A Performance Audit of the

All-Payers Claims Database

A Review of Data Accessibility and Data Usage in Utah's Behavioral Health System

Office of the Legislative Auditor General

Report to the **UTAH LEGISLATURE**

LEGISLATIVE
AUDITOR GENERAL
1975 - 2025

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August 19th, 2025

TO: THE UTAH STATE LEGISLATURE

Transmitted herewith is our report:

"A Performance Audit of the All-Payers Claims Database: A Review of Data Accessibility and Data Usage in Utah's Behavioral Health System" [Report #2025-14].

An audit summary is found at the front of the report. The scope and objectives of the audit are included in the audit summary. In addition, each chapter has a corresponding chapter summary found at its beginning.

Utah Code 36-12-15.3(2) requires the Office of the Legislative Auditor General to designate an audited entity's chief officer. Therefore, the designated chief officer for the Department of Health and Human Services is Tracy Gruber. Tracy Gruber has been notified that they must comply with the audit response and reporting requirements as outlined in this section of **_Utah Code_**.

We will be happy to meet with appropriate legislative committees, individual legislators, and other state officials to discuss any item contained in the report in order to facilitate the implementation of the recommendations.

Sincerely,

Kade R. Minchey, CIA, CFE

Auditor General

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PERFORMANCE AUDIT

DATA ACCESSIBILITY AND USAGE

⊚ KEY FINDINGS

✔ 1.1 All-Payers Claims Data Can Be Used to Better Inform State Health Policy

✔ 2.1 Department of Health and Human Services Data-Sharing Barriers Prevent Employees from Fulfilling Job Responsibilities

✔ 2.3 More Robust Behavioral Health Outcome Measures Require Increased Data Sharing with External Agencies

✔ 3.1 Without a Strategic Plan, Healthcare Statistics Fails to Achieve its Full Potential

✔ 3.2 Healthcare Statistics' Inefficiencies Contribute to Its Minimal Impact on Health Policy

▷ AUDIT REQUEST

The Legislative Audit Subcommittee requested an audit of Utah's behavioral health system. Our office conducted an initial risk assessment and identified data challenges as a contributing factor to broader issues within the behavioral health system. Consequently, this audit focuses on behavioral health data in Utah's All-Payers Claims Database.

▷ BACKGROUND

All-Payers Claims Databases (APCDs) are comprehensive state-level data systems that collect healthcare claims from a wide range of public and private payers. Behavioral health policy analysis benefits significantly from APCDs due to their ability to provide longitudinal, population-level data on service utilization, costs, and outcomes. These databases enable policymakers to identify trends in behavioral health treatment, assess disparities in access and quality, and evaluate the impact of interventions.

⊞ RECOMMENDATIONS

✔ 2.1 The Legislature should consider policy options allowing for more data sharing within the Department of Health and Human Services for public health cases.

✔ 2.2 The Department of Health and Human Services should explore the potential for creating an expedited review process for interal data requests.

✔ 3.1 The Department of Health and Human Services should ensure the Healthcare Statistics Program follows the guidance of GOPB's Guide to Strategic Planning to create and implement a strategic plan for the APCD.

✔ 3.3 The Department of Health and Human Services should ensure the Healthcare Statistics Program adopt and implement performance metrics that include revenue, customer retention and growth, data quality, and public engagement.

✔ 3.4 The Legislature should consider establishing a defined purpose for the All-Payers Claims Database.

REPORT SUMMARY

The All-Payers Claims Database is Underutilized for Decision Making

The All-Payers Claims Database (APCD) could support more informed behavioral health policymaking and decisionmaking. However, the Behavioral Health Commission and the Department of Health and Human Services lack a strategic approach to utilizing the data. Without a more informed approach, the department and commission risk making decisions with significant blind spots.

Data Sharing Policies Should be Reviewed to Optimize APCD's Potential

Strict data-sharing policies and a complex internal review process within the Department of Health and Human Services hinder staff from fulilling their job responsibilities, which can result in diminished public health outcomes.

These review processes also contribute to operational inefficiencies throughout the department. The department must accompany and data sharing process improvements with a new willingness to share data when possible.
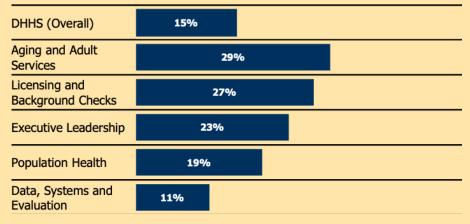
APCD has No Strategic Plan and Poor Service Delivery, Leading to Inefficiencies

The Healthcare Statistics Program oversees the APCD but does not have the clarity and vision needed to use the data to inform decisionmaking. We identify several opportunities for program leadership to better leverage the data. These include automating program processes, realloacting funds, and improving service delivery to data users.

Data Sharing Restrictions Create Inefficiencies Within the Department of Health and Human Services

Fifteen percent of DHHS employees report that they don't have access to the data they need to fulfill their job responsibilities. Some divisions report higher rates, with almost a quarter of executive leadership expressing as much.

Percentage of DHHS Staff That Report They Do Not Have Access to the Data They Need to Fullfill Their Job Responsibilities.

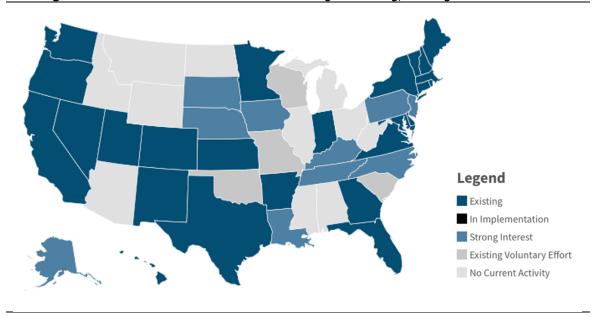| Division	Percentage
DHHS (Overall)	15%
Aging and Adult Services	29%
Licensing and Background Checks	27%
Executive Leadership	23%
Population Health	19%
Data, Systems and Evaluation	11%

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Introduction

An All-Payers Claims Database (APCD) is a comprehensive data source that collects health care claims from a wide range of payers, including commercial insurers, Medicaid, and third-party administrators. The data within an APCD includes medical claims, pharmacy claims, and dental claims, as well as enrollment and provider files. The Utah Legislature authorized the creation of Utah's APCD during the 2007 General Legislative Session.[1] The Healthcare Statistics Program (HCS) within the Department of Health and Human Services (DHHS) was chosen as the administrator to collect, validate, and analyze the claims data. Along with collecting and analyzing the data, HCS aims to use the data to support health improvement initiatives.

Currently, 25 states operate an APCD.

Figure 1.1 APCDs Are a Common Source of Physical and Behavioral Health Data Throughout the U.S. Utah's APCD is one of the longest running, starting in 2009.

Legend
- Existing
- In Implementation
- Strong Interest
- Existing Voluntary Effort
- No Current Activity
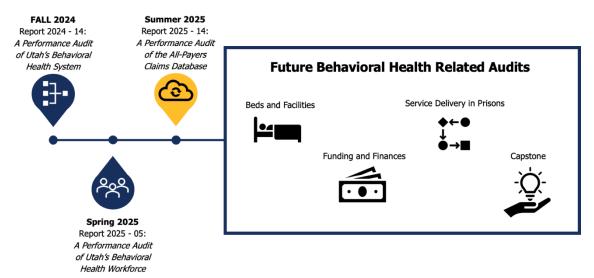
Source: Graphic generated by the APCD Council.

This is the third in our series of audits that focus on challenges in Utah's behavioral health system. Further audits will address the funding, facilities, and quality of behavioral health services. This report will focus on the use of the All-Payers Claims Database within Utah's behavioral health system, as well as behavioral health data sharing. Although OLAG's audits do not cover every aspect of Utah's behavioral health

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[1] House Bill 9, 2007 General Legislative Session

system, they highlight the key priorities and recommendations we identified as essential for improvement.

FALL 2024
Report 2024 - 14:
A Performance Audit of Utah's Behavioral Health System

Summer 2025
Report 2025 - 14:
A Performance Audit of the All-Payers Claims Database

Future Behavioral Health Related Audits

Beds and Facilities

Service Delivery in Prisons

Funding and Finances

Capstone

Spring 2025
Report 2025 - 05:
A Performance Audit of Utah's Behavioral Health Workforce

Source: Auditor generated.

Utah's APCD is funded primarily by legislative appropriations.[2] Additionally, HCS generates some revenue by charging user fees to public and private institutions that request access to APCD data. Requestors are also required to enter into a Data Use Agreement. This agreement undergoes a multi-level review process within DHHS to ensure appropriate use and data governance.

Given the breadth and depth of data within an APCD, it has the capacity to allow to track physical and behavioral health metrics over time, which could support health policy decisions and interventions. DHHS staff report that Utah's APCD collects data for 60-70% of the population. Analysis from the One Utah Health Collaborative indicates that Utah's APCD includes upwards of 90% of the population's total healthcare spending.[3] However, there have been federal

> **The One Utah Health Collaborative indicates that Utah's APCD covers approximately 90% of Utah's total healthcare spending.**

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[2] The Healthcare Statistics Program is funded through a mix of General Funds, Medicaid, fees, private payments (HMOs), federal funds, and contracts.

[3] The One Utah Health Collaborative is a 501c3 founded by the Governor. The collaborative works with healthcare institutions to improve healthcare costs and services.

mandates that have limited which claims data can be collected.[4,5] As a result, behavioral health data related to substance use may be incomplete in Utah's APCD, limiting the ability to analyze trends, outcomes, and service gaps in this area.

Despite federal constraints and other restrictions, Utah's APCD can be an important resource in evaluating and implementing behavioral health initiatives. It can enhance legislative oversight of the state's behavioral health system, improve public reporting of behavioral health trends, and support targeted interventions to improve outcomes and reduce costs. The following chapters analyze the causes behind the limited use of Utah's APCD within the state's behavioral health system:

1 The All-Payers Claims Database is Underutilized for Decision Making

2 Data Sharing Policies Should be Reviewed to Optimize APCD's Potential

3 APCD Has No Strategic Plan and Poor Service Delivery, Leading to Inefficiencies

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[4] In 2016, the U.S. Supreme Court ruled that the Employee Retirement Income Security Act (ERISA) would override state laws that require self-funded employment plans to submit claims data to state APCDs. Self-funded plans can cover a large portion of insured populations, and the inability to collect claims from these plans limits the comprehensiveness of APCDs.

[5] Another federal regulation, 42 CFR Part 2, overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA), protects the confidentiality of data related to substance use disorder treatment. Updates to the rule in 2024 allowed for the disclosure of these records to public health authorities, provided the data is de-identified in accordance with Health Insurance Portability and Accountability Act (HIPAA) standards. While states are permitted to collect substance use claims, some report challenges in getting cooperation from payers. Additionally, although the revised rule permits data collection, it does not clearly define how the data may be used, leading some states to hesitate in sharing or utilizing them.
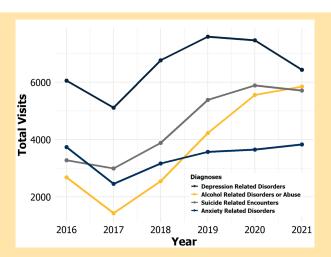
BACKGROUND

The All-Payers Claims Database (APCD) can be used to inform state health policy and decision making. The database is a comprehensive source of information for public health, healthcare spending, healthcare utilization, healthcare workforce tracking, and more. However, the Department of Health and Human Services's limited vision for the database contributes to its minimal use in public policy and decision making.

