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Restrictive Medicaid Policies Will Impede Innovation to Improve Care and Reduce Costs

By Hannah Katch

There is broad, bipartisan support for changes to the health care payment system that reward providers for managing patients' care and providing low-cost, high-value services. Federal and state programs, including Medicaid, are increasingly shifting to these models, with the goals of reducing costs and improving beneficiaries' health outcomes. But the Trump Administration's approval of state Medicaid policies that restrict access to coverage and care will impede these models' success.

Many value-based payment models pay providers a set amount for all or most of a patient's care — rather than paying for each service they provide — while requiring them to meet certain quality and outcomes standards. Value-based payment models are intended to give providers greater incentive to reduce costs and improve care by strengthening care coordination, avoiding duplicative or low-value care, and helping patients obtain high-value, low-cost services, such as preventive and primary care and medications to manage chronic conditions.

However, it is difficult for providers to coordinate and manage patients' care if they are not continuously enrolled in health coverage. Medicaid policies that take coverage away from people who don't meet work requirements, pay premiums, or overcome other hurdles lead to gaps in coverage that prevent beneficiaries from developing ongoing relationships with providers and getting appropriate, regular care — especially preventive services, primary care, and medications to control chronic conditions. Thus, these policies not only harm beneficiaries directly but also work in opposition to the goals of state and federal value-based payment models.¹

Restrictive Waivers Will Increase Coverage Gaps, Reduce Primary Care Access

Under the Trump Administration, the Centers for Medicare & Medicaid Services (CMS) has allowed states to impose unprecedented restrictions on Medicaid eligibility and coverage. In 2018, CMS allowed states — for the first time — to take coverage away from beneficiaries who don't meet

¹ For another discussion of the issues addressed in this paper, see Cindy Mann, "Are New Medicaid Waivers on a Collision Course with State Delivery System Reform?" Commonwealth Fund, September 26, 2018, <https://www.commonwealthfund.org/blog/2018/are-new-medicaid-waivers-collision-course-state-delivery-system-reform>.

work requirements. CMS has also approved state waivers that impose premiums at low income levels and lock people out of coverage if they don't meet these or other program requirements, which will increase coverage gaps.

- **Work requirements.** Arkansas is the first state to take coverage away from Medicaid beneficiaries who don't meet a work requirement. Between June 2018 and January 2019, the state terminated coverage for more than 18,000 adults — more than 1 in 5 of those subject to the new policy — who did not report at least 80 hours per month of work or work-related activities for three months. People whose coverage is terminated weren't able to reenroll in coverage for the rest of the calendar year, even if they reported 80 hours of work or work-related activities in later months or newly qualified for an exemption from the requirement due to illness or other reasons.²

As of February 2019, CMS has approved work requirement policies in seven other states,³ and additional proposals are pending with CMS or under consideration in states. If implemented, these policies will cause coverage gaps or long-term coverage loss for hundreds of thousands of people. This includes many people who are working but in unstable jobs. Nationally, 46 percent of low-income workers who could be affected by Medicaid work requirements would be at risk of losing coverage for one or more months under an 80-hour-per-month work requirement due to fluctuating hours or spells between jobs.⁴

- **Premiums and cost-sharing.** Premiums serve as a barrier to obtaining and keeping Medicaid coverage, robust research shows.⁵ For example, when Wisconsin imposed a \$10 monthly Medicaid premium for adults with incomes at or above 150 percent of the poverty line and children beginning at 200 percent, enrollees were 12 percentage points less likely to remain enrolled for a full year.⁶

In Indiana, evidence clearly shows that premiums increase coverage gaps. Indiana's Medicaid expansion program, HIP 2.0, includes two types of coverage: Healthy Indiana Plan (HIP) Plus and HIP Basic, which has narrower coverage and additional co-pays. Beneficiaries may

² Jennifer Wagner, "Medicaid Coverage Losses Mounting in Arkansas From Work Requirement," Center on Budget and Policy Priorities, January 17, 2019, <https://www.cbpp.org/blog/medicaid-coverage-losses-mounting-in-arkansas-from-work-requirement>.

³ CMS approved waivers that include work requirements in Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, and Wisconsin. CMS also approved a Maine waiver that included a work requirement, but Governor Janet Mills did not accept the terms of the waiver, so it did not go into effect.

