

## **Medicaid ED Copayments: Effects on Access to Emergency Care and the Practice of Emergency Medicine**

### ***An Information Paper***

Spurred on by piecemeal expansion of Medicaid across the United States in the wake of the Patient Protection and Affordable Care Act, states are implementing Medicaid section 1115 waiver demonstrations to better serve their unique populations. While many Medicaid waiver policy trends inevitably trickle down to impact our health care safety net in the emergency department (ED), increasing use of ED copayments (copays) is of particular interest to our practice and patients. In general, governmental efforts to analyze and report effects of these waiver demonstrations have been lacking.<sup>9</sup> The American College of Emergency Physicians (ACEP) aims to use available data as well as reports from practicing emergency physicians to summarize the effects of ED copays on the access to emergency care and practice of emergency medicine.

### **Expanding Cost Sharing for Emergency Department Care**

The Deficit Reduction Act (DRA) of 2005 gave states the flexibility to enforce cost-sharing to Medicaid beneficiaries, including ED copayments for non-emergent visits, with a federal limit set at \$8 for those with income less than 150% of the federal poverty level (FPL). More recently, several states have used the section 1115 waiver demonstration process to request Center for Medicare and Medicaid Services (CMS) approval for variance from this \$8 limit. To date, only Indiana has successfully obtained approval for an increased copay in their waiver demonstration known as Healthy Indiana Plan 2.0 (HIP 2.0). Since its implementation in 2016, Managed Care Entities (MCEs) have been allowed to apply a \$25 copay if beneficiaries make a second or subsequent non-emergent visit to the ED within one year (after an \$8 copay applied to first non-emergent visit).<sup>26</sup> This copay is applied to the facility fee. As per waiver language, it is to be applied only after a medical screening exam (MSE) indicates no emergency condition exists and the hospital refers the beneficiary to an alternate, non-emergency provider available to provide timely care. After the beneficiary is informed they have a non-emergent condition as a result of the MSE, the beneficiary may either choose treatment in the ED with responsibility for copayment or referral to alternative venue of care with avoidance of copayment.<sup>12</sup> If the beneficiary chooses ED care, providers can withhold services until the copayment is made, if the beneficiary's annual income is above 100% of the FPL.<sup>11</sup> The copayment is waived if the beneficiary calls the MCE's nurse line prior to going to ED, or is admitted to the hospital.<sup>12</sup> Based on physician testimony, the co-pay is collected by registration personnel after the physician sees the patient. Of note, Anthem's MCE announced that, as of January 2018, it will only apply an \$8 ED copay rather than a \$25 copay for second and subsequent non-emergent ED visits.<sup>3</sup>

Kentucky's waiver demonstration, which will be implemented in July 2018, also contains financial repercussions for use of the ED, although not technically a copay. Kentucky Medicaid beneficiaries have a "My Rewards Account," an incentive account for funds that can be used for non-covered benefits such as dental, vision, over-the-counter medications, and gym memberships. Funds will be deposited by the state into these incentive accounts for "healthy behaviors," one of which includes avoiding non-emergent use of the ED for a calendar year.<sup>17</sup> Funds will also be deducted from these accounts for any non-emergent visit to an ED, ranging from \$20 for the first occurrence up to \$75 for the third and subsequent occurrences, down to a minimum balance of -\$150. Similar to Indiana, the funds will not be deducted for

anyone who calls the health plan nurse triage line and is instructed to go to the ED. Based on the final waiver application, it is unclear how a visit will be determined non-emergent in Kentucky, but the initial waiver application included a list of non-emergent diagnoses. This language is no longer available on Kentucky Health website, but stated “when a premium plan member has an ER claim the MCO will run the claim against the states criteria using medical diagnosis (ICD-10) ... The state has established a list of approximately 400 diagnosis that indicate nonemergent us[e] of the ER ...”