Finding 1.1
The All-Payers Claims Database Can Be Used to Better Inform State Behavioral Health Policy

No Recommendation

The Reasons for Mental Health Emergency Department Visits Has Changed Over Time

Policymakers and agency staff can use All-Payers Claims data to monitor behavioral health trends and evaluate if current initiatives are changing outcomes. Claims data can also be used to identify if the types of treatments patients receive and where they receive them influence recovery rates.

CONCLUSION

Other states use their All-Payers Claims Databases to inform public policy, evaluate programs, and identify where to administer targeted behavioral health treatments. The Department of Health and Human Services and the Behavioral Health Commission should prioritize using Utah's APCD to better guide data-driven decision-making, improve behavioral health outcomes, and ensure resources are allocated where they are most needed.

Chapter 1
The All-Payers Claims Database Is Underutilized for Decision Making

1.1 The All-Payers Claims Database Can Be Used to Better Inform State Behavioral Health Policy

Despite its potential, the All-Payers Claims Database (APCD) remains an underutilized resource in shaping Utah's behavioral health policy. The APCD contains important, actionable data that could help policymakers, the Behavioral Health Commission (commission), and the Department of Health and Human Services (DHHS or department) navigate the complexities of behavioral health and make more informed decisions. However, the current APCD leadership lacks a clear vision for how to harness this data to drive meaningful policy change. Currently, APCD has had little demonstrable impact on health policy. Without a strategic approach to leveraging the APCD, the department and commission risk making decisions with significant blind spots—overlooking trends, gaps, and opportunities that the data could reveal.

Due to DHHS' Limited Vision, the Legislature has Not Been Adequately Informed of APCD's Policy Potential

The Legislature can use the APCD to create actionable behavioral health outcome metrics and inform their decisions about how to allocate limited resources. Between 2020 and 2024, Utah legislators and legislative staff requested information from Utah's APCD eight times. Information that has been shared has had minimal impact due to quality issues of the analysis. The Legislature could use this rich cache of medical data to inform policymaking, particularly when it comes to behavioral health. The APCD has not informed policy due to a lack of clear vision at DHHS, limitations in staff capacity, and data sharing challenges. Each of these will be discussed more fully in chapters two and three.

DHHS Has Not Effectively Demonstrated the Value of APCD to Inform Legislative or Agency Decision Making. In September and October 2023 the Health and Human Services Interim Committee reviewed the sunset provision of the Utah Health Data Authority Act. This act authorizes DHHS to collect and use healthcare data, including APCD data.[6] As a part of the sunset review, DHHS staff were asked to describe some of the most impactful use cases of APCD data that have informed past legislative efforts. In both meetings, DHHS staff

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[6] *Utah Code* 26B-8-501 (1)

struggled to describe how APCD data has informed legislative decision-making or solved problems related to public health and healthcare.

The concern that Utah's APCD is not providing enough value to the state was expressed by a leader from a private insurance provider. The leader described that Utah's APCD has the potential to inform policy decisions, but the database currently does not have much of an impact on improving decision making.

For example, in 2020 the Legislature directed the Department of Health to use insurance claims data to track wasteful spending in healthcare and publish their findings in annual reports.[7] These reports, spanning 2021-2023, identified wasteful medical spending in areas such as anti-psychotic medications and opiates for lower back pain. This is the only example we identified where DHHS produced actionable insights using the APCD. Eventually, wasteful medical spending reports were discontinued after the Legislature removed their funding.

We were able to identify only one example where actionable APCD information generated by Healthcare Statistics was presented to the Legislature.

The Health Care Statistics program—which houses the APCD within DHHS—has used Utah's APCD to create other analyses, but those analyses have had limited impact on policymaking. Their uses included an annual report on primary care spending and blog posts titled Databytes on topics like opioid prescriptions and major depressive disorder.

APCD Can Be Used to Inform Policymaking

To demonstrate the potential usefulness of Utah's APCD, we replicated studies designed by other states to inform their legislative efforts. We also conducted original analysis to demonstrate the power of this information to inform policy makers. Specifically, we explored the effect of receiving behavioral healthcare on emergency department utilization.
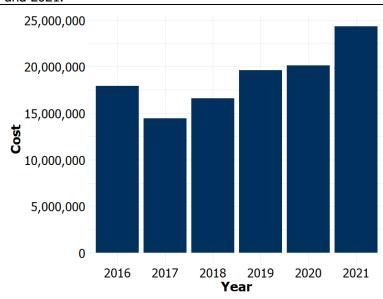
> ## Colorado Used Its APCD to Estimate Mental Health and Self-Harm Emergency Department Utilization

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[7] House Bill 195, 2020 General Legislative Session

Colorado's APCD conducted a study to determine the change in emergency department usage for mental health and self-harm over time.[8] We replicated their study. When taken together, the following charts from our replicated study using Utah's APCD demonstrate information that can be used to inform policymaking. The total spending on mental health emergency department visits increased by 36% between 2016 and 2021. In the same time period, the average cost per visit only increased by 2%. This suggests that increased spending is driven primarily by increased utilization. APCD data reveal that depression, anxiety, alcohol related disorders, and suicide related encounters are the primary diagnoses that lead people to visit the emergency department for mental health reasons. The data also show that substance use is the dominant method for those who self-harm and end up in the emergency department. By understanding trends in behavioral health emergency department cost and utilization, policymakers can evaluate the effectiveness of initiatives designed to improve cost and lower utilization.

Figure 1.1 Total Cost of Emergency Department Visits for Mental Health by Year Is Steadily Increasing. Mental Health Emergency Department spending increased by 36% between 2016 and 2021.

Source: Auditor generated from APCD data.

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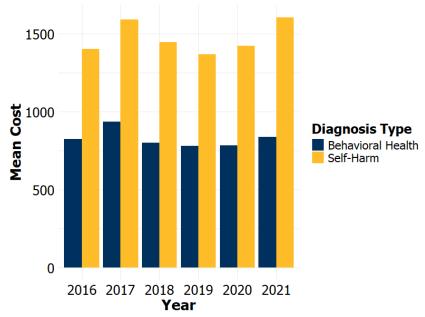
[8] Colorado Center for Improving Value in Healthcare. *Emergency Department Use for Mental Health and/or Potential Self-Harm.*
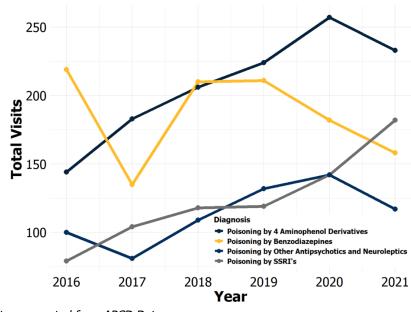
Figure 1.2 Self-Harm Emergency Department Visits Cost Almost Twice as Much as Other Behavioral Health Emergency Department Visits. Cost differences highlight the importance of upstream mental health services and early interventions.

Source: Auditor generated from APCD Data.

Figure 1.3 APCD Has Information That Can Inform Behavioral Health Policy and Interventions. Substance abuse is the primary self-harm method reported for emergency department visits in claims data; knowing the primary substance used can allow policymakers to refocus their efforts accordingly. Without further research, the causes for these changes are unknown.

Source: Auditor generated from APCD Data.
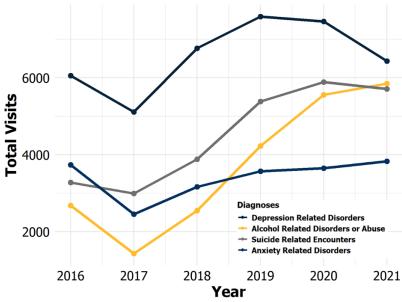
Figure 1.4 The Reasons for Mental Health Emergency Department Visits Have Changed Over Time. Policymakers and agency staff can use APCD data to monitor behavioral health trends and evaluate if current initiatives are changing outcomes.

Source: Auditor Generated from APCD Data.

As shown in this study, information in an APCD can be used to inform the Legislature. Specifically, these data can be used when making legislative decisions on where best to spend limited funds to strengthen behavioral health support systems. This study using Utah's APCD provides useful information that could inform efforts to increase the number of behavioral health beds in medical facilities.[9] Colorado's study was initiated by a state legislator. The study aimed to estimate the cost of increasing the capacity of hospitals to handle the increasing numbers of patients with mental health and self-harm conditions treated in the emergency department. Additionally, our replication of the study identifies the primary methods by which Utahns self-harm, which can drive potential policy discussions about prevention.

> **This study shows how information in an APCD can be used to inform legislative decisions on how to strengthen behavioral health support systems.**

> ## Vermont Used Its APCD to Categorize Youth with High Behavioral Health Needs

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[9] We will review behavioral health bed availability in one in our series of behavioral health audits.

In 2020, Vermont's Department of Health Access was interested in developing mobile response units to improve access to mental health services and reduce the need for both emergency department visits and inpatient admissions.[10] The department used APCD data to identify a subgroup of young people that were high utilizers of emergency departments for mental health diagnoses. The results of the study provided baseline data that could be used to evaluate whether a mobile response unit improved outcomes or lowered healthcare costs over time.

In 2021, young people in Utah with high behavioral health needs cost approximately five times as much as young people with low to moderate behavioral health needs ($2,015 vs $10,072). They were also significantly more likely to be in the emergency department because of self-harm, and/or be diagnosed with an alcohol related disorder.

> **Young People with High Behavioral Health Needs Cost Five Times More than those with Low to Moderate Needs**

This study demonstrates how claims data can supply the information required to evaluate public programs that aim to improve behavioral health treatments and outcomes.

Utah Can Use Its APCD to Create Behavioral Health Outcome Metrics

We worked with stakeholders to identify practical and measurable outcome metrics for Utah's behavioral health system. Stakeholders explained that information on how people with behavioral health needs interact with public and private institutions can serve as a proxy for their recovery. Factors like a person's

- Hospital/emergency department utilization
- Incarceration frequency
- Housing
- Employment
- Educational attainment

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[10] Vermont Blueprint for Health. *Using APCD Data to Identify Young People with High Mental-Health Needs. 2020*

can serve as indicators for how they are progressing or regressing. These data have the potential to help create system-level outcome measures because they apply to most Utahns and are currently being collected by various state agencies.

We analyzed the high-level association between behavioral health treatment and hospitalization. Specifically, we examined the rates at which patients returned to the emergency department after an initial visit for a behavioral health related reason. We calculated the rate patients who received behavioral health treatment after their first visit returned to the emergency department compared to those who did not receive any treatment after their first visit. We controlled for patient age, race, and if they were diagnosed with a serious mental illness. The results are displayed in Figure 1.5.

