
PMPM COST			$ 497.33	$ 517.23	$ 537.92	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE				163.71%	14.25%	
ELIGIBLE MEMBER MONTHS				153.57%	9.86%	
PMPM COST				4.00%	4.00%	

Family Planning Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES					$ 2,948,569	$ 2,948,569
ELIGIBLE MEMBER MONTHS					63,684	
PMPM COST					$ 46.30	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE						
ELIGIBLE MEMBER MONTHS						
PMPM COST						

Pregnant Women and 12-Month Extended Postpartum	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ 37,047,495	$ 77,939,061	$ 114,986,555
ELIGIBLE MEMBER MONTHS				45,165	89,892	
PMPM COST				$ 820.27	$ 867.03	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE					110.38%	
ELIGIBLE MEMBER MONTHS					99.03%	
PMPM COST					5.70%	

Reentry Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ 348,863	$ 358,407	$ 707,270
ELIGIBLE MEMBER MONTHS				321	312	
PMPM COST				$ 1,086.80	$ 1,148.74	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE					2.74%	
ELIGIBLE MEMBER MONTHS					-2.80%	
PMPM COST					5.70%	

Reentry Non-Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ 500,000	$ 2,000,000	$ 2,500,000
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE						

HRSN Services	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ 382,337	$ 143,651	$ 525,988

HRSN Infrastructure	DY 21 (SFY23)	DY 22 (SFY24)	DY 23 (SFY25)	DY 24 (SFY26)	DY 25 (SFY27)	5-YEARS
TOTAL EXPENDITURES				$ 250,000	$ 4,000,000	$ 4,250,000

The table below shows the projected expenditures for each demonstration year (DY).

Table 4: Annual Expenditures					
Enrollment	**DY26**	**DY27**	**DY28**	**DY29**	**DY30**
ESI Adults w/ or w/o Children	$801,639	$841,105	$875,434	$909,179	$944,825
Reentry Services	$333,856	$351,550	$370,183	$389,802	$410,462
HRSN Non-Medical Transportation	$5,988	$7,513	$7,904	$8,315	$8,076
Adult Expansion	$824,661,133	$863,420,206	$904,000,956	$946,489,000	$990,973,983
Dental Benefits	$138,693,370	$146,876,090	$155,541,780	$164,718,745	$174,437,151
Employer Sponsored Insurance	$2,307,137	$2,415,520	$2,543,543	$2,678,351	$2,820,303
Cryopreservation	$161,059	$169,596	$178,584	$188,049	$198,016
Family Planning Services	$3,111,864	$3,276,793	$3,450,463	$3,633,337	$3,825,904
Fertility Treatment for Individuals Diagnosed with Cancer-Female	$281,408	$296,323	$312,028	$328,565	$345,979
Fertility Treatment for Individuals Diagnosed with Cancer-Male	$9,478	$9,980	$10,509	$11,066	$11,652
Former Foster	$363,514	$382,417	$402,303	$423,222	$445,230

Care Youth from Another State					
In Vitro Fertilization and Genetic Testing	$1,310,285	$1,375,940	$1,444,884	$1,517,284	$1,593,311
Reentry Non-Services	$4,271,744	$4,271,744	$4,271,744	$4,271,744	$4,271,744
HRSN Services	$94,157,357	$94,157,357	$94,157,357	$94,157,357	$94,157,357
HRSN Infrastructure	$12,450,000	$12,450,000	$12,450,000	$12,450,000	$12,450,000
SMI IMD	$56,712,906	$59,494,260	$62,647,456	$65,967,771	$69,464,063
SUD IMD	$77,020,048	$81,025,090	$85,238,395	$89,670,791	$94,333,673
Pending Amendments					
Chronic Conditions Support	$3,477,600	$3,477,600	$3,477,600	$3,477,600	$3,477,600
Community Engagement	$824,661,133	$863,420,206	$904,000,956	$946,489,000	$990,973,983
Disability Wraparound Coverage	$118,440	$118,440	$118,440	$118,440	$118,440
Integrated Behavioral Health Services	$243,117	$255,273	$268,036	$281,438	$295,510
Long Term Services and Supports for Behaviorally Complex Individuals	$6,985,270	$7,334,533	$7,701,260	$8,086,323	$8,490,639
Native American Health	$7,664,300	$7,664,300	$7,664,300	$7,664,300	$7,664,300

Amendments					

Section VI. Requested Waiver and Expenditure Authorities

The following table summarizes the current 1115 Demonstration and expenditure authorities, and whether Utah is requesting to continue these authorities with this renewal request.

Table 5: Requested Waiver Authorities

Waiver Authority	Reason and Use of Waiver	Demonstration Populations Applicable To	Status under Renewal
Section 1902(a)(84)(D)-Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release	To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.	Reentry Demonstration	Continue

Table 6: Requested Non-Applicables			
Waiver Authority	**Reason and Use of Waiver**	**Demonstration Populations Applicable To**	**Status under Renewal**
Section 1902(a)(10)(B) and Section 1902(a)(17)-Comparability; Amount, Duration and Scope of Services and Comparability	To enable the state to vary the amount, duration, and scope of services offered to individuals by demonstration group. To enable the state to include additional benefits, such as behavioral health, case management, and health education not otherwise available, to Medicaid beneficiaries who are enrolled in a managed care delivery system. To enable the state to provide benefit packages to the Demonstration population that differs from the state plan benefit package. To enable the State to provide additional benefits to AEM members compared to the benefits available to members eligible under the State Plan that are not affected by the Demonstration.	-Individuals affected by this demonstration with the exception of Former Foster Care Youth from Another State -Adult Expansion -Populations III and V -Fertility Preservation for Beneficiaries Diagnosed with Cancer -In Vitro Fertilization and Genetic Testing -Reentry Demonstration -HRSN -Family Planning Services -Chronic Conditions -Community Engagement -Disability Wraparound Coverage -Long Term Services and Supports for Behaviorally Complex Individuals	Continue and Approval Requested
Section 1902(a)(34)-Retroactive Eligibility	To permit the state to not provide retroactive eligibility for individuals under this demonstration.	-Demonstration Populations III and V -Family Planning Services	Continue
Section 1902(a)(1)-Statewideness/ Uniformity	To enable the state to provide differing types of managed care plans in certain geographical areas of the state for Title XIX	-Title XIX Populations affected by this demonstration -Reentry Demonstration -HRSN	Continue and Approval Requested

	populations affected by this demonstration. To enable the state to provide pre-release services to qualifying individuals on a geographically limited basis. To enable the state to provide housing and home environment interventions without room and board, short-term recuperative care, and short-term rental assistance services on a less-than statewide basis. This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.	-Integrated Behavioral Health Services	
Section 1902(a)(23)(A)-Freedom of Choice	To enable the state to restrict freedom of choice of providers for individuals under this demonstration. To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers. To enable the state to restrict freedom of choice of providers for Title XIX populations affected by this Demonstration	-Title XIX Populations affected by this demonstration -Reentry Demonstration -Chronic Conditions Support -Long Term Services and Supports for Behaviorally Complex Individuals	Continue and Approval Requested
Section 1902(a)(43)-Early Periodic	To enable the state to not furnish or arrange for EPSDT	Family Planning Services	Continue

Screening, Diagnosis and Treatment (EPSDT)	services to the demonstration population receiving family planning services and family planning related services.		
Section 1902(a)(8), (a)(10) and (a)(10)(A) -Eligibility and Provision of Medical Assistance and Eligibility Requirements	To the extent necessary to enable the State to suspend eligibility for, and not make medical assistance available to members subject to the community engagement requirements who fail to comply with those requirements as described in the STCs, unless the member is exempted, or demonstrates good cause, as described in the STCs. To the extent necessary to enable the State to require community engagement and associated reporting requirements as a condition of eligibility, as described in the STCs. To permit the State to cap enrollment for individuals eligible under the Disability Wraparound Coverage demonstration group.	-Community Engagement -Chronic Conditions Support	Approval requested
Section 1902(a)(10)(A)(i)(VIII) and 1902(a)(17) Comparability of Eligibility Requirements	To the extent necessary to enable Utah to require work, training, and/or engagement as a condition to qualify for and maintain eligibility for the eligibility category defined in 1902(a)(10)(A)(i)(VIII).	Community Engagement	Approval Requested

Section 1902(a)(14) Cost Sharing Requirements	To permit individuals affected by this demonstration, whose benefits are limited to wraparound coverage, to have cost sharing requirements.	Disability Wraparound Coverage	Approval Requested
Section 1902(a)(B) of the Social Security Act and 42 CFR 440.240 (comparability)	To the extent necessary to enable the State to reimburse for traditional healing services for AI/AN members provided in, at, or as part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program.	-Native American Health Amendments	Approval Requested
Expenditure authority for services not covered under Section 1905 of the Social Security Act	To the extent necessary to enable the State to claim FFP for the cost of traditional healing services provided in, at, or as a part of services offered by facilities and clinics operated by the Indian Health Service, a tribe or tribal organization, or an Urban Indian health program and receive 100 percent FMAP.	-Native American Health Amendments	Approval Requested

Expenditure Authorities

Table 7: Requested Expenditure Authorities

Demonstration Population	Reason and Use of Expenditure Authority	Status Under Renewal
Demonstration Population III	Expenditures for premium subsidies related to providing 12 months of guaranteed eligibility to subsidize the employee's share of the costs of the health insurance premium for employer sponsored insurance (ESI) to	Continue

	non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the federal poverty level (FPL), but at or below 200 percent of the FPL, as well as their spouses and their children, age 19 through 26, who are enrolled in their parents' ESI plan, who are not otherwise eligible for Medicaid, as described in the Special Terms and Condition (STCs).	
Demonstration Population V	Expenditures for premium subsidies related to providing up to a maximum of 18 months of eligibility to subsidize the employee's share of the costs of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) premium for COBRA continuation of coverage to non-disabled and non-elderly low-income workers age 19 through 64 with incomes above 133 percent of the FPL, but at or below 200 percent of the FPL, as well as their spouses, who are not otherwise eligible for Medicaid, as described in the STCs.	Continue
Former Foster Care Youth from Another State	Expenditures to extend eligibility for full Medicaid state plan benefits to former foster care youth who are defined as individuals under age 26, that were in foster care under the responsibility of a state other than Utah or tribe in such other state on the date of attaining 18 years of age or such higher age as the state has elected for termination of federal foster care assistance under title IV-E of the Act, were ever enrolled in Medicaid, and are now applying for Medicaid in Utah.	Continue
Targeted Adults	Expenditures to provide state plan coverage to certain individuals, age 19 through 64, without dependent children, who have incomes at zero percent of the FPL (effectively up to five percent with the five percent income disregard), as described in these STCs. Expenditures for state plan coverage for individuals who have been determined eligible as a Targeted Adult for continued benefits during any periods within a twelve-month eligibility period when these individuals would be found ineligible if subject to redetermination (continuous eligibility).	Discontinue beginning June 30, 2027, and transition these individuals into the Adult Expansion group.
Substance Use Disorder	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).	Continue
Adult Expansion	Expenditures to provide coverage to adults, age 19 through 64 and have household income at or below 133 percent of the FPL.	Continue

Mandatory Employer Sponsored Insurance	Expenditures to provide premium assistance and wrap around benefits to the Adult Expansion Population beneficiaries who are enrolled in ESI plans.	Continue
Residential and Inpatient Treatment for Individuals with Serious Mental Illness	Expenditures for services furnished to eligible individuals age 21 through 64 who receive treatment for a serious mental illness (SMI) and who are short-term residents in facilities that meet the definition of an IMD.	Continue
Expenditures Related to Fertility Preservation for Beneficiaries Diagnosed with Cancer	Expenditures for fertility preservation provided to eligible individuals with an active diagnosis of cancer which puts them at risk for sterility or iatrogenic infertility.	Continue
Expenditures Related to In Vitro Fertilization and Genetic Testing Services	Expenditures for in vitro fertilization and genetic testing services for qualifying individuals.	Continue
Expenditures for Pre-Release Services	Expenditures for pre-release services furnished to individuals who meet qualifying criteria for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.	Continue
Expenditures for Pre-Release Administrative Costs	Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.	Continue
Dental Services	Expenditures for dental services provided to all Medicaid-eligible adults and children as well as Medicaid-eligible pregnant and postpartum women.	Continue
Health-Related Social Needs (HRSN) Services	Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria.	Continue
Health-Related Social Needs Services Infrastructure	Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act.	Continue
Expenditures for Non-Medical Transportation (NMT)	Expenditures for NMT.	Continue
Expenditures for Continuous Eligibility for State Plan Benefits for the Full Pregnancy and 12-Month Period	Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12- month extended postpartum eligibility period.	Continue

Family Planning Services and Family Planning Related Services	Expenditures for providing Medicaid eligibility for family planning services and family planning related services, limited to: Women and men age 18 and older with family income at or below 185 percent of the FPL (using MAGI methodology which includes a 5 percent FPL income disregard) who are not in a public institution and are not otherwise enrolled in Medicaid or the Children's Health Insurance Program (CHIP).	Continue
COBRA Children (Demonstration Population VI)	Expenditures to provide premium assistance and benefits to children up to age 19 with family income up to and including 200 percent of the FPL who would meet the definition of a targeted low-income child except for continuation of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. 99-272. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.	Continue
Current Eligible CHIP Children	Expenditures to provide premium assistance to children up to age 19 with family income up to and including 200 percent of the FPL who meet the definition of a targeted low-income child, but the child's parents have elected to receive premium subsidies for the employee's share of the cost of ESI instead of receiving direct coverage under the CHIP state plan. Such matching expenditures are authorized under section 1115(a)(2) of the Act, as incorporated under section 2107(e)(2)(A) of the Act.	Continue

Table 8: Title XXI Requirements Not Applicable to Children's Health Insurance Program (CHIP) Expenditure Authorities for Demonstration Population VI and Current Eligible CHIP Children

Demonstration Population	Reason and Use of Expenditure Authority	Status Under Renewal
Section 2102-General Requirements, and Eligibility Screening Requirements	The state child health plan does not have to reflect the demonstration population. Eligibility screening is not required to exclude eligibility for individuals enrolled in continuation coverage pursuant to COBRA.	Continue
Section 2103 and 2110-Restrictions on Coverage and Eligibility to Targeted Low-Income Children	Coverage and eligibility are not restricted to targeted low-income children, to the extent that it includes individuals enrolled under continuation coverage pursuant to COBRA.	Continue
Section 2105(c)(10)-Qualified Employer Sponsored Coverage	To permit the state to offer a premium assistance subsidy that does not meet the requirements of section 2105(c).	Continue

Table 9: Title XXI Requirements Not Applicable to Current Eligible CHIP Children		
Demonstration Population	**Reason and Use of Expenditure Authority**	**Status Under Renewal**
Section 2102-Cost Sharing Exemption for American Indian/Alaskan Native (AI/AN) Children	To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.	Continue
Section 2103-Benefit Package Requirements	To permit the state to offer a benefit package for all CHIP populations affected by this demonstration that is limited to premium assistance.	Continue
Section 2103(e)-Cost Sharing	To the extent necessary to permit all CHIP populations affected by this demonstration, whose benefits are limited to premium assistance, to have cost sharing imposed by employer-sponsored insurance plans.	Continue
Section 2102-Cost Sharing Exemption for American Indian/Alaskan Native (AI/AN) Children	To the extent necessary to permit AI/AN children who are in all CHIP populations affected by this demonstration, and whose benefits are limited to premium assistance, to be charged premiums and/or cost sharing by the plans in which they are enrolled.	Continue

Section VII. Annual Public Forums

As required by the demonstration Special Terms and Conditions, the state held several annual public forums during the currently approved demonstration period. The forums were held during the Medicaid Advisory Committee (MAC) meetings on the following dates, and include all comments provided. The date, time and location of the forums were published on the state's 1115 Demonstration website 30 days prior to the date of the forum:

- January 20, 2022
    - One commenter asked about the status of the State's pending 1115 Demonstration renewal. No other comments were received.
- January 19, 2023
    - No comments received.
- January 18, 2024
    - One commenter asked about the delayed reporting of data counts for certain demonstrations. The state responded that we do not have control over this as we are unable to obtain enrollment data until all claims are submitted by providers and loaded into our PRISM system. No additional comments were received.
- January 6, 2025
    - One commenter expressed concern about the state's AEM enrollment and that the number seems to drop each month and is not stable. The commenter indicated she

did not expect a response but just wanted to provide the comment. No additional comments were received.

- March 26, 2026
    - One commenter asked for clarity on pregnant women moving to the 1115 Demonstration. The state responded with additional information on the demonstration. No additional comments were received.

Section VIII. Review of Documents and Submission of Comments

The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss the 2027-2032 Renewal to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comments regarding the amendment online, by email, or mail during the public comment period from April 21, 2026, through May 21, 2026.

Utah Medicaid is requesting authority from the Centers for Medicare and Medicaid Services (CMS) to renew Utah's Medicaid Reform 1115 Demonstration for an additional five years (2027-2032).

Public Hearings:

The Department will conduct two public hearings to discuss the renewal. The dates and times are listed below.

- Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting.
    - Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
    - Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#
- Thursday, May 7, 2026, from 2:30 pm to 3:30 pm.
    - Martha Hughes Cannon Building, Room 125
      288 North 1460 West
      Salt Lake City, UT 84116
- Thursday, May 7, 2026, from 4:00 pm to 5:00 pm.
    - Video Conference: Google Meet Meeting meet.google.com/btm-baiv-hmy
    - Or join by phone: (US) +1 413-679-2772 PIN: 668 611 216#

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by May 5, 2026.

Public Comment:

A copy of the public notice and renewal application is available online at:
https://medicaid.utah.gov/1115-waiver/

CMS State Waivers List:
https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list

The public may comment on the proposed amendment request during the public comment period from April 21, 2026, through May 21, 2026.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

A copy of the DHHS's proposed renewal application may be requested in writing from:

Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Utah Department of Health & Human Services

Public Notice

Utah's Medicaid Reform 1115 Demonstration Renewal

The Utah Department of Health and Human Services, Division of Integrated Healthcare, will hold public hearings to discuss the renewal of the state's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the demonstration renewal during the 30-day public comment period from April 21, 2026, through May 21, 2026.

The Utah Department of Health and Human Services is requesting a five-year renewal of Utah's Medicaid Reform 1115 Demonstration under Section 1115 of the Social Security Act. Utah's existing 1115 Demonstration is currently approved through June 30, 2027. With this application, Utah is seeking a renewal period from July 1, 2027, through June 30, 2032. This 1115 Demonstration renewal requests authority to continue to operate the currently approved programs and benefits listed below, with minimal changes:

- Adult Expansion
- Utah's Premium Partnership Program (UPP)
- Dental Services
- Premium Assistance for Employer Sponsored Insurance
- Extended Postpartum Coverage
- Family Planning
- Fertility Preservation for Individuals Diagnosed with Cancer
- Former Foster Care Youth from Another State
- Health Related Social Needs
- In Vitro Fertilization and Genetic Testing for Qualified Conditions
- Reentry Pre-Release Services
- Serious Mental Illness (SMI) Services in Institutions for Mental Disease (IMD)
- Substance Use Disorder Services (SUD) in an IMD
- Utah Medicaid Integrated Care (UMIC)

In addition to the renewal of the current demonstration and expenditure authorities, the state is requesting the following changes:

- The state is requesting to end Targeted Adult Medicaid (TAM) on June 30, 2027. If approved, TAM Members will transition to Adult Expansion Medicaid effective July 1, 2027.
- Combining the four UPP demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population.
- The removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion Population.

The state is also requesting that the following pending amendments be considered in addition to the 1115 Demonstration renewal, with the hope of gaining approval for these amendments prior to the approval of the full 1115 Demonstration renewal:

- Chronic Conditions Support
- Community Engagement
- Disability Wraparound Coverage
- Integrated Behavioral Health Services
- Long Term Services and Supports for Behaviorally Complex Individuals
- Native American Health Amendments

Public Hearings:

The Department will conduct two public hearings to discuss the Renewal. The dates and times are listed below.

- Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting.
  - Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
  - Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#
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Email: Medicaid1115waiver@utah.gov

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Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Public Notice

Utah's Medicaid Reform 1115 Demonstration

2027-2032 Renewal

The Utah Department of Health and Human Services, Division of Integrated Healthcare will hold public hearings to discuss the 2027-2032 Renewal to Utah's Medicaid Reform 1115 Demonstration. The Department will also accept public comments regarding the amendment online, by email, or mail during the public comment period from April 21, 2026, through May 21, 2026.

Utah Medicaid is requesting authority from the Centers for Medicare and Medicaid Services (CMS) to renew Utah's Medicaid Reform 1115 Demonstration for an additional five years (2027-2032).

Public Hearings:

The Department will conduct three public hearings to discuss the renewal. The dates and times are listed below.

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Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Laura Belgique (DHHS) <lbelgique@utah.gov>

QAZ: Renewal of Utah's Medicaid Reform 1115 Demonstration

1 message

Sharon Steigerwalt (DHHS) <ssteigerwalt@utah.gov> Mon, Apr 27, 2026 at 2:33 PM
Bcc: lbelgique@utah.gov

An in-person public hearing has been added. Information is below.

Please find attached the full public notice from the Utah Department of Health and Human Services, Division of Integrated Healthcare, regarding its intent to submit a renewal request for Utah's Medicaid Reform 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS).

The Department requests authority from CMS to renew the 1115 Demonstration for an additional five years (2027-2032).

Public Hearings:

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--

Laura Belgique
1115 Demonstration Program Manager
801.538.6241
lbelgique@utah.gov

Utah Department of
Health & Human Services
Integrated Healthcare

---------- Forwarded message ---------
From: **Sharon Steigerwalt (DHHS)** <ssteigerwalt@utah.gov>
Date: Tue, Apr 21, 2026 at 9:26 AM
Subject: QAZ: Renewal of Utah's Medicaid Reform 1115 Demonstration
To:

Please find attached the full public notice from the Utah Department of Health and Human Services, Division of Integrated Healthcare, regarding its intent to submit a renewal request for Utah's Medicaid Reform 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS).

The Department requests authority from CMS to renew the 1115 Demonstration for an additional five years (2027-2032). Two public hearings to discuss the renewal request and take public comment will be held. The first public hearing will take place on Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting. The second public hearing will be held on Thursday, May 7, 2026, from 4:00 pm to 5:00 pm.

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--
Laura Belgique
1115 Demonstration Program Manager
801.538.6241
lbelgique@utah.gov

Utah Department of
Health & Human Services
Integrated Healthcare

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If you are not the intended recipient, any distributions or copying of this message, or the taking of any action based on its content is strictly prohibited.

--
Sharon Steigerwalt
Division of Integrated Healthcare
ssteigerwalt@utah.gov

--
Sharon Steigerwalt
Division of Integrated Healthcare
ssteigerwalt@utah.gov

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Full Public Notice_ 2027-2032 Renewal.REVISED.FINAL.1.pdf
853K

UTAH

Laura Belgique (DHHS) <lbelgique@utah.gov>

QAZ: Renewal of Utah's Medicaid Reform 1115 Demonstration

1 message

Sharon Steigerwalt (DHHS) <ssteigerwalt@utah.gov> Mon, Apr 27, 2026 at 2:33 PM
Bcc: lbelgique@utah.gov

An in-person public hearing has been added. Information is below.

Please find attached the full public notice from the Utah Department of Health and Human Services, Division of Integrated Healthcare, regarding its intent to submit a renewal request for Utah's Medicaid Reform 1115 Demonstration to the Centers for Medicare and Medicaid Services (CMS).

The Department requests authority from CMS to renew the 1115 Demonstration for an additional five years (2027-2032).

Public Hearings:

The Department will conduct three public hearings to discuss the Renewal. The dates and times are listed below.

Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting.
- Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
- Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#

Thursday, May 7, 2026, from 2:30 pm to 3:30 pm.
- **Martha Hughes Cannon Building, Room 125**
  288 North 1460 West
  Salt Lake City, UT 84116

Thursday, May 7, 2026, from 4:00 pm to 5:00 pm.
- Video Conference: Google Meet Meeting meet.google.com/btm-baiv-hmy
- Or join by phone: (US) +1 413-679-2772 PIN: 668 611 216#

The public may comment on the proposed renewal request during the public comment period from April 21, 2026, through May 21, 2026.

