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Submitted electronically at:
https://cmsmedicaidaccessrfi.gov1.qualtrics.com/jfe/form/SV_6EYj9eLS9b74Npk

April 14, 2022

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Information: Access to Coverage and Care in Medicaid & CHIP

Dear Administrator Brooks-LaSure:

The Association of American Medical Colleges (AAMC or the Association) welcomes the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS or the Agency) “Request for Information: Access to Coverage and Care in Medicaid and the Children’s Health Insurance Program (CHIP).” The Association supports CMS’s efforts to ensure that individuals eligible for Medicaid and CHIP are enrolled. Further, we support outreach to individuals informing them of alternative health insurance coverage options if it is determined they are no longer eligible for Medicaid or CHIP. Our comments to the specific Objectives are outlined below.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members comprise all 155 accredited U.S. and 16 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 191,000 full-time faculty members, 95,000 medical students, 149,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. In 2022, the Association of Academic Health Centers and the Association of Academic Health Centers International merged into the AAMC, broadening the AAMC’s U.S. membership and expanding its reach to international academic health centers.

Insurance coverage alone does not guarantee access. The use of narrow networks has expanded, often excluding teaching hospitals and their associated providers who furnish primary, specialty and sub-

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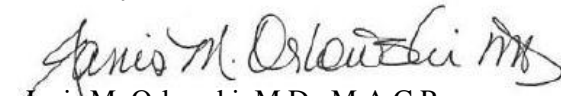
specialty care. Limiting access to needed health care hurts Medicaid beneficiaries, some who already struggle with access in areas with insufficient numbers of providers. To address access, Medicaid should institute minimum network adequacy standards to ensure coverage as well as optimizing telemedicine capabilities.

Low Medicaid reimbursement rates also exacerbate access issues. Low Medicaid payment rates relative to other payers directly impacts lower physician participation in the program. On average, Medicaid fee-for-service physician rates are two-thirds of Medicare rates.¹ CMS should focus on increasing Medicaid base rates to improve equitable access to needed services for Medicaid beneficiaries.

We also encourage the Agency to collaborate with trusted community partners to help educate individuals about Medicaid and CHIP enrollment eligibility and alternative options for coverage to decrease churn. The [AAMC Center for Health Justice](#) has valuable resources on engaging with community leaders as outlined in its [10 Principles of Trustworthiness](#).

Thank you for the opportunity to respond to this RFI. We would be happy to work with CMS on any of the issues discussed in our comments or other topics that involve the academic medical community. If you have questions regarding our comments, please feel free to contact Mary Mullaney (mmullaney@aamc.org).

Sincerely


Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

¹ <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>

Objective 1: Strategies to ensure that eligible individuals are aware of coverage options and how to obtain and retain coverage

Align Medicaid Determinations with Other State Programs

The AAMC supports efforts to ensure that individuals eligible for Medicaid and CHIP are supported during the unwinding period following the end of the public health emergency (PHE) and, if deemed ineligible for Medicaid and CHIP, that states assist individuals with necessary information and assistance with enrollment into Marketplace plans that meet their needs. To ensure that current Medicaid beneficiaries do not lose coverage as a result of the current unwinding process and upcoming enrollment determinations, states should optimize the use of electronic communications with beneficiaries. Approximately 86 percent of Medicaid beneficiaries have a cell phone and 69 percent own a tablet.² Using text or email to communicate with these beneficiaries will be the most expeditious way to ensure that they receive notifications and that they are able to timely respond.

Beyond the unwinding process, states should be encouraged to align determinations for Medicaid eligibility with other state-sponsored programs to decrease the need for multiple submissions of information. For example, states should be encouraged to review documentation currently collected, such as recent state tax returns or information submitted with applications for the Supplemental Nutrition Assistance Program (SNAP), to determine modified adjusted gross income (MAGI) and decrease burden on both individuals and the state when determining Medicaid eligibility. CMS and states should optimize outreach and navigator programs to inform the public of insurance coverage options beyond Medicaid.