Figure 1.5 Reentry to the Emergency Department Varies by Behavioral Health Treatment Status. Those who receive behavioral health treatment return to the emergency department sooner than those who do not. This could indicate a strong relationship between severity of behavioral health conditions and the likelihood to receive treatment. Exploring the relationship between treatment and returning to the emergency department requires further study.

Source: Auditor generated from APCD data.
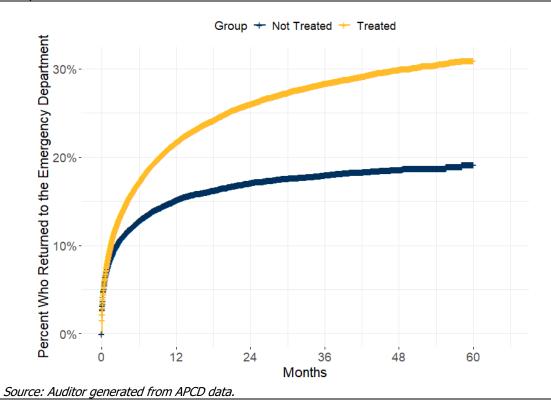
Figure 1.5 indicates that patients who received behavioral health treatment after their first emergency department visit returned to the emergency department sooner than those who did not. This result provides an incomplete picture of the effect behavioral health treatment has on a patient's well-being. For example,

without knowing the mortality, employment, and incarceration rates of patients who did and did not receive follow up care prior to returning to the emergency department, it is difficult to determine the effect behavioral health treatment had on Utahns who received it.[11] Much of our inability to analyze this information is due to data sharing issues. Initially these results may seem counterintuitive, but they lead to further questions about treatment that can be answered by existing data.

Other potential use cases to inform legislative decisions related to behavioral health include

- Identifying behavioral health patients who use emergency department beds instead of behavioral health facility beds

- Exploring cost differences in boarding patients in emergency departments compared to behavioral health facilities

- Identifying areas in the state that could benefit from having a mobile response behavioral health team

- Identifying parity in behavioral health claims coverage between commercial and Medicaid payers

These potential use cases demonstrate areas where information from APCD can produce actionable insights that inform policymaking aimed at improving behavioral health outcomes for Utahns.

The Behavioral Health Commission Should Use Utah's APCD to Inform Their Strategic Plan

The commission can use Utah's APCD for more dependable ways to measure the success of their efforts. The commission's recently adopted strategic plan identifies population indicators that guide their operations. These population indicators include

- Prevalence of substance use disorder in adults
- Prevalence of mental illness in adults
- Youth need for behavioral health treatment
- Number and rate of deaths due to drug overdose/suicide

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[11] The need for more connected data to understand behavioral health outcomes is a central theme of this report and will be addressed more fully in Chapter Two.

The commission plans to measure the first three indicators with surveys administered by DHHS to a representative sample of Utahns.[12] They plan to measure the fourth indicator using data from Vital Records and Statistics. These data primarily include death certificates.

Using surveys to measure progress is hard because they are self-reported. Though they provide important information about behavioral health trends, they can be more subjective than other forms of data.[13] Additionally, analysts cannot link surveys to other data sources, which limits their ability to study the relationships between behavioral health treatments and outcomes.

Claims data, on the other hand, documents the diagnoses and treatments patients receive from medical professionals. These data are more concrete and enable analysts to view the full spectrum of the conditions patients have and the treatments they receive. For example, the youth survey provides information about alcohol use rates among adolescents. The APCD includes when youth are diagnosed with alcohol abuse disorder, the corresponding treatments they received, and how long those diagnoses lasted. Information from Vital Records and Statistics shows deaths caused by suicide and drug overdose. Claims data can show all the diagnoses and treatments people received (or did not receive) leading up to their deaths.

Ultimately the APCD offers more concrete information the commission can use to monitor progress towards its strategic priorities. Because the commission's annual report emphasizes addressing the full continuum of care they should actively incorporate claims data to inform their planning, implementation, and evaluation efforts. Without claims data, the commission risks making decisions with notable blind spots related to the how Utahns interact with their behavioral healthcare.

Another advantage of using Utah's APCD to inform the commission's strategic plan is that the database includes both Medicaid and private insurance information. Commission members and staff have indicated that without private

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[12] This survey is called the Public Health Indicator Based Information System. It aims to provide population level estimates of physical and behavioral health conditions throughout Utah.

[13] These inaccuracies are largely due to biases such as social desirability bias.

insurance information, they will naturally skew their efforts towards the needs of Utahns covered by Medicaid. An example of how the APCD can be used to address the behavioral health needs of all Utahns can be found by analysts at the University of Utah Health who describe that

> *APCD density maps of psychiatric emergency department claims and frequent inpatient admissions highlighted South-Salt Lake as a community in need of acute mental and behavioral health care. This analysis informed the siting of the Huntsman Mental Health Institute Crisis Center that opened last fall. Potential future crisis centers would rely heavily on the APCD to find the best sites for the Wasatch Front Community.*[14]

The U of U used APCD data to inform where they built the Huntsman Mental Health Crisis Center to fill unmet demand for mental health services.

The University of Utah Health used the APCD to identify where Utahns needed additional behavioral health services. Insights generated from APCD information were key in determining where to build a new mental health facility. With the Behavioral Health Commission's expressed priority to fund two additional rural behavioral health receiving centers, information in the APCD could inform where they recommend those centers be located.

The commission has an opportunity to use APCD data to improve how it monitors progress towards its priorities. It can also use claims data to identify where Utahns need more behavioral health services and recommend where more capacity should be built.

DHHS Can Use the APCD to Augment Current Behavioral Health Workforce Tracking Efforts

A recent performance audit of Utah's behavioral health workforce found that a lack of quantitative data hindered the ability of stakeholders to make informed workforce decisions.[15] DHHS's Health Work Advisory Council and its accompanying analytics arm—the Health Workforce Information Center—distribute and analyze a survey to behavioral health providers to track the workforce and understand its needs. The survey attempts to measure

- Provider characteristics
- Practice location

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[14] The University of Utah Health Science Strategy Team.

[15] Utah Office of the Legislative Auditor General. *A Performance Audit of Utah's Behavioral Health Workforce: A Review of Workforce Efforts, Entities, Indicators, and Oversight.* Report No. 2025-05, April 2025.

- Patient characteristics
- Facility type
- Other information

Much of this information is already included in Utah's APCD, in a more reliable fashion than a survey. For example, Figure 1.6 is taken from the State Auditor's Utah Health Cost Compare dashboard. They created this dashboard using APCD data to enable Utahns to compare the cost of common healthcare treatments. The figure displays every behavioral health provider in the state that provided psychotherapy to patients who billed insurance. Because tracking the physical and behavioral health workforces are not the intended use of the Health Cost Compare dashboard, DHHS could build a similar dashboard that maps out the locations of key behavioral health services that accept insurance. This information could also be used to identify any provider-deserts.

Figure 1.6 The State Auditor's Office Has Previously Used APCD to Show Provider Locations. DHHS Could Use APCD to Map Behavioral Health Provider Locations and Deserts. State Audit's Utah Health Cost Compare tool demonstrates APCD's potential for behavioral health workforce tracking.

Source: Generated by the Office of the State Auditor.

In addition to having information about provider and patient characteristics, Utah's APCD includes information on the types and frequencies of treatments administered by providers. As described in the Behavioral Health Workforce performance audit, New Hampshire leverages its All-Payers Claims Database to

> *…analyze adequacy based on actual service volume, rather than solely relying on the number of providers in a network. [The state also] compares a provider's listed specialty in the [state] directory to actual [services provided]. This [allowed] regulators to identify errors in [their state's] directory such as misclassifications or identify providers that are no longer participating in a health plan's network.*

DHHS can improve its ability to track the behavioral healthcare workforce by using the APCD. Developing better insights into where workers are located and what services they provide can inform the department's efforts to improve access to treatments for those who need them. Recommendations to accomplish this can be found in chapters two and three.

📖 BACKGROUND

The Department of Health and Human Services (DHHS) data sharing policies and processes hinder staff from fulfilling job responsibilities and contribute to inefficiencies throughout the department. This chapter focuses on potential changes that can be made to improve data sharing while still maintain important data privacy principles.

FINDING 2.1
DHHS Data-Sharing Barriers Prevent Employees from Fulfilling Job Responsibilities

RECOMMENDATION 2.1
The Legislature should consider policy options allowing for more data sharing within the Department of Health and Human Services for public health cases.

FINDING 2.2
Data Sharing Review Processes Create Inefficiencies Throughout the Department

RECOMMENDATION 2.2
The Department of Health and Human Services should explore the potential for creating an expedited review process for internal data requests.

FINDING 2.3
More Robust Behavioral Health Outcome Measures Require Increased Data Sharing with External Agencies

RECOMMENDATION 2.3
The Legislature should consider balancing the need for more robust behavioral health metrics with data privacy principles.
RECOMMENDATION 2.4
If the Legislature desires more robust behavioral health metrics, it should consider which entity should be charged with connecting, protecting, and analyzing inter-agency data.

💡 CONCLUSION

The Legislature has opportunities to consider changes to *Utah Code* if it desires more robust behavioral health metrics and more efficient data sharing processes within DHHS. The Department of Health and Human Services should also review the potential to expedite internal department data requests within effective data privacy protections.

Chapter 2
Data Sharing Policies Should Be Reviewed to Optimize APCD's Potential

Strict data-sharing policies and a complex internal review process within Utah's Department of Health and Human Services (DHHS or department) hinder staff from fulfilling their job responsibilities, which can result in diminished public health outcomes. These review processes also consume substantial amounts of staff time, which contribute to operational inefficiencies throughout the department. Departments of health in other states have policies that balance data privacy with improved access for internal staff. DHHS could improve their data review processes, and the Legislature could consider revising statute to improve data sharing within the department. DHHS must accompany any process improvements with a new willingness to share data when possible. For years, the culture at DHHS has been to silo all data, often at the expense of improvement and innovation.

Additionally, data required to create more robust behavioral health metrics are collected by various state agencies. While connecting these data could enhance the Legislature's ability to monitor the state's behavioral health system, there are important data privacy principles to consider. If the Legislature desires more robust behavioral health metrics, there are several entities that could connect and protect the data required to produce those measures.

2.1 DHHS Data-Sharing Barriers Prevent Employees From Fulfilling Job Responsibilities

Strict policies create data-sharing barriers and prevent DHHS staff from effectively fulfilling their responsibilities. Other states have been able to balance data privacy concerns with providing government agencies access to data. Changes in *Utah Code* and internal organizational processes would allow for more flexible data sharing within DHHS without undue risk to data privacy. By eliminating some of these barriers, DHHS employees would be able to access the data they need to fulfill their job responsibilities and better inform decision making for the department and Legislature.