The proposed renewal request is available online at https://medicaid.utah.gov/1115-waiver/

--

Laura Belgique
1115 Demonstration Program Manager
801.538.6241
lbelgique@utah.gov

Utah Department of
Health & Human Services
Integrated Healthcare

---------- Forwarded message ---------
From: **Sharon Steigerwalt (DHHS)** <ssteigerwalt@utah.gov>
Date: Tue, Apr 21, 2026 at 9:26 AM
Subject: QAZ: Renewal of Utah's Medicaid Reform 1115 Demonstration
To:

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The Department requests authority from CMS to renew the 1115 Demonstration for an additional five years (2027-2032). Two public hearings to discuss the renewal request and take public comment will be held. The first public hearing will take place on Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting. The second public hearing will be held on Thursday, May 7, 2026, from 4:00 pm to 5:00 pm.

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Laura Belgique
1115 Demonstration Program Manager
801.538.6241
lbelgique@utah.gov

Utah Department of
Health & Human Services
Integrated Healthcare

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--
Sharon Steigerwalt
Division of Integrated Healthcare
ssteigerwalt@utah.gov

--
Sharon Steigerwalt
Division of Integrated Healthcare
ssteigerwalt@utah.gov

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Full Public Notice_ 2027-2032 Renewal.REVISED.FINAL.1.pdf
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PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Utah Medicaid Reform 1115 Demonstration Renewal

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

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Notice Information

Add Notice to Calendar

Notice Title:

Utah Medicaid Reform 1115 Demonstration Renewal

Notice Type(s):

Meeting, Hearing

Event Start Date & Time:

April 23, 2026 10:00 AM

Event End Date & Time:

April 23, 2026 12:00 PM

Event Deadline Date & Time:

04/23/26 12:00 PM

Description/Agenda:

Public Notice

Utah's Medicaid Reform 1115 Demonstration Renewal

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Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

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Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

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Notice Posted On:

April 13, 2026 12:51 PM

Notice Last Edited On:

April 13, 2026 04:07 PM

Deadline Date:

April 23, 2026 12:00 PM

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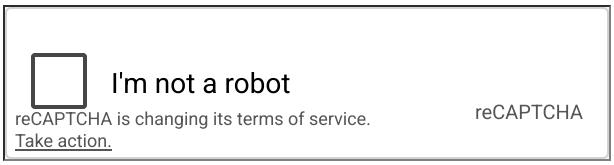

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PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Utah Medicaid Reform 1115 Demonstration Renewal

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

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Notice Information

Add Notice to Calendar

Notice Title:

Utah Medicaid Reform 1115 Demonstration Renewal

Notice Type(s):

Meeting

Event Start Date & Time:

May 7, 2026 02:30 PM

Event End Date & Time:

May 7, 2026 03:30 PM

Event Deadline Date & Time:

05/07/26 03:30 PM

Description/Agenda:

Public Notice

Utah's Medicaid Reform 1115 Demonstration Renewal

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- Salt Lake City, UT 84116

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Public Comment:

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Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

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Notice of Electronic or Telephone Participation:

N/A

Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 27, 2026 04:40 PM

Notice Last Edited On:

April 27, 2026 04:40 PM

Deadline Date:

May 7, 2026 03:30 PM

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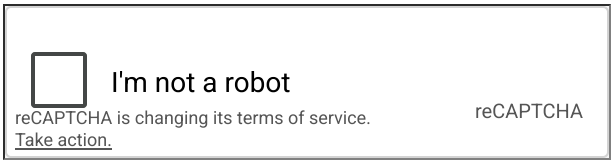

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PUBLIC NOTICE WEBSITE
DIVISION OF ARCHIVES AND RECORDS SERVICE

Utah Medicaid Reform 1115 Demonstration Renewal

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

Public Body:

Medicaid Expansion Workgroup

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Notice Information

Add Notice to Calendar

Notice Title:

Utah Medicaid Reform 1115 Demonstration Renewal

Notice Type(s):

Notice, Meeting

Event Start Date & Time:

May 7, 2026 04:00 PM

Event End Date & Time:

May 7, 2026 05:00 PM

Event Deadline Date & Time:

05/07/26 05:00 PM

Description/Agenda:

Public Notice

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Division of Integrated Healthcare
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Meeting Information

Meeting Location:

Video/Teleconferencing
Video/Teleconferencing, UT 84116
Show in Apple Maps | Show in Google Maps

Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 13, 2026 01:50 PM

Notice Last Edited On:

April 13, 2026 04:09 PM

Deadline Date:

May 7, 2026 05:00 PM

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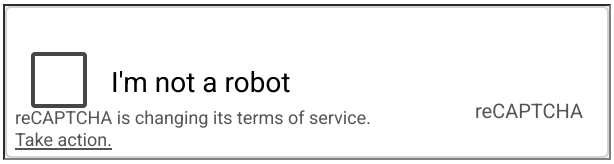

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DIVISION OF ARCHIVES AND RECORDS SERVICE

Utah Medicaid Reform 1115 Demonstration Renewal

General Information

Government Type:

State Agency

Entity:

Department of Health and Human Services (DHHS)

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Medicaid Expansion Workgroup

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May 7, 2026 04:00 PM

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Contact Name:

Laura Belgique

Contact Email:

lbelgique@utah.gov

Contact Phone:

(801)538-6241

Notice Posting Details

Notice Posted On:

April 13, 2026 01:50 PM

Notice Last Edited On:

April 27, 2026 03:46 PM

Deadline Date:

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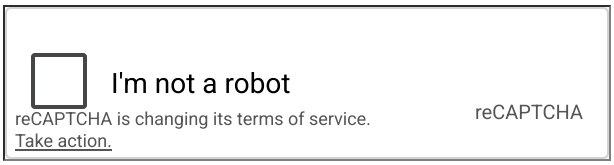

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PO BOX 143102
SALT LAKE CITY, UT 84114
cdevashrayee@utah.gov

ACCOUNT NUMBER

8405

ACCOUNT NAME

DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE

801-538-6641

ORDER #

SLT0037808

CUSTOMER REFERENCE NUMBER

CAPTION

Public Notice Utah's Medicaid Reform 1115 Demonstration Renewal The Utah Department of Health and Human Services, Division of Integrated Healthcare, will hold public hearings to discuss the renewal of the state's Medicaid Reform 1115 Demonstration.

TOTAL COST

$325.40

Public Notice

Utah's Medicaid Reform 1115 Demonstration Renewal

The Utah Department of Health and Human Services, Division of Integrated Healthcare, will hold public hearings to discuss the renewal of the state's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the demonstration renewal during the 30-day public comment period from April 21, 2026, through May 21, 2026.

The Utah Department of Health and Human Services is requesting a five-year renewal of Utah's Medicaid Reform 1115 Demonstration under Section 1115 of the Social Security Act. Utah's existing 1115 Demonstration is currently approved through June 30, 2027. With this application, Utah is seeking a renewal period from July 1, 2027, through June 30, 2032. This 1115 Demonstration renewal requests authority to continue to operate the currently approved programs and benefits listed below, with minimal changes:

- Adult Expansion
- Utah's Premium Partnership Program (UPP)
- Dental Services
- Premium Assistance for Employer Sponsored Insurance
- Extended Postpartum Coverage
- Family Planning
- Fertility Preservation for Individuals Diagnosed with Cancer
- Former Foster Care Youth from Another State
- Health Related Social Needs
- In Vitro Fertilization and Genetic Testing for Qualified Conditions
- Reentry Pre-Release Services
- Serious Mental Illness (SMI) Services in Institutions for Mental Disease (IMD) • Substance Use Disorder Services (SUD) in an IMD
- Utah Medicaid Integrated Care (UMIC)

In addition to the renewal of the current demonstration and expenditure authorities, the state is requesting the following changes:

- The state is requesting to end Targeted Adult Medicaid (TAM) on June 30, 2027. If approved, TAM Members will transition to Adult Expansion Medicaid effective July 1, 2027. • Combining the four UPP demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population.
- The removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion Population.

The state is also requesting that the following pending amendments be considered in addition to the 1115 Demonstration renewal, with the hope of gaining approval for these amendments prior to the approval of the full 1115 Demonstration renewal:

- Chronic Conditions Support
- Community Engagement
- Disability Wraparound Coverage
- Integrated Behavioral Health Services
- Long Term Services and Supports for Behaviorally Complex Individuals
- Native American Health Amendments

Public Hearings:
The Department will conduct two public hearings to discuss the Renewal. The dates and times are listed below.

- Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting.
  - Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
  - Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#
- Thursday, May 7, 2026, from 4:00 pm to 5:00 pm.
  - Video Conference: Google Meet Meeting meet.google.com/btm-baiv-hmy
  - Or join by phone: (US) +1 413-679-2772 PIN: 668 611 216#

Individuals requiring an accommodation to fully participate in either meeting may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by April 21, 2026.

Public Comment:
A copy of the full public notice and renewal application is available online at: https://medicaid.utah.gov/1115-waiver/

The public may comment on the proposed amendment request during the public comment period from April 21, 2026, through May 21, 2026.

Comments may be submitted:

Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0037808

AFFIDAVIT OF PUBLICATION

AS THE SALT LAKE TRIBUNE, INC. LEGAL BOOKER, I CERTIFY THAT THE ATTACHED ADVERTISEMENT OF Public Notice Utah's Medicaid Reform 1115 Demonstration Renewal The Utah Department of Health and Human Services, Division of Integrated Healthcare, will hold public hearings to discuss the renewal of the state's Medicaid Reform 1115 Demonstration. FOR DIVISION OF MEDICAID AND HEALTH FINANCING WAS PUBLISHED BY THE SALT LAKE TRIBUNE, INC., WEEKLY NEWSPAPER PRINTED IN THE ENGLISH LANGUAGE WITH GENERAL CIRCULATION IN UTAH, AND PUBLISHED IN SALT LAKE CITY, SALT LAKE COUNTY IN THE STATE OF UTAH. NOTICE IS ALSO POSTED ON UTAHLEGALS.COM ON THE SAME DAY AS THE FIRST NEWSPAPER PUBLICATION DATE AND REMAINS ON UTAHLEGALS.COM INDEFINITELY. COMPLIES WITH UTAH DIGITAL SIGNATURE ACT UTAH CODE 46-2-101; 46-3-104.

PUBLISHED ON 04/19/2026

DATE 04/24/2026

SIGNATURE

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 24th DAY OF APRIL IN THE YEAR 2026

BY Doug Ryle

NOTARY PUBLIC SIGNATURE

48 W MARKET ST, STE 200
SALT LAKE CITY, UT 84101

The Salt Lake Tribune

PROOF OF PUBLICATION CUSTOMER'S COPY

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ACCOUNT NUMBER

8405

ACCOUNT NAME

DIVISION OF MEDICAID AND HEALTH FINANCING

TELEPHONE

801-538-6641

ORDER #

SLT0037997

CUSTOMER REFERENCE NUMBER

CAPTION

Public Notice Utah's Medicaid Reform 1115 Demonstration Renewal The Utah Department of Health and Human Services, Division of Integrated Healthcare, will hold public hearings to discuss the renewal of the state's Medicaid Reform 1115 Demonstration.

TOTAL COST

$336.20

Public Notice

Utah's Medicaid Reform 1115 Demonstration Renewal The Utah Department of Health and Human Services, Division of Integrated Healthcare, will hold public hearings to discuss the renewal of the state's Medicaid Reform 1115 Demonstration. The Department will also accept public comment regarding the demonstration renewal during the 30-day public comment period from April 21, 2026, through May 21, 2026.

The Utah Department of Health and Human Services is requesting a five-year renewal of Utah's Medicaid Reform 1115 Demonstration under Section 1115 of the Social Security Act. Utah's existing 1115 Demonstration is currently approved through June 30, 2027. With this application, Utah is seeking a renewal period from July 1, 2027, through June 30, 2032. This 1115 Demonstration renewal requests authority to continue to operate the currently approved programs and benefits listed below, with minimal changes:

- Adult Expansion
- Utah's Premium Partnership Program (UPP)
- Dental Services
- Premium Assistance for Employer Sponsored Insurance
- Extended Postpartum Coverage
- Family Planning
- Fertility Preservation for Individuals Diagnosed with Cancer
- Former Foster Care Youth from Another State
- Health Related Social Needs
- In Vitro Fertilization and Genetic Testing for Qualified Conditions
- Reentry Pre-Release Services
- Serious Mental Illness (SMI) Services in Institutions for Mental Disease (IMD) ● Substance Use Disorder Services (SUD) in an IMD
- Utah Medicaid Integrated Care (UMIC)

In addition to the renewal of the current demonstration and expenditure authorities, the state is requesting the following changes:

- The state is requesting to end Targeted Adult Medicaid (TAM) on June 30, 2027. If approved, TAM Members will transition to Adult Expansion Medicaid effective July 1, 2027. ● Combining the four UPP demonstration populations (III, V, VI and Current Eligible CHIP children) into one demonstration population.
- The removal of Supportive Living Services (mental health services in residential treatment settings) from the behavioral health benefits for the Adult Expansion Population.

The state is also requesting that the following pending amendments be considered in addition to the 1115 Demonstration renewal, with the hope of gaining approval for these amendments prior to the approval of the full 1115 Demonstration renewal:

- Chronic Conditions Support
- Community Engagement
- Disability Wraparound Coverage
- Integrated Behavioral Health Services
- Long Term Services and Supports for Behaviorally Complex Individuals
- Native American Health Amendments

Public Hearings:
The Department will conduct three public hearings to discuss the Renewal. The dates and times are listed below.

- Thursday, April 23, 2026, from 10:00 am to 12:00 pm, during the Medicaid Advisory Committee (MAC) meeting.
  - Video Conference: Google Meet Meeting meet.google.com/ieq-jggb-pec
  - Or join by phone: (US) +1 513-818-1049 PIN: 510 813 429#
- Thursday, May 7, 2026, from 2:30 pm to 3:30 pm.
  - Martha Hughes Cannon Building, Room 125
    288 North 1460 West
    Salt Lake City, UT 84116
- Thursday, May 7, 2026, from 4:00 pm to 5:00 pm.
  - Video Conference: Google Meet Meeting meet.google.com/btm-baiv-hmy o Or join by phone: (US) +1 413-679-2772 PIN: 668 611 216#

Individuals requiring an accommodation to fully participate may contact Laura Belgique at lbelgique@utah.gov or 1 (801) 538-6241 by May 5, 2026, for the two meetings scheduled on May 7, 2026.

Public Comment:
A copy of the full public notice and renewal application is available online at: https://medicaid.utah.gov/1115-waiver/

The public may comment on the proposed amendment request during the public comment period from April 21, 2026, through May 21, 2026.

Comments may be submitted:
Online: https://medicaid.utah.gov/1115-waiver/
Email: Medicaid1115waiver@utah.gov
Mail: Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique
SLT0037997

AFFIDAVIT OF PUBLICATION

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PUBLISHED ON 05/02/2026, 05/03/2026

DATE 05/08/2026

SIGNATURE

STATE OF UTAH
COUNTY OF SALT LAKE

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 8th DAY OF MAY IN THE YEAR 2026

BY Doug Ryle

NOTARY PUBLIC SIGNATURE

2027-2032 Renewal

Attachment 6

Summary of Public Comments and State Responses

Utah's Medicaid Reform 1115 Demonstration
Summary of Public Comments and State Responses
April 21, 2026 - May 21, 2026 Public Comment Period

The State received and appreciates the 81 comments submitted regarding this demonstration renewal from individuals, advocacy groups, and other community partners. This includes comments provided during the three public hearings, email and online comments, and mailed comments. While the complete email letters are provided in the attachment, this document summarizes all submissions (including email, verbal, and online feedback) and details the State's responses below.

Removal of Targeted Adult Medicaid/Transition to Adult Expansion Medicaid

The majority of the comments received opposed the removal of TAM/12 month continuous enrollment from the 1115 Demonstration. Many commenters expressed concern with this leading to coverage loss, gaps in coverage and subsequent health risks including SUD relapses and lost recovery opportunities, lack of preventative care and treatment continuity, increased crises, and emergency room services. Several commenters stated that ending TAM will create more paperwork, increase barriers, and that continuous eligibility and the open network model creates critical access to mental health care, substance abuse disorder and serious mental illness treatment, and other essential services for individuals facing significant barriers to care. Many commenters expressed how the program's 12 months of continuous eligibility has been vital in supporting recovery and stability during transitions from higher levels of care into housing, employment, and community-based treatment and that without this continuity of care, many individuals are at great risk of relapse, homelessness, hospitalization, and reentry into the criminal justice system. They are also more likely to delay care, receive less preventative care, and refill prescriptions less often. Many stated that the removal of TAM would fundamentally remove a key safeguard that has helped some of Utah's most vulnerable residents maintain consistent access to healthcare during periods of extreme instability.

Many commenters also expressed concern with the associated costs of removing TAM, stating this will shift costs downstream to emergency rooms, law enforcement, shelters, and local communities, often at significantly greater expense both financially and socially. One commenter stated that TAM represents a fiscally responsible approach to providing treatment and stabilization services.

A few comments emphasized the importance of ensuring a seamless process for transitioning TAM members to the Adult Expansion demonstration. Suggestions included proactively leveraging existing data to identify and apply community engagement exemptions to minimize the risk of inappropriate coverage losses.

Many commenters expressed concern with switching from fee-for-service (under TAM) to Accountable Care Organizations (ACOs) under Adult Expansion Medicaid. Several commenters stated the shift will significantly increase administrative complexity for both patients and providers and place significant stress on Medicaid's enrollment and billing systems. A few other commenters stated this shift will likely result in reduced access to providers who are not contracted with ACOs, additional prior authorization requirements and administrative barriers, disruptions in established treatment relationships, long wait times, and less options for treatment centers resulting in increased emergency department utilization, greater instability in housing, the net fiscal impact of which may exceed any savings generated by consolidating TAM into Adult Expansion Medicaid. Similar comments included concerns on whether the system is prepared to support the Adult Expansion Medicaid population without disruption, noting the existing networks may not have sufficient capacity to absorb TAM members, particularly those requiring residential mental health and substance use treatment, services for justice-involved individuals, and support for individuals experiencing homelessness. One commenter expressed concern with the lack of care continuity given how vulnerable TAM members will inevitably shift back and forth from ACO to fee-for-service. Another commenter suggested allowing TAM members that are actively engaged in substance abuse or behavioral health treatment to remain in the fee-for-service model for the duration of their treatment episode. Another commenter suggested the State conduct a formal assessment of the administrative and billing infrastructure needed to absorb the transition without creating backlogs that harm both patients and providers.

> **Response:** Following recent federal legislative changes (the One Big Beautiful Bill Act or H.R.1) and new guidance from the Centers for Medicare and Medicaid Services (CMS), Utah will transition the Targeted Adult Medicaid (TAM) program members onto the Adult Expansion Medicaid (AEM) program effective July 1, 2027. While TAM is federally categorized under the broader Adult Expansion eligibility group, it has historically operated as a distinct Utah sub-program providing 12 months of continuous eligibility to vulnerable adults experiencing chronic homelessness, are justice-involved, or require intensive substance abuse or mental health treatment.

The State understands and acknowledges the critical importance of continuous enrollment in maintaining coverage and stability and recognizes that the 12-month continuous eligibility has been vital in supporting successful transitions to housing, employment, and community-based treatment, and that ending this provision carries significant risks. The State also notes the concerns regarding increased administrative burden and barriers to care that may result from this change.

The primary goal for the Department of Health and Human Services (DHHS) is to provide a seamless transition and supportive resources for current TAM participants. DHHS is working closely with CMS to support members through this change and prevent gaps in care.

DHHS appreciates the commenters' feedback regarding the transition of the Targeted Adult Medicaid (TAM) population from a fee-for-service (FFS) model to Accountable Care Organizations (ACOs) and Utah Medicaid Integrated Care (UMIC) under Adult Expansion Medicaid. The primary goal of integrating the TAM population into the ACO and UMIC plans is to improve care coordination, foster holistic health outcomes, and provide a more integrated approach to physical and behavioral healthcare. To address continuity of care and network adequacy concerns, the department plans to work with the managed care plans to identify providers that frequently provide services to TAM members to determine which providers need to be paneled with the managed care plans. DHHS will continue to discuss and monitor these concerns through monthly meetings with the managed care plans and providers. DHHS will work closely with the managed care plans to ensure a robust care transition plan is in place. To address prior authorization concerns, the ACOs will be required to honor pre-existing prior authorizations approved by FFS during this transition.

DHHS believes this transition will not create significant stress on Medicaid's enrollment and billing systems. The managed care plans already enroll members and handle claims for the majority of Medicaid members in Utah. Processes are already in place to handle these systems. DHHS also believes this transition will create less churn between FFS and ACOs than experienced today. This change will allow the member to remain with the same plan throughout their eligibility period. Whereas today, some TAM members transition from FFS to an integrated care plan and then back to FFS, creating confusion, billing issues, and provider issues. In addition, this transition will provide for the care and case management services

provided by managed care plans, which TAM members do not receive under a FFS model today.

Six-month Continuous Eligibility

Many comments that supported the continuation of TAM also suggested the State advance an amendment requesting the continuation of TAM with a six-month continuous eligibility period. Commenters suggested the State work with CMS to best determine how to implement the requirements of H.R.1 while still providing a six-month continuous eligibility period. Many comments noted the importance of engaging with federal partners to resolve discrepancies between federal law and CMS policies. One commenter noted that congress did not prohibit continuous eligibility; it set six months which allows the State strong grounds to argue to CMS that a six-month continuous eligibility floor is consistent with that order's goals. Many commenters recommended including partial continuity measures, including the six-months of uninterrupted coverage as allowed by H.R.1, as this would represent a meaningful step toward improving outcomes and system efficiency. A few commenters stated that preserving TAM with a six-month continuous eligibility framework represents a practical and evidence-informed path forward that protects both community safety and public investment, and is an acceptable alternative that would preserve critical access to care during periods of highest vulnerability. A few commenters suggested allowing a grace period before terminating coverage and implementing continuous eligibility during substance abuse treatment episodes.

> **Response:** We understand and acknowledge the critical importance of continuous enrollment in maintaining coverage and stability and recognize that a six-month continuous eligibility provision would be vital in supporting this vulnerable population. However, on July 17, 2025, CMS issued a Dear Colleague letter announcing that continuous eligibility provisions under the 1115 Demonstration will not be renewed. In addition, on May 1, 2026, CMS issued a letter to Utah responding to Utah's request for clarification. The letter clarifies that CMS does not anticipate extending existing section 1115 demonstration expenditure authority for continuous eligibility for any time frame beyond the durations and populations for which continuous eligibility is available under the applicable statute.

H.R. 1 and Community Engagement Requirement/Amendment

The State received a dozen comments expressing opposition to the Community Engagement Amendment request and urged the State to withdraw its request and instead devote resources for ensuring proper implementation of H.R.1. Commenters stated work

requirements do not help low-income individuals find work and that continuous coverage can help people find and sustain employment. Commenters stated this requirement will increase administrative burdens and complexities, churn, increase costs and coverage loss, and will fail to increase employment rates. Several commenters emphasized the importance of ensuring certain groups are exempt including American Indians/Alaskan Natives, those with rare diseases or chronic conditions and care-givers.

Several commenters urged the State to ensure proper and detailed development and implementation of the Community Engagement requirements under H.R.1. This includes ensuring no loss of coverage, paperwork barriers, or rigid verification tools and to include ex-parte reviews though existing State data. Other suggestions included proactively identifying exempt individuals by using existing data to automate exemptions, avoid placing undue administrative burden on providers and patients in the exemption process, accept self-attestation where permitted, ensure clear communication with beneficiaries throughout the implementation process, and avoid duplicative documentation requests. Other suggestions included providing clear, plain-language communication in the notices and appeals processes. Medical exemptions should be defined and operationalized broadly so that individuals who are physically or mentally unable to meet requirements are protected.

One commenter stated the definition of medically frail is vague and requested that the State adopt a more expansive definition and that the process for medically frail exemptions and good cause be clearly defined and administered. Suggestions also included leveraging feedback from existing government advisory bodies throughout the planning and implementation process.

One commenter requested clarification on several aspects of the Community Engagement Amendment and their interaction with H.R.1. and to clarify the planned timeline for implementing the community engagement requirements. Another agency requested clarification on the State's intention to implement the pending Community Engagement amendment and whether it will be pursued as a standalone work requirement program. The agency suggested the State formally clarify the status and intended purpose of the amendment in the renewal application.

> **Response:** The State appreciates and acknowledges these concerns and recognizes the importance of ensuring that appropriate exemptions and protections are in

place for individuals with significant health care needs, caregivers, and other populations identified by commenters.