⁴ Aviva Aron-Dine, Raheem Chaudhry, and Matt Broaddus, "Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements," Center on Budget and Policy Priorities, April 11, 2018, <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>.

⁵ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 01, 2017, <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

⁶ Laura Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," *Journal of Health Economics*, September 2014, <https://www.sciencedirect.com/science/article/abs/pii/S0167629614000642>.

keep HIP Plus only if they pay premiums; otherwise they are moved to HIP Basic or lose coverage altogether, depending on their income level.

A 2017 evaluation of the first three years of Indiana’s waiver found that 55 percent of people eligible to make a premium payment didn’t do so. The large majority of them had incomes below the poverty line, so they were moved to less comprehensive coverage when they failed to pay. But nearly 60,000 individuals with incomes above the poverty line were either disenrolled from coverage because they didn’t pay their premiums or were never enrolled because they didn’t make their first payment.⁷

- **Coverage lockouts.** Lockout policies are another coverage restriction that directly leads to increased “churn” of people on and off Medicaid. Both Kentucky’s waiver and the current version of Indiana’s waiver disenroll people and lock them out of coverage for up to six months if they don’t submit renewal paperwork on time, even if they remain eligible for coverage. Such policies are virtually certain to create gaps in coverage.⁸

Health System Shifting Toward Value-Based Payments

Policymakers in both parties have expressed support for shifting health care payments toward models that reward providers for managing beneficiaries’ health outcomes. The Obama Administration set ambitious goals of increasing the share of value-based Medicare payments over time and encouraged state Medicaid programs to shift toward similar payment models.⁹ The Trump Administration has also pursued several value-based payment models through the Centers for Medicare & Medicaid Innovation (CMMI), and Department of Health and Human Services Secretary Alex Azar called for accelerating the shift to value-based payment in a major address to the Federation of American Hospitals.¹⁰

Congress has also shown support for this shift, passing the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, which created financial rewards for providers that

⁷ The Lewin Group, “Healthy Indiana Plan 2.0: POWER Account Contribution Assessment,” March 31, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

⁸ Judith Solomon, “Locking People Out of Medicaid Coverage Will Increase Uninsured, Harm Beneficiaries’ Health,” Center on Budget and Policy Priorities, February 22, 2018, <https://www.cbpp.org/research/health/locking-people-out-of-medicaid-coverage-will-increase-uninsured-harm-beneficiaries>.

⁹ Department of Health and Human Services, “Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value,” January 26, 2015, <http://wayback.archive-it.org/3926/20170127185400/https://www.hhs.gov/about/news/2015/01/26/better-smarter-healthier-in-historic-announcement-hhs-sets-clear-goals-and-timeline-for-shifting-medicare-reimbursements-from-volume-to-value.html>.

¹⁰ Alex M. Azar II, “Remarks on Value-Based Transformation to the Federation of American Hospitals,” Department of Health and Human Services, March 5, 2018, <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-on-value-based-transformation-to-the-federation-of-american-hospitals.html>.

participate in value-based payment models. While these incentives were initially targeted to Medicare providers, Medicaid providers can now begin to qualify as well.¹¹

Many states have also shown interest in value-based payment models. For example:

- **Colorado’s Accountable Care Collaborative** is moving toward paying capitated rates (that is, making fixed payments per beneficiary) to “regional accountable entities” made up of health plans, providers, and non-profit community organizations, which contract directly with providers to offer the full range of physical and behavioral health care services. These entities can earn bonuses based on their performance in specific areas and are encouraged to form value-based payment arrangements with providers.¹²
- **Minnesota’s Hennepin Health** targets adults with chronic conditions who frequently use the emergency department. The county health department, the public hospital, a health center, and a Medicaid health plan partnered to care for the county’s highest-need patients, accepting full financial risk for these members and providing the full range of their care.¹³
- **Oregon’s Coordinated Care Organizations** are integrated partnerships between health plans and providers that receive a capitated rate to provide all medical, mental health, and dental care services for their members.¹⁴ They also collect and report data on more than 30 different measures of health care quality, and 3 percent of their monthly payments are withheld and redistributed among the organizations based on their achievement of specified quality goals.¹⁵
- **Provider-led Arkansas Shared Savings Entity** is a new model set for implementation in 2019. Arkansas has contracted with provider-led entities to serve high-need individuals with behavioral health conditions or disabilities. The entities can receive additional payments based on quality performance.¹⁶

¹¹ Centers for Medicare & Medicaid Services, “Participation Criteria for the Quality Payment Program,” May 22, 2017, <https://www.youtube.com/watch?v=Fw8d3Sg6qP0&feature=youtu.be>.

