MEDICAID IN UTAH

A Primer on Managed Care

Abstract

Provider payment and delivery system design is a complex but important aspect of healthcare administration. Managed care has emerged as a component of Utah's Medicaid program with capacity to create opportunities for increased value in the healthcare services that program enrollees receive. However, implementing strategies that encourage optimization of public funds in Medicaid managed care must be a deliberate effort. The next two years will be an important time for policymakers to consider their goals for Utah's Medicaid managed care program; the upcoming procurement process offers a chance for restructuring of contracts and implementation of mechanisms to ensure managed care organizations are delivering the highest value care that a managed care delivery system can offer.

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KEY FINDINGS

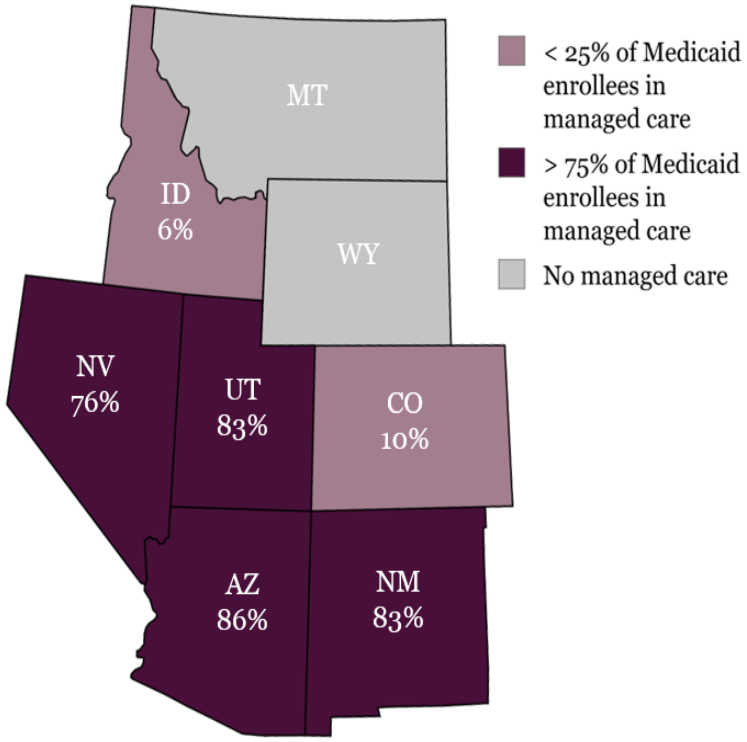
- Utah's Medicaid managed care program could increase financial incentives for quality.
- Utah's Medicaid per-enrollee costs are higher than most other Mountain West states.
- Significant fee-for-service exposure remains in Utah's Medicaid program despite high managed care enrollment, indicating substantial services are carved out of managed care contracts.
- The upcoming procurement process for Utah's Medicaid managed care program represents an opportunity to restructure contracts and implement new mechanisms to ensure high-value care delivery.

Introduction

Medicaid plays a major role in the nation's healthcare system, representing almost $1 out of every $5 spent on health care in the United States[1]. There is substantial variation in Medicaid program design between states, but there are certain fundamental similarities – Medicaid is a way to provide health coverage to low-income individuals, families, and specific populations like the elderly and people with disabilities. However, states have a great deal of flexibility in designing plan benefits, eligible populations, program funding mechanisms, and provider payment models.

One aspect of Medicaid program design that states have coalesced behind is managed care. As of 2022, the most recent year for which national Medicaid managed care enrollment data is available, 75% of Medicaid beneficiaries across the nation were enrolled in comprehensive Managed Care Organizations (MCOs)[2]. Utah is like most other states in this regard, and, as of 2022, approximately 83% of Medicaid beneficiaries were enrolled in an MCO in Utah (see **Figure 1**).

Figure 1: Percentage of Medicaid Enrollees in Managed Care, Mountain West, 2022



Source: Kaiser Family Foundation: Total Medicaid MCO Enrollment

This brief will consider:

- Managed care versus its alternative – fee-for-service (FFS)
- Utah's Medicaid managed care program
- Contract mechanisms for optimizing high value care and coordination among providers.