Although the \$200 ED-copay that Arizona initially applied for was not approved by CMS,<sup>23</sup> Arizona does have an \$8 copay for non-emergent visits to the ED through 2021.<sup>1</sup> This copay is retrospectively collected by the state, “so members are not denied services and providers are not burdened with uncompensated care and administrative hassle.”<sup>1</sup> Interestingly, resources provided by Arizona specify that this copay will be required for all ED visits coded 99281 and 99282.<sup>4</sup> Again, similar to Indiana, Arizona does indicate that after the MSE determines the visit is non-emergent, hospitals will inform the patient of the amount of copay if the patient chooses to stay in the ED or will refer the patient to an available non-emergency provider who can provide timely care.<sup>4</sup>

### **Pending Waivers with ED Copays**

Maine and Wisconsin have applied for waiver demonstrations that are still pending approval by CMS and included requests for increased ED copays. Maine’s waiver asked for a \$10 copay for nonurgent use of the ED to be collected by the state retrospectively. Maine proposes to determine non-emergent visits based on a diagnosis list. This list includes diagnoses such as “severe persistent asthma, uncomplicated,” “headache,” and “weakness.”<sup>18</sup> Notably, the ED copay amount was \$20 in the initial Maine waiver draft application, but this was decreased to \$10 on the final application to CMS after public hearings. Wisconsin also has a pending waiver demonstration application, which originally asked for a \$25 ED copay, but was changed to an \$8 copay in the final application to CMS.<sup>6</sup> Importantly, this \$8 ED copay in Wisconsin is to be applied to all ED visits by this population, not just to non-emergent visits, and “Providers will be responsible for collecting copayments from members but cannot refuse treatment for nonpayment of the copay.”<sup>6</sup>

### **Non-Waiver ED Copays**

Many states have implemented ED copays for non-emergent use of the ED with copay amounts within the federal limit of \$8 (See Table).<sup>24, 25</sup> Rhode Island’s Governor Gina Raimondo has also included an \$8 copay for non-emergent ED visits in her recent state budget proposal.<sup>7</sup>

Although these copayments for non-emergent care are meant to apply after an initial MSE shows no emergent condition and an alternative provider is available to furnish timely care,<sup>19</sup> not all states are implementing these non-waiver copays in this way. For example, in Iowa, which implemented an \$8 ED copay in 2015, each hospital has been tasked with determining how to collect the copay. According to billing staff of a hospital in Cedar Rapids, several hospitals are assessing the copay for all patients triaged to Emergency Severity Index (ESI) levels 4 and 5. Patients either pay the money at the time of service or they receive an envelope to mail the copay in to the hospital. The Iowa Department of Health does provide hospitals with The Acute Hospital Provider Manual, which describes how non-emergent use of an ED affects provider payment and member copay.<sup>15</sup> In contrast to other states that have listed non-emergent diagnoses, this handbook from Iowa includes a 27-page list of Emergency Diagnosis Codes which is “updated frequently”, implying that visits with a final diagnosis not on this list are therefore non-emergent.<sup>16</sup> Notably, this list of “emergency diagnosis codes” is also used to determine reimbursement rates for ED care of some Medicaid populations. In calculating those reimbursement rates, consideration is given if a patient is referred to the ED by a healthcare provider or admitted. It is unclear if similar exceptions apply to the definition of emergent care for the sake of copays.<sup>15</sup>

## **Effects of ED Copayments on Access to Care**

Emergency physicians are concerned that copayments may deter our patients from seeking appropriate emergency care, ultimately leading to worse health outcomes. Studies have shown that higher levels of cost-sharing do delay ED use<sup>10</sup> and are associated with unmet healthcare needs.<sup>27</sup> Many ED copays are being implemented contrary to the federal Prudent Layperson (PLP) Standard. Imposing cost sharing on those seeking care with such a prudent concern will no doubt delay or decrease the likelihood that they will seek appropriate emergency care in the future. Iowa clearly communicates to facilities that they should use the “emergency diagnosis list” to apply copays, and some facilities apply copays to all Medicaid beneficiaries triaged as ESI 4 or 5. Kentucky’s financial disincentives, although not implemented yet, are clearly intended to be applied to patients with specific final diagnoses. Pending waivers in Maine and Wisconsin are clear departures from federal standards with non-emergent final diagnoses lists and plans to apply the copay to all ED visits, respectively.