Data-Sharing Challenges Prevent DHHS Employees From Fulfilling Their Job Responsibilities

Current language in the Health Data Authority Act is unclear, leading to strict data-sharing processes throughout DHHS.[16] DHHS applies these processes to external requestors, as well as their own staff.

The act indicates that personally identifiable information (PII) attached to health data can only be shared for the following purposes:

- To assist with tracking immunization records for Utah's Statewide Immunization Information System

- To provide information to help support cancer prevention, control, and research for Utah Cancer Registry

- To help the Office of the Medical Examiner investigate sudden or unexpected deaths in Utah

- Research and statistical purposes

> **Utah Code only allows identifiable data within the APCD to be shared for four use cases.**

Beyond the uses specified by law, individuals may request de-identified data from DHHS. Those who apply go through a review process to identify the minimum amount of deidentified data the applicant is eligible to receive. Although the act does not define what constitutes PII, DHHS has chosen to follow the Health Information Privacy Protection Act's (HIPPA) Safe Harbor standards.[17] Data protected under Safe Harbor include

- Names
- Locations more granular than the first three digits of a zip code
- Dates of service (except for year)
- Social Security numbers

DHHS staff find the time-consuming data request process an obstacle to their work. DHHS staff who access data go through data privacy and security trainings to ensure data privacy principles are upheld throughout the department. We will discuss this later in the chapter. We observed examples in the department where teams had clear uses for the APCD but could not access

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[16] The Utah Health Data Authority Act was established by Senate Bill 235 during the 1990 General Legislative Session and remains in effect.

[17] Under HIPPA's Public Exemption, state public health authorities are exempt from HIPPA guidelines when they perform job functions related to public health.

the data. These examples include chronic disease tracking and behavioral healthcare workforce tracking.

The Office of Communicable Diseases Has Been Unable to Access APCD Data to Track Chronic Diseases

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DHHS's Office of Communicable Diseases (OCD) monitors, investigates, and prevents the spread of infectious diseases in Utah. They have not been able to access APCD data, making their work harder and less effective.

During the November 2024 Health Data Committee meeting, the state epidemiologist testified that, due to data sharing restrictions, her team was unable to use APCD to identify when and where chronic diseases occur. Because chronic diseases are one of the primary causes of death in Utah, understanding where they are concentrated is essential for providing preventative services. OCD has been limited in their ability to make data driven decisions because they were not granted access to critical variables in the APCD, despite having the vision to use the data to improve public health outcomes.

Other states have demonstrated the value of using APCDs to monitor chronic disease trends. For instance, the Oregon Health Authority (OHA) recently released a cost and utilization report that offers meaningful insights into patterns associated with chronic conditions. This report was presented to a state policymaking committee to help inform their policy decisions.

The Healthcare Workforce Information Center Has Been Unable to Access APCD Data to Track Utah's Behavioral Health Workforce

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The Healthcare Workforce Initiative Center (HWIC) is tasked with studying and tracking Utah's healthcare workforce. HWIC was established to serve as the state entity for healthcare workforce data analytics. Specifically, they aim to assess the supply, demand, distribution, and retention of healthcare providers. However, HWIC has been denied access to the APCD data needed for behavioral

> **Divisions within DHHS are not able to fulfill job responsibilities because they don't have access to data that would improve decision making.**

healthcare workforce tracking. Unlike Utah, Arkansas, Oregon, and Virginia use their APCDs to track their healthcare workforces.

Without APCD data, HWIC primarily relies on workforce surveys to support their analyses. Survey data is less reliable and using it as their only source of information limits HWIC's ability to produce methodologically sound reports. HWIC's inability to access APCD limits its capacity to analyze how changes in the healthcare workforce affect people's access to services, continuity of care, and healthcare outcomes. Because HWIC has been denied access to APCD data, they are unable to fully accomplish their mission.

These cases—chronic disease and behavioral health workforce tracking—highlight how some staff at DHHS are unable to fully do their jobs because they cannot access APCD data.

> **Staff report that the culture around data sharing is to first say "no".**

Staff report that access to data has been more locked down even since the merger of the Department of Health and the Department of Human Services. Ironically, this makes collaboration between the divisions more difficult, which was one of the purposes behind the merger. Staff describe that they feel the department has a culture of saying "no" to data requests. In response, DHHS leadership told us that they are working to change both the culture and the perception of that culture. Our own experience auditing DHHS entities in the past aligns with DHHS's staff concerns. To make meaningful progress towards collaborating and breaking down data silos, this culture must change.
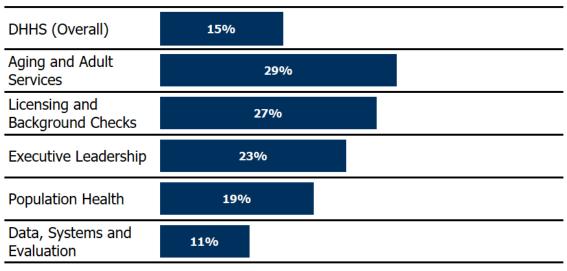
Fifteen percent of DHHS employees report that they don't have access to the data they need to fulfill their job responsibilities. Some divisions report higher rates, with almost a quarter of executive leadership expressing as much. Additionally, 24% of employees feel that they do not have access to the data they need to innovate within DHHS.[18]

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[18] These results came from our OLAG Organizational Culture Survey.

Figure 2.1 Fifteen Percent of DHHS Employees Do Not Have Access to Data to Do the Job the Legislature Has Charged Them to Do. Divisions that require data for their jobs report that they do not have the necessary access to data.

Percentage of DHHS Staff That Report They Do Not Have Access to the Data They Need to Fullfill Their Job Responsibilities.

Division	Percentage
DHHS (Overall)	15%
Aging and Adult Services	29%
Licensing and Background Checks	27%
Executive Leadership	23%
Population Health	19%
Data, Systems and Evaluation	11%

Source: Auditor generated from OLAG Organizational Culture Survey.

Adjusting *Utah Code* to allow for broader use of data within DHHS for public health purposes could enable better access and usage. The way that it is currently interpreted makes it easier for external requestors (such as university researchers) to access APCD data than internal DHHS staff. Other states provide flexibility for health data, such as the APCD, to be shared internally for uses that can improve public health. For example, Colorado statute mandates that the APCD should "be available to state agencies and private entities…engaged in efforts to improve health care." Similarly, New Hampshire statute allows sharing public health data with government entities if they have a legitimate reason. Policymakers can look for a Utah approach that allows access for recognized policy areas while maintaining data privacy.

> **Currently the Health Data Authority Act makes it easier for external requestors to access public health data than internal department staff.**

Changes to *Utah Code* would clarify DHHS's ability to better share data internally so that employees can fulfill their job responsibilities. DHHS interprets the Health Data Authority Act as prohibiting them from sharing identifiable health data except for the four identified exceptions. Potential changes to statute would provide DHHS staff with the same access to data as university researchers. It could also allow sharing deidentified data at a more specific level within the department for specified use cases.

Current Statute

- 26B-8-508 Section 2 limits sharing of identifiable data to three specific purposes.
- 26B-8-508 Section 3 allows sharing with approved researchers under strict conditions.

Proposed Legislative Options

Option A

Amend Section 3 to expand "research and statistical purpose" to include public health.

Option B

Revise Section 2 to permit internal DHHS sharing of identifiable data at more granular levels.

Targeted statutory changes could remove the barriers staff throughout DHHS currently face when working to fulfill their job responsibilities and improve the work performed by DHHS.

RECOMMENDATION 2.1

The Legislature should consider policy options allowing for more data sharing within the Department of Health and Human Services for public health cases.

2.2 Data Sharing Review Processes Create Inefficiencies Throughout the Department

Healthcare Statistics (HCS) has a complex and time-consuming data-sharing process which prevents DHHS staff from efficiently accessing the data needed to fulfill their responsibilities. Other states have adopted streamlined internal review processes that maintain privacy while improving access. Utah could similarly revise statute and internal procedures to enable more flexible data sharing within DHHS. These changes would reduce delays, support

It takes an average of 57 days for a data request to get approved.

informed decision-making, and better align with the department's operational needs.

Data-sharing approvals take an average of 57 days. This number does not include the time needed to then compile and submit the data to the requestor. Employees who use data as a part of their job responsibilities report that the process is frustrating, opaque, inefficient, and slow with unclear procedures.

These inefficiencies stem from a complex approval process designed to ensure compliance with privacy laws and data governance standards. DHHS requires the same data review process for all requestors, internal and external, shown in the image below. We support privacy laws and data governance and have written recommendations in the past supporting greater clarity of these statutes. However, it needs to be determined whether the process for handling internal data requests should mirror that of external requests. We believe DHHS should review the process to determine if internal requestors can certify their compliance with necessary laws and policies. This could include internal staff obtaining and then renewing that certification on an annual basis, for example. This would allow for internal information to be more easily shared.

HCS Data-Sharing Process

A data request is submitted by a standardized form.	The request is reviewed and processed by HCS staff, including any necessary preparation steps.
The finalized DSA is uploaded to a designated SharePoint site for formal review.	HCS prepares and finalizes a Data Sharing Agreement (DSA).
The DSA is reviewed and approved by: HCS leadership, privacy office, legal team, and data governance.	A designated official signs the DSA on behalf of the department.
Once both parties have signed, HCS is authorized to share the requested data.	The signed DSA is sent to the external party for their signature.
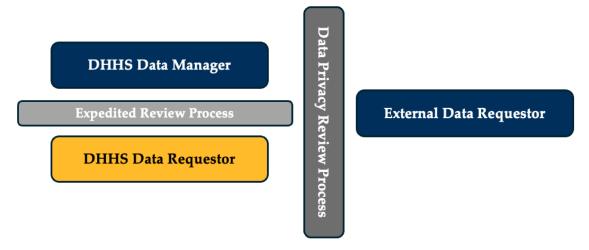
Source: Auditor generated.

Other states use different review processes for internal department staff and external requestors. For instance, Oregon uses a streamlined process for other government agencies that is faster than the one required for researchers.[19] Similarly, Massachusetts exempts government agencies from the full review process, while researchers must still undergo the complete procedure.[20] Adjusting *Utah Code* to allow broader internal use of data could enable DHHS to implement a similar expedited process, improving access and efficiency for internal staff. The graphic below illustrates how the approval process could be changed to allow for better data sharing for internal data requests. Creating an expedited process for internal requests would allow for a faster turnaround while external requests would still require a full data sharing agreement. As a part of the expedited review, internal staff would still be required to undergo regular training in data privacy and certify that they will adhere to all required data privacy policies.

Source: Auditor generated.

Simplifying the request process for internal staff could make the data request process more efficient while preserving data privacy. It could also encourage innovation and reduce silos. We believe this can be accomplished while still maintaining high standards of data privacy. Enabling divisions within DHHS greater access to data could improve department efficiencies and free up large quantities of resources currently tied up in data review processes.

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[19] Oregon Health Authority (OHA)
[20] The Center for Health and Information Analysis (CHIA)

DHHS has Internal Controls to Maintain Data Privacy

DHHS has adopted internal privacy guidelines that assign data to categories of risk. Each level of risk has its own controls and restrictions.