¹² Colorado Department of Health Care Policy and Financing, 1915(b) waiver, approved August 28, 2018, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/CO_ACC-PCCM-PIHP-Program_CO-04.pdf.

¹³ Martha Hostetter, Sarah Klein, and Douglas McCarthy, “Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries,” Commonwealth Fund, October 7, 2016, <https://www.commonwealthfund.org/publications/case-study/2016/oct/hennepin-health-care-delivery-paradigm-new-medicaid-beneficiaries>.

¹⁴ State of Oregon, 1115 Waiver Demonstration Renewal, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf>.

¹⁵ Jim Lloyd, Rob Houston, and Tricia McGinnis, “Medicaid Accountable Care Organization Programs: State Profiles,” Center for Health Care Strategies, October 2015, <http://www.chcs.org/resource/medicaid-accountable-care-organization-programs-state-profiles/>.

¹⁶ Arkansas 1915(i) State Plan Amendment, <https://medicaid.mmis.arkansas.gov/general/comment/comment.aspx>.

Value-Based Payment Models Rely on Effective Care Coordination and Care Management

Value-based payment models typically require providers to accept some financial responsibility for the cost and overall outcomes of a patient's care. In some cases, providers receive a capitation payment and are financially responsible for all or a set of their beneficiaries' health care services; providers bear the financial risk of managing costs within their capitation payments and suffer a loss when they don't. In other cases, providers share financial risk with a state, the federal government, or other payer; for example, they might keep a share of the savings (or repay a share of the costs) relative to a benchmark standard. Providers often also have financial incentives to meet quality and outcomes measures.

The goals of value-based payment models are to structure providers' payments to create incentives to manage beneficiaries' care, prevent unnecessary health care utilization, and ensure that beneficiaries receive timely primary and preventive care. Ideally, this arrangement benefits all sides, as the provider and the payer (whether the federal government, a state, or a private insurer) share the savings from providing better-coordinated care to patients.¹⁷

In several state Medicaid programs, accountable care organizations (ACOs) — groups of providers and other entities such as health plans that partner to provide a range of health care services — operate through a value-based model as described above. The ACO receives capitation payments in return for covering some or all of its beneficiaries' health care services and has incentives to meet quality and outcomes measures.¹⁸

The largest national example of this approach is the Medicare Shared Savings Program (MSSP), which ties ACOs' payments to an annual spending target and quality of care thresholds. ACOs that spend less than their target amount on their assigned Medicare beneficiaries share their savings with the federal government; those that exceed their target either do not receive a bonus or face a penalty. MSSP has saved \$1.1 billion since its inception in 2012, CMS estimates.¹⁹

ACOs' success in reducing costs while maintaining quality likely reflects, in part, their investment in managing beneficiaries' care, such as helping beneficiaries consistently obtain low-cost, high-value

¹⁷ Deloitte, "Alternative Payment Models in Medicaid: Could MACRA Be a Catalyst for States' Value-Based Care Efforts?" October 2017, <https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-alternative-payment-models-in-Medicaid-MACRA.pdf>.

¹⁸ Center for Health Care Strategies, "Medicaid Accountable Care Organizations: State Update," February 2018, <https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf>.