Background

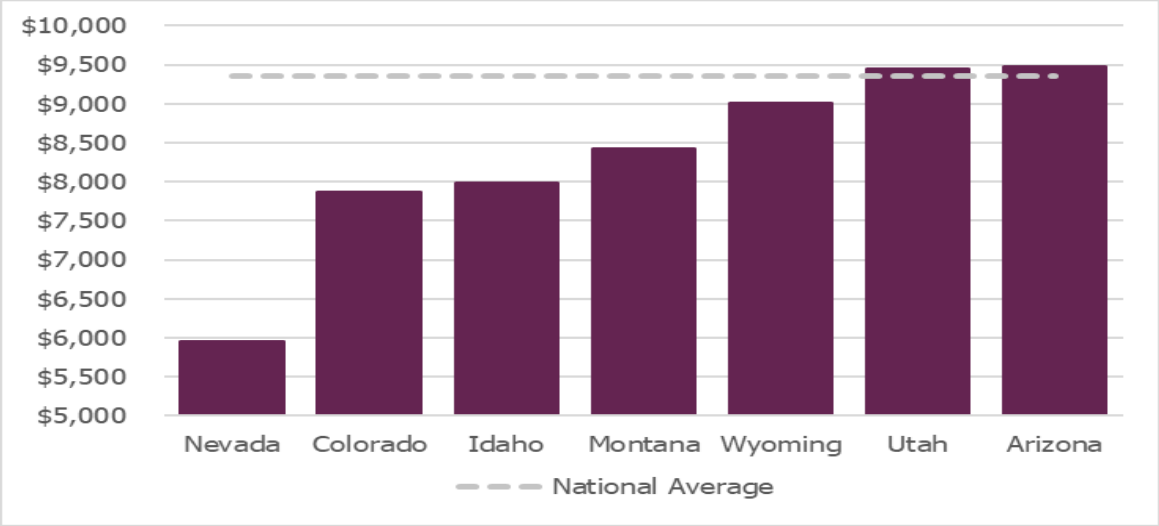
Average Cost per Enrollee

The Medicaid program primarily functions as a payer and program administrator, rather than a direct provider of care. Instead of directly providing care to program enrollees at a doctor's office or hospital, Medicaid directs enrollees to participating providers and reimburses those providers for care they delivered.

Figure 2 displays the average annual Medicaid expenditures per enrollee across Mountain West states for fiscal year 2022. Nevada had the lowest per enrollee spending at $5,951 while Utah had the second highest at $9,457 – slightly above the national average of $9,361[3].

A variety of factors may contribute to higher or lower per enrollee spending amounts for a state's Medicaid program. These include differences in state plan benefits, overall health of population, age distribution, and how easily residents can access hospitals and healthcare providers. Per enrollee cost is only one measure of success of a state's Medicaid program, and understanding the reasons for variation in per enrollee cost can be a useful tool to inform policy proposals that may affect certain eligibility groups and the overall administration of the Medicaid program[4]. This Kaiser Family Foundation document contains a more thorough discussion of the factors that policymakers may want to consider when looking at per enrollee cost comparisons.

Figure 2: Average Annual Medicaid Spending Per Enrollee for Full-benefit Enrollees, Mountain West, Fiscal Year 2022



Source: Medicaid and CHIP Payment and Access Commission (MACPAC) – 2024 Medicaid and CHIP Data Book

Fee-for-service versus Managed Care

Fee-for-service (FFS) has traditionally been the primary method for reimbursing healthcare providers through health insurance entities, including Medicaid. Its appeal lies in its simplicity: providers deliver a service, submit a claim, and receive payment. However, FFS has faced growing scrutiny for potentially incentivizing the volume of services over efficiency, care quality, and patient outcomes.

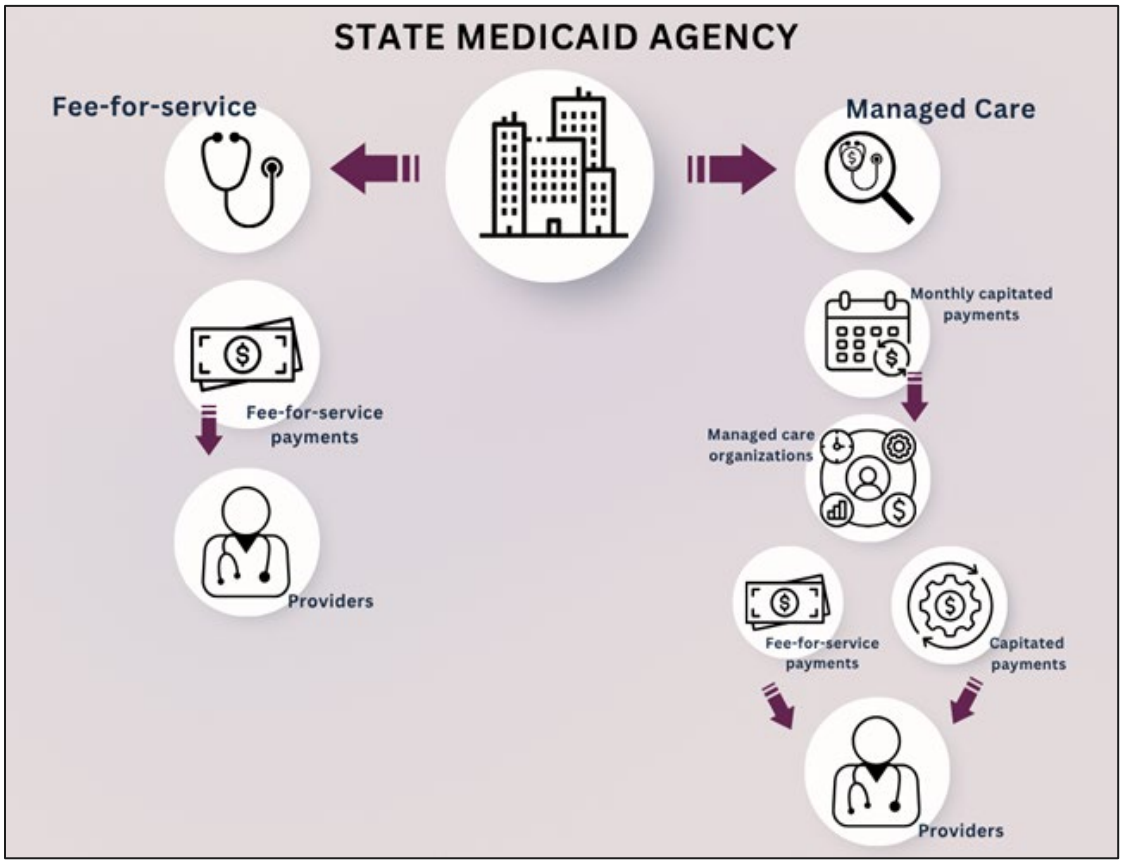
In response, healthcare system experts have explored alternative models that promote care coordination across providers and emphasize services that contribute to long-term health improvements.