- By participating in data privacy trainings, DHHS employees affirm their commitment to protecting data privacy rights and not publicly disclosing any identifiable information.

- Employees must also adhere to all data privacy policies within the agency as well as complete regular data privacy training.

Even with controls and restrictions, DHHS has had instances where data disclosure agreements were inadvertently violated. However, documentation shows these situations were appropriately handled.

DHHS has sufficient controls in place to support an expedited review process for internal data requests.

These existing safeguards demonstrate that DHHS has the controls necessary to support more effective data sharing. Rather than introducing new risks, statutory and organizational changes would operate within these protections, allowing the department to better fulfill its responsibilities while maintaining data privacy.

RECOMMENDATION 2.2

The Department of Health and Human Services should explore the potential for creating an expedited review process for internal data requests.

2.3 More Robust Behavioral Health Outcome Measures Require Increased Data Sharing with External Agencies

Combining data from multiple state agencies could produce stronger behavioral health metrics. While connecting these data could enhance the Legislature's ability to monitor the state's behavioral health system, there are important data privacy principles to consider. If the Legislature desires more robust behavioral health metrics, there are several entities that could connect and protect the data required to produce those metrics.

Data Sharing with External Agencies Can Facilitate Stronger Behavioral Health Outcome Tracking

Combining state agency data can help uncover patterns in how people with behavioral health diagnoses make progress towards stabilization. As described in chapter one, incarceration, hospital utilization, employment stability, and housing stability can act as indicators for how people with behavioral health diagnoses are progressing or regressing. However, each of these data sources are stored within different state agencies. For example, DHHS gathers data related to hospitalization, the Department of Workforce Services (DWS) tracks employment information, the Utah Department of Corrections (UDC) and local jails collect incarceration data, and the Utah Homeless Management Information System (UHMIS) tracks interactions with homeless shelters. Combining these data could be a powerful source of information for policymakers.

To provide an example of how these data can be combined, we merged APCD data with Salt Lake County Jail data. We then examined recidivism rates of Salt Lake County Jail inmates with behavioral health diagnoses for those who did and did not receive behavioral health treatments covered by insurance. The results are displayed in Figure 2.2. This figure presents the recidivism rate of former Salt Lake County Jail inmates who received at least one behavioral health treatment. Figure 1.5 in chapter one demonstrates the rate at which patients return to the emergency room after having received at least one behavioral health treatment.

Figure 2.2 Data From Agencies Can Be Combined to Inform Behavioral Health Public Policy. Combining behavioral health treatment data and Salt Lake County Jail data shows that former inmates who received behavioral health treatment are more likely to return to the jail. Combining data from other agencies can illuminate why this trend exists.

Source: Auditor generated from APCD data.

Figure 2.2 shows that on average, inmates who received behavioral health treatment after being booked into the Salt Lake County Jail returned more quickly than those who did not receive any services.

Without additional information, we are unable to know the effect receiving services has on recidivism. The reality is that former inmates who receive behavioral health treatment could also be more likely to have severe mental illnesses, use drugs, experience homelessness, or be unemployed. These unobserved factors could be the real drivers of recidivism. For example, a former inmate with substance abuse disorder could be more likely to seek out behavioral health treatment than a former inmate without substance abuse disorder. However, that same inmate could also be more likely to engage in activity that leads to recidivism. Without incorporating more data, these analyses are two pieces of a much larger puzzle. We believe more robust analyses that combine these data should be conducted, but doing so was outside the time constraints of this audit.

Stakeholders outside of DHHS explained this problem. Many of them are only able to analyze the isolated data to which they have access. They indicated they
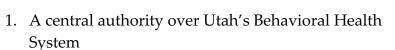
could improve their analyses and services if they were able to connect more data together. This would enable them to better identify the factors that drive improvements in behavioral health outcomes. A local program director voiced a need for better data to improve program and policy design for at-risk populations, saying, "We are hungry for good data so we can design better programs and policies to help these populations."

The Benefits of Data Sharing and Utilization Should Be Balanced with Data Privacy Principles

Data usage and privacy exist on a spectrum, and identifying the right balance can be difficult. While many analyses can be conducted on deidentified data, there are still concerns that individual people can be re-identified after their names and Social Security numbers have been removed. While research has shown that deidentified data can be reidentified if released publicly, DHHS has policies prohibiting the data behind the research from being released. To mitigate these risks associated with re-identification, it is essential that any data connected across state and local agencies be similarly safeguarded. Entities with access to connected data should have strong internal controls governing data use, including penalties for those who violate data privacy law and policy.

As a policy decision, if the Legislature desires to have behavioral health data connected to create more robust metrics, there are several entities that could house and protect that connected data.

If the Legislature desires more robust behavioral health metrics, there are several entities that could connect and protect the required data.

1. A central authority over Utah's Behavioral Health System

2. The Department of Health and Human Services

3. The Utah Data Research Center

4. Utah Commission on Criminal and Juvenile Justice

However, each of the external data sets described in this section have legal requirements that guide their usage. These laws would need to be appropriately navigated prior to any attempts to connect protected data.

RECOMMENDATION 2.3

The Legislature should consider balancing the need for more robust behavioral health metrics with data privacy principles.

RECOMMENDATION 2.4

If the Legislature desires more robust behavioral health metrics, it should consider which entity should be charged with connecting, protecting, and analyzing inter-agency data.

BACKGROUND

The Healthcare Statistics Program within DHHS administers Utah's All-Payers Claims Database. The program lacks a strategic plan, which limits its ability to maximize the value of claims data for state policymaking and decision making. Currently, statute does not define the purpose of Utah's APCD, which is uncommon when compared to other states.

FINDING 3.1: Without a Strategic Plan, Healthcare Statistics Fails to Achieve Its Full Potential

RECOMMENDATION 3.1: The Department of Health and Human Services should ensure the Healthcare Statistics program follows the guidance of Governor's Office of Planning and Budgeting's Guide to Strategic Planning to create and implement a strategic plan for the All-Payers Claims Database.

RECOMMENDATION 3.2: The Department of Health and Human Services should ensure that the Health Data Plan includes a clear vision for the role of the Healthcare Statistics program in processing and analyzing data to inform decisions and support behavioral health.

RECOMMENDATION 3.3: The Department of Health and Human Services should ensure that the Healthcare Statistics program adopt and implement performance metrics that include revenue, customer retention and growth, data quality, and public engagement.

RECOMMENDATION 3.4: The Legislature should consider establishing a defined purpose for the All-Payers Claims Database in state statute.

FINDING 3.2: Healthcare Statistics' Inefficiencies Contribute to Its Minimal Impact on Healthcare Policy

RECOMMENDATION 3.5: The Department of Health and Human Services should ensure that the Healthcare Statistics program explores renegotiating vendor contracts to invest more resources in Healthcare Statistics staff.

RECOMMENDATION 3.6: The Legislature should decide whether to require that the Healthcare Statistics program prioritize improving operational revenue through data user fees.

RECOMMENDATION 3.7: The Department of Health and Human Services should redefine Healthcare Statistics' staff roles and responsibilities to better align with the program's redefined vision.

RECOMMENDATION 3.8: The Department of Health and Human Services should determine whether monthly submissions of claims data are necessary.

RECOMMENDATION 3.9: The Department of Health and Human Services should work with Healthcare Statistics staff to automate all possible data submission and delivery processes.

RECOMMENDATION 3.10: The Department of Health and Human Services should update the APCD data dictionary to include better descriptions of data variables, how to interpret data values, and their limitations.

CONCLUSION

Healthcare Statistics can increase their effectiveness in administering and analyzing claims data by developing and implementing a strategic plan that prioritizes using the data to inform public policies and decisions. By automating its processes, redefining staff roles, and reallocating program resources, the program can increase its capacity to conduct analyses it currently is unable to.

Chapter 3
APCD Has No Strategic Plan and Poor Service Delivery, Leading to Inefficiencies

3.1 Without a Strategic Plan, HCS Fails to Achieve Its Full Potential

The Office of Healthcare Statistics (HCS) handles data that can shape important decisions about health in our state, but without a mission and strategy the office has not performed at an acceptable level. Vital information within the All-Payers Claims Database (APCD) is not being used to produce analysis that furthers the health of Utahns. A good strategic plan clarifies why an organization exists (mission), what they are aiming for, and how they will measure progress (metrics). Without this plan HCS cannot operate effectively. We have found that organizations without meaningful strategic plans might work hard but not always on the right things. As outlined in chapters one and two, operational inefficiencies and poor-quality information within the Department of Health and Human Services (DHHS or department) stem from how HCS currently utilizes claims data. HCS leadership does not have the clarity and vision needed to create and implement the elements of a strategic plan. Because of this, HCS is not able to maximize the potential of the APCD to provide better data on which policymakers could make decisions.

HCS Needs Stronger Vision and Direction to Maximize Its Value
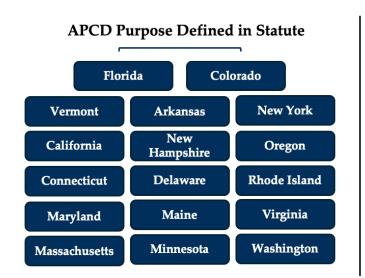
Currently, Utah statute does not clearly define the intended purpose for how claims data should be used to benefit public health. In 2022, out of 19 states with APCDs, Utah was one of only two whose authorizing statutes did not express a purpose or goal for what its APCD should accomplish.[21] In 2019, HCS established strategic priorities.[22] Since then, HCS has fallen away from these priorities instead of using them to continue to drive vision and value in the organization. In this same time frame, the Health Data Committee has also failed to guide HCS in developing a strategic plan.

Other states' purposes included improving population health, evaluating state health reforms, and measuring the quality of care. For example, Oregon's statute

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[21] RAND Corporation. *Linking State Health Care Data to Inform Policymaking: Opportunities and Challenges.* June 2022

[22] Utah Department of Health. *Health Data Transparency: Utah's All Payer Claims Database.* June 2019

explains that the purpose of its APCD is to help healthcare policymakers make informed choices, identify demands for health care, and evaluate the impact of health intervention programs. Similarly, Colorado's statute indicates that its APCD should be used to improve health outcomes, patient experience, and cost control.

APCD Purpose Defined in Statute

Florida	Colorado

Vermont	Arkansas	New York
California	New Hampshire	Oregon
Connecticut	Delaware	Rhode Island
Maryland	Maine	Virginia
Massachusetts	Minnesota	Washington

APCD Purpose Not Defined in Statute

Kansas	Utah

Source: Auditor generated from RAND Corporation analysis.

In 2007 the Legislature charged the Health Data Committee to create a data plan that identified key healthcare issues that are likely to benefit from improvement through better data.[23] The resulting plan identifies that the core purpose of the Health Data Committee is to use the data it oversees—which includes the APCD—to "support health improvement initiatives."[24] Although this plan is statutorily required, current directors within DHHS indicated the plan is outdated and does not guide the operations of HCS. We believe this is due to an absence of a clear vision to build upon initial frameworks and guide ongoing planning efforts.