¹⁹ Robert Mechanic and Clifton Gaus, "Medicare Shared Savings Program Produces Substantial Savings: New Policies Should Promote ACO Growth," Health Affairs Blog, September 11, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180906.711463/full/>.

services in outpatient settings and reducing stays in hospitals and other costly facilities.²⁰ Nearly all ACOs have care management programs.²¹

ACOs have achieved the most savings on post-acute care, such as the use of skilled nursing facilities for patients discharged from the hospital.²² This area has long been considered a major source of wasteful spending, which ACOs can reduce through care management techniques.²³ Notably, spending reductions on post-acute care have *not* been accompanied by reductions in quality of care, such as increases in 30-day readmissions, in the proportion of patients discharged to poorly rated nursing facilities, or in mortality among MSSP patients.²⁴ ACO enrollees themselves have rated their own providers as offering better access to care and care coordination than similar patients not enrolled in an ACO receive.²⁵

Early results from Medicaid ACOs are also promising. Hennepin Health, for example, created teams of health and social service providers to coordinate clinical and social services for its members. Hennepin saw emergency department visits drop nearly 10 percent while the number of primary care visits and the share of members receiving recommended care both increased; also, members receiving stable housing through Hennepin Health were 35 percent less likely to visit the emergency room and 16 percent less likely to be admitted to the hospital.²⁶ Similarly, Oregon reported that its coordinated care organizations reduced spending by \$2.2 billion between 2012 and 2017,²⁷ while substantially reducing avoidable use of the emergency department.²⁸

²⁰ David B. Muhlstein *et al.*, “Medicare Accountable Care Spending Patterns: Shifting Expenditures Associated with Savings,” *American Journal of Accountable Care*, February 2018, <https://www.ajmc.com/journals/ajac/2018/2018-vol6-n1/medicare-accountable-care-spending-patterns-shifting-expenditures-associated-with-savings>.

²¹ Kristen A. Peck, “How ACOs Are Caring for People with Complex Needs,” Commonwealth Fund, December 2018, <https://www.commonwealthfund.org/publications/fund-reports/2018/dec/how-acos-are-caring-people-complex-needs>.

²² Medicare Payment Advisory Commission, “Report to the Congress: Medicare and the Health Care System,” June 2018, http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0; see also National Academies Press, “Variation in Health Care Spending: Target Decision Making, Not Geography,” October 2013, <https://www.ncbi.nlm.nih.gov/books/NBK201647/>.

²³ J. Michael McWilliams *et al.*, “Changes in Post-Acute Care in the Medicare Shared Savings Program,” *JAMA Internal Medicine*, April 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5415671/>.

²⁴ *Ibid.*

²⁵ J. Michael McWilliams *et al.*, “Changes in Patients’ Experiences in Medicare Accountable Care Organizations,” *New England Journal of Medicine*, October 30, 2014, <https://www.nejm.org/doi/full/10.1056/NEJMsa1406552>.

²⁶ Hostetter 2016.

²⁷ Oregon Health Authority, “Health system transformation in Oregon: lessons from the first five years,” March 2018, <https://stateofreform.com/wp-content/uploads/2018/03/Lessons-from-the-first-five-years.pdf>.

²⁸ Oregon Health Authority, “Oregon Health System Transformation: CCO Metrics 2016 Final Report,” June 27, 2017, <http://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/CCO-Metrics-2016-Final-Report.pdf>.

Coverage Gaps Due to Restrictive Waivers Will Impede Care Management

For several reasons, successful care management — and the cost savings it can produce — are only feasible for providers if a high proportion of their members are continuously enrolled in coverage. Care management requires a sustained relationship with a beneficiary to meet individual needs, ensure access to primary and preventive care, and avoid unnecessary and costly acute care services.²⁹ Coverage gaps prevent people from developing sustained relationships with providers, which can undermine their quality of care.³⁰

- Care management depends on regular access to preventive care. If Medicaid beneficiaries experiencing coverage gaps go without screening and other preventive services due to cost, their health outcomes will likely be worse when they reenroll in coverage.³¹

For example, beneficiaries who were not continuously enrolled in Medicaid for at least six months prior to a cancer diagnosis were more likely to be diagnosed with cancer at later stages, one study showed. Those who were continuously enrolled had improved clinical outcomes, including higher survival rates.³²

- Care management depends on regular access to medications to manage chronic conditions. Poor adherence to medications has been associated with worsening of disease, increased mortality, and increased health care costs. Improving access and adherence to medication is among the strongest examples of a low-cost intervention that can prevent hospitalizations, improve health outcomes, and reduce costs.³³

Robust evidence also demonstrates that adherence to medication depends heavily on beneficiaries' out-of-pocket costs.³⁴ While Medicaid typically provides access to medication

²⁹ Aaron J. Dawe *et al.*, “The Impact of Continuous Medicaid Enrollment on Diagnosis, Treatment, and Survival in Six Surgical Cancers,” *Health Services Research*, September 26, 2014, <https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.12237>.