At this time, the State is actively working to implement the provisions of H.R.1 and related federal requirements timely and in an effective and thoughtful manner. This includes careful consideration of operational feasibility, fiscal impacts, administrative capacity, and the potential effects on beneficiaries and providers. Requirements will be implemented in accordance with the due dates outlined in the law.

The State is continuing to evaluate all applicable federal guidance and statutory requirements, including the standards established under H.R.1., while assessing how best to align ongoing policy initiatives and pending waiver or amendment requests with evolving federal expectations. As part of this process, the State will continue engaging with stakeholders, reviewing public feedback, and coordinating across agencies to support implementation efforts that are equitable, fiscally responsible, operationally sustainable, and responsive to the needs of impacted communities.

The State's communication plan for H.R. 1 includes providing members with coordinated messaging through broad and targeted member letters, a dedicated website, social media campaigns, FAQs, and a stakeholder community engagement group that meets monthly to advise the State on communication strategies and the member experience.

In regards to one agency's question on the status of the Community Engagement Amendment, the State provided a written response stating, "Utah's Community Engagement waiver was proposed independent of Congressional action. Utah's State statute directs DHHS to seek that authority. We have been clear that Utah will not seek to approve two different versions of Community Engagement, and Utah will implement the version passed under HR1. However, Utah's waiver remains DHHS's proposal for an alternate implementation, as well as the potential to implement parts of the waiver that may be beneficial to Utah (e.g., federal fund authority for member support)."

Utah received questions related to the Community Engagement provisions from HR1. As those provisions are not part of the State's 1115 Waiver renewal, the State will provide written responses directly to the agencies that requested them.

Personal Testaments to the Effectiveness of TAM

Several commenters provided personal statements on how TAM has helped them become and remain healthy and stable. Commenters stated TAM fundamentally removes a key safeguard that has helped some of Utah's most vulnerable residents maintain consistent access to healthcare during periods of extreme instability and that TAM is a safety net, has saved many lives, and has been a powerful tool to help improve the health of many Utahns. One commenter noted that, due to the unique complexities of the individuals, no single program is capable of fully securing the complete range of required services. Others expressed the support they have seen TAM provide with connecting individuals to resources and community providers, and case management support. Others provided firsthand accounts of TAM's success, citing improvements in public safety, reduced justice-involved recidivism, decreased homelessness and hospitalizations, and significant socioeconomic benefits such as lifting individuals out of poverty, providing psychiatric stabilization, and increasing access to medications. One commenter, a formerly incarcerated individual, credited TAM with being a "beacon of hope" that provided the second chance necessary to achieve stability and employment, and urged the State to reconsider the severe consequences of removing the program. Another commenter emphasized that TAM is a desperately needed option for individuals at their most vulnerable point, appealing for the program's continuation to ensure the community does not abandon those who still require its assistance.

> **Response:** The State agrees with and recognizes that TAM is a critical safety net that has helped many of Utah's most vulnerable residents maintain consistent access to essential healthcare during periods of instability. The State shares the view that TAM has been vital in improving the health and well-being of many Utahns.

Opposition to Retroactive Eligibility and NEMT

A few comments expressed concern over the State's continued waiver of non-emergency transportation (NEMT) and its proposal to limit retroactive eligibility to one month.

> **Response:** The State is only reviewing and responding to public comments related to the State's 1115 Demonstration Renewal proposal. The State is <u>not</u> requesting an exclusion of NEMT in the 1115 Demonstration or renewal application. The one-month retroactive eligibility limitation for Adult Expansion Medicaid members (and two months for all other programs) is part of H.R. 1. The State is actively working to implement the provisions of H.R. 1 and related federal requirements in an effective and thoughtful manner.

Support for Existing Demonstrations and Approval of the Disability Wraparound Coverage Pending Amendment

Eight commenters expressed support of current programs in the 1115 Demonstration including postpartum coverage, Re-entry, SUD, and HRSN. A few other comments expressed specific support for the approval of the pending Disability Wraparound Coverage amendment. A couple of commenters requested specific consideration of pregnant/postpartum women in the design and operationalization of the Re-entry demonstration.

> **Response:** The State fully supports the continued operation and success of the current programs within the 1115 Demonstration and affirms its support for the approval of all pending amendments, including the Disability Wraparound Coverage amendment. Furthermore, the State ensures its consideration of pregnant and postpartum women in the design and operationalization of the Re-entry demonstration.

Support to Transition Postpartum Coverage to the State Plan Amendment (SPA)

Two commenters recommended transitioning the authority for the 12-month extended postpartum coverage from the 1115 Demonstration to a SPA.

> **Response:** To preserve enhanced federal funding for Utah's postpartum population, the State must maintain this program under the 1115 Waiver authority rather than a SPA. Although Utah initially implemented 12-month extended postpartum coverage through a SPA on January 1, 2024, the State transferred this coverage group to the 1115 Waiver authority effective January 1, 2026. Because Utah's Adult Expansion group is housed within the 1115 Waiver, the extended postpartum group must also remain under waiver authority in order to utilize the CMS-approved proxy methodology and claim the higher Adult Group Federal Medical Assistance Percentage (FMAP)..

Recommendations for Reentry and HRSN Initiatives

A few other comments recommended ensuring smooth transitions specifically for justice-involved individuals under the Reentry and HRSN initiatives, emphasizing the importance of investing in infrastructure that supports cross-system collaborations between Medicaid providers, housing agencies, and correctional facilities, and to utilize data-driven evaluations to measure the effectiveness of housing-related supports and pinpoint areas requiring adjustment or expansion.

Response: The State affirms these recommendations, recognizing that successful Re-entry is fundamentally dependent on robust cross-system coordination. The State is committed to the strategic development and continuous implementation of the Re-entry Demonstration, focusing on maximizing positive outcomes for our members. The State is committed to integrating evaluation measure outcomes into the development and enhancement of its current demonstrations, including Re-entry.

NORD®
National Organization for Rare Disorders

Alone we are rare. Together we are strong.®

NORD Oral Public Comments on Utah's §1115 Medicaid Demonstration Renewal
Utah Department of Health and Human Services
May 7, 2026

[redacted]

Good evening.

[redacted]

NORD represents the 30 million Americans living with any of over **10,000 known rare diseases**. Tonight I'm holding space for the NIH-estimated **one-in-ten** folks who are part of the rare disease patient community here in **Utah** and their caregivers. I am also thinking about Utah's **Rare Disease Advisory Council**, which operates as a grant-based program out of the health department and represents ready-made, in-state-rare-disease expertise the department can draw on as this hefty work continues.

NORD will be submitting formal written comments by the May 21st deadline. Tonight, we wanted to take the opportunity this hearing provides to raise a few questions that have emerged in our review of the waiver — so that our comments and our outreach to potentially impacted community members across Utah can accurately reflect the state's approach to this federal mandate.

A full set of questions has been submitted in writing to **Laura Belgique (lbelgique@utah.gov)**. Being mindful of the time, I want to highlight a few that are particularly important to NORD:

First – HR1 §71119 establishes a specific framework – hours thresholds, exemption categories, hardship provisions, verification requirements. Utah's CE amendment operates through a different program model. Would the state provide a crosswalk showing how the two frameworks are meant to interact and align? A specific equivalence NORD is seeking clarification on is how "physically or mentally unable to meet requirements" will be operationalized – similarly to "medically frail?"
Second – Utah's CE amendment indicates a July 1, 2026 start date, however, the state's published OBBBA decisions indicate implementation will not begin prior to January 1, 2027. What is the controlling implementation date, and would the CE requirement expire June 30, 2032 if the renewal is approved?
Third – Utah has stated it will offer all federal short-term hardship exemptions. Are the Good Cause provisions intended to carry the equivalent force and scope of those short-term hardships, including the medical travel hardship provision?
And finally - Does "childcare responsibilities" under Good Cause G extend to clinical caregiving for a child aged 14–19 who is not formally designated as disabled?

We would deeply appreciate follow-up from staff on these and the remainder of our submitted questions, so that our written comments can be as useful and as accurate as possible in reflecting Utah's approach to this federal mandate.

Thank you.

ADDENDUM

The National Organization for Rare Disorders (NORD) submits the following questions for the record in full in connection with Utah's public hearing on its Mediacid §1115 Demonstration Renewal. These questions focus on the **Community Engagement (CE) amendment** (originally submitted July 3, 2025) and its implications for people living with rare, serious, and complex medical conditions and the caregivers who support them. They are intended to inform the public record and NORD's formal written comment, due May 21, 2026.

1 Federal Interaction: Crosswalk Request – HR1 §71119 and the Utah CE Amendment

Q1.1 Would the state provide a written crosswalk document mapping each element of the CE amendment to its corresponding provision – or intentional departure – under HR1 §711119?
HR1 §71119 and Utah's CE amendment operate through fundamentally different program models. HR1 establishes an 80-hour monthly activity threshold met through self-selected qualifying activities. Utah's CE amendment establishes a 4-step, state-administered employment pipeline where engaging in qualifying activities (work, school, SNAP compliance, etc.) **exempts members from the pipeline** rather than satisfying a hours threshold. NORD respectfully requests that the state provide a formal crosswalk explaining how each element of the CE amendment corresponds to — or intentionally differs from — HR1's framework. Specific equivalences NORD seeks clarification on include:

- **Exemption C: "Physically or mentally unable to meet requirements"** =? **HR1 §71119 Medically Frail / Special Medical Needs Exemption** — *If so, how will the state operationalize this determination — what standard applies, what documentation is required, and who decides?*
- **"Good Cause" provisions** =? **HR1 §71119(3)(B) Short-Term Hardship Exemptions** — *If so, do they carry equivalent legal force and scope, including the medical travel hardship provision?*
- **3-Month CE Participation Pipeline** =? **HR1 §71119(6)(A) 30-Day Noncompliance Notice and Cure Period** — *If not, how does the state satisfy HR1's 30-day due process requirement within the CE amendment's structure?*

Q1.2 HR1 requires verification of eligibility, and thus HR1 community engagement requirements, at least every 6 months. How does this eligibility verification requirement interact with the Utah CE amendment's 12-month eligibility periods and 3-month participation windows?

2 Implementation Dates and Program Expiration

Q2.1 Utah's published OBBBA decisions document states Utah will not implement earlier than January 1, 2027. However, the CE amendment identifies July 1, 2026 as the anticipated start date and the full renewal runs July 1, 2027 – June 30, 2032. What is the controlling implementation date of community engagement requirements for Utah's AEM demonstration population?

Q2.2 Does the CE requirement expire on June 30, 2027 if the full renewal has not yet been approved by CMS? If approved as part of the renewal, does it continue uninterrupted through June 30, 2032?

3 Good Cause, Short-Term Hardship, and Medical Travel

Q3.1 Utah has stated it elected all federal short-term hardship events, including the optional medical travel exemption for individuals traveling for serious or complex conditions not available locally. The current CE amendment text does not include medical travel as a good cause provision. How and when will this stated decision be reflected in the waiver text?

4 Caregiving Responsibilities and Good Cause

Q4.1 The good cause provision exempts a "primary caretaker of a child age 6 or older unable to meet requirements due to childcare responsibilities." How does the state define "childcare responsibilities"? Does this include caregiving that is clinical in nature — managing medical appointments, administering treatments, coordinating care — for a child who is over age 6, over age 13, and not formally classified as disabled under Medicaid, but who requires significant ongoing caregiving support due to a medical condition?

> ***Context:*** *Exemption D covers caregivers of children 13 and under. Exemption E covers caregivers of individuals with a disability defined under ADA/§504/§1557. A parent providing intensive clinical caregiving for a child over 13 who does not meet the formal disability definition may not qualify for either exemption – leaving the undefined "childcare responsibilities" good cause provision as the only potential protection.*

5 Coverage During the 3-Month Participation Period

Q5.1 Will members who are approved for AEM but do not meet exemption criteria or demonstrate good cause receive Medicaid coverage benefits during the 3-month period where they must complete Utah CE's work search tasks?

6 Budget Neutrality, Projected Enrollment and Coverage Losses

Barring misinterpretation, NORD identified inconsistency between enrollment projects in the CE amendment and those in the full demonstration renewal:

Source Document	Population	Eligible Member Months
Demonstration Renewal	Without Waiver (CE and AEM)	1,006224/month – flat across all demo years
Demonstration Renewal	With Waiver (CE and AEM)	1,006224/month – flat across all demo years
CE Amendment (2025)	Without Waiver (AEM)	1,537,011 (FY23) declining to 902,445 (FY27)
CE Amendment (2025)	With Waiver (AEM)	Same declining trajectory: 1,537,011 → 902,445

Q.6.1 The CE amendment projects declining AEM member members (1,537,011 to 902,445 by FY27) with identical figures with and without the waiver. The full renewal holds member months flat at 1,006,224 annually. To help get a sense of potential coverage losses, which is the controlling budget neutrality figure?

Q.6.2 The CE amendment projects that approximately 50% of the non-exempt, non-good-cause members will not comply. How are projected coverage losses reflected in calculations?

Q.6.3 Barring misinterpretation, the TAM population has a different cost profile than the AEM (trend rate 22% vs. 4.7%, higher PMPM costs). How is the TAM to AEM transition account for in budget projections?

[redacted]

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Blood Cancer United

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BloodCancerUnited.org

May 21, 2026

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

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Director Ewing:

Blood Cancer United appreciates the opportunity to submit comments on Utah's Medicaid Reform 1115 Demonstration Extension Request.

At Blood Cancer United, our mission is to cure blood cancer and improve the quality of life of all patients and their families. To achieve it, we unite a community of people — patients and their families, volunteers, healthcare providers, scientists, staff, partners, fundraisers, and philanthropists — who believe all blood cancer patients deserve longer, fuller lives. We fund innovative research, offer free resources and personalized support, and advocate at the state and national levels for more accessible and affordable healthcare for all patients.

Blood Cancer United is committed to ensuring that Utah's Medicaid program provides quality and affordable healthcare coverage. While some of the proposals in the waiver would improve coverage for the patients we serve, there are other policies that would restrict access to coverage for our patients. Blood Cancer United offers the following comments on Utah's Medicaid Reform 1115 Demonstration Extension Request:

Adult Expansion

Blood Cancer United supports the state's efforts to continue to provide coverage to adults up to 138% of federal poverty level (FPL). Medicaid expansion has positive impacts on patients and has led to a substantial improvement in survival among people with acute lymphoblastic leukemia.[i] These impacts are not limited to blood cancers: Medicaid expansion has also improved outcomes for other cancers including breast, cervical, and colon cancers[ii] and is also associated with improved access to cancer surgery.[iii] States that expanded Medicaid also experienced a 6.4% increase in early cancer detection from pre-ACA levels.[iv]

Blood Cancer United opposes Utah's proposal to end the Targeted Adult Medicaid (TAM) program. This program provides one year of continuous eligibility (CE) to adults age 19-64 at zero percent FPL with no dependent children who are chronically homeless, involved in the criminal justice system, or in need of substance use or mental health treatment. Blood Cancer United encourages Utah to maintain the TAM program. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[v] Blood cancers and blood cancer treatments are highly variable in their intensity, acuity, pace of symptom onset, and length of treatment, and even patients who achieve stable remission often require heightened surveillance for years after their primary treatment has ended. However, one factor remains constant: patients at any stage of their blood cancer journey need comprehensive, stable, and reliable health coverage access free of unnecessary or avoidable interruptions which can significantly impair a treatment plan and, consequently, a prognosis.[vi]

If CMS does not approve continuation of this program, individuals would transition to Medicaid expansion on July 1, 2027, and at that time be subject to both the work reporting requirements and biannual redeterminations. In this case, Utah should prioritize a seamless coverage transition. Some participants, by definition, do not have permanent addresses, requiring a thoughtful approach to providing required notices. Because TAM participants frequently have histories of substance use disorder or recent incarceration, many are likely to qualify for exemptions from the work reporting requirements mandated under Public Law 119-21. Utah should proactively leverage existing data to identify and apply these exemptions to minimize the risk of inappropriate coverage losses.

Postpartum Extension

Blood Cancer United supports Utah's proposal to continue to provide 12 months of postpartum coverage for individuals enrolled in Medicaid. The state would continue to prevent gaps in healthcare coverage for low-income women during the postpartum period, helping patients to better manage serious conditions and reducing maternal mortality in Utah. According to the Centers for Disease Control and Prevention (CDC), more than 80% of pregnancy-related deaths are preventable.[vii] And approximately 55% of women with coverage through Medicaid or the Children's Health Insurance Program (CHIP) at the time of delivery experienced at least one month without healthcare coverage during the six months after delivery.[viii] Access to a regular source of healthcare is important for conditions to be caught early and negative health outcomes to be avoided when possible. Utah should consider submitting a State Plan Amendment to extend postpartum coverage, which is allowed under the American Rescue Plan Act of 2021.

Work Reporting Requirements

Work reporting requirements do not help low-income individuals to find work. Most people on Medicaid who can work already do so. According to the Kaiser Family Foundation, more than 90% of adults with Medicaid coverage that do not have SSI or SSDI are either full or part-time workers, caregivers, students, or unable to work due to illness.[ix] And actually, continuous Medicaid coverage can help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[x] That report also found that many enrollees were able to get

treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[xi]

Reduced Benefits

Blood Cancer United opposes Utah's continued waiver of non-emergency transportation (NEMT). NEMT helps low-income patients overcome barriers to care due to transportation and allows patients to keep appointments with doctors and other healthcare providers. Unfortunately, it is estimated that 5.8 million individuals in the US delayed or missed care due to lack of transportation.[xii] In November of 2025, CMS sunset Iowa's waiver of NEMT, citing that it would not promote the objectives of the Medicaid program. CMS said, it, "recognizes the significance of covering NEMT, as reflected in the broader research on NEMT that shows that providing NEMT can increase access to care and improve health outcomes."[xiii]

Blood Cancer United opposes the state's proposal to limit retroactive eligibility to the first day of the month in which an individual applies for Medicaid for some Medicaid eligibility groups, including demonstration groups with moderate incomes. Currently, retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to three months prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[xiv] Medicaid enrollees who face substantial costs at their doctor's office or pharmacy could end up delaying their treatment because of these costs. As noted above, a person with blood cancer may present with varying intensity of symptoms or side effects depending on what phase of their diagnosis or treatment they are in, yet at no point can their access to care or treatment be safely delayed.

Blood Cancer United urges Utah to end its waivers of NEMT and retroactive eligibility.

Re-Entry Medicaid Services for the Justice Involved Population

Blood Cancer United supports Utah's proposal to continue to provide a targeted set of Medicaid services for justice-involved populations who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with both the goals of Medicaid and CMS guidance and will be an important step in improving the continuity of care. Services will include case management, medication-assisted treatment (MAT) with counseling, and a 30-day supply of prescription medications upon

release. Utah's reentry policy is consistent with CMS guidance. and helps high-risk populations access critical supports needed to treat physical and behavioral health conditions.

Conclusion

Blood Cancer United urges Utah to consider our comments and patients' experiences accessing care. We encourage Utah to continue the Adult Expansion program, the TAM program and the re-entry Medicaid services for the Justice Involved population, while continuous eligibility while transitioning the authority for the post-partum coverage extension to a SPA. Utah should remove the requests for the work reporting requirement, waiving NEMT and retroactive eligibility from the waiver prior to submitting the request to CMS. Thank you for the opportunity to provide comments.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[i] O. Akinyemi et al. "Medicaid Expansion and Cancer-Specific Survival Among Individuals with Acute Lymphoblastic Leukemia." *Blood*, 66th ASH Annual Meeting Abstracts, 144 (November 5, 2024): 2343. https://doi.org/10.1182/blood-2024-201834.

[ii] Primm, Kristin M., Hui Zhao, Naomi N. Adjei, Charlotte C. Sun, Alen Haas, Larissa A. Meyer, and Shine Chang. "Effect of Medicaid Expansion on Cancer Treatment and Survival among Medicaid Beneficiaries and the Uninsured." *Cancer Medicine* 13, no. 13 (July 6, 2024): e7461. https://doi.org/10.1002/cam4.7461.

[iii] J. Mesquita-Neto et al. "Disparities in Access to Cancer Surgery after Medicaid Expansion." *The American Journal of Surgery* 219, no. 1 (January 1, 2020): 181–84. https://doi.org/10.1016/j.amjsurg.2019.06.023.

[iv] A Soni et al. "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses." *American Journal of Public Health* 108, no. 2 (February 2018): 216–18. https://doi.org/10.2105/AJPH.2017.304166.

[v] S. Sugar et al. "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic." Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[vi] X. Hu et al. "Association Between Medicaid Coverage Continuity and Survival in Patients With Newly Diagnosed Pediatric and Adolescent Cancers." *JCO Oncology Practice*. September 30, 2024. Available at: https://ascopubs.org/doi/abs/10.1200/OP.24.00268

[vii] "Preventing Pregnancy-Related Deaths." Centers for Disease Control and Prevention. September 25, 2024. Available at: https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html

[viii] J.R. Daw et al. "Women in the United States experience high rates of coverage 'churn' in months before and after childbirth." *Health Aff (Millwood)*. 2017; 36(4): 598–606. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241.

[ix] J. Tolbert et al. "Understanding the Intersection of Medicaid & Work: An Update." KFF. February 4, 2025. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/.

[x] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Available at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[xi] B.D. Sommers, A.A. Gawande, and K. Baicker. "Health insurance coverage and health — what the recent evidence tells us." *New England Journal of Medicine*. 2017; 377(6): 586-593. 10.1056/NEJMsb1706645

[xii] M.K. Wolf, N.C. McDonald NC, and G.M. Holme. "Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017." *American Journal of Public Health*. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.

[xiii] Deputy Administrator, CMS to Lee Grossman, Iowa Medicaid Director. November 28, 2025. Accessed at: ia-wellness-plan-cms-temp-ext-amnd-aprvl-11282025.pdf

[xiv] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

May 15, 2026

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

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Director Ewing:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Utah's Medicaid Reform 1115 Demonstration Extension Request published on June 30, 2026.[1] ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

ACS CAN is committed to ensuring that Utah's Medicaid program provides quality and affordable healthcare coverage. While some of the proposals in the waiver would improve coverage for people impacted by cancer, there are other policies that would restrict access to coverage. We offer the following comments on Utah's Medicaid Reform 1115 Demonstration Extension Request:

Adult Expansion
ACS CAN supports the state's efforts to continue to provide coverage to adults up to 138% of federal poverty level (FPL). Research consistently shows that expanding access to Medicaid increases insurance coverage rates among cancer patients and survivors, early-stage cancer diagnoses, access to timely cancer treatment, receipt of cancer screenings and preventive services, and survival rates.[2] For example, a recent study showed that Medicaid expansion was associated with an increase in survival from cancer at two years post diagnosis, and the increase was most prominent among non-Hispanic Blacks in rural areas, highlighting how expanding Medicaid can reduce health disparities.[3]

[1] Utahs Medicaid Reform 1115 Demonstration 2027 2032 Renewal.pdf
[2] Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. Published May 6, 2021. https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/
[3] Han, Xuesong, et al. Association Between Medicaid Expansion Under the Affordable Care Act and Survival Among Newly Diagnosed Cancer Patients. Journal of the National Cancer Institute. 2022 Aug 8;114(8):1176-1185. doi: 10.1093/jnci/djac077

May 15, 2026

ACS CAN opposed Utah's proposal to end the Targeted Adult Medicaid (TAM) program. This program provides one year of continuous eligibility (CE) to adults age 19-64 at zero percent FPL with no dependent children who are chronically homeless, involved in the criminal justice system, or in need of substance use or mental health treatment. ACS CAN encourages Utah to maintain the TAM program. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[1]

If CMS does not approve continuation of this program, individuals would transition to Medicaid expansion on July 1, 2027 and at that time be subject to both the work reporting requirements and biannual redeterminations. In this case, Utah should prioritize a seamless coverage transition. Some participants, by definition, do not have permanent addresses, requiring a thoughtful approach to providing required notices. Because TAM participants frequently have histories of substance use disorder or recent incarceration, many are likely to qualify for exemptions from the work reporting requirements mandated under Public Law 119-21. Utah should proactively leverage existing data to identify and apply these exemptions to minimize the risk of inappropriate coverage losses.

