Centering Health Equity in Medicaid: Section 1115 Demonstration Strategies

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STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Introduction

Longstanding structural racism and related health inequities experienced by people of color further laid bare by the COVID-19 pandemic have mobilized leadership in many states to take action on health equity.[1] Structural racism across and within systems and institutions in the United States has caused disproportionate health risks and poorer health for people and communities of color.[2] Structural racism has further impeded people of color from accessing resources and opportunities, including home ownership, asset accumulation, employment, educational attainment, affordable and healthy foods, and clean air and water, all of which exacerbate these heightened health risks.[3]

Many states are looking to Medicaid as a critical lever to address health inequities due to the size, scale, and demographics of its coverage footprint. Medicaid covers over 80 million individuals,[4] accounts for almost one-fifth of national health expenditures,[5] and is the single largest payer in many states. Medicaid covers nearly half of all births in the United States (U.S.),[6] nearly one in two children,[7] and over half of total institutional and community based long-term care costs.[8] The racial and ethnic composition of Medicaid programs varies by state. However, people of color are disproportionately represented in the Medicaid program nationally and in many states. Black, Latino(a), and other people of color represent almost two-thirds of all Medicaid enrollees,[9] though they constitute less than half of the U.S. population.[10] As a result, Medicaid is a critical tool for addressing racial and ethnic disparities in healthcare access, quality, and outcomes. While states vary in their thinking about the relationship between the Medicaid program and health equity, many are evaluating how best to use Medicaid to reduce structural inequities experienced by people of color in their Medicaid programs. Medicaid offers multiple tools and authorities that states can use to advance health equity, including Section 1115 demonstrations.

Section 1115 of the Social Security Act permits states to waive certain Medicaid statutory requirements through demonstration projects that test innovative policies. Demonstrations must be approved by the Secretary of Health and Human Services (HHS), who must determine the demonstration "furthers the goals of the Medicaid program" and is budget neutral to the federal government—meaning that the demonstration costs no more than what expenditures would have been absent the demonstration. States use Section 1115 authority to implement a range of demonstrations, including Medicaid managed care programs, delivery system and payment reform initiatives, and eligibility or benefit design features.[11] Given the broad range of possible flexibilities, Section 1115 demonstrations are a potentially powerful approach for states to advance health equity, in combination with other authorities—like State Plan Amendments (SPAs) and managed care contracts.

As outlined in the companion issue brief, *Centering Health Equity in Medicaid Section 1115 Demonstrations: A Roadmap for States*, states can advance health equity and address structural racism at each stage of the Section 1115 demonstration lifecycle: planning, implementation and monitoring, and evaluation.

This issue brief outlines potential Section 1115 demonstration innovations that states can leverage to use Medicaid to address underlying inequities in healthcare and provides examples of approved and pending state waivers. In particular, this issue brief examines state demonstration strategies and key considerations related to advancing health equity in Medicaid through:

- Eligibility policy;
- Benefit enhancements;
- Coverage affordability strategies; and
- Expenditure authority for pilot programs/delivery system reform.

Insights and recommendations in both issue briefs are informed by recent interviews with federal and state policymakers, as well as secondary research and analysis.

Roadmap to Center Equity Through the Section 1115 Demonstration Lifecycle
1.0. Eligibility Policy
1.1. Global Eligibility Expansion
1.2. Targeted Eligibility Expansion
1.3. Postpartum Eligibility Expansion
1.4. Continuous Eligibility
2.0. Benefit Enhancements
3.0. Coverage Affordability Strategies
4.0. Expenditure Authority for Investment in Targeted Providers/Services

1.0. Eligibility Policy

Medicaid eligibility, enrollment, and continuity of coverage (i.e., getting people covered and keeping them covered) are key drivers of health equity, given that Medicaid offers comprehensive and affordable health coverage. Most states grapple with a range of problems related to Medicaid coverage, access, and retention, including gaps in access to affordable coverage across broad or targeted populations and "churn" (the cycle of eligible people losing and regaining coverage)—and some of these challenges can be addressed through Section 1115 demonstrations related to eligibility policy.