³⁰ Leighton Ku and Erika Steinmetz, “Bridging the Gap: Continuity and Quality of Coverage in Medicaid,” Association for Community Affiliated Plans, September 10, 2013, <http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf>.

³¹ Institute of Medicine, “Care Without Coverage: Too Little, Too Late,” 2002, <https://www.ncbi.nlm.nih.gov/pubmed/25057604>.

³² Dawe 2014, *op cit.*

³³ Lars Osterberg and Terrence Blaschke, “Adherence to Medication,” *New England Journal of Medicine*, August 4, 2005, <https://www.nejm.org/doi/full/10.1056/nejmra050100>; Michael C. Sokol *et al.*, “Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost,” *Medical Care*, June 2005, https://journals.lww.com/lww-medicalcare/Abstract/2005/06000/Impact_of_Medication_Adherence_on_Hospitalization.2.aspx; Gordon D. Schiff *et al.*, “Decompensated Heart Failure: Symptoms, Patterns of Onset, and Contributing Factors,” *American Journal of Medicine*, June 2003, [https://www.amjmed.com/article/S0002-9343\(03\)00132-3/pdf](https://www.amjmed.com/article/S0002-9343(03)00132-3/pdf).

³⁴ Artiga 2017; Ramin Mojtabai and Mark Olfson, “Medication Costs, Adherence, and Health Outcomes Among Medicare Beneficiaries,” *Health Affairs*, July 2003, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.4.220>.

with minimal cost-sharing for beneficiaries, eligibility restrictions cause coverage gaps that can impede both access to needed treatment and effective care management.³⁵

Medicaid beneficiaries who experience gaps in coverage refill their prescriptions 19 percent less often — and use the emergency department between 10 percent and 36 percent more frequently — than adults with continuous coverage, one national study found.³⁶

In a particularly striking example of the harm that restrictive waivers can cause, Arkansas beneficiary Adrian McGonigal was confused about the state’s new requirement to report work hours and only reported hours in one month, failing to report in the following months even though he was working. He learned that he had lost his Medicaid coverage when his pharmacy told him his insurance had been cancelled, after which he couldn’t afford medication for his lung disease. When his lung disease flared up, he landed in the hospital (presumably incurring costs many times the cost of his medication) and lost his job.

- Lack of care management can also lead to a reduction in the use of primary care, which can lead to higher use of the emergency room for conditions that can be managed in an outpatient setting if people have consistent access to treatment, such as asthma and diabetes.³⁷

Restrictive Medicaid waivers that cause coverage gaps will therefore directly impede the success of value-based payment models that rely on care management. Also, coverage gaps may significantly dampen the incentives that these models seek to create. Some states have value-based contracts with providers or ACOs to share the financial risk for the total cost of care for many Medicaid beneficiaries; the contracts typically include methodologies that determine how patients are attributed to providers, which determines which providers are financially responsible for managing the patients’ care. Recognizing that continuity of coverage is essential for care management, the contracts typically include a continuous coverage requirement, usually 6 to 12 months.³⁸ As a result, beneficiaries with coverage gaps will likely never be attributed to a provider under these contracts, which means the contract gives the provider no financial incentive to manage their care. This could compound the negative effects of coverage gaps on these individuals’ care, even after they regain Medicaid coverage. And, if a significant share of a state’s adult Medicaid beneficiaries experience coverage gaps due to restrictive waivers, the shift to value-based payment may have limited reach.

³⁵ Hannah Katch and Judith Solomon, “Restrictions on Access to Care Don’t Improve Medicaid Beneficiaries’ Health,” Center on Budget and Policy Priorities, December 11, 2018, <https://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes>.

³⁶ Ritesh Banerjee, Jeanette Y. Ziegenfuss, and Nilay D. Shah, “Impact of discontinuity in health insurance on resource utilization,” BMC Health Services Research, 2010, <https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/1472-6963-10-195>.