> **HCS's current data plan lacks elements relating to planning, implementation, and evaluations, limiting their ability to maximize the potential of APCD data.**

The Governor's Office of Planning and Budgeting (GOPB) created a guide to help agencies more effectively develop and use strategic plans. This guide outlines eight essential elements that support outcome development and progress measurement. However, the HCS's current data plan lacks several of

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[23] The Legislature created the Health Data Committee to oversee and provide direction for how DHHS processes and uses claims data.

[24] The Health Data Committee's plan is the "Cost and Quality Data Project Plan."

these key elements—particularly those related to planning, implementation, and evaluation—limiting HCS's ability to maximize the potential of APCD data.

The infographic below illustrates the Management Cycle, which is a continuous improvement framework that can be used to advance HCS's goals and mission. Each step in the cycle coincides with the elements in a well-structured strategic plan. While HCS's health data plan outlines how claims data will be collected and includes general strategies for using data to improve healthcare, it does not define specific goals, metrics, or measurable objectives. A well-developed strategic plan could significantly improve the operations of HCS by enhancing impact, accountability, and overall effectiveness.

Source: The Best Practice Handbook by the Office of the Legislative Auditor General.

HCS Needs Better Performance Metrics to Improve Their Impact and Service Delivery

HCS's one performance measure is customer satisfaction. They need to use other key performance metrics to understand its effectiveness and impact. Performance metrics throughout DHHS are formalized through their Results Based Accountability (RBA) Framework. Each year, offices and divisions are reviewed according to the approved metrics within the RBA. Currently, HCS's RBA metric is evaluated by internal agency satisfaction. This is measured by a survey that rates the quality of service HCS provides to other offices within DHHS. In addition to this formal metric, the office recently surveyed external data requestors to better measure external customer satisfaction. In essence, HCS's current performance metrics include

- Internal Agency Satisfaction
- External Agency Satisfaction

While surveying internal and external data requestors measures important aspects of performance, it fails to capture other performance components. Other state APCDs use more holistic metrics to measure their performance. For example, Colorado tracks a suite of metrics that include

- Revenue from data user fees
- Customer retention and growth
- Data quality
- Customer satisfaction
- Public engagement/impact

Colorado incorporates these metrics into their strategic plan as a part of their continuous improvement efforts.[25] Without clear and comprehensive performance metrics that are tied to core operational responsibilities, it can be difficult for organizations to understand how to make continual progress towards achieving their mission and vision.

Healthcare Statistics Does Not Conduct Impactful Analysis

Although the Health Data Authority Act and the Health Data Plan each indicate that Healthcare Statistics should conduct analyses to improve public health, this does not appear to be a priority item for the office. We believe this is partly due to the absence of a current strategic plan that would provide clear focus and direction. Staff also note that most of their time is spent fulfilling data requests, which limits their ability to produce analytical work.[26] While the office does publish several annual reports (only one of which is required by statute) and periodic blog posts, these analyses typically receive little to no engagement from decisionmakers. Outside of publishing reports and blog posts, the office occasionally provides information related to legislative data requests. We spoke with legislative stakeholders who had requested or reviewed analyses from HCS between 2020

> **HCS staff describe that they don't have time to conduct impactful analysis because the majority of their time is spent fulfilling data requests.**

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[25] Colorado's APCD is called the Center for Improving Healthcare.

[26] This was discussed more in depth in chapter two

and 2024, and we identified only one use case where HCS analysis was formally proposed to the legislature.

Other states have stronger track records of using their APCDs to inform legislative decision-making. For example, Massachusetts[27] reported playing a key role in the state's recent healthcare reform efforts. Their staff reported consistent efforts to understand legislative needs and adapt their workflows to provide actionable information to the Legislature and other state agencies. These efforts include, but are not limited to:

Proactively providing baseline spending analysis for behavioral healthcare to inform legislative efforts to increase behavioral health allocations

Regularly conducting mandated benefit reviews to estimate the cost of benefits that the Legislature is considering mandating insurance companies cover

Partnering with the Attorney General's Office to study health market transactions

By contrast, we were unable to identify any strategic efforts from Healthcare Statistics to identify opportunities where claims data could be used to inform policymaking decisions. We were also unable to identify HCS efforts to track whether their analyses helped inform decisions at state agencies. A stakeholder outside of DHHS pointed to the following pieces of legislation as examples where HCS could have used claims data to inform policy.[28]

Despite the APCD being a rich resource, we were unable to identify any efforts or analysis from HCS to help inform decisions at state agencies.

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[27] Massachusetts's APCD is called the Center for Health Information and Analysis

[28] Senate Bill 95 Autism Amendments, 2019 Legislative General Session,
Senate Bill 214 Health Insurance Coverage Amendments, 2025 Legislative General Session,
Senate Bill 256 General Government and Appropriations Amendments, 2025 Legislative General Session

Autism Amendments mandate insurance coverage for autism treatment without age or hour limits and remove insurer opt-outs.

Health Insurance Coverage Amendments broaden the range of professionals who can diagnose autism to improve access and reduce delays.

General Government and Appropriations Amendments revise state budget allocations and administrative procedures across multiple government sectors.

By monitoring legislative priorities and collaborating with legislative staff, HCS can provide impactful analysis designed to help inform the policymaking process.

HCS can increase the value of Utah's APCD by establishing a clear mission and vision that emphasizes the proactive use of data to inform decision-making. This includes identifying opportunities where APCD data can provide meaningful insights both within and beyond the legislative process. By prioritizing analyses that are timely, relevant, and aligned with legislative needs, Healthcare Statistics can better demonstrate the public value of the APCD and strengthen its role in supporting data-driven policy decisions.

RECOMMENDATION 3.1

The Department of Health and Human Services should ensure the Healthcare Statistics program follows the guidance of Governor's Office of Planning and Budgeting's *Guide to Strategic Planning* to create and implement a strategic plan for the All-Payers Claims Database.

RECOMMENDATION 3.2

The Department of Health and Human Services should ensure that the Health Data Plan includes a clear vision for the role of the Healthcare Statistics program in processing and analyzing data to inform decisions and support behavioral health.

RECOMMENDATION 3.3

The Department of Health and Human Services should ensure that the Healthcare Statistics program adopt and implement performance metrics that include revenue, customer retention and growth, data quality, and public engagement.

RECOMMENDATION 3.4

The Legislature should consider establishing a defined purpose for the All-Payers Claims Database in state statute.

3.2 HCS's Inefficiencies Contribute to Its Minimal Impact on Healthcare Policy

Staffing challenges and inefficient operations limit HCS' capacity to fulfill data requests and conduct impactful analysis. The office can address these issues by prioritizing employee compensation in resource allocation decisions and automating or eliminating unnecessary tasks. Improving staff retention and optimizing operations can increase staff capacity to effectively deliver services and conduct analysis that informs legislative and division decision making.

HCS Can Better Optimize Its Resources to Address Employee Shortages

Current staffing challenges impede the office's ability to respond to data requests in a timely manner and conduct impactful analyses. We believe these challenges could be alleviated if DHHS and HCS focused on ensuring that all potential sources of revenue are used to improve their staffing situation. We explored opportunities to address HCS staffing issues through reallocating current spending and improving revenue through data user fees. Between January 2023 and March 2025, the office experienced an average annual turnover rate of 40% (losing 2 of 5 employees each year). During that time frame, it took an average of 79 days to fill each position (ranging from 42 to 200 days in length). Because it takes 1-2 years for an employee to become fully proficient in their position, the office has not had a fully functional team for nearly three years.

40% Annual Turnover

January 2023   March 2025

Average Time to Fill Positions: 79 Days

Source: Auditor generated from DHHS staffing data.

HCS directors frequently cited low starting salaries for data-related positions as the primary reason for consistent turnover. For example, during this audit, one entry level data analyst left HCS to accept a job in the private sector for double the starting salary.

One of HCS's Current Contracts Has an Expensive, Unnecessary Component. The office currently contracts with a private vendor to manage the APCD's data. The vendor contract has two components: the first relates to collecting and storing the data for HCS. The second relates to providing an analytical environment for the office. This second component costs $170,000 each year.

However, program staff indicate that they use the analytical environment infrequently. We reviewed the contract between DHHS and its vendor and believe that it would be better to use the money to improve staffing challenges. Division directors also described the contract provision as an inefficient use of resources. They noted that the funding could be put to better use if used to raise staff salaries to improve recruitment and retention. For context, the office spent over $300,000 on staff salary during the 2024 fiscal year with an average salary of approximately $75,000. This means that the $170,000 spent on the rarely used analytical environment was over half of the total spending on staff salary in 2024. Investing this money into staff could increase the office's capacity to proactively conduct analyses that inform agency and legislative decision making.[29]

The Legislature Should Decide Whether HCS Should Prioritize Increasing Data Sales to Address Staffing Compensation Challenges. Between 2020 and 2024, the office generated $282,173 in average annual revenue through data access fees, compared to $1.6 million in operating expenses.[30] The revenues generated by APCDs throughout the U.S vary widely. For example, Oregon

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[29] Renegotiating the vendor contract could reduce costs, but it may not result in recovering the full $170,000 due to potential changes in the revised terms.

[30] Data user fees refer to payments entities send to DHHS in exchange for using APCD data.

fulfills data requests for free to agencies and students, whereas Colorado generates upwards of $8 million each year.

HCS told us that they are hesitant to become more active in increasing their revenue because of potential concerns related to charging user fees to access private health data. Division staff struggle to navigate increasing the resources for their office while working to avoid any negative implications of charging user fees to access private health data. DHHS staff are unsure if the Legislature wants

HCS is hesitant to become more active in increasing revenue; they generate $282,173 in average annual revenue through data product sales.

them to become self-sustaining through increased data user fees or to limit the availability of the data. This is a policy decision for the Legislature to consider.[31]

While state statute does restrict how data are shared, there are ways that HCS could optimize their resources to allow for better support in agency and legislative decision-making. By re-evaluating their vendor contract and pursuing opportunities that are in line with legislative directives to increase their revenue, HCS can better optimize its resources.

RECOMMENDATION 3.5

The Department of Health and Human Services should ensure that the Healthcare Statistics program explores renegotiating vendor contracts to invest more resources in Healthcare Statistics staff.

RECOMMENDATION 3.6

The Legislature should decide whether to require that the Healthcare Statistics program prioritize improving operational revenue through data user fees.

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[31] Data sharing concerns are discussed in-depth in chapter two.

HCS Can Optimize Their Internal Processes

HCS can optimize their processes to better support data requesters and reduce the burden on submitters and staff. Healthcare Statistics' current operations are shaped by several routine tasks, that, while necessary, consume a significant portion of staff time. These processes, such as data requests, monthly payer submissions, and administrative tasks, limit the office's ability to focus on more strategic or efficiency-driven work. As a result, opportunities to improve internal systems, streamline workflows, or enhance service delivery are often delayed or overlooked. HCS can optimize their processes via automation, streamlining data submissions, and developing staff data knowledge.