Managed care is viewed as a system with the potential to incentivize healthcare providers to deliver high-value, coordinated care.

In this model, as shown in **Figure 3**[5], the Medicaid program contracts with an MCO to manage the delivery of a defined set of services for a fixed amount – typically in the form of a monthly capitated payment, or the Per Member Per Month (PMPM) amount.

MCOs encourage high value care in several ways. As long as they provide the contracted services, they typically have the authority to implement prior authorization requirements, determine which providers to allow in their network, and cover additional services that are not included in the state's Medicaid plan.

Figure 3: FFS vs. Managed Care



Source: U.S. GAO – Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks

Utah's Medicaid Managed Care Program

Managed care has been a component of Utah's Medicaid program since 1982, when the Centers for Medicare and Medicaid Services (CMS) approved the "Choice of Health Care Delivery" 1915(b) waiver application. This allowed the state to require traditional Medicaid beneficiaries (children, pregnant women, caretaker adults, aged and adults with disabilities) that were living in the four urban counties to enroll in managed care[6]. By 1995, enrollment in managed care became mandatory in urban counties.

In 1991, managed care was expanded within Utah Medicaid's program with the introduction of Prepaid Mental Health Plans (PMHPs)[7]. Throughout the 1990s, nearly all Medicaid beneficiaries were enrolled in a mental health managed care plan contracted through the local mental health authorities.

KEY TERMS

Managed care: An approach to health insurance where providers are reimbursed based on a defined set of services.

Fee-for-service (FFS): An approach to health insurance where healthcare providers are reimbursed a fee for each health service provided.

Accountable Care Organizations (ACOs): Managed care entities responsible for delivering physical health care services.

Capitation: An approach to health insurance where health care providers or organizations receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period.

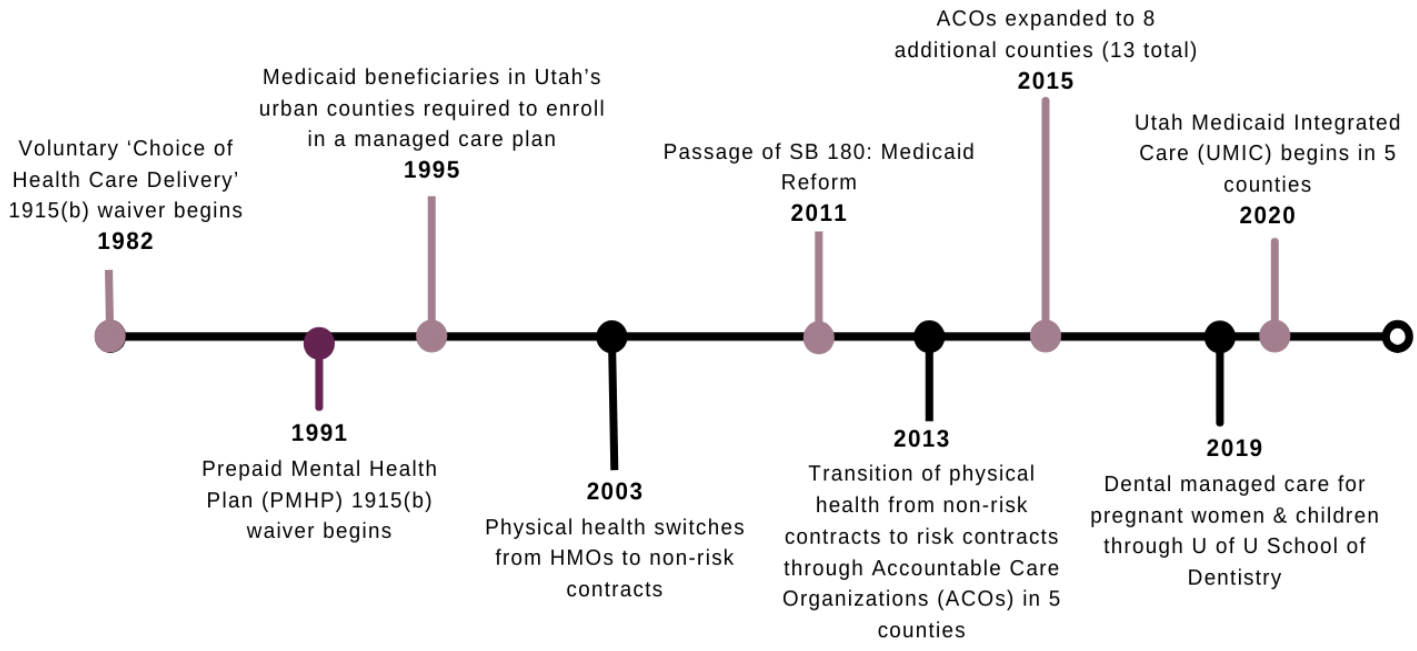
Per member per month (PMPM): The specific amount calculated and paid for each enrollee in a capitated payment system.

In 2011, the Utah Legislature passed SB 180, Medicaid Reform, which marked a major step toward Utah becoming a comprehensive Medicaid managed care state. The legislation instructed the Department of Health to prioritize the replacement of fee-for-service delivery with risk-based delivery models, reimburse providers for comprehensive episodes of care, and reward those who contribute to improved health outcomes.

In 2013, CMS approved Utah's waiver application, allowing the state to implement the Accountable Care Organization (ACO) model. An ACO is a managed care entity responsible for delivering physical health care services. It is Utah's largest managed care program.