Postpartum Extension

ACS CAN supports Utah's proposal to continue to provide 12 months of postpartum coverage for individuals enrolled in Medicaid. The state would continue to prevent gaps in healthcare coverage for low-income women during the postpartum period, helping patients to better manage serious conditions and reducing maternal mortality in Utah. Research shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[4] Unfortunately, some women are diagnosed with cancer during pregnancy – the most common malignancies being melanoma, breast and cervical cancer[5] – and having Medicaid coverage continue into the postpartum period would help these women maintain access to and continuity of care. Additionally, women who have had a full-term pregnancy have an increased risk of certain types of breast cancer in the postpartum period and beyond.[6] More generally, many postpartum women need preventive services – like tobacco cessation treatments or the HPV vaccine – as well as cervical cancer screenings. For all these reasons, ACS CAN supports extending affordable, quality insurance coverage to more individuals in this way to help ensure they have access to the care they need, including preventive services and cancer screenings that can be lifesaving and improve the lives and health of their families.

Utah should consider submitting a State Plan Amendment to extend postpartum coverage, which is allowed under the American Rescue Plan Act of 2021.

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[4] Zhao, J., Han, X., Nogueira, L., Fedewa, S.A., Jemal, A., Halpern, M.T. and Yabroff, K.R. (2022), Health insurance status and cancer stage at diagnosis and survival in the United States. CA A Cancer J Clin, 72: 542-560. https://doi.org/10.3322/caac.21732

[5] Andersson, T.M.-L., Johansson, A.L.V., Fredriksson, I. and Lambe, M. (2015), Cancer during pregnancy and the postpartum period: A population-based study. Cancer, 121: 2072-2077. https://doi.org/10.1002/cncr.29325.

[6] American Cancer Society. Breast Cancer Facts & Figures 2019-2020. Atlanta: American Cancer Society, Inc. 2019.

May 15, 2026

Work Reporting Requirements

Work reporting requirements do not help low-income individuals to find work. Most people on Medicaid who can work already do so. According to the Kaiser Family Foundation, more than 90% of adults with Medicaid coverage that do not have SSI or SSDI are either full or part-time workers, caregivers, students, or unable to work due to illness.[2] And continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[3] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[4]

While ACS CAN appreciates some of the improvements Utah had considered in its community engagement waiver request (such as exempting individuals over age 60), Public Law 119-21 does not permit waivers of the minimum requirements it sets out for work reporting requirements, and the Centers for Medicare and Medicaid (CMS) lacks legal authority to approve 1115 demonstrations that do not comply with minimum Public Law 119-21 standards. The state should withdraw its request and instead devote resources to ensuring proper implementation of Public Law 119-21 standards.

Reduced Benefits

ACS CAN opposes Utah's continued waiver of non-emergency transportation (NEMT). NEMT is a critical service for many low-income Medicaid enrollees who do not have the financial means or access to needed transportation services.[7] The American Community Survey estimates that four percent of occupied housing units in Utah report having no access to a vehicle, and 24 percent report having access to only one vehicle.[8] Without transportation benefits, chronically ill Medicaid enrollees may go without the lifesaving health services they need, leading to delayed care, an increase in avoidable hospitalizations, and poorer health outcomes.[9,10]

NEMT is used by individuals to access preventative services and cancer screenings – especially colon cancer screenings and mammograms. Early detection of cancer results in less expensive treatments and better

[7] Rosenbaum S, Lopez N, Morris MJ, Simon M. Medicaid's medical transportation assurance: Origins, evolution, current trends, and implications for health reform. Washington, D.C.: Department of Health Policy, School of Public Health and Health Services, The George Washington University, 2009.
[8] United States Census Bureau. *American Community Survey: Vehicles Available.* Accessed May 2021. https://www.census.gov/acs/www/about/why-we-ask-each-question/vehicles/
[9] Thomas LV, Wedel KR. Nonemergency medical transportation and health care visits among chronically ill urban and rural Medicaid beneficiaries. *Soc Work Public Health*. 2014;29(6):629-639. doi:10.1080/19371918.2013.865292.
[10] Kim J, Norton EC, Strearns SC, Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care. Health Serv Res. 2009. 44(1):145-61.

health outcomes, which could help offset some short-term Medicaid program costs. In addition, some cancer screenings can prevent cancer from developing (such as colonoscopies and Pap tests) by detecting and removing pre-cancerous polyps or lesions. However, lack of transportation to screening services hinders an individual's ability to obtain the necessary screening and, for some individuals, could result in detection of tumors at a later stage.

ACS CAN also opposes the state's proposal to limit retroactive eligibility to the first day of the month in which an individual applies for Medicaid for some Medicaid eligibility groups, including demonstration groups with moderate incomes. Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition already do not receive recommended services and follow-up care because of cost.[11,12] In 2019, three in ten uninsured adults went without care because of cost.[13] Waiving retroactive eligibility could mean even more people are unable to afford care and forgo necessary care due to cost.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.[14] Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for Medicaid coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.[15] Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save Utah from the high costs of later stage cancer diagnosis and treatment.

ACS CAN urges Utah to end its waivers of NEMT and retroactive eligibility.

Re-Entry Medicaid Services for the Justice Involved Population

ACS CAN supports Utah's proposal to continue to provide a targeted set of Medicaid services for justice-involved populations who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with both the goals of Medicaid and CMS guidance and will be an important step in improving the continuity of care. Services will include case management, medication-assisted treatment (MAT) with

[11] Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.
[12] Foutz J, Damico A, Squires E, Garfield R. The uninsured: A primer – Key facts about health insurance and the uninsured under the Affordable Care Act. *The Henry J Kaiser Family Foundation*. Published January 25, 2019. Accessed November 2019. https://www.kff.org/report-section/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-under-the-affordable-care-act-how-does-lack-of-insurance-affect-access-to-health-care/.
[3.] Tolbert J, Nov 06 ADP, 2020. Key Facts about the Uninsured Population. KFF. Published November 6, 2020. Accessed August 17, 2021. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[14] Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed October 2019. https://www.cms.gov/regulations-and-guidance/legislation/emtala/.
[15] National Association of Community Health Centers. America's Health Centers' Snapshot. Published August 2021. Accessed August 2021. https://www.nachc.org/wp-content/uploads/2020/10/2021-Snapshot.pdf.

counseling, and a 30-day supply of prescription medications upon release. Utah's reentry policy is consistent with CMS guidance. and helps high-risk populations access critical supports needed to treat physical and behavioral health conditions.

Research shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[16] A recent study showed that individuals with incarceration history were more likely to be uninsured and to experience longer periods of uninsurance, and that targeted programs to improve health insurance coverage in this population may reduce disparities associated with incarceration.[17] Cancer is the leading cause of mortality in incarcerated individuals older than 45 years and the fourth leading cause of mortality in the overall incarcerated population. Individuals who have been incarcerated are more than twice as likely to have a history of cancer than general populations.[18] ACS CAN supports extending affordable, quality insurance coverage to more Utahns and taking steps to prevent coverage gaps to help ensure all individuals have access to the care they need, including preventive services, cancer screenings and cancer treatment that can be lifesaving.

Conclusion

ACS CAN urges the Department to consider our comments and patients' experiences accessing care. We encourage you to continue the Adult Expansion program, the TAM program and the re-entry Medicaid services for the Justice Involved population, while continuous eligibility while transitioning the authority for the post-partum coverage extension to a SPA. The Department should remove the requests for the work reporting requirement, waiving NEMT and retroactive eligibility from the waiver prior to submitting the request to CMS. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

[16] Ward EM, Fedewa SA, Cokkinides V, Virgo K. The association of insurance and stage at diagnosis among patients aged 55 to 74 years in the national cancer database. Cancer J. 2010 Nov-Dec;16(6):614-21. doi: 10.1097/PPO.0b013e3181ff2aec. PMID: 21131794.

[17] Jingxuan Zhao, Xuesong Han, Zhiyuan Zheng, Qinjin Fan, Kewei Shi, Stacey Fedewa, K. Robin Yabroff, Leticia Nogueira, Incarceration History and Health Insurance and Coverage Changes in the U.S., American Journal of Preventive Medicine, Volume 64, Issue 3, 2023, Pages 334-342, ISSN 0749-3797, https://doi.org/10.1016/j.amepre.2022.09.023.

[18] Aziz H, Ackah RL, Whitson A, et al. Cancer Care in the Incarcerated Population: Barriers to Quality Care and Opportunities for Improvement. JAMA Surg. 2021;156(10):964–973. doi:10.1001/jamasurg.2021.3754.

[1] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[2] Tolbert, Jennifer et al. Understanding the Intersection of Medicaid & Work: An Update. KFF. February 4, 2025. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/.

[3] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Available at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[4] Sommers BD, Gawande AA, Baicker K. Health insurance coverage and health — what the recent evidence tells us. N Engl J Med. 2017; 377(6): 586-593. 10.1056/NEJMsb1706645

American Lung Association.
Utah

May 19, 2026

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

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Director Ewing:

The American Lung Association in Utah appreciates the opportunity to submit comments on Utah's Medicaid Reform 1115 Demonstration Extension Request.

The American Lung Association is the oldest voluntary health association in the United States, currently representing the more than 35 million Americans living with lung diseases, including more than 409,000 Utahns. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association is committed to ensuring that Utah's Medicaid program provides quality and affordable healthcare coverage. While some of the proposals in the waiver would improve coverage for the patients we serve, there are other policies that would restrict access to coverage for people with lung disease and other health conditions. The Lung Association offers the following comments on Utah's Medicaid Reform 1115 Demonstration Extension Request:

Adult Expansion
The Lung Association supports the state's efforts to continue to provide coverage to adults up to 138% of federal poverty level (FPL). The evidence is clear that Medicaid expansion has important health benefits for people with lung disease. For example, research has found an association between Medicaid expansion and early-stage cancer diagnosis.[1] The five-year survival rate for lung cancer patients is 65% when the cancer is caught before a tumor spreads, compared to just 10% if the cancer is caught at a late stage.[2] Medicaid expansion is also associated with a reduction in preventable hospitalizations, including for asthma and COPD.[3]

The Lung Association opposes Utah's proposal to end the Targeted Adult Medicaid (TAM) program. This program provides one year of continuous eligibility (CE) to adults

age 19-64 at zero percent FPL with no dependent children who are chronically homeless, involved in the criminal justice system, or in need of substance use or mental health treatment. The Lung Association encourages Utah to maintain the TAM program. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[4] For individuals in active treatment for lung cancer or other lung diseases, a gap in coverage could impact access to lifesaving treatment.

If CMS does not approve continuation of this program, individuals would transition to Medicaid expansion on July 1, 2027 and at that time be subject to both the work reporting requirements and biannual redeterminations. In this case, Utah should prioritize a seamless coverage transition. Some participants, by definition, do not have permanent addresses, requiring a thoughtful approach to providing required notices. Because TAM participants frequently have histories of substance use disorder or recent incarceration, many are likely to qualify for exemptions from the work reporting requirements mandated under Public Law 119-21. Utah should proactively leverage existing data to identify and apply these exemptions to minimize the risk of inappropriate coverage losses.

Postpartum Extension

The Lung Association supports Utah's proposal to continue to provide 12 months of postpartum coverage for individuals enrolled in Medicaid. The state would continue to prevent gaps in healthcare coverage for low-income women during the postpartum period, helping patients to better manage serious conditions and reducing maternal mortality in Utah. According to the Centers for Disease Control and Prevention (CDC), more than 80% of pregnancy-related deaths are preventable.[5] And approximately 55% of women with coverage through Medicaid or the Children's Health Insurance Program (CHIP) at the time of delivery experienced at least one month without healthcare coverage during the six months after delivery.[6]

Access to care during the postpartum period is especially important for women with serious and chronic conditions that can impact maternal health outcomes, as well as for women who develop such conditions during their pregnancies. Additionally, the postpartum period is an important time to ensure the women have access to the support they need to quit smoking and stay quit. In addition to the health impact on the mother, babies with mothers who smoke during pregnancy or who are exposed to secondhand smoke after birth have weaker lungs and are more likely to die from sudden infant death syndrome (SIDS).[7] Having a regular source of healthcare is important for these conditions to be caught early and negative health outcomes to be avoided when possible. Utah should consider submitting a State Plan Amendment to extend postpartum coverage, which is allowed under the American Rescue Plan Act of 2021.

Work Reporting Requirements

Work reporting requirements do not help low-income individuals to find work. Most people on Medicaid who can work already do so. According to the Kaiser Family Foundation, more than 90% of adults with Medicaid coverage that do not have SSI or SSDI are either full or part-time workers, caregivers, students, or unable to work due to

illness.[8] And continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[9] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[10]

While the Lung Association appreciates some of the improvements Utah had considered in its community engagement waiver request (such as exempting individuals over age 60), Public Law 119-21 does not permit waivers of the minimum requirements it sets out for work reporting requirements, and the Centers for Medicare and Medicaid (CMS) lacks legal authority to approve Section 1115 demonstrations that do not comply with minimum Public Law 119-21standards. The state should withdraw its request and instead devote resources to ensuring proper implementation of Public Law 119-21standards.

Reduced Benefits

The Lung Association opposes Utah's continued waiver of non-emergency transportation (NEMT). NEMT helps low-income patients overcome barriers to care due to transportation and allows patients to keep appointments with doctors and other healthcare providers. Unfortunately, it is estimated that 5.8 million individuals in the US delayed or missed care due to lack of transportation.[11] In November 2025, CMS sunset Iowa's waiver of NEMT, citing that it would not promote the objectives of the Medicaid program. CMS said, it, "recognizes the significance of covering NEMT, as reflected in the broader research on NEMT that shows that providing NEMT can increase access to care and improve health outcomes."[12] For a patient with asthma or COPD, a missed appointment can prevent them from receiving medications needed to manage their condition, leading to more costly emergency room visits.

The Lung Association opposes the state's proposal to limit retroactive eligibility to the first day of the month in which an individual applies for Medicaid for some Medicaid eligibility groups, including demonstration groups with moderate incomes. Currently, retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to three months prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. Under Public Law 119-21, states can still provide retroactive eligibility to some applicants for up to two months, and to the expansion population for up to a month. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the

elimination of retroactive eligibility.[13] Medicaid enrollees who face substantial costs at their doctor's office or pharmacy could end up delaying their treatment because of these costs. For a patient with COPD, a delay in healthcare coverage can disrupt access to medications needed to control their health condition and lead to an exacerbation that does irreversible damage to their health.

The Lung Association urges Utah to end its waivers of NEMT and retroactive eligibility.

Re-Entry Medicaid Services for the Justice Involved Population

The Lung Association supports Utah's proposal to continue to provide a targeted set of Medicaid services for justice-involved populations who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with both the goals of Medicaid and CMS guidance and will be an important step in improving the continuity of care. Services will include case management, medication-assisted treatment (MAT) with counseling, and a 30-day supply of prescription medications upon release. Utah's reentry policy is consistent with CMS guidance and helps high-risk populations access critical supports needed to treat physical and behavioral health conditions. For example, studies in Washington and Florida reported that people with severe mental illness and Medicaid coverage at the time of their release were more likely to access community mental health services and had fewer detentions and stayed out of jail longer than those without coverage.[14] Research has also shown that cancer mortality is higher among those who are incarcerated or in the first year after incarceration,[15] further highlighting the necessity of transition services for this population.

Conclusion

The Lung Association urges Utah to continue the Adult Expansion program, the TAM program and the re-entry Medicaid services for the Justice Involved population, while transitioning the authority for the postpartum coverage extension to a SPA. Utah should remove the requests for the work reporting requirement, waiving NEMT and waiving retroactive eligibility from the application prior to submitting the request to CMS. Thank you for the opportunity to provide comments.

[1] Aparna Soni, Kosali Simon, John Cawley, Lindsay Sabik, “Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses”, American Journal of Public Health 108, no. 2 (February 1, 2018): pp. 216-218. Available at http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166.
[2] American Lung Association, State of Lung Cancer Report 2025, Available at: https://www.lung.org/research/state-of-lung-cancer.
[3] Hefei Wen Kenton J. Johnston, Lindsay Allen, and Theresa M Waters. “Medicaid Expansion Associated with Reductions in Preventable Hospitalizations.” November 2019. Health Affairs. Doi 10.1377/hlthaff.2019.00483
[3] *Racial Disparities in Access to Timely Cancer Treatment Nearly*. (2019, June 2). [Press release].
[4] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[5] Preventing Pregnancy-Related Deaths. Centers for Disease Control and Prevention. September 25, 2024. Available at: https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html
[6] Daw JR, Hatfield LA, Swartz K, Sommers BD. Women in the United States experience high rates of coverage ‘churn’ in months before and after childbirth. Health Aff (Millwood). 2017; 36(4): 598–606. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241.
[7] Centers for Disease Control and Prevention. Smoking During Pregnancy. April 28, 2020. Available at: https://www.cdc.gov/tobacco/basic_information/health_effects/pregnancy/index.htm
[8] Tolbert, Jennifer et al. Understanding the Intersection of Medicaid & Work: An Update. KFF. February 4, 2025. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/.
[9] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Available at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf
[10] Sommers BD, Gawande AA, Baicker K. Health insurance coverage and health — what the recent evidence tells us. N Engl J Med. 2017; 377(6): 586-593. 10.1056/NEJMsb1706645
[11] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017. Am J Public Health. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.
[12] Deputy Administrator, CMS to Lee Grossman, Iowa Medicaid Director. November 28, 2025. Accessed at: ia-wellness-plan-cms-temp-ext-amnd-aprvl-11282025.pdf
[13] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf
[14] Joseph Morrissey et al. Medicaid Enrollment and Mental Health Service Use Following Release of Jail Detainees with Severe Mental Illness. Psychiatric Services 57, no. 6 (June 2006): 809-815. DOI: 10.1176/ps.2006.57.6.809, and Joseph Morrissey et al. The Role of Medicaid Enrollment and Outpatient Service Use in Jail Recidivism Among Persons with Severe Mental Illness. Psychiatric Services 58, no. 6 (June 2007): 794–801. DOI: 10.1176/ps.2007.58.6.794.
[15] Article Source: Incarceration status and cancer mortality: A population-based study
Oladeru OT, Aminawung JA, Lin HJ, Gonsalves L, Puglisi L, et al. (2022) Incarceration status and cancer mortality: A population-based study. PLOS ONE 17(9): e0274703. https://doi.org/10.1371/journal.pone.0274703

DHHS Leadership,

I am writing to express my strong opposition to the proposed changes within Utah's 1115 Demonstration waiver that would transition individuals currently covered under Targeted Adult Medicaid (TAM) into Adult Expansion Medicaid while eliminating continuous eligibility protections.

After attending today's public hearing, my understanding is that this proposal does not simply modify administrative structure — it fundamentally removes a key safeguard that has helped some of Utah's most vulnerable residents maintain consistent access to healthcare during periods of extreme instability.

Continuous eligibility is not a minor feature of coverage. It is what allows people experiencing homelessness, mental illness, substance use disorders, poverty, and crisis to remain connected to care long enough for treatment and recovery to actually work.

Without continuous eligibility, many individuals will inevitably lose coverage due to administrative barriers, missed paperwork, address instability, or life crises. These are not hypothetical concerns. These are predictable outcomes for populations already struggling to survive day to day.

Transitioning individuals from TAM to Adult Expansion Medicaid while removing continuous eligibility may appear administratively efficient on paper, but in practice it creates gaps in care that will have real human consequences. Interruptions in coverage mean interruptions in medications, mental health treatment, addiction recovery services, preventative care, and case management support. Those interruptions often lead directly to worsening health crises, hospitalization, homelessness, relapse, or incarceration.

Removing this stability does not reduce need. It simply shifts costs downstream to emergency rooms, law enforcement, shelters, and local communities — often at significantly greater expense both financially and socially.

Utah should be focused on creating pathways toward stability and recovery, not increasing barriers for people who are already facing overwhelming challenges. Healthcare continuity is especially critical for vulnerable populations because instability itself is often the very reason they qualify for assistance.

Taking away continuous eligibility at the point people are attempting to stabilize their lives is like removing the floor beneath someone while asking them to stand.

I urge DHHS and state leaders to reconsider this proposal and preserve continuous eligibility protections for individuals currently served through TAM and those transitioning into Adult Expansion Medicaid.

Thank you for your time and consideration.

I also have added a few recommendations below for your consideration.

Preserve 12-Month Continuous Eligibility for High-Risk Populations

Utah could request CMS approval to maintain continuous eligibility specifically for populations with:

- Serious mental illness
- Substance use disorders
- Homelessness or housing instability
- Justice system reentry
- High behavioral health utilization

Create a "Grace Period" Before Coverage Termination

Instead of immediate loss of Medicaid coverage after eligibility issues arise, Utah could propose:

- 90-day cure periods
- Presumptive continuation during redetermination
- Temporary reinstatement while paperwork is corrected

This reduces administrative churn while still allowing the state to meet eligibility review requirements.

Use Ex Parte / Automatic Renewals Aggressively

CMS strongly supports "ex parte renewals," meaning eligibility is renewed automatically using existing data sources rather than requiring beneficiaries to repeatedly submit paperwork.

Utah could commit to:

- Maximizing automatic renewals
- Cross-checking SNAP/TANF/unemployment databases
- Reducing beneficiary paperwork burden

Implement Continuous Eligibility During Treatment Episodes

Utah could propose continuous eligibility protections specifically during:

- Substance use treatment programs
- Intensive outpatient treatment
- Psychiatric stabilization
- Pregnancy/postpartum behavioral health treatment

Add "Health Stability" Protections Instead of Pure Time-Based Eligibility

Utah could propose maintaining eligibility while a participant:

- Remains engaged in treatment
- Has documented behavioral health needs
- Is receiving case management
- Is in supportive housing or recovery programming

Require Outcome Reporting Before Elimination

Utah could ask CMS to require measurable review of:

- ER utilization
- Hospitalizations
- Behavioral health crises
- Incarceration rates
- Homelessness outcomes
- Coverage churn

before permanent removal of continuous eligibility protections.

[redacted]

DIABETES PATIENT ADVOCACY COALITION

May 21, 2026

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

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Director Ewing:

The Diabetes Patient Advocacy Coalition appreciates the opportunity to submit comments on Utah's Medicaid Reform 1115 Demonstration Extension Request.

The Diabetes Patient Advocacy Coalition (DPAC) appreciates the opportunity to submit comments on Nebraska's Sustainable Coverage Demonstration. DPAC is an alliance of people with diabetes, caregivers, patient advocates, health professionals, and others working together to support public policy initiatives to improve the lives of Americans living with and at-risk for diabetes and its complications. As an organization run by and for people with diabetes, we seek to ensure quality of and access to care, medications and devices for our community.

DPAC is committed to ensuring that Utah's Medicaid program provides quality and affordable healthcare coverage. While some of the proposals in the waiver would improve coverage for the patients we serve, there are other policies that would restrict access to coverage for our patients. DPAC offers the following comments on Utah's Medicaid Reform 1115 Demonstration Extension Request:

Adult Expansion
DPAC supports the state's efforts to continue to provide coverage to adults up to 138% of federal poverty level (FPL).

DPAC opposed Utah's proposal to end the Targeted Adult Medicaid (TAM) program. This program provides one year of continuous eligibility (CE) to adults age 19-64 at zero percent

FPL with no dependent children who are chronically homeless, involved in the criminal justice system, or in need of substance use or mental health treatment; DPAC encourages Utah to maintain the TAM program. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[1] When patients with diabetes experience delays in coverage, they frequently ration insulin or skip care altogether, resulting in life-threatening emergencies like diabetic ketoacidosis, preventable hospitalizations, and long-term complications such as kidney disease or vision loss. Gaps in coverage also cut off access to essential monitoring supplies and technologies that patients have in their care plan, worsening blood glucose control.

If CMS does not approve continuation of this program, individuals would transition to Medicaid expansion on July 1, 2027 and at that time be subject to both the work reporting requirements and biannual redeterminations. In this case, Utah should prioritize a seamless coverage transition. Some participants, by definition, do not have permanent addresses, requiring a thoughtful approach to providing required notices. Because TAM participants frequently have histories of substance use disorder or recent incarceration, many are likely to qualify for exemptions from the work reporting requirements mandated under Public Law 119-21. Utah should proactively leverage existing data to identify and apply these exemptions to minimize the risk of inappropriate coverage losses.

Postpartum Extension

DPAC supports Utah's proposal to continue to provide 12 months of postpartum coverage for individuals enrolled in Medicaid. The state would continue to prevent gaps in healthcare coverage for low-income women during the postpartum period, helping patients to better manage serious conditions and reducing maternal mortality in Utah. According to the Centers for Disease Control and Prevention (CDC), more than 80% of pregnancy-related deaths are preventable.[2] And approximately 55% of women with coverage through Medicaid or the Children's Health Insurance Program (CHIP) at the time of delivery experienced at least one month without healthcare coverage during the six months after delivery.[3] Access to a regular source of healthcare is important for conditions to be caught early and negative health outcomes to be avoided when possible. Utah should consider submitting a State Plan Amendment to extend postpartum coverage, which is allowed under the American Rescue Plan Act of 2021.