1.1. Global Eligibility Expansion. Recognizing the importance of Medicaid coverage in improving access, quality, and outcomes for enrollees, states can advance equity by expanding program eligibility. States that have not adopted the Affordable Care Act's (ACA's) Medicaid expansion could choose to expand eligibility up to 138 percent of the federal poverty level (FPL), and all states can consider broader eligibility expansions *above 138 percent of the FPL*. While global expansion does not focus explicitly on addressing disparities for a specific racial or ethnic group, broadly expanding Medicaid can help narrow health disparities, as people of color are more likely to be uninsured and live in households earning incomes below Medicaid thresholds due to underlying structural racism.[12] Medicaid authority permits states to implement these broad eligibility expansions, including for populations above 138 percent of the FPL, through a SPA. However, states could choose to tailor coverage using an 1115 waiver, particularly for expansions above 138 percent of the FPL. Notably, given the availability of subsidized individual market coverage under the ACA and current subsidy enhancements available pursuant to the American Rescue Plan Act of 2021 (ARP), most individuals with incomes above 138 percent of the FPL have access to zero-premium coverage through ACA Marketplaces.[13] To the extent the ARP enhanced subsidies expire, states seeking to advance health equity through Medicaid may be more inclined to pursue 1115 demonstrations that enhance or provide "wrap-around" benefits or cost-sharing subsidies available through the Marketplace for this population, rather than implementing a global expansion of Medicaid above 138 percent of the FPL. Examples of wrap-around benefits to align Medicaid and Marketplace coverage might include non-emergency medical transportation (NEMT) or dental benefits, as directed by legislation in Connecticut.[14]

1.2. Targeted Eligibility Expansion. Section 1115 flexibilities that permit targeted eligibility expansions for specific populations or geographic areas may help states achieve their health equity goals. For example, states are increasingly seeking Section 1115 demonstrations to implement population-specific eligibility expansions for individuals who have traditionally faced barriers to accessing the healthcare system, including individuals with mental health or substance use disorder (SUD) needs, individuals who are in the pre-release period from jail or prison, and immigrant populations who lack access to Medicaid and affordable coverage options. States can also request regional or county-based eligibility expansions above mandatory or Medicaid expansion eligibility thresholds based on health disparities in specific geographic regions. For example, following the water crisis in Flint, Michigan, the state expanded eligibility and services through a Section 1115 demonstration to screen for and address adverse health outcomes resulting from the crisis, which disproportionately impacted people who are Black.[15,16] To date, HHS

has not approved demonstration proposals for Medicaid eligibility or benefit innovations that are focused on specific racial or ethnic groups. States require further discussion and guidance from CMS in developing population-specific demonstrations.

1.3. Postpartum Eligibility Expansion. While ARP establishes a new state option to extend Medicaid and Children's Health Insurance Program (CHIP) coverage for pregnant individuals for one year following the baby's birth, some states are still forging ahead with postpartum extension demonstration requests in order to go above and beyond the SPA option. Using 1115 authority, states are seeking a longer postpartum period or to extend the postpartum period for populations not otherwise eligible under the SPA option (e.g., individuals who apply for coverage past the 60 days postpartum period who were not previously enrolled in Medicaid or CHIP).[17] Studies show that women who are Black or American Indian/Alaska Native have higher rates of pregnancy-related deaths compared to women who are non-Hispanic white and these policies can help address those disparities by expanding access to care.[18] Notably, CMS is still crafting its guidance on the SPA option for postpartum coverage, which may address some of these coverage issues reflected in proposed state demonstrations. Despite these new coverage flexibilities, states are still experiencing coverage gaps for postpartum individuals, specifically immigrants who don't qualify for government sponsored coverage. Illinois, for example, has filled remaining coverage gaps by using CHIP Health Services Initiatives (HSIs) to extend postpartum coverage for immigrants, including Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) 214 and the "unborn child" populations. (For more detail on these options, see *The American Rescue Plan Act's State Option to Extend Postpartum Coverage*.)