Even with statutes in place consistent with federal regulation that ED copays should be applied based on findings from an MSE, implementation does not follow suit in states such as Arizona, where the state also describes that ED copays are to be applied to any encounter with 99281 or 99282 codes. Emergency physicians in Indiana report that they are not involved in the decision-making process of emergency versus non-emergent care. Staff at one Indiana facility believe that the insurance company adjudicates retrospectively whether a visit was emergent or non-emergent and then attempts to collect the copay based on its adjudication. An MCE liaison for one health system in Indiana reported that facilities there were likely to move toward attempts at more regular collection of ED copays, although no clear plans were in place about how to ensure compliance with the PLP and Emergency Medical Treatment and Active Labor Act (EMTALA) or if physicians would be involved in determinations regarding non-emergent complaints.

The Deficit Reduction Act intends to decrease non-emergent use of the ED by withholding services for non-emergent complaints based on MSE unless payment of copay occurs. Conversely, the act does not intend for retrospective determination of non-emergency and application of copayments after provision of emergency care, which is currently happening in many states, contrary to the spirit of the PLP Standard.

## **Effects of ED Copays on Non-Emergent Use of the ED**

Evidence regarding the effect of cost sharing on non-emergent use of the emergency room is limited and contradictory.<sup>5</sup> One study demonstrated that Medicaid beneficiary visits to the ED in states with copays were less likely to be for non-emergent reasons.<sup>23</sup> Yet, a different study found no change in overall ED use in states that had enacted ED copays for non-emergent care, comparing (1) intrastate utilization patterns before and after implementation of ED copays, and (2) comparing ED use in those states that had enacted copays with ED use in control states not requiring copays.<sup>24</sup> Unfortunately, very little data are available on how the increased ED copay of \$25 on the second and subsequent non-emergent ED visits in Indiana has affected non-emergent ED use. Indiana is studying a control group of 5000 beneficiaries having only \$8 copays without regard to frequency of their non-emergent ED visits, by comparing their healthcare utilization to that of a control group of typical HIP 2.0 beneficiaries. CMS reportedly delayed the approval of that study, and availability of results for report to CMS is not expected until late 2019.<sup>14</sup> Indiana state officials do report a decrease in non-emergent use of the ED by their HIP 2.0 beneficiaries, but this is measured using the Billings Algorithm, based on final diagnosis, rather than the federal standard of PLP, based on presenting symptoms.<sup>12</sup>

Importantly, hospitals have had difficulty collecting ED copays, possibly lessening the overall impact that copays would otherwise exert. Michigan successfully collects copays about 50% of the time, securing a significant amount of those funds from garnishment of taxes or lottery winnings.<sup>13</sup> Per practicing

emergency physicians in Indiana, the success rate of collecting the co-pay is 10-30%. If the patient does not pay at the time of visit, it is hospital dependent what happens next. Hospital registration personnel do not force the patient to pay at the time of visit. It is noted that the amount of the co-pay is small, so collecting this on its own is not financially worthwhile for the hospital. Anthem reports that beneficiaries in their HIP 2.0 MCE who pay their premiums and therefore expend fewer copays for outpatient care (except the ED copay) use the ED for non-emergencies less frequently than HIP 2.0 beneficiaries with increased copays for outpatient services or those enrolled in traditional Medicaid.<sup>2</sup> Although this is cited as supporting evidence that HIP 2.0, with its increased ED copays, decreases ED use, infrequency of collection of these copays renders these data more suggestive of a conclusion that if Medicaid recipients face fewer barriers to non-ED outpatient care, they will decrease use of the ED for non-emergent conditions.

### **Effect of ED Copays on Practice of Emergency Medicine**

As mentioned above, emergency physicians do not regularly alter their workflow to determine if patients have non-emergent complaints for the purpose of ED copays. If needed, MSE does often allow an emergency physician to make an accurate determination of the presence of emergency based on PLP Standard. However, if states continue to use CPT codes, ESI levels, or final diagnosis lists to determine who will be subject to ED copays, physicians and hospitals will be faced with a difficult balance between upholding the PLP Standard and avoiding EMTALA violation.