Work Reporting Requirements

Work reporting requirements do not help low-income individuals to find work. Most people on Medicaid who can work already do so. According to the Kaiser Family Foundation, more than 90% of adults with Medicaid coverage that do not have SSI or SSDI are either full or part-time workers, caregivers, students, or unable to work due to illness.[4] And continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%,

respectively).[5] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[6]

While DPAC appreciates some of the improvements Utah had considered in its community engagement waiver request (such as exempting individuals over age 60), Public Law 119-21 does not permit waivers of the minimum requirements it sets out for work reporting requirements, and the Centers for Medicare and Medicaid (CMS) lacks legal authority to approve 1115 demonstrations that do not comply with minimum Public Law 119-21standards. The state should withdraw its request and instead devote resources to ensuring proper implementation of Public Law 119-21standards.

Reduced Benefits

DPAC opposes Utah's continued waiver of non-emergency transportation (NEMT). NEMT helps low-income patients overcome barriers to care due to transportation and allows patients to keep appointments with doctors and other healthcare providers. Unfortunately, it is estimated that 5.8 million individuals in the US delayed or missed care due to lack of transportation.[7] In November of 2025, CMS sunset Iowa's waiver of NEMT, citing that it would not promote the objectives of the Medicaid program. CMS said, it, "recognizes the significance of covering NEMT, as reflected in the broader research on NEMT that shows that providing NEMT can increase access to care and improve health outcomes."[8] For patients with diabetes and those at risk, regular care is essential to reducing the amount of preventable hospitalizations and long-term complications.

DPAC opposes the state's proposal to limit retroactive eligibility to the first day of the month in which an individual applies for Medicaid for some Medicaid eligibility groups, including demonstration groups with moderate incomes. Currently, retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to three months prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[9] Medicaid enrollees who face substantial costs at their doctor's office or pharmacy could end up delaying their treatment because of these costs.

When patients with diabetes experience delays in coverage, they frequently ration insulin or skip care altogether, resulting in life-threatening emergencies like diabetic ketoacidosis, preventable hospitalizations, and long-term complications such as kidney disease or vision loss. Gaps in coverage also cut off access to essential monitoring supplies and routine care, worsening blood glucose control. These disruptions create financial strain, mental health challenges, and higher health system costs.

DPAC urges Utah to end its waivers of NEMT and retroactive eligibility.

Re-Entry Medicaid Services for the Justice Involved Population
DPAC supports Utah's proposal to continue to provide a targeted set of Medicaid services for justice-involved populations who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with both the goals of Medicaid and CMS guidance and will be an important step in improving the continuity of care. Services will include case management, medication-assisted treatment (MAT) with counseling, and a 30-day supply of prescription medications upon release. Utah's reentry policy is consistent with CMS guidance. and helps high-risk populations access critical supports needed to treat physical and behavioral health conditions.

Conclusion
DPAC urges Utah to consider our comments and patients' experiences accessing care. We encourage Utah to continue the Adult Expansion program, the TAM program and the re-entry Medicaid services for the Justice Involved population, while continuous eligibility while transitioning the authority for the post-partum coverage extension to a SPA. Utah should remove the requests for the work reporting requirement, waiving NEMT and retroactive eligibility from the waiver prior to submitting the request to CMS. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

[redacted] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[2] Preventing Pregnancy-Related Deaths. Centers for Disease Control and Prevention. September 25, 2024. Available at: https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html

[3] Daw JR, Hatfield LA, Swartz K, Sommers BD. Women in the United States experience high rates of coverage 'churn' in months before and after childbirth. Health Aff (Millwood). 2017; 36(4): 598–606. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241.

[4] Tolbert, Jennifer et al. Understanding the Intersection of Medicaid & Work: An Update. KFF. February 4, 2025. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/.

[5] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Available at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[6] Sommers BD, Gawande AA, Baicker K. Health insurance coverage and health — what the recent evidence tells us. N Engl J Med. 2017; 377(6): 586-593. 10.1056/NEJMsb1706645

[7] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017. Am J Public Health. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.

[8] Deputy Administrator, CMS to Lee Grossman, Iowa Medicaid Director. November 28, 2025. Accessed at: ia-wellness-plan-cms-temp-ext-amnd-aprvl-11282025.pdf

[9] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

SALT LAKE COUNTY

[redacted]

May 12, 2026

Dear Utah Department of Health and Human Services Leadership,

I am writing in support of Utah's efforts to preserve and renew the Targeted Adult Medicaid (TAM) program established through the Medicaid 1115 Waiver. TAM has become a critical resource for individuals experiencing homelessness, justice involvement, and serious mental health or substance use treatment needs across Utah and particularly within Salt Lake County.

The individuals served through TAM are among those most likely to cycle through jails, shelters, emergency rooms, and crisis systems. The program's 12 months of continuous Medicaid eligibility has been especially important in supporting recovery and stability during transitions from higher levels of care into housing, employment, and community-based treatment.

Continuous eligibility helps ensure individuals can maintain access to outpatient behavioral health services, medication management, and recovery supports even after obtaining employment that temporarily moves them above the extremely low 5% poverty threshold. Without this continuity of care, many individuals are at greater risk of relapse, homelessness, hospitalization, and reentry into the justice system.

For Salt Lake County, where local systems continue working to address behavioral health needs, homelessness, and justice system impacts, TAM has been an important tool in improving outcomes and reducing costly system cycling.

We strongly encourage Utah Medicaid and state leaders to pursue all available options to preserve this program and its continuous eligibility provisions, including continued engagement with federal partners and Utah's congressional delegation.

Thank you for your consideration and continued commitment to supporting Utahns with the greatest behavioral health and reentry needs.

Sincerely,

[redacted]

[redacted]

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NORD®
National Organization for Rare Disorders

Alone we are rare. Together we are strong.®

May 21, 2026

Utah Department of Health and Human Services
Division of Integrated HealthCare
PO Box 143106
Salt Lake City, UT 84114-3106
Attn: Laura Belgique

Re: National Organization for Rare Disorders Comments on Utah's Medicaid Reform 1115 Demonstration, 2027-2032 Renewal

Director Ewing and Dedicated Staff:

The National Organization for Rare Disorders (NORD), on behalf of the 1-in-10 Utahns with a rare disease, appreciates the opportunity to submit comments on the 2027-2032 Renewal to Utah's Medicaid Reform 1115 Demonstration.

For more than 40 years, NORD has served as the leading national patient advocacy organization dedicated to individuals with rare diseases, defined federally in the Orphan Drug Act as any condition affecting 200,000 or fewer Americans[i], and the organizations that serve them. With more than 355 patient organization members, NORD works to improve the health and well-being of people with rare diseases by driving advances in care, research, and policy. We believe that all individuals with a rare disease should have access to high quality, affordable health care that is best suited to meet their medical needs.

We support Utah's commitment to Medicaid expansion and recognize the complexity of implementing the federal community engagement requirements outlined in H.R.1 §71119. Our comments focus on practical steps Utah can take to minimize unintended coverage losses among eligible individuals, particularly people with rare diseases and their caregivers, while meeting federal community engagement requirements. Our detailed comments are as follows:

Operative Status of the Community Engagement Amendment
NORD sincerely appreciates the clarification provided by DHHS staff that Utah intends to implement H.R.1 as its operative community engagement framework and does not intend to pursue the 1115 CE waiver as a standalone work requirement program. We note that this clarification was provided in response to a direct inquiry and is not yet reflected in the renewal documents as submitted. NORD respectfully asks that the Department formally clarify the status and intended purpose of the CE amendment in the public record so that all stakeholders have accurate information on which to base their comments and future engagement.

The Unique Risk to People with Rare Diseases
Medicaid work and community engagement requirements enacted under H.R.1 present states with consequential design choices: none more important than how they account for people living with rare and complex conditions.

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Rare disease affects fewer than 200,000 people per condition; yet collectively impact approximately 30 million Americans – one in ten – half of whom are children[ii]. For these individuals and their caregivers, Medicaid is often the only pathway to care. Analysis of national hospital discharge data found that public payers, Medicaid and Medicare, covered more than 70% of adult rare disease inpatient stays; among children hospitalized with a rare disease, Medicaid alone was the primary payer for more than half of all visits (50.1%)[iii]. The burden falls most heavily on those with the fewest options: among rare disease patients from underrepresented communities, individuals were three times more likely to report Medicaid as their primary insurance[iv].

Fewer than 5% of the 10,000+ known rare diseases have any FDA-approved treatment and the average time from symptom onset to diagnosis, i.e., the "diagnostic odyssey," is 6 years. Medical expertise is often limited to a small number of providers nationwide, symptoms may fluctuate and not fit neatly into traditional disability criteria, and for many patients, clinical trials are the only available therapeutic option (which requires a diagnosis). These realities make uninterrupted health coverage incredibly important; even short disruptions in Medicaid coverage can delay treatment, interrupt access to specialists, derail clinical trial participation, and lead to worsening health outcomes.

According to NORD's 30-Year Barriers to Access Survey, 76% of rare disease patients report some or great financial burden and 62% of adults have had to miss work because of their rare disease.[v] Although the federal community engagement requirements outlined in H.R.1 §71119 and subsequent guidance are intended only for "able-bodied" adults, prior experience from states that have implemented similar work requirement policies resulted in substantial coverage losses including among people with disabilities and serious, chronic conditions. For example, after Arkansas implemented work requirements in 2018, approximately 18,000 people lost coverage, including people who were working or eligible for an exemption[vi], encompassing a significant number of people with disabilities despite exemptions and other safeguards reportedly in place[vii]. Adults with chronic conditions were found more likely than adults without such conditions to lose coverage for failure to comply with the work requirements[viii]. These lessons emphasize the need for layers of strong safeguards to prevent unintentional coverage loss.

To reduce inappropriate coverage loss, we recommend that Utah leverage existing government advisory bodies, such as the Medicaid Beneficiary Advisory Council and the Rare Disease Advisory Council, to incorporate feedback from patients and caregivers with lived experience of rare diseases throughout the process of planning and implementing community engagement requirements. We also suggest utilizing this engagement to identify existing resources and avenues for support for patients and caregivers to prevent loss of coverage and to develop plans for targeted outreach prior to implementation.

Specific Excluded Individuals

Regarding the "Medically Frail" Exemption

H.R.1 §71119 requires that an individual who is medically frail or otherwise has special needs will be excluded from work requirements and sets a minimum of five groups that must be included in the "medically frail or otherwise has special needs" definition. The Utah community engagement amendment does not contain an exemption for medical frailty and instead provides exemption C for those who are "physically and mentally unable to meet the requirements," which may not fully align with the federal exemption. We respectfully suggest that Utah revise exemption C to align with federal law.

When implementing health related exemptions, we recommend that the state consider those with complex and rare conditions whose health status may not fit cleanly within diagnostic codes or other standard documentation forms. People with rare diseases and patients with potentially rare diseases

amid their diagnostic odyssey may have substantial functional limitations or unpredictable health needs that do not allow for sustained employment. A broad definition of "medical frailty" to meet requirements would minimize coverage losses for people with complex or chronic conditions – the exact population Congress intended to protect.

For further clarity, we also recommend that the state shares its plans to operationalize this exemption, what criteria it will be using to determine exemption verification, and examples of conditions that would exempt an individual from community engagement requirements.

Clear, Plain-Language Communication
Since some people may not know to identify themselves as exempt from community engagement requirements based on their health condition, we suggest that Utah describe any exemption comprehensively and in plain language in application materials, renewal forms, and outreach communications and include examples that encompass rare, complex conditions that eligible individuals can understand the exemption that applies to them. This will reduce both wrongful denials and administrative churn.

Automatic Exemptions Using Existing Data
We support and appreciate the state's plan to maximize the use of available data sources before requiring members or applicants to provide proof of eligibility for an exemption. Many rare and chronic conditions are unlikely to change over time, and automatic exemptions reduce unnecessary paperwork burdens for enrollees as well as the state's administrative workload from reviewing documentation. Automatic verification will decrease inappropriate coverage losses for people with serious conditions that need uninterrupted access to health care.

Accepting Self-Attestations
H.R.1 allows states to accept information that indicates an individual is exempt without any further verification. We recommend Utah utilizes this option and accepts self-attestation as verification for exemption status. Additionally, we ask the state to establish clear pathways for individuals where diagnostic confirmation is unavailable or incomplete, including acceptance of specialty referrals or documentation of a pending workup.

With a scarcity of physicians familiar with rare diseases and the prevalence of undiagnosed conditions, it is often challenging, sometimes impossible, for rare disease patients and those still seeking a diagnosis to convey the extent of their symptoms in a way that meets state requirements. Those with a rare disease diagnosis require access to very specialized providers, subjecting them to delays in appointments for treatment and difficulties producing regular documentation.

Requiring patients to frequently produce formal documentation or using narrow diagnostic codes risks excluding individuals whose conditions are serious but not fully captured in medical records. Though there are over 10,000 known rare diseases, there are only about 500 rare disease-specific ICD-10-CM codes, leaving many to fall under broad codes, such as metabolic disorders and genetic syndromes. Some rare immune or neurologic disorders are coded under unspecified inflammatory or degenerative categories. If a state relies on diagnostic codes to determine medical frailty exemptions, people with diseases under such broad categories would be indistinguishable from individuals with milder, unrelated conditions and would likely fall through the cracks, along with the many individuals still searching for a rare disease diagnosis. Accepting self-attestation through simple screening questions would meaningfully reduce wrongful disenrollment and administrative burden.

Caregiver Cliff

Caregivers are a vital and oftentimes invisible component of the rare disease community and health care system more broadly. They conduct daily caretaking activities such as dressing and feeding, manage medical appointments and treatments, travel long distances to access specialist care, and provide emotional support that would otherwise fall to the health care system. The work caregivers perform is critical to the wellbeing of rare disease patients, yet community engagement requirements outlined in H.R.1 §71119 do not fully consider the unique needs of patients and the dynamics of family caregiving.

Of the estimated million 53 family caregivers in the United States, 61% are simultaneously employed, but 50% have reported going into work late, leaving early, or taking time off because of caregiving responsibilities.[ix] Performing 80 hours of community engagement requirements may create barriers to care for many caregivers, and Utah's community engagement waiver only provides certain exemptions for caregivers of children 13 and younger, or individuals federally recognized as disabled. This gap in exemptions creates a meaningful risk of coverage loss for caregivers, with potential downstream consequences for the caregiver and the patients they support.

Federal Interaction with H.R.1

We have observed some aspects of the community engagement amendment that are a departure from what is outlined in H.R.1 or may not clearly align with other plans for implementing community engagement requirements that the state has otherwise communicated[x]. We respectfully ask that Utah provide further information on the following aspects of the community engagement amendment and their interaction with H.R.1:

Three Month Participation Period and Participation Activities

Utah's community engagement amendment operates through a different program model than what is described in H.R.1 §71119. While the federal law establishes an 80-hour community engagement activity threshold as a prerequisite for Medicaid eligibility for certain populations, Utah categorizes 80 hours of community engagement activity as an exemption from a 3-month, 4-step employment placement program that serves as a gateway to Medicaid coverage. If Medicaid enrollees complete the required steps in 3 months, they are presumably eligible for Medicaid, regardless of whether they are meeting community engagement requirements, for the remainder of the year-long eligibility period. This may conflict with the intent of H.R.1 §71119 to require all able-bodied Medicaid expansion recipients to perform community engagement activities to receive Medicaid coverage and could result in the amendment being rejected.

Eligibility Redetermination and Participation Period

H.R.1 §71107 requires state Medicaid programs to redetermine eligibility at a minimum of every 6 months, while the eligibility period in the community engagement amendment is 12 months. While we support longer eligibility periods, we believe this amendment conflicts with federal law and suggest that the state provides explanation for how it plans to reconcile this timeline with federal requirements or revise the amendment to comply with H.R.1 §71107.

Lookback Period

Utah has publicly stated that it has elected to require one month of compliance with community engagement requirements for new applicants and for renewing enrollees on its Medicaid website. Longer compliance periods require more data to verify eligibility and add to the administrative load,

heightening the risk for inappropriate coverage loss and leading to increased error rates. We support the state's choice for one month of compliance and lookback for new applicants, and we ask that this decision is made explicit in the community engagement waiver.

30-Day Grace Period
Per H.R.1 § 71119, states must notify Medicaid enrollees who fail to comply with community engagement requirements 30 days prior to disenrollment. The suspension and disenrollment mechanisms within Utah's community engagement amendment do not clearly align with the mandate set forth in H.R.1, as Utah plans to suspend coverage immediately following the 3-month participation period if the enrollee fails to complete the required participation tasks. We ask for further clarification of the state's plans to reconcile this with the federal mandate, and recommend the state prioritize proactive outreach to enrollees wherever possible.

Optional Short-Term Exemptions
We support and appreciate Utah's plan to implement all options for short-term hardship exemptions that are offered by H.R.1 §71119, as indicated on the state's public-facing Medicaid website. We suggest that the state explicitly include in the community engagement amendment a specific exemption for medical travel, among the good cause exemptions in section 1.5 along with the other short-term hardship exemptions provided by H.R.1 §71119. Rare disease patients often must travel long distances to access providers as there are frequently only a handful of specialists nationwide, or even worldwide, who have expertise in their rare conditions. 39% of rare disease patients have reported travelling at least 60 miles to receive medical care.[xi]

To ensure this exception captures those who should qualify, we recommend: (1) defining the travel circumstances as broadly as possible to cover those needing to travel to seek care; (2) allowing individuals to self-report their qualification, or if this is not possible, requiring as little information as possible from individuals to demonstrate qualification for this exception; (3) providing a clear explanation of the exception and instructions on how people can qualify in outreach materials; and (4) developing a process to transition individuals with ongoing medical hardship into longer-term exemptions where appropriate.

Targeted Adult Medicaid
The discontinuation of Targeted Adult Medicaid may result in gaps in coverage that we wish to draw attention to. While we believe most TAM recipients would qualify for coverage via standard or good cause exemptions, certain TAM populations, particularly domestic violence survivors temporarily living in shelters, may be subjected to community engagement requirements which may be difficult to fulfill. NORD recognizes that rare diseases do not discriminate among those that they affect, and the challenges of a rare disease compound during traumatic experiences like domestic violence. We respectfully urge the state to strongly consider safeguards it can provide so that members of such an extremely vulnerable population do not lose health coverage at times when it is most needed.

Implementation Timeline
Finally, we ask for additional clarity on the state's planned timeline for implementing community engagement requirements. Publicly, Utah has indicated on its Medicaid website that it has elected not to implement earlier than the mandatory start date of January 1st, 2027. We support this decision as we believe that the serious complexities of designing community engagement requirements warrant adequate time to plan, train staff, develop new systems, and conduct beneficiary outreach to prevent inappropriate loss of coverage. We ask that this decision is explicitly referenced in the community engagement amendment, which currently identifies a start date of July 1st, 2026. We also ask for

additional information on the duration for the community engagement amendment, specifically, if state still plans for an expiration on June 30, 2027.

Conclusion
Consistent access to affordable health care coverage is critical to ensuring that Utahns living with rare diseases and others with serious and chronic conditions receive the care they need.

We appreciate that the implementation of H.R.1 is a complex undertaking, and Utah has flexibility in how it structures exemptions, verification, and timelines. In addition to the elections for all short-term hardship exemptions and one month eligibility lookback periods, Utah can minimize unintended loss of needed health care coverage while meeting federal requirements by broadly interpreting the medically frail exemption, accepting self-attestation for exemptions, and waiting until the federal deadline to implement as it had indicated it would do. We appreciate the opportunity to provide these recommendations and welcome the opportunity to serve as a resource as DHHS refines and implements these policies.

Thank you for your consideration and the opportunity to contribute our expertise on behalf of the rare disease community and for your service to the State of Utah. For questions or more information, please contact [redacted].

[redacted],

[redacted]

[redacted]

[redacted]

[ix] SHRM Care and Careers: Navigating Caregiving and Work Responsibilities, 2025 https://www.shrm.org/content/dam/en/shrm/topics-tools/research/care-and-careers_worker-report.pdf
[x] Utah DHHS HR1 (One Big Beautiful Bill Act, 2025) https://medicaid.utah.gov/obbba/
[xi] National Organization for Rare Disorders. "30-Year Barriers to Access Survey" https://rarediseases.org/wp-content/uploads/2020/11/NRD-2088-Barriers-30-Yr-Survey-Report_FNL-2.pdf

RDAC
Utah Rare Disease Advisory Council

May 21, 2026

To: Utah Department of Health and Human Services
RE: Public Comment on the 1115 Medicaid Demonstration Renewal

The Utah Rare Disease Advisory Council (RDAC), representing the 1-in-10 Utah residents living with a rare disease and their family caregivers, appreciates the opportunity to comment on Utah's 1115 Medicaid demonstration renewal. The Utah RDAC also appreciates the efforts of the state to protect the long-term viability of our Medicaid program while improving the health and well-being of Utah's most vulnerable..

The Utah RDAC was established during the 2020 session of the Utah Legislature (Utah Code Annotated Section 26-1-41) to advise and make recommendations to the legislature and state agencies on improving access to treatment and services provided to individuals with a rare disease, and identify best practices to improve the care and treatment of individuals in the state with a rare disease. https://utahrdac.org

Our comments focus on the implementation of a Medicaid Community Engagement (CE) program. We understand that certain CE requirements are driven by federal law pursuant to the enactment of H.R. 1, the *One Big Beautiful Bill,* and for that reason, the RDAC's primary concern is not the version of CE included in the Utah 1115 waiver renewal as potential alternate implementation, but whether the Utah Department of Health and Human Services (DHHS) uses the renewal and transition period to design implementation systems that prevent eligible rare disease patients and caregivers from losing coverage because of paperwork barriers, rigid verification tools, or medical realities that are not captured in standard eligibility systems.

Many Utahns with rare and undiagnosed conditions experience years-long diagnostic delays, lack condition-specific diagnostic codes, and may not yet have formal disability determinations despite serious, fluctuating, or treatment-intensive conditions. The RDAC urges DHHS and CMS to use every available administrative tool to minimize coverage loss for eligible individuals.

Utah should limit verification to federal minimums, maximize ex parte review through existing state data, accept self-attestation where permitted, avoid duplicative documentation requests, and provide clear, plain-language notices and appeals processes. Medical exemptions should be defined and operationalized broadly so that individuals who are physically or mentally unable to meet requirements, individuals with serious or complex medical conditions, and individuals with pending or incomplete diagnoses have a clear pathway to protection.

DHHS should establish a clearly defined, public-facing initial submission process for medically frail exemptions that identifies acceptable documentation, such as physician letters, specialist referrals, care plans, clinical trial participation records, pending diagnostic workups, and other evidence of medical complexity. The process should explain how members and providers may submit documentation, how DWS caseworkers should review it, and the expected timeline for approval, while remaining simple for members and providers, standardized for caseworker review, and auditable for program integrity.

Good cause and hardship standards should explicitly recognize hospitalization, temporary illness, medical flare-ups, lack of transportation, lack of internet access, long-distance travel for specialty care, intensive treatment schedules, and clinical trial participation. For ongoing or

chronic conditions, approved medically frail exemptions should be properly flagged and retained in the eligibility system so members can be renewed ex parte whenever possible and are not required to resubmit the same documentation every six months when the underlying condition or caregiving responsibility has not changed. Because many rare and disabling conditions involve highly variable symptoms, occasional or intermittent work should not disqualify an otherwise eligible individual from a medical exemption or trigger more frequent recertification when the underlying condition remains ongoing.

The Utah RDAC further recommends that Utah protect caregivers, including caregivers of adolescents over the age of 13 with serious medical needs and caregivers of adults with complex conditions who lack formal disability paperwork. These households should not lose their own health coverage because they are providing essential care at home. Even where federal law controls the underlying requirement, Utah retains responsibility for building an implementation process that is clear, flexible, and medically realistic.The RDAC urges DHHS and CMS to use the 1115 renewal process and the broader implementation timeline to preserve access to care for Utahns with rare and complex conditions.

We appreciate your leadership, civic service, and thank you for your consideration of the rare disease community.

Sincerely,

SALT LAKE COUNTY COUNCIL

May 7, 2026

Dear Utah Department of Health and Human Services Leadership,

We understand that you are in an impossible situation and have received a letter from Centers for Medicare and Medicaid Services (CMS) informing the state that a waiver to renew the Targeted Adult Medicaid (TAM) Expansion program would not be approved. We also understand that including this in your other waivers could be problematic and that the legislature has specifically directed you not to submit a waiver unless it will be approved.