In December of 2019, following the passage of SB 96, Medicaid Expansion Amendments, CMS approved Utah's full Medicaid expansion. This expansion extended eligibility to adults with an income up to 138% of the federal poverty level ($17,608 for an individual or $36,156 for a family of four)[8]. In accordance with the provisions of SB 96, newly eligible adults were enrolled in a Utah Medicaid Integrated Care (UMIC) plan, which are managed care plans that provide both physical and behavioral health benefits. See **Figure 4** for a detailed timeline.

Figure 4: Utah Medicaid Managed Care Timeline



Source: Department of Health and Human Services

Managed care budgeting and accountability

Under the managed care model, managed care entities receive a PMPM and must cover the contractually defined set of services for each enrollee in the plan.

The PMPM amount varies depending on the population category. For example, the PMPM amount will be higher for disabled and pregnant enrollees, and lower for non-disabled adults and children. The PMPM is important because MCOs are at financial risk if the amount they spend on enrollee services and administration exceeds the PMPM. Conversely, if the MCO spends less on enrollee services and administration than the PMPM, they are generally allowed to retain the remaining amount.

Evaluating whether MCO incentives are effectively promoting efficient and cost-effective service delivery is complex, but several tools are available to support this assessment. One commonly used strategy is the Medical Loss Ratio (MLR), a standardized metric that shows how much of the PMPM an MCO spends on covered services. The MLR is one of a few metrics that states use to demonstrate compliance with federal Medicaid managed care statute, which mandate that PMPM payments be actuarily sound[10].

Since 2017, federal law has required states to report MLR data. Beginning in 2019, states have also been required to set managed care capitation rates to allow MCOs to reasonably achieve an MLR of at least 85 percent. This threshold ensures that no more than 15 percent of capitation revenue is spent on administration costs and profit.

As shown in **Table 1**, for Fiscal Year 2021, the most recent year for audited and finalized MLR numbers, Utah's ACOs show some variation in MLRs, but all generally fall in the mid to high eighty percentiles.

Table 1: Utah Medicaid ACO MLRs, FY 2021

ACO	MLR
Health Choice Utah	87.3%
Healthy U	87.5%
Molina Healthcare	86.0%
SelectHealth Community Care	91.5%

Source: Department of Health and Human Services

Utah Medicaid Budget Growth Controls and Capitation Rate Adjustments

In addition to establishing Utah's Medicaid ACO structure, SB 180 also established the Medicaid Growth Reduction and Budget Stabilization Account, aimed at aligning the rate of Medicaid expenditure growth with the overall growth of the state's General Fund[12].

While the Medicaid managed care budgeting process has evolved since 2011, a base budget appropriations framework remains codified in UCA 26B-3-203, tying PMPM payments to the General Fund growth factor. The structure is as follows:

- **If the general fund growth factor is less than 100%**, then the PMPM for ACOs, PMHPs, and UMICs remains the same.
- **If the general fund growth factor is more than 100% but less than 102%**, then the PMPM for ACOs, PMHPs, and UMICs increase an equal amount to the general fund growth factor.
- **If the general fund growth factor is more than 102%**, then the PMPM for ACOs, PMHPs, and UMICs increase a minimum 2%[13].

Table 2 on the following page illustrates key characteristics of Utah's Medicaid Managed Care Plans.

Table 2: Utah's Medicaid Managed Care Plans

Utah Medicaid Managed Care Plans	Characteristics
Accountable Care Organizations (ACOs)	• Primarily covers physical health • Mandatory enrollment in 13 counties • Four plans
Dental Plans	• Mandatory enrollment for pregnant women and members eligible for Early and Periodic Screening, Diagnostic and Treatment program benefits • Two plans
Prepaid Mental Health and Substance Use Disorder Plans (PMHPs)	• Covers mental health services in all counties except Wasatch County • Covers substance use disorder services in all but four counties which remain FFS • Enrollment is coordinated by DHHS and is based on county of residence • 11 plans
Utah Medicaid Integrated Care (UMIC)	• Covers integrated physical and behavioral health services for Adult Expansion Medicaid members • Mandatory enrollment for Adult Expansion members in Davis, Salt Lake, Utah, Washington, and Weber Counties • Four plans
HOME Program	• For individuals with developmental disabilities
Children's Health Insurance Plan (CHIP)	• Mandatory enrollment • Covers general healthcare, mental health, and medicine • Three plans • One dental plan

Source: Department of Health and Human Services

Medicaid Managed Care Contracts

Most states use the procurement process to establish goals and expectations with managed care. Typically, these contracts last three to five years, after which states initiate a competitive procurement process. In contrast, Utah has largely retained its existing contracts since implementing the ACO model in 2011, opting instead to update contract provisions over time.

Utah Medicaid has indicated that it plans to issue a Request for Proposals (RFP) in July 2027 – its first competitive procurement since adopting the ACO model. The RFP process can last 18 to 24 months, including preplanning, bidding, and contract implementation[15].

States have broad flexibility in structuring an RFP, but generally include specific requirements MCOs must address in their bids. Competitive bidding can result in substantial program savings. For instance, Minnesota's 2015 RFP process yielded $445 million in savings for the next calendar year[16].

However, expectations for large-scale savings in Utah should be tempered. The statutory provisions in UCA 26B-3-203, which tie Medicaid capitation amounts to the General Fund growth factor, reduce the likelihood of major transformations in the state's spending on Medicaid managed care.

The following section outlines a few contract design mechanisms Utah Medicaid uses, which could be considerations in the upcoming RFP process.