Engage Trusted Community Partners to Facilitate Interactions Between the State and Community Members

CMS should work with states and communities to identify ways to proactively engage with community partners who are trusted, respected and knowledgeable individuals, institutions, or organizations from a specific community. Partnerships like this can facilitate meaningful interaction between the state and community members/community partners to communicate coverage options to individuals. Effective bi-directional communication channels help build and sustain a shared leadership and trust to meet the needs of all individuals.

Community partnerships are most successful when they are built on trust, respect, and a shared vision. The [AAMC Center for Health Justice](#), in partnership with community stakeholders, recently released [10 Principles of Trustworthiness](#) and a corresponding toolkit to guide organizations, including government entities, in their efforts to equitably partner with communities and build trust among members of those communities. The principles and toolkit integrate local perspectives with established precepts for community engagement, serving as valuable resources that agencies can proactively adopt as they are developing and implementing engagement priorities and strategies. The AAMC Center for Health Justice [Principles of](#)

² <https://www2.deloitte.com/us/en/insights/industry/public-sector/mobile-health-care-app-features-for-patients.html>

[Trustworthiness Toolkit](#) can serve as a useful tool to help agencies facilitate discussions with community members and develop strategies to address the issues raised in the RFI.

To better identify patient health-related social needs and make the relevant referrals to community-based organizations and resources, some health systems have started screening for these needs, including screening for the digital divide (i.e., digital literacy skills, inaccessible platforms for those with limited English proficiency (LEP) and disabilities, internet connectivity, device access). Through this screening, usually conducted via an electronic medical record (EMR) or external provider platform, providers can send referrals to the appropriate community partners.

Moreover, it is essential that food security, housing security, and payment for/access to health care services are all recognized as critical for individual and population health. Programs that support these areas, including research, must use evidence-based approaches to learn and respond to improving equity regarding the social determinants of health. The goal of concrete steps towards alignment across federal programs such as Medicaid, WIC, SNAP, and housing support is to reduce the burden on individuals seeking assistance. As the programs currently operate, one must navigate each and every program's requirements and application in a separate and unique process. We believe immediate efforts to coordinate data sharing across federal programs to allow a single application system could be used to ease the burden on individuals and shift these programs towards a more holistic effort to address the SDOHs.

Objective 2: Strategies to ensure that individuals are not inappropriately disenrolled and to minimize gaps in enrollment due to transition between programs

Encourage Continuous Coverage Policies to Decrease Churn

States should be encouraged to utilize automatic renewal processes or continuous coverage policies to decrease churn. The Medicaid and CHIP Payment and Access Commission (MACPAC) found that automatic renewal policies had the greatest benefit for helping individuals who are eligible for MAGI retain coverage. Moreover, MACPAC staff found that mid-year reviews were associated with higher churn, implying that these reviews are potentially unnecessary disruptions in coverage, such as disenrolling a beneficiary on the edge of income eligibility who will become eligible again in another month that year.³

As allowed under 42 CFR § 435.603(h)(2)⁴, states should be encouraged to make eligibility determinations for at least one year to minimize churn rather than basing determinations on monthly eligibility. According to Kaiser Family Foundation, some enrollees may be at a higher risk of churn than others. For example, working individuals whose monthly incomes fluctuate may be more likely to experience churn in states that have frequent electronic data matches during the year.⁵ Individuals who are disenrolled experience barriers to accessing needed care

³ https://www.macpac.gov/public_meeting/september-2021-macpac-public-meeting/

⁴ <https://www.law.cornell.edu/cfr/text/42/435.603>

⁵ <https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/#:~:text=Churn%20can%20result%20in%20access,delay%20in%20getting%20needed%20care.>

and are more likely to be hospitalized with a preventable condition. Additionally, states incur administrative costs associated with disenrolling a beneficiary and then subsequently processing a new application for the same individual.