1.4. Continuous Eligibility. Individuals repeatedly churning on and off insurance coverage results in periods of uninsurance, delays and interruptions in care, and less uptake of preventive care among Medicaid enrollees.[19] To reduce churn among Medicaid enrollees, states can implement continuous eligibility policies for adults, children, or other specific populations through 1115 demonstrations. States can implement 12 months of continuous coverage for children via a SPA, and, to date, at least 32 states have taken up this option.[20] To go beyond the SPA option, Washington and Oregon have legislation and a demonstration application, respectively, proposing continuous coverage for periods up to the first five years of life for children.[21] States may also consider implementing continuous coverage for adults through 1115 authority, or population-specific continuous eligibility for adults at high risk of health disparities, poor health outcomes, and churn. These populations may include adults and/or youth who are justice-involved, individuals who are experiencing homelessness, individuals with mental health or SUD needs, parents of children who are in the foster care system or juvenile justice-involved, or individuals residing in communities that are experiencing health disparities and are historically under-resourced and marginalized.

2.0. Benefit Enhancements

Most Medicaid benefits can be implemented via SPA authority, but Section 1115 waiver authority is required if states wish to cover enhanced benefits or services beyond those authorized under the State Plan, or if they seek to cover enhanced benefits for certain populations or geographies, including those negatively impacted by health disparities. To address longstanding disparities and structural racism in healthcare, states could use Section 1115 authority to offer enhanced benefits that address the social drivers of health (SDOH) that otherwise cannot be covered by Medicaid. Structural racism has resulted in divergent access to home ownership, transportation, asset accumulation, affordable and healthy food, clean air and water, employment, and educational attainment among people of color, and SDOH such as these contribute to where and how individuals live, which exacerbates health risks. Given that Medicaid, by definition, serves populations with lower incomes—and Black, Latino(a), and other people of color disproportionately have lower incomes due to historical inequities and structural racism that underpin social and economic opportunities—states have a particularly strong imperative to understand and address SDOH to improve health outcomes.

States can use 1115 waiver authority to implement a broad range of enhanced benefits that can help address SDOH, including housing supports, health-promoting food, supported employment, transportation, child care, and family care services. For example, North Carolina is implementing the "Healthy Opportunities" pilot program that will fund approved services related to housing, food, transportation, and interpersonal safety and toxic stress that directly impact health outcomes.[22] Similarly, Arizona recently submitted an enhanced benefit request to the Centers for Medicare & Medicaid

Services (CMS) to offer housing supports for individuals experiencing homelessness or housing instability. Notably, California received approval in December 2021 to implement a menu of 14 "Community Supports," which are services that can be covered by managed care plans and offered by local community-based providers as appropriate, cost-effective alternatives to traditional medical services or settings. The Community Supports aim to address SDOH and include assistance with medically tailored meals, transitioning from nursing home care to the community, recuperative care, and short-term post-hospitalization services, among others. Two of these Community Supports—recuperative care and short-term post-hospitalization housing services—are authorized under Section 1115 demonstration authority, while the remaining 12 are approved under managed care regulatory authority as "in lieu of services" and effectuated in California through its Section 1915(b) waiver.

States might also seek flexibilities to expand the types of supports offered through Medicaid to address SDOH, improve chronic disease management and prevention, or expand primary care access. Approaches might include funding broader types of providers, including those with strong ties to the community, such as home-visiting supports, peer supports, doulas, community health workers, or school liaisons. When implementing enhanced benefits, states could consider focusing on those populations with the greatest economic or social support needs, including individuals who are homeless or at risk of homelessness, individuals who are pregnant or postpartum, individuals with mental health or SUD needs, individuals who are justice-involved, or individuals residing in communities that are experiencing health disparities and are historically under-resourced.

3.0. Coverage Affordability Strategies

Initiatives to make coverage more affordable can improve access to services by addressing cost as a significant barrier to care. To help make care more affordable, states can leverage Section 1115 demonstrations to offer wrap-around coverage for people enrolled in Marketplace plans (for example, to increase affordability of premiums, copayments, cost-sharing, or prescription drugs), offer cost-sharing subsidies to support Medicaid-eligible individuals with employer-sponsored insurance or individual coverage that is otherwise prohibitively expensive, or eliminate the asset tests used to determine eligibility for long-term services and supports (LTSS). For example, Massachusetts and Vermont use Section 1115 authority to provide additional subsidies for Marketplace coverage to individuals who are not Medicaid eligible.