We would respectfully ask that you forward these comments to CMS to help them better understand the great strides we have made in helping this population because of this waiver:

Dear Centers for Medicare and Medicaid Services,

As Salt Lake County Council members, we strongly support the renewal of the Targeted Adult Medicaid (TAM) Expansion program. Since its implementation, TAM has provided life-changing support services to a vulnerable and hard-to-reach population that is often chronically homeless and justice-involved.

As overseers of the county budget, we can attest TAM has also improved the County's ability to manage limited public health and public safety resources effectively.

The individuals served by TAM often face complex and overlapping challenges, including behavioral health conditions, substance use disorders, housing instability, and involvement with the criminal justice system. These factors can make it especially difficult for them to navigate frequent eligibility redeterminations.

For this reason, we hope you will reconsider the decision to allow continuous eligibility for TAM recipients. Continuous coverage is not simply a matter of convenience. It ensures stability in receiving care and resources. Interruptions in Medicaid coverage can lead to disruptions in mental health treatment, substance use services, housing supports, and access to medications, often resulting in avoidable crises.

Salt Lake County Government Center
2001 South State Street, Suite N2-200 | PO Box 144575 | Salt Lake City, UT 84114-4575
Tel: 385.468.7500 | Fax: 385.468.7501 | www.slco.org

SALT LAKE COUNTY COUNCIL

Even partial continuity measures, such as six months of uninterrupted coverage as allowed by HR1, would represent a meaningful step toward improving outcomes and system efficiency.

We appreciate your commitment to serving Utah's most vulnerable populations. Thank you for your consideration.

Sincerely,

Salt Lake County Council Members

[redacted]

Salt Lake County Government Center
2001 South State Street, Suite N2-200 | PO Box 144575 | Salt Lake City, UT 84114-4575
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National
Multiple Sclerosis
Society

May 14, 2026

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

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Director Ewing:

The National Multiple Sclerosis Society (Society) appreciates the opportunity to submit comments on Utah's Medicaid Reform 1115 Demonstration Extension Request.

The Society mission is to cure multiple sclerosis (MS) while empowering people affected by MS to live their best lives. To accomplish this, the Society funds cutting-edge research, drives change through advocacy, facilitates professional education, collaborates with MS organizations around the world, and provides programs and services designed to help people with MS and their families live their best lives.

The Society is committed to ensuring that Utah's Medicaid program provides quality and affordable healthcare coverage. While some of the proposals in the waiver would improve coverage for the patients we serve, there are other policies that would restrict access to coverage for our patients. The Society offers the following comments on Utah's Medicaid Reform 1115 Demonstration Extension Request:

Adult Expansion
The Society supports the state's efforts to continue to provide coverage to adults up to 138% of federal poverty level (FPL). Medicaid is a critical safety net program that provides an array of benefits and services for individuals living with MS such as access to rehabilitative services, durable medical equipment (such as wheelchairs), prescription drug coverage and more. 15% of people living with MS nationally are covered by Medicaid and this is not factoring in those who use Medicaid for home and community-based services.

The Society opposes Utah's proposal to end the Targeted Adult Medicaid (TAM) program. This program provides one year of continuous eligibility (CE) to adults age 19-64 at zero percent FPL

National
Multiple Sclerosis
Society

with no dependent children who are chronically homeless, involved in the criminal justice system, or in need of substance use or mental health treatment. The Society encourages Utah to maintain the TAM program. Research has shown that individuals with disruptions in coverage during a year are more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.[i] For many living with MS, loss of coverage would be detrimental to their health as early and ongoing treatment is the necessary to slow the progression of the disease. Without access to comprehensive care, individuals living with MS are likely to see permanent disease progression and irreversible accumulation of disability.

If CMS does not approve continuation of this program, individuals would transition to Medicaid expansion on July 1, 2027 and at that time be subject to both the work reporting requirements and biannual redeterminations. In this case, Utah should prioritize a seamless coverage transition. Some participants, by definition, do not have permanent addresses, requiring a thoughtful approach to providing required notices. Because TAM participants frequently have histories of substance use disorder or recent incarceration, many are likely to qualify for exemptions from the work reporting requirements mandated under Public Law 119-21. Utah should proactively leverage existing data to identify and apply these exemptions to minimize the risk of inappropriate coverage losses.

Postpartum Extension

The Society supports Utah's proposal to continue to provide 12 months of postpartum coverage for individuals enrolled in Medicaid. The state would continue to prevent gaps in healthcare coverage for low-income women during the postpartum period, helping patients to better manage serious conditions and reducing maternal mortality in Utah. According to the Centers for Disease Control and Prevention (CDC), more than 80% of pregnancy-related deaths are preventable.[ii] And approximately 55% of women with coverage through Medicaid or the Children's Health Insurance Program (CHIP) at the time of delivery experienced at least one month without healthcare coverage during the six months after delivery.[iii] Access to a regular source of healthcare is important for conditions to be caught early and negative health outcomes to be avoided when possible. Utah should consider submitting a State Plan Amendment to extend postpartum coverage, which is allowed under the American Rescue Plan Act of 2021.

Work Reporting Requirements

Work reporting requirements do not help low-income individuals to find work. Most people on Medicaid who can work already do so. According to KFF, more than 90% of adults with Medicaid coverage that do not have SSI or SSDI are either full or part-time workers, caregivers,

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students, or unable to work due to illness.[iv] And continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[v] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[vi]

While The Society appreciates some of the improvements Utah had considered in its community engagement waiver request (such as exempting individuals over age 60), Public Law 119-21 does not permit waivers of the minimum requirements it sets out for work reporting requirements, and the Centers for Medicare and Medicaid (CMS) lacks legal authority to approve 1115 demonstrations that do not comply with minimum Public Law 119-21standards. The state should withdraw its request and instead devote resources to ensuring proper implementation of Public Law 119-21standards.

Reduced Benefits

The Society opposes Utah's continued waiver of non-emergency transportation (NEMT). NEMT helps low-income patients overcome barriers to care due to transportation and allows patients to keep appointments with doctors and other healthcare providers. Unfortunately, it is estimated that 5.8 million individuals in the US delayed or missed care due to lack of transportation.[vii] In November of 2025, CMS sunset Iowa's waiver of NEMT, citing that it would not promote the objectives of the Medicaid program. CMS said, it, "recognizes the significance of covering NEMT, as reflected in the broader research on NEMT that shows that providing NEMT can increase access to care and improve health outcomes."[viii]

The Society opposes the state's proposal to limit retroactive eligibility to the first day of the month in which an individual applies for Medicaid for some Medicaid eligibility groups, including demonstration groups with moderate incomes. Currently, retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to three months prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

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Society

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[ix] Medicaid enrollees who face substantial costs at their doctor's office or pharmacy could end up delaying their treatment because of these costs.

The Society urges Utah to end its waivers of NEMT and retroactive eligibility.

Conclusion

The Society urges Utah to consider our comments and patients' experiences accessing care. We encourage Utah to continue the Adult Expansion program, the TAM program and the re-entry Medicaid services for the Justice Involved population, while continuous eligibility while transitioning the authority for the post-partum coverage extension to a SPA. Utah should remove the requests for the work reporting requirement, waiving NEMT and retroactive eligibility from the waiver prior to submitting the request to CMS. Thank you for the opportunity to provide comments.

Sincerely,

[redacted]

[i] Sugar S, Peters C, De Lew N, Sommers BD. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the Covid-19 Pandemic. Assistant Secretary for Planning and Evaluation, Office of Healthy Policy. April 12, 2021. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[ii] Preventing Pregnancy-Related Deaths. Centers for Disease Control and Prevention. September 25, 2024. Available at: https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html

[iii] Daw JR, Hatfield LA, Swartz K, Sommers BD. Women in the United States experience high rates of coverage 'churn' in months before and after childbirth. Health Aff (Millwood). 2017; 36(4): 598–606. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1241.

[iv] Tolbert, Jennifer et al. Understanding the Intersection of Medicaid & Work: An Update. KFF. February 4, 2025. Available at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/.

National
Multiple Sclerosis
Society

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[v] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Available at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[vi] Sommers BD, Gawande AA, Baicker K. Health insurance coverage and health — what the recent evidence tells us. N Engl J Med. 2017; 377(6): 586-593. 10.1056/NEJMsb1706645

[vii] Wolfe MK, McDonald NC, Holmes GM. Transportation Barriers to Health Care in the United States: Findings From the National Health Interview Survey, 1997-2017. Am J Public Health. 2020 Jun;110(6):815-822. doi: 10.2105/AJPH.2020.305579. Epub 2020 Apr 16. PMID: 32298170; PMCID: PMC7204444.

[viii] Deputy Administrator, CMS to Lee Grossman, Iowa Medicaid Director. November 28, 2025. Accessed at: ia-wellness-plan-cms-temp-ext-amnd-aprvl-11282025.pdf

[ix] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

May 6, 2026

Utah Department of Health and Human Services
Attn: Medicaid Policy & Waiver Team

Re: Support for Continued Targeted Adult Medicaid (TAM) with 6-Month Continuous Eligibility

Dear Medicaid Policy Team,

We, the undersigned members of the Weber County Community Reentry Coalition (WCCRC), write to express our strong, collective support for the continuation of Targeted Adult Medicaid (TAM) under Utah's Section 1115 demonstration waiver, with a revised 6-month continuous eligibility period that aligns with current federal parameters.

The WCCRC brings together agencies and providers across the justice system, healthcare, behavioral health, housing, and community services to improve outcomes for individuals returning to Weber County after incarceration. Our collaboration is built on the shared understanding that sustained access to care during reentry is one of the most decisive factors in whether individuals stabilize or cycle back into crisis and system involvement. Across disciplines, we share a common priority: ensuring continuity of care during reentry to improve individual outcomes and strengthen community safety.

TAM as a Critical Reentry Infrastructure

For individuals leaving incarceration, the transition back into the community is both high-risk and time sensitive. Access to healthcare, particularly for mental health and substance use disorders, is often the difference between successful reintegration and rapid destabilization.

Without stable coverage, individuals frequently experience:

- Interruptions in prescribed medication
- Breakdowns in treatment continuity
- Increased risk of relapses or psychiatric destabilization
- Delays or failure in connecting to resources and community providers

TAM directly mitigates these risks by maintaining access to care when it is needed most.

Impact on Reentry Outcomes and Community Stability

In Weber County, collaborative reentry efforts, particularly through the Reentry Success Services program, have demonstrated the tangible impact of coordinated care supported by Medicaid access. Among participants engaged in these services, outcomes include a **45% reduction in local recidivism** and a **59% reduction in total bookings** within one year of program engagement.

These results reflect the effectiveness of coordinated care models that align healthcare coverage with structured reentry support, allowing individuals to remain engaged in treatment and connected to essential services at the point of release and beyond. When coverage is interrupted,

however, individuals are far more likely to disengage from care, experience acute behavioral health episodes, and reenter the justice system. This pattern increases demand across emergency, correctional, and crisis response systems. These outcomes demonstrate that maintaining access to care during reentry is not only a clinical necessity, but a sound investment in public safety and resource efficiency.

Path Forward: Support for 6-Month Continuous Eligibility

We recognize that Centers for Medicare & Medicaid Services (CMS) has expressed limitations regarding continuous eligibility timeframes. A 6-month continuous eligibility model offers a reasonable and compliant solution that preserves the essential function of TAM while aligning with federal direction. This timeframe provides a meaningful window for individuals to initiate and sustain treatment, establish provider relationships, and begin building stability in the community – critical milestones that are significantly less likely without uninterrupted coverage.

Request for State Action and Federal Engagement

We respectfully urge the Utah Department of Health and Human Services to:

1. Advance a waiver amendment that continues TAM with a 6-month continuous eligibility period
2. Pursue coordinated discussions with CMS to support approval of this approach
3. Prioritize efforts to sustain a program that demonstrably improves reentry outcomes, public safety, and system efficiency

As organizations working directly with individuals navigating reentry, we offer our collective on-the-ground experience and unified support to inform and strengthen these efforts.

As cross-sector partners working at the intersection of public safety, behavioral health, and community reintegration, we see daily the consequences of gaps in care and the measurable benefits when those gaps are closed. Targeted Adult Medicaid has been instrumental in advancing a more coordinated, effective, and accountable reentry system in Weber County. Removing that access would reverse meaningful gains and increase strain across multiple public systems.

Preserving TAM, with a 6-month continuous eligibility framework, represents a practical and evidence-informed path forward that protects both community safety and public investment. We strongly encourage Utah to pursue this option and stand ready to support continued engagement with state and federal partners.

Respectfully,

WCCRC Member Name	Community Representation
[redacted]	

UTAH SHERIFFS' ASSOCIATION, INC

[redacted]

[redacted]

May 5, 2026

Tracy Gruber
Executive Director
Utah Department of Health and Human Services

Dear Director Gruber,

On behalf of the Utah Sheriffs' Association, I write to express our strong support for the continuation of Utah's Targeted Adult Medicaid (TAM) program and for the Department's efforts to secure ongoing federal approval through the Medicaid waiver process.

From a public safety perspective, TAM has proven to be an effective and practical tool in addressing some of the most persistent challenges facing law enforcement across our state. A significant majority of TAM participants are justice-involved individuals who often struggle with substance use disorders, mental health conditions, and housing instability. These are the same underlying factors that frequently drive repeated law enforcement contacts, incarceration, and crisis situations in our communities.

By providing continuous eligibility and access to treatment services, TAM allows individuals to stabilize, engage in care, and break cycles of recidivism. Local examples demonstrate this impact clearly. In Sanpete County, the use of TAM to support reentry services for jail inmates has been associated with a reported 61% reduction in recidivism. Outcomes like this translate directly into fewer repeat offenses, fewer victims, and safer communities.

TAM also plays a meaningful role in reducing high-risk law enforcement encounters. When individuals receive consistent mental health and substance use treatment, deputies are less likely to encounter them in crisis situations that can escalate to the use of force. Programs that connect individuals to care before they reach a breaking point improve safety not only for the individuals themselves, but also for responding officers and the public.

In addition to these public safety benefits, TAM represents a fiscally responsible approach. Providing treatment and stabilization services is significantly more cost-effective than repeated incarceration, emergency medical care, and prolonged law enforcement involvement.

Sheriffs across Utah rely on partnerships with behavioral health providers, mobile crisis teams, and community organizations to manage complex populations. TAM strengthens these partnerships by ensuring that the individuals we encounter have access to the services they need to succeed.

We recognize the challenges associated with federal waiver requirements and appreciate the Department's efforts to find a path forward. We strongly encourage continued pursuit

of a waiver structure that preserves the core elements that make TAM effective, including uninterrupted access to care for this high-risk population.

Discontinuing TAM would remove a proven tool that supports public safety, reduces recidivism, and improves outcomes for some of Utah's most vulnerable residents. We respectfully urge you to continue efforts to maintain this program.

Thank you for your leadership and your commitment to the safety and well-being of Utah's communities.

Sincerely,

[redacted]

May 20th, 2026

Utah Department of Health & Human Services Integrated Health
Cannon Health Building
288 North 1460 West
Salt Lake City, UT 84116

Re: Utah's Medicaid Reform 1115 Demonstration (Renewal Request – 2027 – 2032)

On behalf of the EveryLife Foundation for Rare Diseases, we are pleased to submit comment on Utah's Medicaid Reform 1115 Demonstration Renewal Request.[1] The EveryLife Foundation for Rare Diseases is powered by the rare disease community to improve health outcomes by driving change through evidence-based policy, leading science-driven policy and regulatory research, activating the community to advocate for their rights and needs, and strengthening the rare disease community. These comments reflect the engagement of our coalition of rare disease stakeholders around our community's shared priorities to ensure that rare disease patients and families have access to affordable health insurance coverage and the care they need to manage their rare disease.

In Vitro Fertilization and Genetic Testing

The proposed 1115 demonstration provides coverage for genetic testing services to covered individuals, preimplantation of genetic testing on embryos, and IVF services to individuals ages 18 through 35, diagnosed by a physician with a genetic trait associated with cystic fibrosis, mosquito syndrome, sickle cell anemia, spinal muscular atrophy, or myotonic dystrophy. With 70 to 80 percent of rare diseases being genetic in origin, timely and sustainable access to genetic testing that rapidly informs appropriate diagnoses, patient care, and treatments is fundamental to rare disease patients' health and well-being.

For the more than 30 million Americans living with one of the more than 10,000 rare diseases,[2] living with unanswered questions has long played an outsized role in their diagnostic odyssey. Genetic testing plays a crucial role in shortening a patient's diagnostic journey by identifying individuals at risk of developing certain diseases and, as a result, decreasing financial and other burdens on families and the health care system. These include tests such as Whole Genome Sequencing (WGS), which is a comprehensive test determining the entire DNA sequence, or Whole Exome Sequencing (WES), which analyzes the protein-coding regions of a person's DNA.[3] The appropriate test depends on the individual's

[1] Utah's Medicaid Reform 1115 Demonstration (2027-2032). Can be found: REVISED_Utah's Medicaid Reform 1115 Demonstration, 2027-2032 Renewal.pdf and Utah's Medicaid Reform 1115 Demonstration Renewal 2027-2032 - Medicaid - Utah DHHS
[2] Gürkan, H., & Satkın, N. B. (2025). The importance of genetic diagnosis in rare diseases. *Balkan Medical Journal*, *42*(2), 92–93. https://doi.org/10.4274/balkanmedj.galenos.2025.2025-270125
[3] NHS England (2026). Different approaches to gene sequencing. Can be found at: https://www.genomicseducation.hee.nhs.uk/genotes/knowledge-hub/different-approaches-to-gene-sequencing/

medical history as determined by their care provider and rather than insurance coverage. Utah should continue to cover these services for enrollees as determined necessary by a health care provider.

Work Requirements

The proposed demonstration waiver requests the authority to implement Community Engagement (CE) work requirements for the Adult Expansion Demonstration and to implement 6 month verification requirements. While the EveryLife Foundation appreciates some of the improvements Utah considered in its community engagement waiver request (such as exempting individuals over age 60), Public Law 119-21 does not permit waivers of the minimum requirements it sets out for work reporting requirements, and the Centers for Medicare and Medicaid (CMS) lacks legal authority to approve 1115 demonstrations that do not comply with minimum Public Law 119-21 standards. The state should withdraw its request and instead devote resources to ensuring proper implementation of Public Law 119-21 standards.

Implementing Community Engagement Requirements is an administratively complex process that will have a significant impact on Medicaid enrollment. While H.R. 1 (One Big Beautiful Bill) mandated community engagement requirements, states still have discretion on implementation and can take action to ensure that people with rare diseases maintain their access to care. There are several key principles Utah should consider during the process of implementation to ensure policies and processes consider the unique needs of the rare disease community.

Enrollment Verification

We are supportive of the fact that Utah's proposal remains aligned with Federal law by conducting enrollment verification every six months, preventing patients from the additional administrative burden and unnecessary costs that unnecessary checks create for enrollees. Research shows that confusion around reporting requirements was a key reason why many individuals in Arkansas lost coverage despite being eligible. Over 18,000 beneficiaries lost coverage within seven months when Arkansas implemented a work reporting requirement in 2017.[4] Rare disease patients already face a higher burden of administrative challenges in health care access, from the lack of treatment options and specialists, the high cost of treatment, and issues with insurance coverage and prior authorization. Any additional paperwork or administrative requirements will significantly impact rare families and patients.

Medical Fragility and Special Medical Needs

[4] Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, "A Look at November State Data for Medicaid Work Requirements in Arkansas," Kaiser Family Foundation, December 18, 2018. Available at: https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/ ; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018.

Definitions for disability-based exemptions or chronic condition-based exemptions should consider the unique challenges of people with rare diseases, including those with chronic rare diseases and those with episodic or progressive diseases. For this population, clear exemption criteria and accessible appeals processes are essential. CMS is required to release additional guidance defining "special medical needs" and "medically frail" by June 1st, a determination that will significantly affect eligibility for exemptions.

States are expected to have leeway in determining which conditions qualify. For example, the first state to implement these requirements, Nebraska, has elected to the list of eligible conditions to diagnosis codes. For states who adopt this approach, limited coverage under ICD-10-CM could leave rare disease patients who are unable to comply with community engagement requirements without health coverage or, at best, require them to navigate a burdensome, ill-defined bureaucratic process.

Many patients with rare diseases and their families may struggle to provide additional administrative information due to barriers accessing a timely diagnosis or receiving care from a clinician with knowledge about their condition. On average, it takes more than 6 years and nearly 17[5] This extensive diagnostic journey may make it difficult to get an exemption.

Caregiving Exemptions

H.R.1 requires states to provide exemptions for parents, guardians, and caretakers of children under the age of 13 and disabled individuals. To strengthen these exemptions states should explicitly include family members like siblings and grandparents, foster parents, kinship caregivers, or close family friends who support a patient's ability to secure health care as recognized caregivers. In this instance, broader and more explicit exemptions than federal requirements will help clarify who qualifies as a caregiver and improve enrollment verification for families.

While many rare caregivers are providing care to a child under the age of 18 (62%), the average age of the care recipient, the person who had a rare disease, condition, or illness, is 20.9 years old. Importantly, most rare caregivers have been providing care for a significant period, 8.9 years, and caregivers of adults spend an average of 37 hours a week providing care – about 12 more hours a week than general caregivers.[6] Due to the importance of caregiving and the broader implications for the long-term care system if unpaid caregivers are forced to return to work, we encourage states to strongly prioritize exemptions that will protect caregivers, patients, and families.

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[5] EveryLife Foundation for Rare Diseases. (2023, October 31). *Delayed Diagnosis Study - EveryLife Foundation for Rare Diseases*. https://everylifefoundation.org/delayed-diagnosis-study/

[6] National Alliance of Caregiving (2018). Rare disease caregiving in America. Can be found at: NAC-RareDiseaseReport_February-2018_WEB.pdf

Ensuring an Effective Audit and Appeals Process

Utah should proactively set up an effective audit and appeals process that presumptively covers patients who are denied Medicaid coverage during the entire appeals process. H.R. 1 requires that states notify individuals if they are unable to verify any issues with compliance, and that individuals will have 30 days afterward to verify compliance.[7] Since research shows that many disenrollments come from administrative issues, not due to ineligibility, a strong audit and appeals process is crucial for keeping people insured. Implementing a strong system for verifying eligibility during this period will allow for less coverage churn, estimated to be between $400 and $600 per person, which will cost the system additional dollars.[8]

Rare Representation

Patients, their families, caregivers, and the advocacy organizations that support them should be represented in designing and testing the new verification policies and processes, including the criteria for exemptions, the accessibility and design of the online enrollment system, community outreach plans, and educational content to ensure they account for the needs of the rare disease community.

Medicaid is an essential, life-saving program for many in the rare disease community, and the EveryLife Foundation for Rare Diseases remains committed to ensuring that patients can access the care they need. Thank you for your consideration of these policy recommendations to support the rare disease community.

[redacted]

[7] Hinton, E., Diana, A., & Rudowitz, R. (2026, January 30). *A closer look at the work requirement provisions in the 2025 Federal Budget Reconciliation Law*. KFF. https://www.kff.org/medicaid/a-closer-look-at-the-work-requirement-provisions-in-the-2025-federal-budget-reconciliation-law/

[8] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

May 21, 2026

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

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Director Ewing:

On behalf of the nearly 575 people with cystic fibrosis (CF) living in Utah, the Cystic Fibrosis Foundation writes to express our strong opposition to Utah's Medicaid Reform 1115 Demonstration Extension Request, which directs the state to implement work and community engagement requirements under the Medicaid Expansion Program. While Public Law 119-21 (PL 119-21) requires the state to pursue these requirements, the 1115 Demonstration Extension Request goes beyond federal mandates in ways that increase administrative burden and could create coverage gaps for patients, including those with CF. The CF Foundation opposes this legislation and urges Utah to refrain from moving ahead with this proposal.

About Cystic Fibrosis and the Cystic Fibrosis Foundation
Cystic fibrosis is a progressive, genetic disease that affects the lungs, pancreas, and other organs. There are close to 40,000 children and adults living with cystic fibrosis in the United States, and CF can affect people of every racial and ethnic group. CF causes the body to produce thick, sticky mucus that clogs the lungs and digestive system, which can lead to life-threatening infections. As a complex, multi-system condition, CF requires targeted, specialized treatment and medications.