A determination period of at least one year will allow the individual to secure appointments that require advanced scheduling and wait times that may delay access to providers in the short term. Alternatively, if a state chooses not to establish one-year enrollment periods, a way to decrease churn in states that choose to have frequent data matches is to provide Medicaid coverage for individuals deemed ineligible mid-year should have their coverage extended for a minimum of three months. This will ensure that individuals have access to needed medical care while a determination is made about whether they can transition to another form of coverage such as through the Marketplace.⁶

CMS should consider collecting disenrollment data, including the reason for disenrollment, when an individual is disenrolled from Medicaid coverage to better understand churn. For example, did the individual no longer meet the income standard, or did the disenrollment occur because the individual did not respond to requests for supplemental income information because their address was not up to date.

Objective 3: Feedback on how to establish minimum standards or federal “floors” for equitable and timely access to providers and services

Institute Minimum National Access Standards

CMS should consider instituting minimum national access standards for both Medicaid fee-for-service and Managed Care Organizations (MCOs) to improve access for enrollees in both programs. These standards should encompass access to all providers, including specialty and sub-specialty providers. Currently, there is no unified national standard for network adequacy in Medicaid, resulting in significant variation across states, delivery systems, and types of services.

Evaluation of health plan networks relies on plan provider directory data, which is often inaccurate or out of date.⁷ Medicaid MCOs should be required to maintain robust provider networks to ensure that Medicaid enrollees have access to needed medical care. Studies show that Medicaid provider networks for primary care and certain specialties are narrower on average than commercial plans in certain states.⁸

AAMC-member teaching hospitals provide treatment for a disproportionately high percentage of Medicaid beneficiaries, as well as for those who are uninsured. While only 5 percent of the U.S. hospitals, AAMC members account for 26 percent of Medicaid hospitalizations and 30 percent of hospital charity care. In addition to primary care, these institutions and their associated

⁶ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/pdf/nihms708512.pdf>

⁷ <https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/>

⁸ <https://avalere.com/press-releases/medicaid-networks-more-than-60-narrower-than-commercial-in-some-areas>

providers also furnish specialty and subspecialty care that often cannot be accessed in other care settings.

Limiting patients' access to certain providers can be particularly detrimental for patient groups that already suffer from disproportionate levels of disease and death. To make inroads on improving the health and well-being of individuals, meaningful partnerships with local communities are paramount. That includes providing access to high-quality care for patients by ensuring that robust provider networks are offered by MCOs.

Teaching hospitals and their associated physicians and other providers are an important part of ensuring access to high-quality, cutting-edge treatments. However, teaching hospitals and their associated faculty physicians are sometimes excluded from insurer networks. Excluding these institutions and physicians limits patients' access to specialized and sub-specialized care that often is only furnished at teaching hospitals. Ensuring that MCOs have robust provider networks, including teaching hospitals and their associated providers, will safeguard Medicaid beneficiaries' access to a greater number and type of providers, to meet their health care needs.

CMS should consider aligning Medicaid MCO network adequacy standards with the standards that govern plans in the federal Marketplace and Medicare Advantage. Those standards are designed to operate nationwide with sufficient flexibility to account for geographic differences, and so can appropriately be carried into the Medicaid program. In addition to supporting Medicaid and CHIP enrollees by establishing a federal floor for access, aligning standards across programs would create administrative efficiencies for insurance issuers and regulators, and would facilitate cross-program comparisons. CMS should enforce network adequacy standards for Medicaid MCOs and should require states and MCOs to identify and address access issues that are a direct result of inadequate networks.

CMS should require time and distance standards for Medicaid MCOs to ensure that patients have access to all provider types they may need within their geographic area. The AAMC believes time and distance standards to be a bare minimum, yet vital, network adequacy requirement. Federal minimum requirement for the use of time and distance standards should be considered a floor. States should also be allowed to select additional standards with the goal of a comprehensive approach to network adequacy.