Carve-ins and Carve-outs

Medicaid managed care contracts are structured so that not all Medicaid covered services are the responsibility of the MCO. For example, while chiropractic and dental services are part of the Medicaid state plan they are carved out of contracts with Utah's ACO and UMIC plans. A complete list of carved in and carved out services for ACO and UMIC contracts are in **Appendix A**.

Balancing the services that are carved in and carved out of a managed care contract is a complex process that includes extensive negotiation between the state's Medicaid agency and MCOs. There are some services like long-term care that are commonly carved out of managed care contracts[17]. In Utah, recent discussions have focused on whether pharmacy benefits should be entirely carved out of ACO contracts.

The Utah Department of Health and Human Services (DHHS) estimated that a full pharmacy carve-out could generate up to $47.6 million in annual savings to the Medicaid program[18]. However, the ACOs dispute the value of a full pharmacy carve-out strategy and recommend preservation of the current carve-in with certain modifications[19].

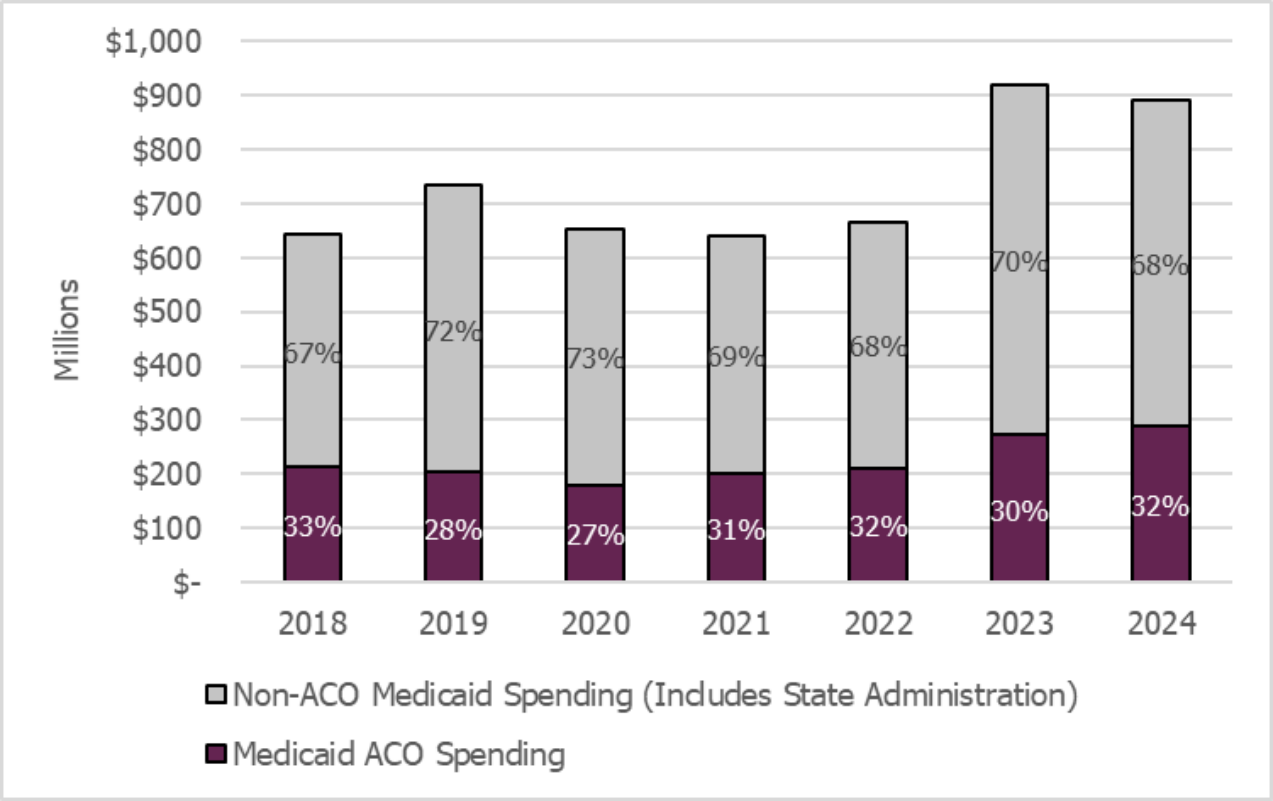
One reason a service might be carved out is to address cost volatility. For example, ultra high-cost drugs are used by relatively few Medicaid enrollees, but including their expense in the PMPM would improperly skew the expense, creating financial uncertainty for the Medicaid program and its contracted managed care entities.

On the other hand, ACOs argue fully carving out pharmacy benefits runs counter to the goals of managed care – where care is intended to be coordinated among providers, and the carve-out would be siloing care in order to obtain modest cost savings to the state.

As is shown in **Figure 5**, for FY 2024, Utah spent $892.4 million from the Medicaid General & Income Tax Fund to pay for the state's portion of the Medicaid program. To illustrate how carve-ins and carve-outs impact spending, for that year, Utah Medicaid estimated that approximately 59% of the state's Medicaid population was enrolled in an ACO legacy plan[20,21]. However, Medicaid ACO-related spending accounted for $288.7 million, which amounts to about 32% of total Medicaid spending that year.

While these numbers should not be interpreted as evidence that Utah's current carve-in/carve-out structure is misaligned, they do demonstrate that even when a large majority of Medicaid enrollees are served through ACOs, the state may still retain substantial fee-for-service (FFS) exposure—depending on which services are included or excluded from managed care contracts.