4.0. Expenditure Authority for Investment in Targeted Providers/Services

States have historically pursued payment and delivery system reform Section 1115 demonstrations to improve the quality of care and reduce healthcare costs, and similar flexibilities can be used to advance equity priorities. In particular, states might consider using demonstration expenditure authority to increase payments to, or otherwise invest in, capacity building for providers that serve communities and populations experiencing health disparities and that have been historically under-resourced, including by Medicaid and other health coverage programs and payers. These types of provider payment enhancements or investments could be made for a range of providers—hospitals, behavioral health providers, Tribal healers, maternal health providers (including doulas), and child health providers among others—and tied to reducing identified health disparities through payment and delivery system reforms such as telehealth capacity building, and establishing critical anchor services, including services that address SDOH. Payment enhancements and other investments could also be broad based to stabilize and sustain providers that serve as anchor institutions[23] in communities experiencing health disparities, given that these investments will have positive impact on economic development and growth in those communities. Notably, states may consider advancing enhanced payments to targeted providers through the CMS directed payment template. Alternatively, states may use demonstration authority to fashion Delivery System Reform Incentive Payment-like ("DSRIP-like") investment programs for targeted providers to deepen access in historically underserved communities through initiatives like developing community partnerships, establishing child care services, and other activities that strengthen providers' ability to serve the community.

Table 1. Section 1115 Demonstration Strategies to Advance Health Equity

1115 Waiver Elements	Potential 1115 Waiver Strategies to Advance Health Equity	Select State Examples of 1115 Waivers *(approved, pending, or under consideration)*	Notes / Considerations
1.0. Eligibility Policy			
1.1. Global Eligibility Expansion	• Eligibility expansion above 138% of the FPL	**Expansion above 138% of the FPL** • To date, no state has proposed a broad-based expansion above 138% of the FPL	• Global eligibility expansions can be implemented through a SPA without waiver authority; waiver required if further tailoring benefits or other program features • SPA authority is the most straightforward and expeditious authority for states implementing ACA expansion
1.2. Targeted Eligibility Expansion	**Population-Specific Eligibility Expansion** • Individuals with mental health or SUD needs • Parents of children who are in the foster care system • Individuals who are American Indian, Alaska Natives, or Native Hawaiians *(To date, HHS has not approved demonstration proposals for Medicaid eligibility or benefit innovations that are focused on specific racial or ethnic groups, and states seeking such population-specific demonstrations may need to have additional conversations with federal partners to advance these types of proposals)* • Individuals who are undocumented immigrants *(States can implement coverage expansions for other immigrant populations through a SPA; HHS may not approve federal funding for coverage expansions for undocumented populations)* **Geographic Eligibility Expansion** • Regional/county-based expansion above mandatory/ expansion eligibility levels based on health disparities **Coverage of Pre-Release Period for Justice Involved** • Individuals who are inmates during the pre-release period *(current state requests are for 30-90 days of pre-release coverage, but states could request longer)*	**Expansion for Individuals with Mental Health or SUD needs** • *Approved:* New Jersey, Rhode Island, Utah **Geographic Eligibility Expansion** • *Approved:* Michigan *(Medicaid Eligibility for Flint Residents Waiver)* **Coverage of Pre-Release Period for Justice Involved** • *Pending:* California, Kentucky, Utah, Vermont	• States can use 1115 authority to pair population-specific eligibility expansions with a targeted benefit package and/or care delivery or management model

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1.3. Postpartum Eligibility Extension	Postpartum coverage extensions up to 12 months postpartum	*Approved:* Georgia, Illinois, Missouri, Virginia *Pending:* Florida, Massachusetts	• ARP gives states the option to extend Medicaid postpartum coverage to 12 months via a SPA; waiver needed until April 2022 • Using Section 1115 authority, states may seek a longer postpartum period or to extend the postpartum period for populations not otherwise eligible under the SPA option (e.g., individuals who apply for coverage past the 60 days postpartum period who were not previously enrolled in Medicaid or CHIP)
1.4. Continuous Coverage	**Adults** • Continuous coverage for 12 months **Children** • Continuous coverage for periods up to the first five years of life *(currently under consideration by states)* or potentially longer **Population-Specific Continuous Coverage** • Continuous coverage (12 months or longer) for adult and/or juvenile populations who are justice-involved • Continuous coverage for individuals with mental health or SUD needs • Continuous coverage for parents of children such as those who are in the foster care system • Continuous coverage for individuals residing in communities that are experiencing health disparities and are historically under-resourced and marginalized • Continuous coverage for individuals who are American Indian, Alaska Natives, or Native Hawaiians *(To date, HHS has not approved demonstration proposals for Medicaid eligibility or benefit innovations that are focused on specific racial or ethnic groups, and states seeking such population-specific demonstrations may need to have additional conversations with federal partners to advance these types of proposals)*	**Adults** *Approved:* Montana[24] *Pending:* Kansas **Children** *Under consideration:* Washington *Pending:* Oregon **Population-Specific Continuous Coverage** *Approved:* Utah[25]	• States can implement 12 months of continuous coverage to children via a SPA (32 states have taken up this option) • To provide continuous coverage to children for periods up to the first five years of life or longer, states would need Section 1115 waiver authority; no states are currently implementing this option • Population-specific continuous coverage can be paired with demonstration initiatives related to providing tailored benefits including enhanced care management, family case management, among other benefits