The AAMC supports tracking appointment wait times as one indicator of network adequacy. For wait times to be a meaningful metric for Medicaid beneficiaries, however, they should be compared to wait times for commercially insured and Medicare patients for the same specialist and/or service within a defined area. For example, if commercial patients in a certain geographic area have an average wait time of four weeks to get a non-urgent appointment with a primary care provider or specialist, then it is not reasonable for Medicaid wait times to be longer.

Expand the Use of Telemedicine Services

The expansion of telehealth services through the CMS waivers during the COVID-19 public health emergency (PHE) allowed health care providers to quickly transition to using telehealth

services to furnish needed care. This expanded use of telehealth has enabled providers to maintain continuity of care and reach patients who may have difficulty accessing need care during the PHE. The AAMC is supportive of the expansion of telehealth services to better serve patients. This will allow patients to access needed care, including specialty and sub-specialty care from AAMC-member providers. However, we believe it is premature to provide time and distance credit or network adequacy credit for telehealth services.

CMS should encourage state Medicaid agencies to permanently implement coverage for telemedicine services – real-time audio and video visits – after the PHE ends. The Government Accountability Office’s (GAO’s) recent report noted that data from five states showed an exponential increase in the number of Medicaid beneficiaries utilizing telehealth services. The number and percentage of services delivered via telehealth increased as did the number of beneficiaries receiving telehealth services. The report notes that from March 2020 to February 2021, 32.5 million services were delivered via telehealth as compared with 2.1 million services the prior year.⁹

Coverage for audio-only services is imperative as access to necessary internet technology, such as broadband, remains a challenge for some beneficiaries; audio-only covered services will allow those individuals to access needed care. Further, not having access to reliable transportation forces some patients to miss scheduled appointments. Telemedicine has proven to be more convenient in addition to saving time and money on transportation, child care, and requiring less time off from work.¹⁰ CMS should encourage states to continue expanded coverage of telemedicine for Medicaid beneficiaries.

As noted in President Biden’s State of the Union [fact sheet](#) on mental health, CMS should encourage states to provide coverage under Medicaid for “interpersonal consultations so primary care providers can consult with a specialist and provide needed care for patients.” Over the past seven years, the AAMC has collaborated with 35 academic medical centers and children’s hospitals through [Project CORE](#) (Coordinating Optimal Referral Experiences) to implement interprofessional internet consultations, or eConsults. In the CORE model, eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. When eConsults can take the place of a referral, patients benefit from more timely access to the specialist’s guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream visits and related costs. The model utilizes specialty and condition-specific templates to enable focused clinical exchanges between providers. A high quality eConsult includes a clear clinical question that can be answered with information available to the specialist in the EHR, and the response includes clear recommendations, a rationale and a contingency plan. There is an expectation that the specialist will respond within 72 hours; however, response times have averaged closer to 24 hours at most academic medical centers. The goals of the program include

⁹ <https://www.gao.gov/products/gao-22-104700>

¹⁰ <https://aspe.hhs.gov/sites/default/files/2021-07/medicaid-telehealth-brief.pdf>

increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. More widespread adoption of this model could help expand access to specialty care and mental health services.

Evaluate Current Data Collection

Medicaid MCOs are required to report on CMS beneficiaries' access to needed care, or lack thereof. CMS should review the data currently submitted and determine whether other factors impacting access should be reported, both to the state and to CMS, and should enforce reporting requirements if it is determined that Medicaid MCOs are not adequately reporting required data.

Workforce shortages and narrow networks impact such things as appointment wait times, resulting in delays in patients receiving timely care. Fewer provider choices could mean that enrollees must travel farther or wait longer to see a provider. Further, delaying needed preventive care often results in costlier care in acute care settings, such as emergency departments and inpatient care. Identifying an access problem is the first step in determining the underlying cause and developing a policy solution.

