

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.

T.N. # 17-0001

Approval Date 8-18-17

Supersedes T.N. # 07-010

Effective Date 7-1-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

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

T.N. # 17-0001

Approval Date 8-18-17

Supersedes T.N. # 02-001

Effective Date 7-1-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

- 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.

T.N. # 17-0001

Approval Date 8-18-17

Supersedes T.N. # 10-010

Effective Date 7-1-17

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____ UTAH

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.

T.N. # _____ 17-0001

Approval Date _____ 8-18-17

Supersedes T.N. # _____ New

Effective Date _____ 7-1-17