For example, if the Maine waiver is approved as written, an emergency physician could have the onus of explaining to a patient with the final diagnosis of headache that a copay is owed or they can be referred to an alternate, non-emergency provider. However, in accordance with EMTALA, the physician may have to spend hours examining the patient, interpreting imaging studies, and even performing procedures to ensure the stability of the patient in the setting of their headache. If the physician continues with evaluation and treatment following determination that the patient with a headache is stable, the patient does not have a fair chance to opt for referral and avoidance of the copay. If the physician stops the evaluation too early to discuss options of copay or referral, the physician may violate EMTALA by moving toward referral away from the ED before stabilization. Furthermore, seeing as the PLP standard is based on the patient's reasoning for seeking care, not the physician's perception of why the patient sought care, a physician would have to pursue an additional line of questioning regarding the patient's reasoning before fully determining the PLP standard was not met. Any state or system that attempted to implement such a workflow where patients may be subject to copay after hours of appropriate ED evaluation would certainly inhibit emergency physician practice and impose financial priorities between emergency physicians and their patients.

In addition, EMTALA preempts any state law or regulation that could block access to emergency care. Thus, informing an individual of an ED copay obligation, in advance and prior to completion of the MSE to determine if an emergency medical condition exists, could be an intimidating impediment to care for some patients. In this way, sharing information with Medicaid beneficiaries that an ED copay exists for non-emergencies could be interpreted as an EMTALA violation. Although this is only one possible interpretation of EMTALA, similar logic seemed to apply when CMS ruled against a state hospital association in South Carolina that sought to limit hospital ED visits by patients with chronic pain by endorsing signage informing such patient that the ED would not routinely refill prescriptions for opioid analgesic.<sup>22</sup> Conclusion seems evident that if implementation of ED copays at the time of service does not occur with extreme precision, hospitals may risk EMTALA violations.

Importantly, available information does not suggest that implementation of ED copays through Medicaid waiver demonstrations reduces ED volumes or affects acuity of patients presenting to involved EDs. For example, anecdotal reporting from Indiana suggests increased ED copays have not impacted frequency of

ED visits in urban areas; nor has there been a notable change in acuity. In Arizona, it is unclear whether this waiver system is affecting overall ED volume, as volume increases over the past few years have followed general historical trends. Data is not yet available to compare Arizona ED volume changes to those of surrounding states and areas.

Review of claims data from two emergency physician groups in Iowa, found no significant change in the number or acuity of patients in the emergency department before and after the addition of co-pays. In 2014-2015, a decrease in the number of self-pay patients in Iowa was concurrent with expansion of financial eligibility for Medicaid through the waiver. Increased revenue could be anticipated for emergency physician groups in states with Medicaid waivers, due to expanded Medicaid coverage for a segment of the population that was previously self-pay, but a direct result of imposition of ED copays themselves. Uniquely, Indiana increased the fee schedule for Medicaid emergency professional fees to Medicare parity at the time it initially implemented HIP 2.0.

### **ACEP Policy Implications**

Ideological beliefs, rather than solid evidence-based health policy, seem to have led to the recent uptick in states adopting or increasing ED copays for their Medicaid beneficiaries. Previous studies have shown that increased cost sharing leads to delayed care for true emergencies and unmet health needs. Whereas the federal government's initial description of how ED copays should be implemented accorded with the Prudent Layperson Standard, actual implementation of these copays in many states violates this important pillar of unobstructed access to emergency care. Studies have conflicting conclusions regarding the efficacy of ED copays actually meeting their intended outcome of decreasing non-emergent ED use. Clear data in this regard are not available for Indiana's HIP 2.0, which has allowed an increased ED copay since 2016. A new report by the Centers for Disease Control and Prevention suggests that almost 95% of all patients who present to EDs do have true emergencies.<sup>20</sup> States have had limited success collecting ED copays, consistent with previous studies showing states have not saved money by implementing ED copays.<sup>24</sup> Hospitals have not attained a return on investment for their significant resources to collect copays applied to their facility fees and have not found a way to implement ED copay workflows while steering comfortably clear of EMTALA and PLP violations.

Overall, ED copays provide insufficient benefit to justify risks of associated infractions of the physician-patient relationship, decreased access to appropriate emergency care, and the risk of illegalities. Given the current lack of substantiating data and analyses, states and CMS ought to reevaluate the intent and ethical, economic, and legal ramifications of the continued acceptance and use of ED copays for Medicaid beneficiaries, contrary to EMTALA and the Prudent Laypersons Standard.