The AAMC supports the following MACPAC's preliminary proposals¹¹ on improving access monitoring in the Medicaid program:

- Develop a core set of access measures that span acute care, preventive care and long-term services and supports that are comparable across states and delivery systems.
- Collect standardized data on beneficiary perceptions and experiences with care through a periodic and ongoing beneficiary survey.
- Standardize and improve the Transformed Medicaid Statistical Information System (T-MSIS) to gather information on beneficiaries' access to providers and stratification by key demographic characteristics such as race and ethnicity.
- Support states efforts through analytical resources and technical assistance.

Additionally, CMS should improve transparency, availability, and timeliness of T-MSIS data to allow researchers and other stakeholders to assist in identifying deficiencies and making recommendations for improvement. Medicaid program data should be at least as accessible as comparable data in the Medicare program, including the administrative steps and financial costs associated with data transfers for research purposes.

Monitor Out-of-Network Utilization

As more states provide coverage to their Medicaid beneficiaries through comprehensive MCOs – more than two-thirds of Medicaid enrollees in July 2019¹² – network adequacy remains an important indicator of access. Beneficiaries in plans with a closed network – the hallmark of health maintenance organizations – may find themselves requiring access to care to out-of-

¹¹ https://www.macpac.gov/public_meeting/january-2022-macpac-public-meeting/

¹² <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

network providers in order to receive timely care from an appropriate specialist. Increased use of out-of-network providers could signal network *inadequacy*.

Therefore, CMS should begin the process of collecting data on Medicaid beneficiaries' use of out-of-network providers, including accessing care across state lines. In addition to monitoring the execution of single case agreements for out-of-network care, CMS should monitor appeals, grievances, and fair hearings concerning a delay or a denial in approval for out-of-network access.

Further, we recommend that these data be stratified by beneficiary medical condition and provider specialty to help states and CMS identify outliers. If a given condition or specialty is associated with a disproportionate number of requests for out-of-network access, that may be a sign of inadequate access within the network. CMS should work with states to take corrective action where access gaps are identified.

Focus on Social Determinants of Health, Race, and Ethnicity Data

An individual's health and access to health care are affected by a myriad of factors, including housing, transportation, food insecurity, and social support.¹³ Further, all communities are impacted by the lack of coordination between these social determinants of health (SDOH) relevant sectors. States and communities should be incentivized to develop policies to collect meaningful data needed to ensure efficient alignment between sectors so that individual and community needs are addressed holistically.

Medicaid and CHIP families and individuals with limited incomes are most at risk of having health-related economic and social needs. Identifying meaningful SDOH measures is part of the foundation needed to change health care outcomes. Collection of this data does not need to rest solely with managed care plans or providers. Community health workers and other trusted voices within the community should be employed – and fairly compensated – to gather standardized information that can be used to remedy access issues, address social needs, and improve health. Without meaningful data collection, the social factors promoting or inhibiting health are not identified and will likely result in significant negative health consequences for patients.

Modernization of existing data sources where possible will work to decrease reporting burden. Additionally, expanding data collection of social determinants of health information through the expanded use of Z-codes will help to capture social risk factors. CMS should gather this information in a de-identified manner and publicly share the data to seek feedback on addressing SDOHs. Efforts should also focus on the accuracy and completeness of states' collection of race and ethnicity data. The Government Accountability Office (GAO) recently found that only 21 out of 50 states had acceptable race and ethnicity data for 2016 in T-MSIS.¹⁴ According to the GAO, accurate and complete race and ethnicity data reported by states, coupled with routine

¹³ <https://www.aamc.org/media/56566/download>

¹⁴ <https://www.gao.gov/assets/gao-21-196.pdf>

analysis of the data to evaluate health outcomes, helps states and the federal government better understand existing health disparities and enables them to take action to promote health equity.¹⁵

Ensure Compliance with the CLAS Standards

One way to begin to increase and diversify the pool of available providers for Medicaid and CHIP is for states to require providers to work to achieve compliance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care that were developed by the HHS Office of Minority Health. The principal standard is to “provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.”¹⁶ CMS must recognize that it will take time to meet the fifteen CLAS standards and provide adequate support to make this possible.