Consistent care and specialized therapies are essential for people with CF, and any interruptions in coverage—even for a short period— may put people with CF at risk of declining health by forcing them to forgo daily therapies due to cost.[1] A 2024 study by the Cystic Fibrosis Foundation and the Dartmouth Institute found that even with health care coverage, more than one-third of people with CF delayed or went without at least one aspect of their CF care in the last year due to cost concerns—such as skipping medication doses, taking less medicine than prescribed, delaying prescription fills, or skipping a treatment altogether.[2] Because CF is a progressive disease, patients who delay or forgo treatment face an increased risk of lung exacerbations, irreversible organ damage, and costly hospitalizations.[3]

[1] Sugar, S., Peters, C., De Lew, N., & Sommers, B. D. (2021). Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. *US Department of Health & Human Services.* https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf
[2] Van Citters, A. D., Carey, K., Ren, C. L., Phan, H., Beidler, L., King, J. R., ... & Dieni, O. (2025). Financial and healthcare tradeoffs associated with cystic fibrosis care in the United States: A cross-sectional study. *Journal of Cystic Fibrosis*. https://doi.org/10.1016/j.jcf.2025.12.021
[3] Trimble, A. T., & Donaldson, S. H. (2018). Ivacaftor withdrawal syndrome in cystic fibrosis patients with the G551D mutation. *Journal of Cystic Fibrosis*, *17*(2), e13-e16. https://doi.org/10.1016/j.jcf.2017.09.006

As the world's leader in the search for a cure for CF and an organization dedicated to ensuring access to high quality, specialized CF care, the Cystic Fibrosis Foundation accredits more than 130 care centers nationally—including two in Utah—that provide multidisciplinary, specialized care in accordance with clinical practice guidelines. As experts in CF care, the CF Foundation and our care centers understand the critical role of adequate, affordable health coverage, including through Medicaid. In Utah, nearly one fifth of children and of adults living with CF rely on Medicaid for some or all of their health care coverage.

Work and Community Engagement Reporting Requirements

While we acknowledge that Utah is required to implement work and community engagement reporting requirements under PL 119-21, and that the standards in PL 119-21 cannot be waived, Utah has the opportunity and obligation to be cautious in its implementation.

Historical Evidence Demonstrates High Risk of Coverage Loss

Work reporting requirements have historically led to significant coverage losses, largely because enrollees misunderstand how to comply with the new requirements.[4] Current estimates indicate that approximately 5.2 million people could lose Medicaid coverage as a result of these new requirements, including 48,000 Utahns. [5,6] When Arkansas implemented similar reporting requirements, the state terminated coverage for over 18,000 individuals.[7,8,9] Similarly, Georgia's Pathways to Coverage Program enrolled fewer than 5,000 individuals in its first year—far below the projected 31,000-100,000 beneficiaries eligible.[10]

Administrative Complexity, Coverage Churn, and Excessive State Costs

Work reporting requirements are administratively complex and burdensome. Coverage churn in Medicaid is already common; roughly one in ten Medicaid enrollees experience a short-term gap in coverage, typically due to temporary income changes or administrative barriers rather than true ineligibility.[11] Improper changes to coverage status are likely to lead to increased churn, the cost of which is estimated to be between $400 and $600 per person,[12] placing greater administrative and financial burden on the Utah Medicaid program. Inappropriate loss of coverage also creates gaps in care for patients and disrupts access to critical and often lifesaving services.

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[4] Sommers, B. D., Goldman, A. L., Blendon, R. J., Orav, E. J., & Epstein, A. M. (2019). Medicaid work requirements—results from the first year in Arkansas. *New England Journal of Medicine*, *381*(11), 1073-1082. https://doi.org/10.1056/NEJMsr1901772

[5] Congressional Budget Office. (2025). Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[6] Burns, A., Ortaliza, J., Lo, J., Rae, M., & Cox, C. (2025). How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State? Allocating CBO's Estimates of Additional Uninsured People Across the States. *KFF.* https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/

[7] Rudowitz, R., Musumeci, M., & Hall, C. (2018). A Look at November State Data for Medicaid Work Requirements in Arkansas. *KFF*. https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/

[8] Arkansas Department of Health and Human Services. (2018). Arkansas Works Program. http://d31hzlhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

[9] Chan, L. (2024). One-Year Anniversary of Georgia's Pathways to Coverage Program Highlights Need for Reform. *Georgia Budget and Policy Institute*. https://gbpi.org/one-year-anniversary-of-georgias-pathways-to-coverage-program-highlights-need-for-reform/

[10] Chan, Leah. "One-Year Anniversary of Georgia's Pathways to Coverage Program Highlights Need for Reform," Georgia Budget and Policy Institute. July 2, 2024. Available at: https://gbpi.org/one-year-anniversary-of-georgias-pathways-to-coverage-program-highlights-need-for-reform/

[11] Corallo, B., Garfield, R., Tolbert, J., & Rudowitz, R. (2021). Medicaid Enrollment Churn and Implications for Continuous Coverage Policies. *KFF*. https://www.kff.org/medicaid/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/

[12] Swartz, K., Short, P. F., Graefe, D. R., & Uberoi, N. (2015). Reducing Medicaid churning: extending eligibility for twelve months or to end of calendar year is most effective. *Health Affairs*, *34*(7), 1180-1187. https://doi.org/10.1377/hlthaff.2014.1204

Need for Broad and Clear Exemptions for Medically Frail Individuals

Chronic conditions like cystic fibrosis can limit an individual's ability to work; declines in health status due to pulmonary exacerbations, infections, and other events are common and can take a person with CF out of the workforce for periods of time. Importantly, PL 119-21 requires states to exempt "medically frail" individuals from work and community engagement requirements, which must include people with CF given the disease's progressive nature and complex care needs. However, the 1115 demonstration adopts an extremely vague definition of "medically frail," exempting those who are "physically or mentally unable to meet the requirements". This fails to account for complex chronic conditions like cystic fibrosis that can impact an individual's ability to maintain employment. Under the restrictive definition proposed in this legislation, such individuals would not qualify for a medical frailty exemption and would lose coverage as a result—at grave risk to their health and well-being. Importantly, clinical experts from more than 40 state Medicaid agencies have emphasized that medical frailty determinations should be based on clinical risk, rather than the ability to work.[13] We ask that Utah adopt a more expansive definition of medical frailty that will capture all enrollees with serious health conditions that limit their ability to work.

Identification and Reverification of Exemptions

The 1115 demonstration provides insufficient detail on who would qualify for a medical frailty exemption and the process for obtaining and reverifying the exemption. Utah should take this opportunity to clearly define medically frail in a way that includes all people with CF. Because CF is a lifelong condition, with no cure and no change in diagnosis over time, coverage policies must also reflect the chronic nature of this disease.

Utah should use all available data sources—particularly medical claims data—to proactively identify eligible individuals and automatically apply and reverify exemptions where possible. If the state chooses to require providers to verify medical frailty for exemptions, it should ensure that a broad range of qualified providers—including, but not limited to, physicians, nurses, and social workers—are permitted to attest to a patient's status using multiple modalities like email, mail, or fax. Overall, the exemption process should be flexible, streamlined, and designed to avoid placing undue administrative burden on providers and patients. Utah should also provide clear, timely, and accessible notice to individuals regarding medical frailty exemption status, including approvals, renewals, and denials. Notices should explain exemption status, duration, and appeal rights in plain language so individuals can easily track and maintain their exemption status.

It is also critical that Utah design a system that incorporates the option for individuals to self-attest they qualify for an exemption, as there will always be people who are not properly identified through external data sources. Without self-attestation, individuals must rely on state and federal data systems—which often lack real-time accuracy—or submit extensive documentation to prove their exemption. The option to self-attest is particularly important for medically frail individuals, who often face time-sensitive health needs and cannot afford delays in coverage. Removing this option increases the risk of disenrollment for otherwise eligible individuals and undermines the goal of maintaining continuous access to care. As such, it is critical that enrollees can self-attest as to whether they are capable of working so that vulnerable populations are not erroneously disenrolled from coverage.

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[13] Chen, C., Filice, C. E., & White, J. (2026, May). Implementing Medical Frailty Exemptions Under HR 1: Clinical Considerations From Medicaid Medical Directors. In JAMA Health Forum (Vol. 7, No. 5.11, pp. e261808-e261808). American Medical Association.

Additionally, individuals with CF should be eligible to receive long-term-ideally lifelong-exemptions, as CF is a genetic condition. Requiring people with CF to repeatedly verify an unchanging diagnosis creates unnecessary administrative burdens for both individuals and the state. Providing a lifelong or very long-term exemption would not only improve stability and health outcomes for people with CF, but would also save state resources by avoiding the expense of repeatedly reviewing and confirming a condition that will never change.

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While community engagement requirements are mandated by PL 119-21, states retain discretion and responsibility to protect eligible individuals from losing coverage. Utah's Medicaid Reform 1115 Demonstration Extension Request does not advance Medicaid's goals and jeopardizes access to care for Utahns with chronic conditions like cystic fibrosis who rely on stable Medicaid coverage to stay healthy. As Utah moves forward with implementing PL 119-21, we recommend using all available levers to ensure that eligible individuals can maintain coverage without undue burden.

The Cystic Fibrosis Foundation appreciates the opportunity to provide comments on Utah's Medicaid Reform 1115 Demonstration Extension Request. If you have any questions about cystic fibrosis or would like to discuss the importance of affordable and accessible Medicaid coverage in Utah, please contact [redacted]. We appreciate your attention to this important matter.

[redacted]

LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

May 21, 2026

Utah Department of Health and Human Services
Division of Integrated Healthcare
PO Box 143106
Salt Lake City, UT 84114
Attn: Laura Belgique

Re: Utah's Medicaid Reform 1115 Demonstration Extension Request

Dear Ms. Belgique:

Legal Action Center (LAC) appreciates the opportunity to submit comments on Utah's Medicaid Reform 1115 Demonstration Extension Request. LAC seeks to ensure that people with arrest and conviction records, people with substance use disorders (SUDs), and people with HIV/AIDs have equitable access to health care, particularly to Medicaid coverage that adequately addresses their unique health needs. Mental health (MH) is also central to LAC's efforts, as MH conditions often co-occur in the populations LAC serves. We believe that all justice-involved people and individuals with SUDs—including those with co-occurring MH conditions—deserve accessible, affordable, and comprehensive health care, which is essential for successfully managing their needs and wellbeing.

LAC is committed to ensuring that Utah's Medicaid program provides quality and affordable healthcare coverage. While some of the proposals in the waiver would improve coverage for the populations we serve, there are other policies that would restrict access to coverage for these populations. LAC offers the following comments on Utah's Medicaid Reform 1115 Demonstration Extension Request:

Adult Expansion

LAC supports the state's efforts to continue to provide coverage to adults up to 138% of federal poverty level (FPL). Medicaid expansion in Utah provides vital coverage for individuals with SUD, MH conditions, and justice-involvement. Individuals now have access to a wide range of services including life-saving medications to treat SUD and MH conditions. Medicaid helps cover access to comprehensive SUD treatment, especially in underserved areas that have been heavily affected by the opioid overdose epidemic.[1] Early intervention through Medicaid expansion can save the lives of people living with SUDs and MH conditions, as well as reduce the costs to the health care system, through required screenings for substance use and MH conditions.

LAC encourages Utah to continue the Targeted Adult Medicaid (TAM) program that provides one year of continuous eligibility (CE) to adults age 19-64 at zero percent FPL with no dependent children who are chronically homeless, involved in the criminal justice system, or in need of substance use or mental health treatment. Research has shown that individuals with disruptions in coverage during a year are

[1] https://healthlaw.org/resource/why-medicaid-is-important-for-treating-substance-use-disorders/

more likely to delay care, receive less preventive care, refill prescriptions less often, and have more emergency department visits.

Like expansion, TAM helps individuals with SUDs, MH conditions, and justice-involvement to receive timely medical care that would lead to long-term stability. Through the Housing Related Services and Supports (HRSS) waiver, individuals in the TAM program can get help with tenancy support, community transition, and supportive living services that can help justice-involved individuals to find proper housing after reentry.[2] TAM also helps provide intensive case management pre-release, which allows justice-involved individuals to transition successfully into the workforce.

If CMS does not approve continuation of this program, Utah should prioritize a seamless coverage transition as individuals in the TAM program become expansion enrollees on July 1, 2027 and subject to work reporting requirements and biannual redeterminations. Because TAM participants include individuals with substance use disorder or recent incarceration who should qualify for exemptions from the work reporting requirements, Utah should proactively leverage existing data to identify and apply these exemptions to minimize the risk of inappropriate coverage losses.

Re-Entry Medicaid Services for Justice Involved Individuals

LAC strongly supports Utah's proposal to continue to provide a targeted set of Medicaid services for justice-involved populations who are otherwise eligible for Medicaid for up to 90 days prior to release. This is consistent with both the goals of Medicaid and CMS guidance and will be an important step in improving the continuity of care of individuals leaving incarceration. Preventing overdose and strengthening access to opioid and other substance use disorder medications and services at reentry are central goals of this CMS initiative and directly align with Utah's continued overdose prevention and response work. Following federal approval of Utah's initial reentry waiver in July 2024, the state undertook significant planning and implementation work to ensure continuous coverage and provision of services including pre-release case management services, medication-assisted treatment (MAT) with counseling, and a 30-day supply of prescription medications upon release. Last year, in support of this work, Utah was also awarded a four-year CMS grant to help develop capacity to promote continuity of care for incarcerated individuals eligible for CHIP or Medicaid. These initiatives to improve health and justice outcomes are consistent with CMS guidance and help high-risk populations, including those with opioid and other substance use disorders, access critical medications, services, and supports needed to proactively identify and treat physical and behavioral health conditions. Medicaid provides continuous access to health care, bridging the gap between the carceral system and community care[3].

LAC commends Utah's efforts to enhance cross-system collaboration between carceral settings and community-based services and ensure continuing of care for the those leaving incarceration. This plan would help increase coverage, ensure access to the minimum set of pre-release services for individuals who are incarcerated, improve care transitions upon return to the community, promote continuity of care, and connect members to post-release services. By providing incarcerated individuals the tools necessary to help them succeed post-release, Utah is helping set people up for success by making sure that there is no coverage gap. This helps reduce rates of recidivism and has many long-term benefits.

[2] https://medicaid.utah.gov/hrss/Medicaid - Utah DHHS
[3] https://medicaid.utah.gov/programs-and-services/justiceinvolved/

Utah is a national leader in reentry policy. A renewal of Utah's reentry waiver provisions will allow the state to build upon the strong foundation it has established and to help reentering people, their families, and their communities become healthier, safer, and stronger.

Work Reporting Requirements

Work reporting requirements do not help low-income individuals find meaningful work. Most people on Medicaid who can work already do so. According to KFF, more than 90% of adults with Medicaid coverage that do not have SSI or SSDI are either full or part-time workers, caregivers, students, or unable to work due to illness.[4] And continuous Medicaid coverage can actually help people find and sustain employment. In a report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that being enrolled in Medicaid made it easier to work or look for work (83.5% and 60%, respectively).[5] That report also found that many enrollees were able to get treatment for previously untreated health conditions, which made finding work easier. Additionally, a study in *The New England Journal of Medicine* found that Arkansas's work reporting requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[6]

LAC urges Utah to implement the work reporting requirements in Public Law 119-21 in a way that minimizes coverage losses, particularly for vulnerable populations including people with SUD and justice impacted individuals.

Reduced Benefits

LAC opposes the state's proposal to limit retroactive eligibility to the first day of the month in which an individual applies for Medicaid for some Medicaid eligibility groups, including demonstration groups with moderate incomes. Currently, retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to three months prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. Individuals are often unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not understand or receive a notice of Medicaid renewal and only discover the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[7] Medicaid enrollees who face substantial costs at their doctor's office or pharmacy could end up delaying their treatment because of these costs. For people with SUDs, MH conditions, and justice-involvement, timely healthcare is critical

[4] https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/
[5] https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Reports/Annual/Group-VIII-Final-Report.pdf
[6] https://www.nejm.org/doi/pdf/10.1056/NEJMsr1901772
[7] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/ByTopics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

to adequately supporting their needs. Medications for individuals with SUDs are often lifesaving and can help sustain recovery and prevent or reduce opioid overdose.[8]

Conclusion

We encourage Utah to continue the Adult Expansion program, the TAM program and the re-entry Medicaid services for the justice involved population. We urge the state to withdraw its request related to retroactive eligibility from the waiver prior to submitting the request to CMS.

Thank you for the opportunity to provide these comments on this important issue. Please don't hesitate to reach out if you have any questions or would like to discuss these comments further.

Sincerely,

[redacted]

[8] https://www.samhsa.gov/substance-use/treatment/options

May 1, 2026

Julie Ewing, JD
Director
Utah Medicaid
Department of Health & Human Services
195 North 1950 West
Salt Lake City, Utah 84116

Re: People with HIV and Implementation of Medicaid Work Requirements

Dear Director Ewing:

ViiV Healthcare Company (ViiV) appreciates the opportunity to share comments regarding the renewal application for Utah's Medicaid Reform 1115 Demonstration, which includes a request that CMS consider and approve its pending Community Engagement Amendment on which we commented last year.[1] We continue to stand with the community of HIV advocates in urging Utah to ensure that people with HIV are included within the community engagement exemption category for "serious or complex medical conditions." We continue to urge the state to make its exemptions automatic and *ex parte*, whenever possible.

Recommendation: Clarify that people with HIV are exempted from the work requirements as having a "serious or complex medical condition"

ViiV encourages Utah to ensure that people with HIV enrolled in the adult Medicaid expansion group are classified as having a "serious or complex medical condition," which would exempt them from the forthcoming work requirements per H.R.1 – The One Big Beautiful Bill Act (2025).[2] People with HIV fall squarely within this category per the definition of "serious and complex medical condition[s]" provided in the bipartisan No Surprises Act (2021):[3,4]

> ***(2) Serious and complex condition***
>
> *The term "serious and complex condition" means, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage-*
>
> *(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or*
>
> *(B) in the case of a chronic illness or condition, a condition that is-* [1]
>
> *(i) is life-threatening, degenerative, potentially disabling, or congenital; and*
>
> *(ii) requires specialized medical care over a prolonged period of time.*

Within this definition, people with HIV fall squarely within paragraph (B), given that HIV is a chronic condition that is life-threatening, degenerative, potentially disabling, and requires specialized medical care over an entire lifetime.

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1 Utah Department of Health & Human Services. Utah's Medicaid Reform 1115 Demonstration Amendment Request: Community Engagement. July 3, 2025. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-medicaid-reform-pa-comm-engagement.pdf. Accessed April 29, 2026.

2 One Big Beautiful Bill Act P.L. 119-21. July 4, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1/text.

3 The Public Health and Welfare, Title 42 U.S.C. §300gg–113(b)(2). 2025. https://uscode.house.gov/view.xhtml?req=(title:42%20section:300gg-113%20edition:prelim)%20OR%20(granuleid:USC-prelim-title42-section300gg-113)&f=treesort&edition=prelim&num=0&jumpTo=true. Accessed April 28, 2026.

4 Consolidated Appropriations Act, 2021 P.L. 116-260. December 27, 2020. https://www.congress.gov/bill/116th-congress/house-bill/133.

Indeed, the US Department of Health and Human Services, the US Department of Justice, and some states have categorized people with HIV as having a "serious chronic medical condition," as being protected by the Americans with Disabilities Act, or as medically frail.[5,6,7,8]

Classifying people with HIV as having a serious or complex medical condition is essential to prevent coverage disruptions and to ensure continuity of care and access to antiretrovirals, which can improve adherence and reduce HIV transmission. If people with HIV are not classified in this category, they risk losing their health coverage, which would make managing their condition more challenging and, as a result, could hinder their ability to work or participate in their communities to regain coverage.

Recommendation: Create an automatic *ex parte* exemption process for people with HIV

We urge Utah to establish processes for making work requirement exemptions for people with HIV automatic and *ex parte*, whenever possible, as required by H.R.1[9]—and when not possible, to allow for self-attestation or provider attestation from a wide-range of providers.

As a recent example, Nebraska just published its list of ICD-10 codes that will be used to identify people who will be exempt from work requirements and included HIV.[10] Similarly, in 2018, the state of Michigan submitted a Medicaid demonstration waiver that exempted medically frail individuals—including people with HIV—through claims analysis codes specific to HIV.[11] Arizona has proposed the same.[12] We recommend Utah follow a similar process by creating an automatic exemption using data matching or a retrospective claims data analysis of diagnosis and utilization codes analysis. This process would allow most people with HIV to be efficiently exempted and would reduce unnecessary redisclosures of serostatus. For example, some diagnosis codes that could be used to identify people with HIV include:

B20	Human immunodeficiency virus [HIV] disease	ICD10CM
B97.35	Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere	ICD10CM

---

5 Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment. 78 F.R. 42233. July 15, 2013. https://www.govinfo.gov/content/pkg/FR-2013-07-15/pdf/2013-16271.pdf. Accessed April 28, 2026.

6 U.S. Department of Justice Civil Rights Division. Questions and Answers: The Americans with Disabilities Act And the Rights of Persons with HIV/AIDS To Obtain Occupational Training and State Licensing. (n.d.) https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/specialtopics/hiv/factsheethivlincense.pdf. Accessed April 28, 2026.

7 Kentucky Health. Kentucky Medically Frail Medical Condition Guide v5 for Providers. June 2018. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjn0t--54uSAxXjw_ACHQeeGHkQFnoECB0QAQ&url=https%3A%2F%2Fwww.wellcareky.com%2Fcontent%2Fdam%2Fcentene%2Fwellcare%2Fky%2Fpdfs%2Fprovider%2FKY_CAID_PROV_Medically_Frail_Provider_Attestation_Form_ENG_6_2018_R.pdf&usg=AOvVaw32OtU1cAoePKQx0tRi6vt_&opi=89978449. Accessed April 28, 2026.

8 Indiana Family and Social Services Administration. Conditions that may qualify you as medically frail. https://www.in.gov/fssa/hip/am-i-eligible/conditions-that-may-qualify-you-as-medically-frail/. Accessed April 28, 2026.

9 One Big Beautiful Bill Act P.L. 119-21. July 4, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1/text.

10 Nebraska Department of Health and Human Services. Nebraska Medicaid Work Requirements Medically Frail Exemption Conditions Index. https://dhhs.ne.gov/Documents/Nebraska%20Medicaid%20Work%20Requirements%20-%20Medically%20Frail%20and%20SUD%20Conditions.pdf. Accessed April 24, 2026.

11 State of Michigan. Healthy Michigan Plan 1115 Demonstration Extension Application. Project No. 11-W-00245/5, AMENDED: September 10, 2018. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf. Accessed April 28, 2026.

12 Arizona Health Care Cost Containment System. AHCCCS Works Waiver Amendment Request. March 30, 2025. https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AHCCCSWorks_Final_Submission2025.pdf. Accessed April 28, 2026.

O98.711	Human immunodeficiency virus [HIV] disease complicating pregnancy, first trimester	ICD10CM
O98.712	Human immunodeficiency virus [HIV] disease complicating pregnancy, second trimester	ICD10CM
O98.713	Human immunodeficiency virus [HIV] disease complicating pregnancy, third trimester	ICD10CM
O98.719	Human immunodeficiency virus [HIV] disease complicating pregnancy, unspecified trimester	ICD10CM
O98.72	Human immunodeficiency virus [HIV] disease complicating childbirth	ICD10CM
O98.73	Human immunodeficiency virus [HIV] disease complicating the puerperium	ICD10CM
V08	Asymptomatic human immunodeficiency virus [HIV] infection status	ICD9CM
Z21	Asymptomatic human immunodeficiency virus [HIV] infection status	ICD10CM

To fulfill the requirements of H.R.1, the state should use *ex parte* verification whenever possible. If data-matching is not possible, however, we recommend the state verify an individual's status through self-attestation, prioritizing the least burdensome processes with the fewest steps, parties, and necessary documentation as possible. This could take the form of a simple application question or self-affidavit. If the state requires provider attestation, it should certify a wide array of providers, including nurses, pharmacists, social workers, community health workers, and other healthcare professionals.

Medicaid and people with HIV

Medicaid plays a critical role in HIV care as the largest source of coverage for people with HIV.[13] ViiV encourages the state of Utah to ensure that people with HIV who are Medicaid beneficiaries have continuous access to comprehensive health care, including antiretroviral therapy (ART). Research on a prior state work requirement programs has found that many individuals who were qualified lost their coverage due to the confusion or burden associated with the reporting requirements.[14] We are concerned that without a clear and automatic exemption from work requirements, people with HIV could have their treatment disrupted, threatening their health and creating a public health risk for the people of Utah.

