STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

A. The following charges are imposed on the categorically needy for services:

Service	Type of Charge Deduct.	Coins.	Copay	Amount and Basis for Determination
Non-emergency services received in emergency departments		X		$6 for each emergency department visit for non-emergency services. The average payment per claim to Emergency Departments is $169.
Impatient hospital stay		X		$220 for the first inpatient hospital stay of each calendar year. The average first day stay based on hospital claims data exceeds an average payment of $450.
Physician or podiatrist services			X	$3 for each physician or podiatrist service visit, maximum of one per date of service. Physician or podiatrist services are reimbursed at greater than $50.01 per visit.
Outpatient hospital services			X	$3 for each outpatient hospital service visit, maximum of one per date of service. Limited to $100 annual out-of-pocket expense per client. Outpatient services are reimbursed at greater than $50.01 per visit.
Pharmacy services			X	$3 for each prescription, limited to $15 per month. Average prescription exceeds $50.01.
Chiropractic services			X	$1 for each chiropractic visit, maximum of one per date of service. Chiropractic services are reimbursed at less than $25 per visit.
Vision Services			X	$3 for each pair of eyeglasses. Eyeglasses average over $60 per pair.

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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. Any individuals whose total gross income, before exclusions or deductions, is above the Temporary Assistance to Needy Families standard payment allowance is determined to have the ability to pay for cost sharing measures.

Cost sharing eligible clients who present at an emergency department for a non-emergency service will be charged a copayment. If the presenting client indicates to the emergency department that he/she is unable to pay a copayment at that time, the provider shall not charge the copayment and shall provide the services.

D. Clients outside the exempt status will have "copayment due" printed on the Medicaid cards they receive each month. Providers will use the Medicaid card to identify those clients who should pay a copayment.

Medicaid clients in the following categories are exempt from copayment requirements:

1. children;
2. pregnant women;
3. institutionalized individuals;
4. individuals whose total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy Families standard payment allowance; and
5. American Indian/ Alaska Native (AI/AN).

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

Through June 30, 2011, all individuals who have a verified or pending AI/AN status on their eligibility record will be exempted from cost sharing.

Beginning July 1, 2011, only 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;
2. emergency services; and
3. services provided to an individual who is receiving hospice care.

E. Cumulative maximums on charges:

__ State policy does not provide for cumulative maximums.

X Cumulative maximums have been established as described below:

- $220 for the first inpatient hospital stay of each calendar year.
- There is no cumulative annual maximum coinsurance amount for non-emergency use of the hospital emergency room.
- A cumulative copayment amount that does not exceed $100 per year is allowed for physician services, podiatrist services, outpatient hospital services, and chiropractic services.
- $15 cumulative monthly maximum copayment amount aggregated for pharmacy services.