#### ***Created by members of the State Legislative Committee, May 2018***

Lisa Maurer, MD FACEP, Objective Lead

Daniel Freess, MD

Sarah Hoper, MD, JD

Dennis Hsieh, MD, JD

Nathaniel Miller, MD

James Mitchiner, MD, MPH, FACEP

Nathan Vafaie, MD

Editorial assistance from Bryn DeKosky, DO

#### ***Reviewed by the Board of Directors, June 2018***

1. AHCCCS Care Fact Sheet. Distributed by the State of Arizona.  
[https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AHCCCS\\_CARE\\_Fact\\_Sheet.pdf](https://www.azahcccs.gov/Resources/Downloads/1115Waiver/AHCCCS_CARE_Fact_Sheet.pdf)
2. Anthem Public Policy Institute. July 2016. “Healthy Indiana Plan 2.0: Enhanced Consumer Engagement and Decision-Making Are Driving Better Health.”  
[https://www.antheminc.com/cs/groups/wellpoint/documents/wlp\\_assets/d19n/mjuy/~edisp/pw\\_g252936.pdf](https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjuy/~edisp/pw_g252936.pdf)
3. Anthem BlueCross BlueShield Central Regional Network Update. February 2018.
4. Arizona Waiver and Expenditure Authorities and STCs. December 29, 2017.  
[https://www.azahcccs.gov/Resources/Downloads/Arizona1115WaiverAndExpenditureAuthoritiesAndSTCs\\_12292017.pdf](https://www.azahcccs.gov/Resources/Downloads/Arizona1115WaiverAndExpenditureAuthoritiesAndSTCs_12292017.pdf)
5. Artiga S., et al. June 2017. “The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings.” Kaiser Family Foundation. June 2017.
6. BadgerCare Reform Childless Adults Waiver - Waiver Amendment Final Application. June 2017.  
<https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-finalapp.pdf>
7. Bogdan, Jennifer. January 2018. “Copays proposed as part of \$166M in Medicaid Cuts.” *Providence Journal*.
8. Demillo, Andrew. March 5, 2018. “Work requirement approved for Arkansas’ Medicaid expansion.” *The Wichita Eagle*.
9. Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures. GAO-18-220. Published: January 19, 2018. Publicly Released: February 20, 2018.
10. Fung, V., et al., July 2014. Financial Barriers to Care among Low-Income Children with Asthma: Health Care Reform Implications. *JAMA Pediatrics*,  
<http://jamanetwork.com/journals/jamapediatrics/fullarticle/1872780>
11. Healthy Indiana Emergency Room Co-Payment Protocol. Milliman Client Services.
12. Healthy Indiana Plan 2.0: Interim Evaluation Report. The Lewin Group, Inc. July 6, 2016
13. Healthy Michigan Executive Summary Report. November 2017. [http://www.michigan.gov/documents/mdhhs/MIHA\\_Monthly\\_Exec\\_Summary\\_Report\\_506215\\_7.pdf](http://www.michigan.gov/documents/mdhhs/MIHA_Monthly_Exec_Summary_Report_506215_7.pdf)
14. Indiana Family and Social Services Administration, Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application. January 2017.  
[https://www.in.gov/fssa/hip/files/HIP\\_Extension\\_Waiver\\_FINAL1.pdf](https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf)
15. Iowa Department of Human Services. The Acute Hospital Provider Manual, 2014. <http://dhs.iowa.gov/sites/default/files/AHosp.pdf>
16. Iowa Department of Human Services. List of Emergency Diagnosis Codes.  
<http://dhs.iowa.gov/sites/default/files/RC-0113.pdf>