> ## HCS Should Automate Processes

 The director of HCS has identified several internal workflows, such as data request handling and the querying process, that could be automated. Although current staff have the technical skills needed to implement automation, they report that they don't have the time to do so due to ongoing challenges, including data sharing agreement complexities,[32] frequent staff turnover, and various administrative responsibilities. Automating these processes would reduce the reliance on manual tasks and allow staff to dedicate more time to quality control and data analysis. By fully automating feasible workflows, HCS could increase its capacity to conduct more impactful analyses that support legislative and agency decision-making.

> ## HCS Should Make the Data Submission Process More Efficient

Several practices embedded in the data submission process appear to consume large amounts of staff time while yielding little additional benefit. For example, insurance companies are required to submit their claims data to HCS's contracted vendor once a month. If insurance companies fail to submit their data on time, or if there are quality issues with their submissions, HCS staff work with insurance companies to resolve these problems. The vendor then updates APCD only twice a year.

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[32] For detailed information on data sharing issues, see chapter two.

The monthly submission cycle is unique to Utah. Surrounding states like Washington and Oregon have adopted quarterly submission cycles. It's unclear if there are benefits from requiring monthly data submissions for updates that occur every six months. Managing this process is a full-time role for one of their five staff members, and at times, a second employee contributes as needed. Transitioning to a quarterly submission schedule may allow HCS to reallocate staff resources toward tasks that require their expertise, such as data analysis and quality assurance.

Managing the data submission process is a full-time role for one of their five staff members, and at times, a second employee contributes as needed.

When there are data quality issues in the submittal process, HCS staff work directly with insurance companies to resolve them. However, the exception process for submissions by small insurers is a reoccurring challenge. Smaller insurers may be flagged repeatedly due to low claim volumes, even when the issue is out of their control. Each flag requires a separate exception, often with different timelines, which can be burdensome for both payers and staff. By contrast, some states offer annual exceptions for recurring issues. Streamlining Utah's exception process could ease submission demands and free up staff time to engage in more strategic and analytic efforts.

HCS Should Help Staff Develop Better Data Knowledge

It is essential for HCS staff to have a deep understanding of the data within the APCD. However, office staff explain that only one team member understands the data within the database. Current job descriptions and constant turnover contribute to the concentration of knowledge in one team member. The concentration of knowledge in one team member leads to bottlenecks in workflows throughout the office. These bottlenecks reduce office productivity and result in increased time to fulfill data requests. Having multiple team members who have deep familiarity with the data was cited as an essential practice by APCD teams in other states.

In fact, these bottlenecks impacted our own ability to acquire and understand the data. Employees repeatedly acknowledged their lack of understanding of the

variables in the database. Paired with a data dictionary that contains limited descriptions of variable values and limitations, it took considerable effort from our team to conduct accurate analysis.

Only one team member in HCS truly understands the data within the APCD, creating bottlenecks in workflows throughout the office.

To build a shared understanding of the database, staff need training, responsibilities that include accessing and analyzing the data, and access to clear and consistent reference materials. HCS's current Data User Manual does not have descriptions for key variables in the data set and the limitations of those variables. By contrast, the Utah Data Research Center's Data Dictionary provides accessible descriptions of what data variables mean, how to interpret data values, and the limitations of those values.

Through automation, development of staff knowledge, and streamlining workflows, HCS can improve its efficiency and effectiveness. Currently, the data request and submission processes require substantial staff time and limit opportunities for staff to develop deeper familiarity with the data. Optimizing these processes would reduce the burden on both staff and payers, allowing the office to operate more efficiently and better allocate resources toward its core analytical functions.

RECOMMENDATION 3.7

The Department of Health and Human Services should redefine Healthcare Statistics' staff roles and responsibilities to better align with the program's redefined vision.

RECOMMENDATION 3.8

The Department of Health and Human Services should determine whether monthly submissions of claims data to Healthcare Statistics are necessary.

RECOMMENDATION 3.9

The Department of Health and Human Services should work with Healthcare Statistics staff to automate all possible data submission and delivery processes.

RECOMMENDATION 3.10

The Department of Health and Human Services should update the All-Payers Claims Database data dictionary to include better descriptions of data variables, how to interpret data values, and their limitations.

Complete List of Audit Recommendations

Complete List of Audit Recommendations

This report made the following fourteen recommendations. The numbering convention assigned to each recommendation consists of its chapter followed by a period and recommendation number within that chapter.

Recommendation 2.1
We recommend the Legislature consider policy options allowing for more data sharing within the Department of Health and Human Services for public health cases.

Recommendation 2.2
We recommend that the Department of Health and Human Services should explore the potential for creating an expedited review process for internal data requests.

Recommendation 2.3
We recommend the Legislature should consider balancing the need for more robust behavioral health metrics with data privacy principles.

Recommendation 2.4
If the Legislature desires more robust behavioral health metrics, we recommend it should consider which entity should be charged with connecting, protecting, and analyzing inter-agency data.

Recommendation 3.1
We recommend the Department of Health and Human Services should ensure the Healthcare Statistics program follows the guidance of Governor's Office of Planning and Budgeting's Guide to Strategic Planning to create and implement a strategic plan for the All-Payers Claims Database.

Recommendation 3.2
We recommend that the Department of Health and Human Services should ensure that the Health Data Plan includes a clear vision for the role of the Healthcare Statistics program in processing and analyzing data to inform decisions and support behavioral health.

Recommendation 3.3
We recommend that the Department of Health and Human Services should ensure that the Healthcare Statistics program adopt and implement performance metrics that include revenue, customer retention and growth, data quality, and public engagement.

Recommendation 3.4
We recommend the Legislature should consider establishing a defined purpose for the All-Payers Claims Database in state statute.

Recommendation 3.5
We recommend the Department of Health and Human Services should ensure that the Healthcare Statistics program explores renegotiating vendor contracts to invest more resources into Healthcare Statistics staff.

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Appendix

A. Department of Health and Human Services Organizational Culture Survey Results

Question		Responses
	How likely would you be to recommend your organization to someone seeking employment? (with 0 being extremely unlikely and 10 being extremely likely)	6.2

Job Satisfaction and Morale

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
My organization has a positive culture.	9%	22%	57%	12%
Currently, employee morale is high in my organization.	16%	38%	40%	6%
Over the last year, employee morale has improved in my organization.	19%	40%	34%	7%
A spirit of teamwork exists in my workgroup.	5%	13%	49%	34%
I am treated with respect.		10%	52%	34%
I feel appreciated.	9%	18%	46%	27%
I feel passionate about the work I do.	8%		46%	44%
I know what is expected of me at work.	8%		54%	37%
My current workload is manageable.	7%	17%	56%	20%
In the past year, have you voluntarily looked for other employment?	No: 54%		Yes: 46%	

Communication

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
I receive clear information about changes being made within my organization.	11%	29%	44%	15%
My day to day work impacts the goal(s) of my organization.	6%		59%	33%
My direct supervisor values my ideas.		7%	38%	51%
Overall, strategies and goals are shared with staff.	7%	21%	55%	18%
There is a clear process for sharing new ideas.	10%	29%	45%	16%

Legend

No		Yes	
Strongly Disagree	Disagree	Agree	Strongly Agree

	Strongly Disagree	Disagree	Agree	Strongly Agree
Leadership				
Hiring, raises, and promotion decisions are based on clear criteria.	16%	32%	41%	11%
I feel comfortable bringing up issues to my supervisor.	9%	9%	31%	52%
Management decisions align with the organization's strategic plan and mission.	7%	18%	57%	18%
Management hires employees who have the necessary experience and skills.	8%	17%	59%	16%
My immediate supervisor models: Accountability		7%	33%	56%
My immediate supervisor models: Empathy		7%	32%	58%
My immediate supervisor models: Innovation		11%	37%	49%
My immediate supervisor models: Integrity			32%	60%
My immediate supervisor models: Leadership		8%	33%	55%
My immediate supervisor models: Professionalism		6%	32%	59%
My immediate supervisor models: Respect			31%	61%
My organization is driven by goals.		15%	60%	21%
My organization is driven by performance measures.		17%	58%	20%
My supervisor(s) has the necessary knowledge about my programs.	7%	8%	38%	46%
My supervisor(s) has the necessary management skills needed to lead my program.	8%	8%	38%	47%
Senior leadership models ethical behavior.	8%	14%	52%	27%
Senior leadership strives for excellence and innovation.	7%	16%	52%	25%
DHHS Audit Specific				
Do you analyze data sets or make decisions based on data analysis as a part of your job responsibilities?	40%	60%		
I have access to the data I need to fulfill my job responsibilities.		12%	55%	29%
I have access to the data I need to innovate work performed by the Department of Health and Human services.		20%	51%	25%
The data I need to fulfill my job responsibilities or innovate work performed by the Department includes personally identifiable information.	8%	15%	47%	30%

Professional Behavior					
Are you aware of the procedure for filing grievances (i.e. complaints that could include violations of policy, mistreatment, etc.)?		33%		67%	
To the best of my knowledge, senior leadership is held accountable when they behave inappropriately.	8%	16%	61%		15%
To the best of my knowledge, staff are held accountable when they behave inappropriately.		15%	61%		19%
To the best of my knowledge, supervisors and managers are held accountable when they behave inappropriately.	7%	14%	61%		18%

Professional Development					
Do you receive a performance evaluation annually?			99%		
I am able to get the training I need to do my job effectively.		15%	58%		22%
I am given opportunities to innovate to improve current practices inside my organization.	8%	22%	47%		24%
I am provided with the appropriate resources to complete my job duties.		16%	57%		22%
I am given feedback from my supervisor on a regular basis to help improve my job performance.		8%	49%		40%
I find my performance evaluation feedback valuable	9%	13%	50%		28%
Mistakes are met with corrective, rather than punitive, action.		11%	55%		29%
My organization is dedicated to my professional development.	8%	23%	50%		19%
Training is ongoing.		12%	59%		26%

Legend

No		Yes	
Strongly Disagree	Disagree	Agree	Strongly Agree

Overall Survey Score

Y-axis: Percent of Total Respondents (0% to 40%)
X-axis: Strongly Disagree, Disagree, Neutral, Agree, Strongly Agree
Average line marked near Agree

Agency Response Plan

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

State of Utah

SPENCER J. COX
Governor

DEIDRE M. HENDERSON
Lieutenant Governor

August 8, 2025

Mr. Kade Minchey
Utah Legislative Auditor General
Utah Capitol Complex
P.O. Box 145315
Salt Lake City, UT 84114-5315

Dear Mr. Minchey,

Thank you for the opportunity to respond to the recommendations in *A Performance Audit of the All-Payers Claims Database* (Report No. 2025-14). This letter includes the response from the Utah Department of Health and Human Services (department) and the Division of Data, Systems, and Evaluation (DSE). We appreciate the work of the Office of the Legislative Auditor General in providing this audit. DHHS agrees that the data is critical to serving the public in a result-driven and cost effective manner while balancing the need to maintain the privacy of those we serve.