Figure 5: ACO Spending vs. Non-ACO Spending (General and Income Tax Fund Only)



Source: Office of the Legislative Fiscal Analyst

Financial Incentives tied to Quality

As reported by DHHS, in 2023 Utah was one of three Medicaid managed care states that did not have a quality initiative tied to direct or indirect financial incentives for its MCOs[22]. For FY 2024, DHHS established a quality incentive pool in four key domains:

- Timely and accurate data submission
- Member engagement
- Achieving national accreditation
- Improvement on Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Detailed in **Appendix B**, during that year, ACOs were eligible to receive up to a 4.3% increase in risk-adjusted base capitation payments if they successfully demonstrated completion of all the domains. This program was operational just for one year due to a budget surplus associated with CMS' maintenance of effort requirements for the unwinding of Medicaid continuous enrollment.

Promotion Programs

Worth noting is that Utah's Medicaid ACOs all have several care management and health promotion programs that operate without direct financial incentive from DHHS. These programs are listed in **Appendix C**, and range from diabetes control measures, Hepatitis-C medication management, maternity care management, and asthma care programs.

This information was provided to legislative staff upon request but does not seem to be generally available to the public.

DHHS does post links and phone numbers for the managed care plans on their website, and they also make available a 'Utah Medicaid Member Guide'. However, navigating individual healthcare provider websites is challenging and locating information like what is included in **Appendix C** would take a vast amount of time and motivation from Medicaid enrollees.

Auto-assignment and Enrollment

Currently, Utah Medicaid auto-assigns Medicaid members to a managed care plan if the member lives in a mandatory enrollment county and does not select a plan within the first 90 days of enrollment. The current process is to auto-assign enrollment equally to each available plan. HB 7 (2024) included intent language directing DHHS to report to the Social Services Appropriations Subcommittee on 'options to implement a quality-based auto-assignment of Medicaid managed care clients who do not select a health plan.'

DHHS reported on this topic on June 1, 2024, providing options for implementation of quality-based auto-assignment. DHHS has proposed a 2026 implementation date for this tool.

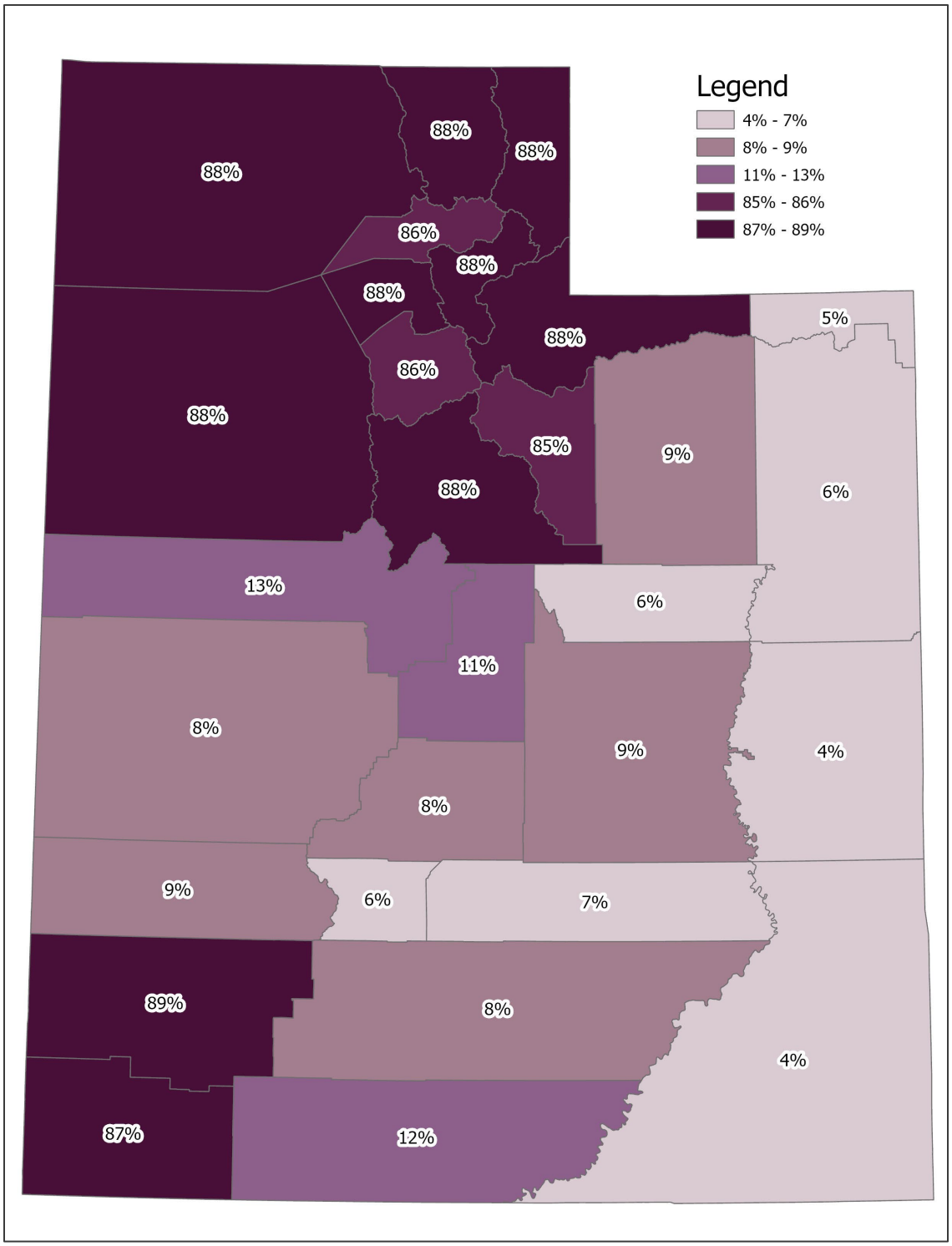
Mandatory enrollment vs. optional enrollment counties

According to current ACO contracts, Medicaid eligible individuals residing in Salt Lake, Weber, Davis, Utah, Box Elder, Iron, Rich, Tooele, Washington, Cache, Morgan, Summit and Wasatch counties are mandatorily enrolled in an ACO.