Objective 5: Ensure that payment rates are sufficient to enlist and retain providers so that services are accessible

Ensure Adequate Reimbursement

AAMC members play an integral role in the nation’s health care safety-net. Our members provide advanced and expert patient care – specifically specialty and sub-specialty care – that is often unavailable at other institutions. These well-established and respected regional referrals centers, in partnership with their physician faculty practices are centers for cutting-edge tertiary and quaternary care. Additionally, these institutions provide treatment for a disproportionately high percentage of Medicare and Medicaid beneficiaries, as well as those who are uninsured. AAMC member teaching hospitals represent 5 percent of all hospitals and provide 24 percent of all hospital inpatient days. That includes 22 percent and 27 percent of all Medicare and Medicaid inpatient days, respectively.

As hospitals meet the demands of caring for medically complex patients, they continue to face inadequate payment rates from federal programs. According to MACPAC, on average, Medicaid FFS base payments are below hospitals’ costs of providing care to Medicaid enrollees and are below Medicare payment rates for comparable services. In 2011, FFS base payment rates were 78 percent of Medicare rates for the 18 Medicare-severity diagnostic-related groups (MS-DRG) that MACPAC studied.¹⁷ By contrast, there is limited data available on managed care payments to hospitals, but MACPAC analysis of the available data suggests that these payments vary widely by state.¹⁸

Therefore, to holistically evaluate the impact of Medicaid payment rates on access, CMS should more frequently monitor payment rates for both MCOs and FFS to determine if they are

¹⁵ <https://www.gao.gov/assets/gao-22-104700.pdf>

¹⁶ <https://thinkculturalhealth.hhs.gov/clas/standards>

¹⁷ <https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf>

¹⁸ Ibid.

sufficient. In order to undertake a meaningful evaluation of the impact, the agency should develop precise standards regarding the indicators of adequate access. CMS should also have a system in place to monitor whether states and MCOs are meeting the requirements and enforce compliance actions if states are not providing adequate rates. Hospitals and providers also should have the ability to appeal rates that are below a standard set by CMS.

Access to providers can be challenging for all patients, but particularly for those in areas where an insufficient number of providers means that patients have unreasonably long waits for appointments. Moreover, low reimbursement rates can exacerbate access issues for individuals enrolled in Medicaid. MACPAC found that overall, providers are less likely to accept new patients with Medicaid than those with other forms of insurance.¹⁹ MACPAC has noted that while there are multiple factors that impact physician participation in the Medicaid program, low payment rates relative to other payers directly impacts lower physician participation in the program. On average, Medicaid FFS physician payment rates are two-thirds of Medicare rates.²⁰

CMS should also focus on increasing base rates to improve equitable access to needed services for Medicaid beneficiaries rather than forcing providers in some states to rely on supplemental payments. For example, CMS could consider using average commercial rates to determine the adequacy of Medicaid base reimbursement rates in a geographical region as a way to improve patient access to providers. Currently states utilize supplemental payments to increase reimbursement for providers. While these additional payments are an important means of increasing Medicaid reimbursement and improving access, a way to provide for more uniformity across states is to require that base rates are adequate. This is particularly true for specialty and sub-specialty care which often is available to Medicaid patients only at teaching institutions.

According to MACPAC, Medicaid reimbursement rates vary considerably from state to state. CMS should also examine ways to ensure adequate reimbursement for care furnished to a patient who has traveled from another state. It is not unusual for patients to seek care in other states, particularly individuals who live near the border of another state. These individuals may be closer to providers in a neighboring state than to ones within their state or require specialty or sub-specialty care only available at certain institutions. However, some MCOs pay out-of-state providers less than FFS rates paid to in-state providers, further limiting access to care. By ensuring adequate payment rates under Medicaid, individuals seeking care across state lines will continue to have access to needed care, including specialty and sub-specialty care.

¹⁹ <https://www.macpac.gov/subtopic/measuring-and-monitoring-access/>

²⁰ <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>