[13] Kaiser Family Foundation. Medicaid and HIV, http://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/. Accessed April 28, 2026.
[14] Sommers BD, Goldman AL, Blendon RJ, et al. Medicaid Work Requirements — Results from the First Year in Arkansas. N Engl J Med. 2019 Sep 12;381(11):1073-1082. Accessible at https://pubmed.ncbi.nlm.nih.gov/31216419/.

For people with HIV, retention in medical care and adherence to treatment are critical. Individuals with HIV require regular medical care, consistent access to antiretroviral medications, and comprehensive support services to effectively manage their condition. Effective HIV treatment can help people with HIV live longer, healthier lives and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.[15,16] Effective HIV treatment can also prevent transmission of the disease.[17] People who are virally suppressed (with an undetectable viral load) cannot transmit HIV to others through sexual contact, a concept known as "undetectable = untransmissible," or U=U.[18]

People living with HIV who are not retained in medical care, however, may transmit the virus to more than 5 additional individuals per 100 person-years.[19] Each person with HIV is estimated to cost the US health care system $2.9 million over a lifetime.[20] An analysis of US investment in HIV treatment from 1987 to 2023 found that the public sector gained $4.30 for every $1 it spent on HIV treatment, with the rate of return peaking at $7.60 in the most recent years due to treatment innovation.[21]

Conclusion

ViiV Healthcare Company (ViiV) urges Utah to ensure that people with HIV are included within the exemption category for "serious or complex medical conditions." We further urge the state to make its exemptions automatic and *ex parte*, whenever possible. Doing so will help prevent disruptions to care and treatment, maintain health outcomes, and prevent new HIV transmissions.

Thank you for your consideration of our comments. Please feel free to contact me with any questions at [redacted]om.

[redacted]

[redacted] Severe P, Juste MA, Ambroise A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. N Engl J Med. Jul 15 2010;363(3):257-265. Accessible at: https://pubmed.ncbi.nlm.nih.gov/20647201/.

[16] Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. N Engl J Med. Apr 30 2009;360(18):1815-1826. Accessible at: https://pubmed.ncbi.nlm.nih.gov/19339714/.

[17] Rodger AJ, Cambiano V, Bruun T, et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. Lancet. 2019 Jun 15;393(10189):2428-2438. Accessible at: https://pubmed.ncbi.nlm.nih.gov/31056293/.

[18] National Institutes of Health. HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention. May 21, 2019. https://www.niaid.nih.gov/diseases-conditions/treatment-prevention. Accessed April 28, 2026.

[19] Skarbinski J, Rosenberg E, Paz-Bailey G, et al. Human immunodeficiency virus transmission at each step of the care continuum in the United States. JAMA Intern Med. 2015;175(4):588-596. Accessible at https://pubmed.ncbi.nlm.nih.gov/25706928/

[20] Cohen JP, Anupindi VR, Doshi R, et al. Estimation of Lifetime Costs Among Insured Persons with HIV in the United States. Pharmacoecon Open. 2025 Nov;9(6):869-886. Accessible at https://pubmed.ncbi.nlm.nih.gov/40490607/

[21] Paquete AT, Mordi U, Jarrett J, et al. Evaluating the Fiscal Impact of Antiretroviral Therapy for the Management of HIV in the United States 1987-2023. Clinicoecon Outcomes Res. 2025 May 28:17:407-418. Accessible at https://pubmed.ncbi.nlm.nih.gov/40453870/

About ViiV: ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in HIV treatment and prevention to support the needs of people with HIV and those who may benefit from prevention. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this chronic and preventable disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

May 4, 2026

Utah Department of Health and Human Services
Attn: Medicaid Policy & Waiver Team

Re: Support for Continued Targeted Adult Medicaid (TAM) with 6-Month Continuous Eligibility in Utah's 1115 Waiver Demonstration

Dear Director and Medicaid Policy Team,

On behalf of the Weber-Morgan Criminal Justice Coordinating Council (CJCC), we write to express our strong support for the continuation of Targeted Adult Medicaid (TAM) under Utah's Section 1115 demonstration waiver, with a revised 6-month continuous eligibility period to align with federal guidance.

The CJCC represents a cross-system partnership of public safety agencies, behavioral health providers, local government, courts, and community-based organizations. Our shared strategic mission is to improve public safety outcomes through coordinated, evidence-based approaches that address the underlying drivers of justice system involvement.

Impact on Justice-Involved Populations

Within Weber and Morgan Counties, our CJCC partners have observed that when individuals maintain Medicaid coverage:

- Engagement in treatment is sustained
- Transitions from jail to community care are more successful
- Law enforcement and emergency systems experience fewer repeat contacts

Conversely, disruptions in coverage frequently result in:

- Treatment discontinuation
- Increased relapses and behavioral health crises
- Higher rates of reoffending and system cycling

These outcomes carry significant costs, not only to individuals and families, but to public safety systems, healthcare providers, and taxpayers. Local reentry initiatives aligned with TAM have demonstrated measurable reductions in recidivism and system utilization, reinforcing that coordinated access to care is not only clinically appropriate but fiscally responsible.

TAM as a Public Safety Strategy

TAM has proven to be one of Utah's most effective tools for supporting individuals with complex behavioral health needs, including those:

- Experiencing homelessness
- Living with serious mental illness or substance use disorders
- Transitioning from incarceration back into the community

From a public safety perspective, access to consistent healthcare coverage, particularly behavioral health and substance use treatment, directly reduces recidivism, improves compliance with court and probation conditions, and enhances community stability.

Support for 6-Month Continuous Eligibility

We understand that Centers for Medicare & Medicaid Services (CMS) has raised concerns regarding continuous eligibility parameters. We support a pragmatic and compliant path forward by adopting a 6-month continuous eligibility period, consistent with Congressional intent, while preserving the core function of TAM. Even a 6-month eligibility window provides critical stability during the highest-risk transition periods, particularly for individuals reentering the community from incarceration.

Request for State Action and Federal Engagement

We respectfully urge the Utah Department of Health and Human Services to:

1. Submit or amend Utah's 1115 waiver demonstration to include continuation of TAM with a 6-month continuous eligibility period
2. Engage directly with CMS to seek flexibility and approval for this approach
3. Advocate for Utah's demonstrated success in using TAM to improve public safety and reduce system costs

We recognize that state action is contingent upon signals of openness from CMS. As a CJCC representing front-line system partners, we offer our collective voice to support those federal conversations and emphasize the real-world impact of this policy.

In conclusion, discontinuing TAM would represent a significant step backward in Utah's efforts to address complex behavioral health needs within justice-involved populations. Maintaining this program, with appropriate adjustments, supports safer communities, more efficient use of public resources, and better outcomes for the individuals we collectively serve.

We appreciate your leadership and stand ready to support ongoing discussions with state and federal partners.

[redacted]

Weber-Morgan Criminal Justice Coordinating Council

[redacted]

2027-2032 Renewal

Attachment 7

Tribal Consultation

Utah Indian Health Advisory Board (UIHAB) Meeting

4/10/2026 8:30 AM –12:00 PM	Join via Google Meeting: https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
In person: 195 N 1950 W, Salt Lake City, UT 84116 - Multi Agency State Office Building Room 4009 - 4th floor	Join via Phone: 1-(414)-909-6377 PIN: 211 599 534

Time	Agenda Topic	Presenter
8:30 am	Welcome and Introductions and Roll Call	(Vacant), Chairperson
8:35 am	DHHS/DWS and Committee Updates	
	DHHS Medicaid Policy Update	Jim Stamos (DHHS)
	DHHS Medicaid Eligibility Update	Gina Boren (DHHS) Michelle Smith (DHHS)
	DWS Medicaid Eligibility Operations	Brooke Godzsak (DWS)
	SNAP	Frank Vega (DWS)
	MCAC Committee Next Mtg: 4/23-10:00-12:00	Matt Poss
	CHIP Advisory Committee Next Mtg: 4/16- 1:00	mountain
9:35 am	Utah's Medicaid Reform 1115 Demonstration Renewal Overview	Laura Belgique (DHHS)
9:50 am	PHEP spend down update	Andrea Skewes
10:00 am	Officer Nomination - UIHAB	UIHAB members
10:15 am	IHFS Updates	IHFS
10:45 am	UIHAB Priorities	IHFS

Time	Agenda Topic	Presenter
11:00 am	I/T/U Updates	I/T/U partners
11:30 pm	**Adjourn**	

Next UIHAB Meeting will be May 8, 2026

Hosted by: Utah Department of Health & Human Services

Location: 195 N 1950 W, Salt Lake City, UT 84116

Facilitated by: Utah Department of Health and Human Services Office of AI/AN Health & Family Services

Note Taker: Dorrie Reese (All meetings are recorded)

UIHAB Meeting

Apr 10, 2026 (Hybrid)
8:30 a.m. – 11:00 a.m.

Participants: (Hybrid)

Madeline Greymountain, *Confederated Tribes of the Goshute*
Edna Steele, *Confederated Tribes of the Goshute*
Hunter Timbimboo, *Northwestern Band of Shoshone Nation*
Michelle Morris, *Navajo Nation*
Shawn Begay, *Utah Navajo Health Systems*
Craig Sandoval (Vice-Chair), *Urban Indian Center of Salt Lake*
Matt Poss, *Urban Indian Center of Salt Lake*
Kay Ridley, *PHX, IHS*
Lucy Lansing, *PHX, IHS*
Maurice James, *Ute & Ouray, IHS*
Tyler Deines, *CMS*
Barbara Prehmus, *CMS*

Guests:

Brooke Godzsak, *AI/AN Eligibility Specialist, DWS*

Frank Vega, *AI/AN SNAP, DWS*

DHHS Staff:

Brian Roach, *Assistant Division Director, DHHS*
Jim Stamos, *Office Director, Office of Healthcare Policy & Authorizations, DHHS*
Gina Boren, *Assistant Office Director, Office of Eligibility Policy, DHHS*
Jeremy Taylor, *Tribal Health Liaison, Office of AI/AN Health Affairs, DHHS*
Alex Merrill, *EPI, Office of AI/AN Health Affairs, DHHS*
Hilary Makris, *Office of AI/AN Health Affairs, DHHS*
Kassie John, *Opioid & Tobacco Health Program Coordinator, Office of AI/AN Health Affairs, DHHS*
Dorrie Reese, *Recorder/Minutes, DIH Administrative Assistant, DHHS*

Welcome and Introductions:

The UIHAB Chairperson welcomed everyone starting the meeting at 8:30 a.m.

Approval of Minutes:

The Oct 11, 2019, Nov 15, 2019, Dec 13,2019, Jan 10, 2020, Mar 13,2020, Apr 10, 2020, May 8, 2020, Jun 12, 2020, Aug, 14, 2020, Sep 11, 2020, Oct 9, 2020, Nov 13, 2020, Dec 11, 2020, Jan, 21, 2021, , Feb 12, 2021, Mar 12, 2021, Apr 9, 2021, May 14, 2021, Jun 11, 2021, Aug 13, 2021, Sep 10, 2021, Oct 8, 2021, Nov 12, 2021, Dec 10, 2021, Jan 28, 2022, Mar 11, 2022, Apr 8, 2022, May 13, 2022, Jun 10, 2022, Aug 12, 2022, Sep 9, 2022, Oct 14, 2022, Nov 10, 2022, Dec 9, 2022, Jan 13, 2023, Feb 10, 2023, Mar 10, 2023, Apr 14, 2023, May 12, 2023, June 9, 2023, Aug 11, 2023, Sep 8, 2023, Oct 13, 2023, Nov 9, 2023, Dec 9, 2023, Jan 12, 2024, Mar 8, 2024, Apr 12, 2024, May 10, 2024, Jun 14, 2024, Aug 9, 2024, Sep 13, 2024, Oct 11, 2024, Nov 8, 2024, Dec 13, 2024, Jan 10, 2025, Mar 14, 2025, Apr 11, 2025, May 9, 2025, Jun 13, 2025, Aug 8, 2025, Sep 12, 2025, Oct 10, 2025, Nov 8, 2025, Dec 13, 2025, Jan 9, 2026, and Mar 13, 2026 UIHAB minutes will be approved at a later UIHAB meeting.

DRAFT

Medicaid Policy Update:

Jim Stamos gave an update.

UIHAB Meeting - Utah Medicaid Policy

Medicaid Eligibility Policy:

Gina Boren gave an update.

UIHAB - Eligibility Policy Updates.pdf

UIHAB_April - AI_AN Tribal Verification Dat

DWS Medicaid Eligibility/SNAP:

Brooke Godzsak gave an update on DWS Medicaid Eligibility.

Frank Vega gave an update on SNAP benefits (Flyers)

MAC & CHIP Advisory Committees:

Matt Poss gave an update from the March 26, 2026, MAC meeting. The next MAC meeting is scheduled for Apr 23, 2026, at 10:00 -12:00pm.
The next CHIPAC meeting is scheduled for April 16, 2026, at 1:00-1:55 pm

Utah's Medicaid Reform 1115 Demonstration Renewal Overview:

Laura Belgique gave an overview on the 1115 Demonstration Renewal. Public comments are accepted April 2026 through May 21, 2026.

Utah's Medicaid Reform1115 Demonst

Medicaid Reform 1115 Demonstration A

PHEP Spenddown Update:

Andrea Skewes gave an update

4.10.2026 UIHAB PHEP Updates.pdf

Officer Nomination:

Craig Sandoval made the motion to nominate Lorena Horse as Chair. The group unanimously agreed.

Craig Sandoval made the motion to nominate Shawn Begay as the Vice Chair. The group unanimously agreed.

IHFS Updates:

Alex Merrill:
Uheart | Measles Outbreak | Pilot project
https://www.uheart.org/

DRAFT

Kassie John
kassiejohn@utah.gov

2026 Substance Misuse Survey: Complete by Apr 20, 2026:
https://forms.gle/YMyesMSTvWqDGAvP9

IHFS Naloxone Training Form: https://forms.gle/HpWV8SkQv44L8NAP8

April 2026 - UIHAB Opioids and Tobacco

National Tribal Tobacco Conference
Jun 23-24, 2026
Minneapolis, MN
Reclaim Sacred Tobacco offering "Travel Scholarships"-Deadline-April 16, 2026
Travel Scholarship Application Link

RST Travel Scholarship and Appli

Funding opportunity for tribal smoke-free policies: **Proposals open March 26, 2026, and closes April 30, 2026**

- Direct funding to implement short-term goals outlined in smokefree tribal policy plan
- Up to five awards ranging from $10,000 to $30,000
- Selected applicants will participate in a structured two-day, in-person Smokefree Tribal Policy Guide training

Purpose of this funding Opportunity.p

Jamie Harvey

Actions - S.4179 - 119th Congress (2025

H.R.8048 - 119th Congress (2025-2026)

Take Action - NICWA for CAPTA.pdf

UIHAB Priorities:

Jeremy Taylor.
Hiliary Makris
hmakris@utah.gov

UIHAB Bylaws 2022 sig NC-Mar 2022.pdf

UIHAB Bylaws 2026-Redlined.pdf

ACTION: Please review the redlined version of the UIHAB Bylaws and provide your feedback prior to the next UIHAB meeting.

DRAFT

I/T/U Updates:

Shawn Begay: Utah Navajo health Systems
Craig Sandoval: Urban Indian Center of Salt Lake
Michelle Morrie: Navajo Nation
https://ndoh.navajo-nsn.gov/
Edna Steele | Madeline Greymountain: Confederate Tribe of Goshute Reservation

Wendover Groundbreaking invite

Adjourn:

The meeting ended at 11:04. Matt Poss made that motion to adjourn the meeting. Michelle Morris seconded that motion.

The next meeting: May 8, 2026 @ 8:30 a.m. (Hybrid)
Utah Department of Health & Human Services
195 N. 1950 W, SLC, UT 84116
Multi-State Agency Building (MASOB), Room 2082
(385) 227-2078

DRAFT

Utah Indian Health Advisory Board (UIHAB) Meeting

5/8/2026 8:30 AM –11:00 AM	Join via Google Meeting: https://meet.google.com/krh-kvdf-svj?hs=122&authuser=0
In person: 195 N 1950 W, Salt Lake City, UT 84116 - Multi Agency State Office Building Room 4009 - 4th floor	Join via Phone: 1-(414)-909-6377 PIN: 211 599 534

Time	Agenda Topic	Presenter
8:30 am	Welcome and Introductions and Roll Call	Lorena Horse, Chairperson
8:35 am	DHHS/DWS and Committee Updates	
	DHHS Medicaid and CHIP State Plan Amendments	Craig Devashrayee (DHHS)
	DHHS Medicaid Policy Update	Jim Stamos (DHHS)
	H.R. 1 (OBBBA) update	Michelle Smith (DHHS)
	DHHS Medicaid Eligibility Update	Gina Boren (DHHS) Michelle Smith (DHHS)
	DWS Medicaid Eligibility Operations	Brooke Godzsak (DWS)
	SNAP	Frank Vega (DWS)
	MCAC Committee	Matt Poss
	CHIP Advisory Committee	Rachel Greymountain
9:35 am	Utah's Medicaid Reform 1115 Demonstration Renewal Overview	Laura Belgique (DHHS)
9:45 am	IHFS Updates	IHFS
10:00 am	Tribal Liaison Updates	Jeremy Taylor (DHHS)
10:15 am	SNS - RSS Operation Course	Evan Crook (DHHS)

Time	Agenda Topic	Presenter
10:30 am	I/T/U Updates	I/T/U partners
11:00 am	**Adjourn**	

Next UIHAB Meeting will be June 12, 2026

Hosted by: Utah Department of Health & Human Services

Location: 195 N 1950 W, Salt Lake City, UT 84116

Facilitated by: Utah Department of Health and Human Services Office of AI/AN Health & Family Services

Note Taker: Dorrie Reese (All meetings are recorded)

UIHAB Meeting

May-8, 2026 (Hybrid)
8:30 a.m. – 10:00 a.m.

Participants: (In-Person)

Lorena Horse (Chair), *Confederated Tribes of the Goshute*
Josh Andrson, *Confederated Tribes of the Goshute*
Selwyn Whiteskunk, *Ute Mountain Ute Tribe*
Craig Sandoval, *Urban Indian Center of Salt Lake*
Sharon Austin, *Urban Indian Center of Salt Lake*

Participants: (Hybrid)

Rachel Greymountain, *Confederated Tribes of the Goshute*
Michelle Richards, *Northwestern Band of Shoshone Nation*
LaTosha Mayo, *Paiute Indian Tribe of Utah*
Tiarrah Sims, *Paiute Indian Tribe of Utah*
Tyler Goddard, *Paiute Indian Tribe of Utah*
Angie Searle, *Paiute Indian Tribe of Utah*
Shawn Begay (Vice-Chair), *Utah Navajo Health Systems*
Matt Poss, *Urban Indian Center of Salt Lake*
Tracie Tso, *Utah Division of Indian Affairs*
Tyler Deines, *CMS*

Clarissa ??
Lucy Lansing – Ute Mtn Ute?

Guests:

Brooke Godzsak, *AI/AN Eligibility Specialist, DWS*

Frank Vega, *AI/AN SNAP, DWS*

DHHS Staff:

Brian Roach, *Assistant Division Director, DIH, DHHS*
Jim Stamos, *Office Director, Office of Healthcare Policy & Authorizations, DHHS*
Marcel Larsen-Jones, *Office of Eligibility Policy, DHHS*
Craig Devashrayee, *Office of Reimbursement Coordinated Care & Audit, DHHS*
Laura Belgique, *Office Director, Office of Eligibility Policy, DHHS*
Jeremy Taylor, *Tribal Health Liaison, Office of AI/AN Health Affairs, DHHS*
Jamie Harvey, *ICWA, Office of AI/AN Health Affairs, DHHS*
Alex Merrill, *EPI, Office of AI/AN Health Affairs, DHHS*
Kassie John, *Health Equity, Office of AI/AN Health Affairs, DHHS*
Dorrie Reese, *Recorder/Minutes, DIH Administrative Assistant, DHHS*

Welcome and Introductions:

The UIHAB Chairperson welcomed everyone starting the meeting at 8:30 a.m.

Approval of Minutes:

The Oct 11, 2019, Nov 15, 2019, Dec 13,2019, Jan 10, 2020, Mar 13,2020, A2025,0, 2020, May 8, 2020, Jun 12, 2020, Aug, 14, 2020, Sep 11, 2020, Oct 9, 2020, Nov 13, 2020, Dec 11, 2020, Jan, 21, 2021, , Feb 12, 2021, Mar 12, 2021, Apr 9, 2021, May 14, 2021, Jun 11, 2021, Aug 13, 2021, Sep 10, 2021, Oct 8, 2021, Nov 12, 2021, Dec 10, 2021, Jan 28, 2022, Mar 11,

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2022, Apr 8, 2022, May 13, 2022, Jun 10, 2022, Aug 12, 2022, Sep 9, 2022, Oct 14, 2022, Nov 10, 2022, Dec 9, 2022, Jan 13, 2023, Feb 10, 2023, Mar 10, 2023, Apr 14, 2023, May 12, 2023, June 9, 2023, Aug 11, 2023, Sep 8, 2023, Oct 13, 2023, Nov 9, 2023, Dec 9, 2023, Jan 12, 2024, Mar 8, 2024, Apr 12, 2024, May 10, 2024, Jun 14, 2024, Aug 9, 2024, Sep 13, 2024, Oct 11, 2024, Nov 8, 2024, Dec 13, 2024, Jan 10, 2025, Mar 14, 2025, Apr 11, 2025, May 9, 2025, Jun 13, 2025, Aug 8, 2025, Sep 12, 2025, Oct 10, 2025, Nov 8, 2025, Dec 13, 2025, Jan 9, 2026, Mar 13, 2026, and Apr 10, 2026 UIHAB minutes will be approved at a later UIHAB meeting.

Medicaid and CHIP State Plan Amendments:

Craig Devashrayee gave an update.

SPA MATRIX 5-8-26.pdf

UIHAB MATRIX 5-8-26.pdf

Medicaid Policy Updates:

Jim Stamos gave an update.

Medicaid Policy Update - May 2026.pd

H.R.1 (OBBBA) Update:

Brian Roach gave an update on H.R.1/OBBBA

Medicaid Eligibility Policy:

Marcel Larsen-Jones gave an update on Eligibility Policy.
https://medicaid-documents.dhhs.utah.gov/Documents/enrollment/edd/eligibility-data.html
https://medicaid.utah.gov/aian/

UIHAB - Eligibility Policy Update.pdf

DWS Medicaid Eligibility/SNAP:

Brooke Godzsak gave an update on DWS Medicaid Eligibility Unwinding.

AI Medical & SNAP Apps _UIHAB 2026_Q1

Frank Vega gave an update on SNAP.

MAC & CHIP Advisory Committees:

The next MAC meeting is scheduled for May 28, 2026, at 10:00 -12:00pm.
The next CHIPAC meeting is scheduled for July 16, 2026, at 1:00-1:55 pm

Utah's Medicaid Reform 1115 Demonstration Renewal Overview:

Laura Belgique gave an update.
https://medicaid.utah.gov/1115-waiver/

Full Public Notice_ 2027-2032 Renewal.RI

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IHFS Updates:

Alex Merrill gave an update on Data Sharing environment project

Kassie John gave an update on Opioid and Tobacco
kassiejohn@utah.gov

Opioid & Tobacco Updates-May 2026 - I

IHFS Naloxone Training.pdf

IHFS Ecig and Vaping Prevention Training.pc

AIAN Health Status Report 2025.pdf

Tribal Health Liaison:

Jeremy Taylor gave an update.

SNS – RSS Operation Course:

Evan Crook gave an update

A-9 - RSS Course Promotional Flyer Sep

I/T/U Updates:

Lorena Horse: Confederated Tribes of the Goshute Reservation
Shawn Begay: Utah Navajo Health Systems
https://twinwarriorwellness.org/?page_id=40
Matt Poss: Urban Indian Center of Salt Lake
Tracie Tso: Utah Division of Indian Affairs

Adjourn:

The meeting ended at 10:07. Craig Sandoval made that motion to adjourn the meeting. Rachel Greymountain seconded that motion.

The next meeting: June 12, 2025 @ 8:30 a.m. (Hybrid)
Utah Department of Health & Human Services
195 N. 1950 W, SLC, UT 84116
Multi-State Agency Building (MASOB), Room 2082
(385) 227-2078

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