Additionally, adult expansion enrollees residing in Davis, Salt Lake, Utah, Washington, and Weber Counties are mandatorily enrolled with a UMIC plan. Enrollees living in a voluntary enrollment county may disenroll from an ACO or UMIC plan at any time and for any reason.

As can be seen in **Figure 6** on following page, there is a fair amount of variation of Medicaid enrollees who are enrolled in an ACO, UMIC plan, or the FFS program in rural counties. Assessing mandatory versus optional managed care enrollment counties will continue to be a factor for Utah's Medicaid managed care system as the state's population changes.

Figure 6: Percentage of ACO and UMIC Enrollees by County



Source: Department of Health and Human Services

Click here to access an interactive version of this map with county-level ACO and UMIC plan enrollment information.

Conclusion

Utah's Medicaid program has long relied on managed care as a core delivery strategy for over forty years. Compared to FFS models, managed care has greater potential to promote high value care and coordination among other healthcare providers. However, realizing these benefits depends on how contracts with managed care entities are structured—emphasizing quality, value, and fiscal responsibility.

Many states periodically conduct competitive procurement processes to ensure that their Medicaid managed care programs are aligned with the state's goals. With Utah preparing for its first managed care procurement since 2011, policymakers have an important opportunity to evaluate their objectives for the Medicaid program.

Appendix A: ACO and UMIC Contract Carve-ins and Carve-outs

ACCOUNTABLE CARE ORGANIZATIONS	
Carve-in	**Carve-out**
- Inpatient Hospital Services - Outpatient Hospital Services - Emergency Department Services - Physician Services - General Preventative Services - Vision Care - Laboratory and Radiology Services - Physical Therapy - Occupational Therapy - Speech and Hearing Services - Podiatry Services - End Stage Renal Disease—Dialysis - Hemophilia and Blood Clotting Disorder - Home Health Services - Hospice Services - Private Duty Nursing - Medical Supplies and Medical Equipment - Abortions and Sterilizations (as specified in the Federal Hyde Amendment) - Transgender Services (following the Department's policy) - Treatment for Substance Use - Organ Transplants - Other Outside Medical Services - Skilled Nursing Facility, Intermediate Care Facility (ICF or ICF-ID) and Long Term Acute Care Stays 30 Days or Less - Services to EPSDT Enrollees - Family Planning Services - High-Risk Prenatal Services - Services for Children with Special Health Care Needs - Medical and Surgical Services of a Dentist - Diabetes Education - Human Immunodeficiency Virus (HIV) Prevention - Pharmacy - Dental Fluoride Varnish - Autism Spectrum Disorder Services - Qualifying Clinical Trials	- Dental Services - Targeted Case Management - Emergency Transport Services - Nursing Facility, Intermediate Care Facility, Long Term Acute Care Hospital (longer than 30 days) - Applied Behavioral Analysis Services - Waiver Services - Specialized Mental Health Services (unless provided by PCP) - Substance Use Disorder Services (except certain services) - Specific Classes of Drugs - Methadone - Non-emergency Transportation - Mental Health Evaluations and Psychological Testing - Services Provided by Indian Health Services (IHS) or Tribal or Urban Indian Organization (UIO) facility - Early Intervention Services - School-based Skills Development Program Services - Chiropractic Services - Services Provided at the Utah State Hospital - Services Provided at the Utah State Developmental Center - Apnea Monitors - Drug Testing for SUD Treatment when performed by an Independent Lab - Ultra High Cost Drugs - Consultation Provided by a Psychiatrist to an Enrollee's Treating Physician

UTAH MEDICAID INTEGRATED CARE	
Carve-in	**Carve-out**
- Inpatient Hospital Services - Outpatient Hospital Services - Emergency Department Services - Physician Services - General Preventative Services - Vision Care - Laboratory and Radiology Services - Physical Therapy - Occupational Therapy - Speech and Hearing Services - Podiatry Services - End Stage Renal Disease—Dialysis - Hemophilia and Blood Clotting Disorder - Home Health Services - Hospice Services - Private Duty Nursing - Medical Supplies and Medical Equipment - Abortions and Sterilizations (as specified in the Federal Hyde Amendment) - Transgender Services (following the Department's policy) - Treatment for Substance Use - Inpatient Hospital Psychiatric Services - Outpatient Mental Health and Substance Use Disorder Services - Additional Services (psychoeducational, personal, respite care, supportive living services) - Organ Transplants - Other Outside Medical Services (at its discretion… freestanding ED, ambulatory surgical centers, birthing centers) - Skilled Nursing Facility, Intermediate Care Facility and Long Term Acute Care Stays 30 Days or Less - Services to EPSDT Enrollees - Family Planning Services - Medical and Surgical Services of a Dentist - Diabetes Education - Human Immunodeficiency Virus (HIV) Prevention - Pharmacy - Services to EPSDT Enrollees - Autism Spectrum Disorder Services - Qualifying Clinical Trials	- Dental services - Emergency transportation services - Nursing Facility, Intermediate Care Facility, Long Term Acute Care Hospital (longer than 30 days) - Applied Behavioral Analysis Services - Waiver Services - Specific Classes of Drugs - Outpatient Methadone Administration - Non-emergency Transportation - Services Provided by Indian Health Services (IHS) or Tribal or Urban Indian Organization (UIO) facility - School-based Skills Development Program Services - Chiropractic Services - Services Provided at the Utah State Hospital - Services Provided at the Utah State Developmental Center - Mental Health Evaluations and Psychological Testing Performed for Physical Health Purposes - Apnea Monitors - Drug Testing for SUD Treatment when performed by an Independent Lab - Behavioral health services provided in an FQHC - Ultra High Cost Drugs - Mental Health Evaluations Ordered by DWS or DHHS

