STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

A. Effective October 1, 2017 unless otherwise noted, the following charges are imposed for services:

Medicaid Service	Cost Sharing Amount and Basis for Determination
Non-Emergency Services Received in Emergency Departments.	$8 for each non-emergency use of the emergency department.
Inpatient Hospital Stay	Effective July 1, 2017, $75 for each inpatient hospital stay (episode of care).
Physician or Podiatrist Services	$4 for each outpatient services visit (physician visit, podiatry visit, physical therapy, etc.).
Outpatient Hospital Services	$4 for each outpatient hospital service visit, (maximum of one per person, per hospital, per date of service).
Pharmacy Services	$4 for each prescription.
Chiropractic Services	$1 for each chiropractic visit (maximum of one per date of service).
Vision Services	$3 for each pair of eyeglasses.

Note: Additional ER copay information is found in Attachment 4.18-H, Page 1.

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B. The method used to collect cost sharing charges for categorically needy individuals:

X Providers are responsible for collecting the cost sharing charges from individuals.

_ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. Individuals whose countable household income, before deductions, is less than the TANF standard payment for a family of the applicable size are exempt from all cost sharing noted in Subsection A.

D. Cost sharing eligible members who present at an emergency department for a non-emergency service will be charged a copayment.

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E. Members outside the exempt status will receive a Medicaid Benefit Letter with co-pay information listed during their eligibility period.

F. The state includes an indicator in the Medicaid Management Information System (MMIS)

G. The state includes an indicator in the Eligibility and Enrollment System

H. The state includes an indicator in the Eligibility Verification System

I. Providers may verify a members copay requirements at: https://medicaid.utah.gov/eligibility.

J. The State applies incurred-cost sharing to the aggregate limit when claims are submitted for dates of service within the current monthly cap period. Once the aggregate limit is reached, cost-sharing liability stops.

For households that may have paid copays in excess of the aggregate limits:
- The member contacts a Utah Medicaid health program representative noting the out-of-pocket amounts paid.
- Medicaid staff verifies the amounts based on paid claims.
- Medicaid staff enters the household as exempt from cost sharing for the duration of the limit period.
- Medicaid staff will initiate, as appropriate, a reprocessing of the claim(s) that made the household exceed the aggregate limits.
- Medicaid staff will work with impacted providers to ensure the household is reimbursed for copay differences that were paid by the household.

K. Medicaid members described in 42 CFR 447.56(a)(1) are exempt from copayment requirements.

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L. The following conditions apply to the AI/AN copayment exemption:

Those individuals who have a verified or pending AI/AN status on their eligibility record and have an established relationship with one of the following types of facilities (I/T/Us) will be exempted from cost sharing:

- Indian Health Service facility
- Tribal clinic
- Urban Indian Organization facility

The State will perform a regular review of Medicaid claims to identify users of I/T/U facilities and will flag those users as exempt from cost sharing. In addition, individuals who present a letter or other document verifying current or previous use of services provided at an I/T/U facility, or services referred through contract health services in any State, will be flagged as exempt from cost sharing.

The following services do not require copayments:

1. Family planning services, including contraceptives and pharmaceuticals;
2. Preventive services, including vaccinations and health education;
3. Pregnancy-related services, including tobacco cessation;
4. Emergency services (emergency use of an emergency room); and
5. Provider-preventable condition (PPC) services.

M. Cumulative maximums on charges:

___ State policy does not provide for cumulative maximums.

_X_ Cumulative maximums have been established as described below:

- $75 for each inpatient hospital stay (episode of care).
- A cumulative copayment amount that does not exceed $100 per year is allowed for physician services, podiatrist services, outpatient hospital services, and chiropractic services.
- $20 cumulative monthly maximum copayment amount aggregated for pharmacy services.