17. Kentucky Health Demonstration Approval. January 2018.  
<https://kentuckyhealth.ky.gov/SiteCollectionDocuments/Kentucky%20HEALTH%20Demonstration%20Approval.pdf>
18. MaineCare 1115 Waiver Submission to Centers for Medicare and Medicaid Services. August 2, 2017. [http://www.maine.gov/dhhs/oms/rules/MaineCare\\_1115\\_application\\_080217\\_to%20submit.pdf](http://www.maine.gov/dhhs/oms/rules/MaineCare_1115_application_080217_to%20submit.pdf)
19. Medicaid Cost-sharing. Based on 42 Code of Federal Regulations (CFR) 447.5. <https://www.medicaid.gov/medicaid/cost-sharing/index.html>
20. National Center for Health Statistics. National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Tables. [https://www.cdc.gov/nchs/data/nhamcs/web\\_tables/2015\\_ed\\_web\\_tables.pdf](https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf)
21. Proposed Changes to Medicaid Expansion in Arizona. The Henry J Kaiser Family Foundation. November 2015 Fact Sheet.
22. Region 4 CMS letter pertaining to signage regarding “Prescribing Pain Medication in the Emergency Department.” February 6, 2013.
23. Sabik LM and Gandhi SO. May 2016. “Copayments and Emergency Department use Among Adult Medicaid Enrollees,” *Health Economics* 25:529-542
24. Siddiqui, M., et al., May 2015. “The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005.” *JAMA Internal Medicine*, <https://www.ncbi.nlm.nih.gov/pubmed/25622203>
25. Utah Department of Health: Copay Information. <https://www.health.utah.gov/umb/forms/pdf/CopaymentChart.pdf>
26. Verma S, Neale B. August 29, 2016. “Healthy Indiana 2.0 Is Challenging Medicaid Norms.” *Health Affairs Blog*.
27. Wright, B., et al., December 2010. “Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out.” *Health Affairs*.  
<http://content.healthaffairs.org/content/29/12/2311.full.html>

## Medicaid ED Copayments

State	Copay	Details
Arizona <sup>1</sup>	\$8	“Non-Emergency Visit”
California <sup>2</sup>	\$5	None
Colorado <sup>3</sup>	\$3	“Non-Emergency Visit”
Florida <sup>4</sup>	15% of allowed charges, max \$15	“Non-Emergency Visit”
Illinois <sup>2</sup>	\$3.90	None
Indiana <sup>5</sup>	\$8/\$25 (First/Each Subsequent)	“Non-Emergency Visit”
Iowa <sup>2</sup>	\$8	None
Kentucky <sup>6</sup>	\$20/\$50/\$75 (Acct Deduction)	“Non-Emergency Visit”
Maine (Pending) <sup>7</sup>	\$10	“Non-Emergency Visit”
Michigan <sup>8</sup>	\$3/\$8 (<100% FPL/>100% FPL)	“Non-Emergency Visit”
Minnesota <sup>9</sup>	\$3.50	“Non-Emergency Visit”
Montana <sup>2</sup>	\$8	None
New York <sup>2</sup>	\$3	None
Pennsylvania <sup>10</sup>	Up to \$3	Fee based on complexity, coding
Utah <sup>11</sup>	\$8	“Non-Emergency Visit”
West Virginia <sup>12</sup>	\$8	“Non-Emergency Visit”
Wisconsin (Pending) <sup>13</sup>	\$8	All ED Visits

1. <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html>
2. <https://www.kff.org/health-reform/state-indicator/premium-and-cost-sharing-requirements-for-selected-services-for-medicaid-expansion-adults/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
3. <https://www.colorado.gov/pacific/hcpf/some-health-first-colorado-co-pays-change-2018>
4. <https://www.flrules.org/gateway/ruleno.asp?id=59G-1.056>
5. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-2016-emrgncy-room-copymt-assessment-rpt-10042017.pdf>
6. <http://familiesusa.org/waivers-kentucky#cos>
7. [https://www.maine.gov/dhhs/oms/rules/MaineCare\\_1115\\_application\\_080217\\_to%20submit.pdf](https://www.maine.gov/dhhs/oms/rules/MaineCare_1115_application_080217_to%20submit.pdf)
8. [https://www.michigan.gov/documents/mdch/Healthy\\_Michigan\\_Handbook\\_Final\\_447363\\_7.pdf](https://www.michigan.gov/documents/mdch/Healthy_Michigan_Handbook_Final_447363_7.pdf)
9. [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionS\\_electionMethod=LatestReleased&dDocName=DHS16\\_146878](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionS_electionMethod=LatestReleased&dDocName=DHS16_146878)
10. [http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin\\_admin/c\\_262167.pdf](http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_262167.pdf)
11. <https://www.health.utah.gov/umb/forms/pdf/Co-PaymentChart.pdf>
12. <https://www.healthplan.org/sites/default/files/documents/resources/medicaid/FINAL%20Member%20Handbook%20SFY2018.pdf>
13. <http://www.modernhealthcare.com/article/20170608/NEWS/170609909>