³⁷ Peter S. Hussey *et al.*, “Continuity and the Costs of Care for Chronic Disease,” *JAMA Internal Medicine*, May 2014, <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1835350>.

³⁸ In Minnesota’s Integrated Health Partnerships, for example, patients must have six months of continuous enrollment (or nine months of total enrollment) in qualifying programs during the “performance period” during which the contract is in place to give providers sufficient time to provide care management. See https://mn.gov/dhs/assets/2017-ihp-rfp-appendix-d_tcm1053-294444.pdf.

Restrictive Eligibility Policies Will Prevent Medicaid Providers from Succeeding in Value-Based Payment Models

Restrictive Medicaid waivers could make it more difficult for providers to realize savings from value-based payment arrangements and pay-for-performance programs. First, gaps in coverage directly impede care management. Second, providers with a large share of their patients experiencing gaps in coverage may not have many patients attributed to them under value-based contracts, as explained above. To obtain bonus payments through MACRA's Quality Payment Program, for example, providers must accept value-based payment for a large share of their total Medicare and Medicaid patients.³⁹ If a large share of a provider's patients have substantial coverage gaps throughout the year, it could threaten their ability to meet their spending and quality goals for those patients, which could jeopardize their Quality Payment Program bonus payments.

If restrictive waivers cause providers to struggle to succeed in value-based payment models, providers may oppose mandatory models and choose not to participate in new voluntary models, which would impede health system progress and prevent states from achieving their goal. If providers that primarily serve Medicaid beneficiaries choose not to participate in successful value-based payment models, this could also increase disparities between Medicaid beneficiaries and people with other sources of coverage, and between states with restrictive waivers and those without such waivers.

Quality Measurement and Evaluation Rely on Stable Patient Population

Testing new models of care requires rigorous evaluation to determine that the model improves quality of care, maintains access to benefits, and maintains or reduces costs. Restrictive waiver policies could make conducting and interpreting such evaluations more difficult.

Measuring quality of care is particularly important in a robust evaluation of new models of care and for holding providers accountable for achieving high-quality outcomes, but coverage gaps inhibit providers' ability to participate in quality measurement. Since coverage gaps negatively affect individuals' use of the health care system and health outcomes, for reasons largely outside providers' control, quality measures generally require a period of sustained coverage before including individuals' experiences in quality measurement.

For example, CMS' core sets of child and adult quality measures in Medicaid typically exclude individuals with coverage gaps exceeding 45 days during the measurement year.⁴⁰ Similarly, the Healthcare Effectiveness Data and Information Set — one of the most common sets of health care

³⁹ Centers for Medicare & Medicaid Services 2017, *op cit.* Medicaid beneficiaries can count toward participating providers' minimum percentage for the purpose of earning a Quality Payment Program payment bonus beginning in 2021.

⁴⁰ Centers for Medicare & Medicaid Services, "Core Set of Adult Health Care Quality Measures for Medicaid: Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting," May 2018, <https://www.medicare.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf>; Centers for Medicare & Medicaid Services, "Core Set of Children's Health Care Quality Measures for Medicaid and CHIP: Technical Specifications and Resource Manual for Federal Fiscal Year 2018 Reporting," February 2018, <https://www.medicare.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf>.

performance measures — typically requires 12 months of continuous Medicaid eligibility for individuals' quality data to be included in quality measurement.⁴¹ If large numbers of adults experience gaps in coverage, fewer Medicaid beneficiaries can be included in quality measurement, which will inhibit the rigorous evaluation of new payment models.

Determining whether value-based payment models have the potential to improve care and reduce costs will also be more challenging in states with restrictive waivers. Beneficiaries who reenroll after a period of uninsurance may have poorer outcomes for reasons unrelated to the payment model. Similarly, beneficiaries who maintain their coverage but must overcome onerous barriers to care, such as cost-sharing and complex health savings account-like programs, may have poorer outcomes as a result of their access barriers.⁴²

⁴¹ National Committee for Quality Assurance, “NCQA Endorses Medicaid and CHIP Quality Improvement Act,” February 4, 2015, <https://www.ncqa.org/comment-letter/ncqa-endorses-medicaid-and-chip-quality-improvement-act/>.

⁴² Artiga 2017.