As always, the professionalism and engagement of your staff is not only appreciated but leads to reports that are action oriented. On behalf of the department, we agree with the recommendations in this report and we stand ready to implement them, as we collectively strive to leverage the data collected by the department through Utah's All-Payers Claims Database.

Sincerely,

Tracy S. Gruber
Executive Director

Recommendation 2.1. The Legislature should consider policy options allowing for more data sharing within the Department of Health and Human Services for public health cases.

Department Response: The Department of Health and Human Services (department or DHHS) concurs with this recommendation.

What: The department strives to balance data utilization and individual privacy. We will work with lawmakers to find solutions for maintaining data privacy while better utilizing the data held by DHHS.

How: The department will work with lawmakers to propose policy ideas for them to consider for the 2026 General Session to allow greater data sharing within the department.

When: March 6, 2026

Responsible Staff: Nate Winters, DHHS Deputy Director; Kyle Lunt, DHHS Director of Data Systems & Evaluation; Paul Ray, DHHS Director of Legislative Affairs

Recommendation 2.2. The Department of Health and Human Services should explore the potential for creating an expedited review process for internal data requests.

Department Response: The department concurs with this recommendation. The department continues to be committed to being efficient and streamlined. It is regularly evaluating its workflows to achieve this objective as part of its strategy of being a high-quality, innovative and trusted organization. Additionally, the department continues to broaden its approach to data sharing, recognizing the importance of accessing data to understand the conditions of the populations it serves and effectively targeting its resources to areas that will have the greatest impact.

What: The department is in the process of establishing a temporary data sharing workgroup to identify solutions to common barriers in the department's data sharing policies and processes. As part of the workgroup charter, it will work with other internal stakeholders to bifurcate the internal and external data sharing agreement review processes to make internal requests easier and faster to submit and approve.

How: The department's data sharing workgroup will make recommendations to the Division of Data, Systems & Evaluation (DSE) on ways to modify the internal data sharing agreement workflows to make them faster and easier. DSE will then implement the new process department-wide.

When: June 30, 2026

Responsible Staff: Kyle Lunt, DHHS Director of Data Systems & Evaluation

Recommendation 2.3. The Legislature should consider balancing the need for more robust behavioral health metrics with data privacy principles.

Department Response: The department concurs with this recommendation. The department recognizes that the current statutory framework is one that limits data sharing in the interest of privacy and as a result, applies a conservative interpretation of privacy laws. This prevents broader uses of the data and limits analysis.

What: The department strives to reflect the Legislature's ongoing preference to protect the privacy of individuals through the limited use of data sharing. While state and federal law demonstrates a more limited and conservative approach to data sharing in order to protect individual privacy, the department will provide any guidance to the Legislature should it consider broadening Utah Code to allow for more data sharing privacy.

How: The department will look for opportunities to collaborate with the Legislature and other entities to use data for analysis during the upcoming 2026 General Session.

When: June 30, 2026

Responsible Staff: Kyle Lunt, DHHS Director of Data Systems & Evaluation; Paul Ray, DHHS Director of Legislative Affairs

Recommendation 2.4. If the Legislature desires more robust behavioral health metrics, it should consider which entity should be charged with connecting, protecting, and analyzing inter-agency data.

Department Response: The department concurs with this recommendation. The department recognizes the value in contributing the data it collects to broader data lakes and warehouses, allowing it to link its data to those data sources outside of DHHS. Through this data sharing, the state will be equipped to address the needs of Utahns served across state agencies. This priority is reflected in Governor Cox's Executive Order 2023-01, *Creating a Time-Limited Task Force on State Agency Collaboration and Data Sharing*, which identifies the need to establish a centralized data hub for state data or leverage the existing, legislatively-established data hub, the Utah Data Research Center residing in the Utah System of Higher Education.

What: DHHS will coordinate with the Utah System of Higher Education to develop plans to contribute behavioral health data into the Utah Data Research Center (UDRC). Additionally, DHHS will coordinate with the Commission on Criminal and Juvenile Justice to ensure that the Public Safety Portal is not already equipped to be the central repository of behavioral health data to avoid any duplication with UDRC.

How: Initially, DHHS will evaluate its behavioral health data, including the data contained in the All-Payers Claims Database, to determine which data it can contribute to the Utah Data Research Center through existing agreements. Upon that review, it will engage the UDRC to determine if the Utah Code requires an amendment to include behavioral health data and if so, work with the Legislature to

adopt the amendment. Additionally, it will amend its existing data sharing agreements with UDRC to include behavioral health data. Simultaneously, DHHS will evaluate the behavioral health data currently being shared with CCJJ to ensure there is at least one entity that has the ability to connect behavioral health data with data that is outside of DHHS.

When: September 30, 2026

Responsible Staff: Kyle Lunt, DHHS Director of Data Systems & Evaluation; Paul Ray, DHHS Director of Legislative Affairs

Recommendation 3.1. The Department of Health and Human Services should ensure the Healthcare Statistics Program follows the guidance of GOPB's Guide to Strategic Planning to create and implement a strategic plan for the APCD.

Department Response: The department concurs with this recommendation. The department strongly believes in the value of strategic planning and to the extent this has not occurred within its Healthcare Statistics Program, that will be addressed.

What: Using the department's Results Based Accountability Plan (RBA) framework, GOPB's Guide to Strategic Planning and in coordination with stakeholders, the department will develop a strategic plan for its Healthcare Statistics Program, including the APCD.

How: The department will use the RBA framework and the GOPB Guide to Strategic Planning and work with the Health Data Committee to develop a strategic plan for the APCD.

When: June 30, 2026

Responsible Staff: Kyle Lunt, DHHS Director of Data Systems & Evaluation; Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.2. The Department of Health and Human Services should ensure that the Health Data Plan includes a clear vision for the role of the Healthcare Statistics program in processing and analyzing data to inform decisions and support behavioral health.

Department Response: The department concurs with this recommendation.

What: In coordination with stakeholders, the department will develop a strategic plan for the APCD that includes a vision and associated objectives and tactics for behavioral health support.

How: DHHS will use the RBA framework and the GOPB Guide to Strategic Planning and work with the Health Data Committee to develop a strategic plan for the APCD.

When: June 30, 2026

Responsible Staff: Kyle Lunt, DHHS Director of Data Systems & Evaluation; Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.3. The Healthcare Statistics program should adopt and implement performance metrics that include revenue, customer retention and growth, data quality, and public engagement.

Department Response: The department concurs with this recommendation.

What: In coordination with stakeholders, DHHS will include in the strategic plan developed for the APCD performance metrics related to revenue, customer retention and growth, data quality, and public engagement.

How: DHHS will use the RBA framework and the GOPB Guide to Strategic Planning and work with the Health Data Committee to develop a strategic plan for the APCD.

When: June 30, 2026

Responsible Staff: Kyle Lunt, DHHS Director or Data Systems & Evaluation; Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.4. The Legislature should consider establishing a defined purpose for the All-Payers Claims Database in state statute.

Department Response: The department concurs with this recommendation.

What: The department values clarity regarding the intent of the APCD and will work with the Legislature to define the purpose in statute. In the absence of legislative direction, the Division of Data Systems and Evaluation, in collaboration with the Health Data Committee, will utilize the strategic planning process referenced in Recommendations 3.1-3.3 to establish a defined purpose for the APCD.

How: The department will work with legislators to propose language defining the purpose of the APCD. If the Legislature does not amend the Utah Code to include a defined purpose for the APCD, DHHS will incorporate the purpose in the strategic plan developed for the Healthcare Statistics Program.

When: June 30, 2026

Responsible Staff: Nate Winters, DHHS Deputy Director; Kyle Lunt, DHHS Director of Data Systems & Evaluation

Recommendation 3.5. The Department of Health and Human Services should ensure that the Healthcare Statistics Program explores renegotiating vendor contracts to invest more resources in Healthcare Statistics staff.

Department Response: The department concurs with this recommendation.

What: Healthcare Statistics (HCS) will review all of their vendor contracts to ensure each expense is still appropriate and needed, and will renegotiate with vendors, if

needed. HCS will terminate or amend any contracts that are deemed partly or wholly unnecessary.

How: HCS staff will review the costs of all their vendor contracts and define for each the desired outcomes and benefits and evaluate if those results have been achieved.

When: December 31, 2025

Responsible Staff: Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.6. The Legislature should decide whether to require that the Healthcare Statistics Program prioritize improving operational revenue through data user fees.

Department Response: The department concurs with this recommendation. The department welcomes clarity from the Legislature regarding the intent to promote opportunities to increase revenue through data sharing.

What: The department will provide any guidance or recommendations with regard to expanding user fees applicable to accessing data from the APCD.

How: At the request of the Legislature, DHHS will coordinate with it and the Office of the Legislative Fiscal Analyst to develop statutory language to increase revenue through fees associated with using this data.

When: March 6, 2026

Responsible Staff: Nate Winters, DHHS Deputy Director; Kyle Lunt, DHHS Director of Data Systems & Evaluation

Recommendation 3.7. The Department of Health and Human Services should redefine Healthcare Statistics' staff roles and responsibilities to better align with the program's redefined vision.

Department Response: The department concurs with this recommendation.

What: The department will analyze current staff roles and budget, and realign staffing with the program's vision.

How: After the department works with the Health Data Committee and other stakeholders to establish a strategic plan for the APCD, the department will analyze current staff roles and realign them with the strategic vision, as needed.

When: August 31, 2026

Responsible Staff: Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.8. The Department of Health and Human Services should determine whether monthly submissions of claims data to Healthcare Statistics are necessary.

Department Response: The department concurs with this recommendation.

What: Healthcare Statistics will align data submission frequencies with the needs of the programs and with consideration for the data submitters' time.

How: The department will evaluate how frequently data should be submitted based on the data processing and loading schedules, and then update rules and processes accordingly.

When: June 30, 2026

Responsible Staff: Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.9. The Department of Health and Human Services should work with Healthcare Statistics staff to automate all possible data submission and delivery processes.

Department Response: The department concurs with this recommendation.

What: Healthcare Statistics will complete efforts to automate data submission and delivery processes to streamline and improve the data request process.

How: The program is testing and implementing a process to automate data pulls for requestors based on a data request worksheet. The department will fully implement this process to save time of query generation and will analyze the data request process for additional automation opportunities.

When: June 30, 2026

Responsible Staff: Patrice Nicholes, DHHS Health Care Statistics Program Manager

Recommendation 3.10. The Department of Health and Human Services should update the APCD data dictionary to include better descriptions of data variables, how to interpret data values, and their limitations.

Department Response: The department concurs with this recommendation.

What: Healthcare Statistics (HCS) will review and update the APCD and HFD data dictionaries to make it easier to understand data variables, how to interpret them, and their limitations.

How: HCS staff will review the existing data dictionary and resources, collect feedback from stakeholders, if needed, and make modifications to the resources.

When: June 30, 2026

Responsible Staff: Patrice Nicholes, DHHS Health Care Statistics Program Manager

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