Appendix B: ACO Quality Incentive Pool – Performance Accountability[23]

IMPROVEMENT DOMAIN	PERFORMANCE GOAL	IMPACT ON MEMBERS
Timely and accurate encounter data submission Maximum incentive payment: 0.60% of risk-adjusted base capitation payments	ACOs collaborate with DHHS to develop complete, accurate quarterly data files to be used for data book development and rate setting process.	Accurate rate setting and measurement are the foundation of our quality improvement process.
Member engagement Maximum incentive payment: 1.2% of risk-adjusted base capitation payments	Improve compliance with initial member contact requirements, actively solicit member feedback through a formal consumer panel, and identify and address enrollee access to care barriers.	Increase member satisfaction and engagement. Decrease barriers and disparities in health care access.
Achieve national accreditation Maximum incentive payment: 0.5% of risk-adjusted base capitation payments	Maintain national NCQA or URAC health plan accreditation or demonstrate progress toward meeting accreditation.	Improves alignment and operations in key MCO areas, leading to better service for members.
Improvement on HEDIS measures Maximum incentive payment: 2.0% of risk-adjusted base capitation payments	Achieve national average or a 5% improvement on base performance.	Standardized measurement of quality in key clinical focus areas, enabling comparison between ACOs and higher transparency for members.

Appendix C: ACO Care Management and Health Promotion Programs

Received from SelectHealth, Molina, HealthChoice, and HealthyU in May, 2025.

SelectHealth	Molina	HealthChoice/HealthyU*
Care Management	P4Q bonuses for several diabetes control measures as well as hypertension control	Opioid Management
Telehealth and Online Digital Resources	P4Q bonuses for appropriate prenatal and postpartum care	Medication Therapy Management (MTM) Program
Quality Provider Program (QPP)	Member outreach calls, education, and IHA for prenatal postpartum care	Unhoused Population Pharmacy Programs
Healthy Beginnings	Initial Health Assessment (IHA) for blood pressure control	Hepatitis-C Medication Compliance Program
Asthma Care Referral Program	IHA for diabetes testing and education including A1c<8%, testing for kidney health, eye examinations	Continuous Glucose Monitoring Management
Non-Emergent Emergency Department (ED) Use	Member outreach, education, and incentives for diabetes, hypertension, and prenatal care	Chronic Condition (Disease Management) Care Management
	Outreach to members to schedule follow up visits after discharge from ED or hospital with mental health or substance use diagnoses	Maternity Care Management
		Complex Care Management
		Care Coordination/Access Assistance
		Behavioral Health
		Restriction Program
		Acute and High-Risk Transitions of Care Program
		Community Liaison Program

**HealthChoice and HealthyU provided a coordinated response to the legislative staff inquiry and it appeared that the care management/health promotion programs were the same across the two ACOs.*

Endnotes

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[20] Ibid. "ACO legacy" refers to the ACO program prior to Utah's Medicaid expansion and includes members in both mandatory and non-mandatory ACO counties.

[21] *Utah Medicaid and CHIP 2024 Annual Report: Managed Care Enrollment*. Utah Department of Health and Human Services. https://medicaid-documents.dhhs.utah.gov/Documents/pdfs/annual%20reports/medicaid%20annual%20reports/2024-Annual-Report.html#managed-care-enrollment

[22] Utah Medicaid, DHHS. (2023). *Utah Medicaid Quality Initiatives*. https://le.utah.gov/interim/2023/pdf/00003458.pdf

[23] Ibid.

Resources for further reading:

Medicaid managed care is a complex topic with a great deal of information that is available. Below are some resources that could be of interest to policymakers who wish to develop a deeper understanding of processes and available policy options.

1. Utah Medicaid Spending Statewide: Office of the Legislative Fiscal Analyst (January, 2025).
2. Utah/Federal Government Nexus: Medicaid. Kem C. Gardner Policy Institute (March, 2025).
3. Medicaid Funding 101: Kem C. Gardner Policy Institute (January, 2025).
4. Utah Department of Health and Human Services Managed Care landing page. This page includes information about all the managed care programs, contracts, Medical Loss Ratio (MLR) reports, Medicaid Managed Care Program Annual Reports (MCPARs), and other valuable resources.
5. Utah Medicaid Member Trends by Local Health District and Health Plan (DHHS Dashboard)
6. 10 Things to Know About Medicaid Managed Care: Kaiser Family Foundation (February, 2025).
7. Why Did They Do It That Way? Medicaid Financing: National Association of Medicaid Directors (April, 2025).
8. Examining the Role of External Quality Review in Managed Care Oversight and Accountability: MACPAC (March, 2025).