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2.0. Benefit Enhancements			
2.1. Enhanced Benefits/ Support Services	**Population-Specific Enhanced Benefits** • Supportive housing • Supported employment • Transportation • Child care • Family care • Medically tailored meals • Supports to address interpersonal violence / toxic stress • Over-the-counter drug coverage • Home-visiting supports • Peer supports • Family specialists or navigators • School liaisons • Dyadic care **Potential Populations to Consider for Targeted Enhanced Benefits:** • Individuals who are homeless or at risk of homelessness • Individuals who are pregnant or postpartum • Individuals with mental health or SUD needs • Individuals who are justice-involved • Individuals residing in specific geographic regions with significant health disparities and inequitable access to healthcare	**Enhanced Benefits for Individuals with Mental Health or SUD Needs** *Approved:* 19 states **Enhanced Benefits for Individuals Who Are Justice-Involved** *Approved:* Illinois, Virginia, Washington **Enhanced SDOH Benefits** *Approved:* California, North Carolina **Enhanced Coverage of Provider Types** *Approved:* Maryland *Pending:* Massachusetts **Wrap-Around Benefits for Marketplace Enrollees** *State Legislation Passed:* Connecticut	• Many enhanced benefits can be implemented via SPA authority • States would need waiver authority if implementing pilot programs for specific populations or limiting to certain geographies
3.0. Coverage Affordability Strategies			
3.1. Initiatives to Make Coverage More Affordable	• Wrap-around coverage *(e.g., wrap-around drug coverage to increase affordability of co-pays/ drug costs)* • Cost-sharing subsidies *(e.g., support individuals with ESI or individual coverage that is otherwise unaffordable)* • Elimination of asset tests for LTSS	**Cost-Sharing Subsidies** *Approved:* Massachusetts, Vermont **Elimination of Asset Tests for LTSS** *State Legislation Passed:* California	• Given the availability of subsidized individual market coverage under the ACA, and current subsidy enhancements available pursuant to the ARP, most individuals with incomes above 138% of the FPL have access to zero-premium coverage through ACA Marketplaces • To the extent the ARP enhanced subsidies expire, states seeking to advance health equity through Medicaid may be more inclined to pursue 1115 demonstrations that enhance or provide "wrap-around" benefits or cost-sharing subsidies available through the Marketplace for this population, rather than implementing a global expansion of Medicaid above 138% of the FPL

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4.0. Expenditure Authority for Delivery System Investments / Pilots			
Investment in Targeted Providers/ Services	**Capacity Building** • Healthcare workforce development • Improvements in population health management • Enhanced data collection and analytic capacity, including for race and ethnicity data **Care Delivery Redesign** • Integration of physical and behavioral healthcare • Improved care coordination • Improved transitions between services and settings • Improved diversion interventions • Flexible services and community partners initiatives for families with children with health-related social needs **Prevention and Early Intervention** • Mental health and SUD treatment • Maternal and child health promotion • Access to oral health services • Chronic disease prevention and management • Access and reimbursement for Tribal healing **Provider Payment Increases** • For range of providers: hospitals, behavioral health providers, Tribal healers, maternal health providers (including doulas), child health providers among others; potentially tied to addressing health disparities	**Capacity Building** *Approved:* California, Massachusetts, Washington *Pending:* Vermont **Care Delivery Redesign** *Approved:* Arizona, Rhode Island, Washington **Prevention and Early Intervention** *Approved:* Massachusetts, Washington	N/A

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ENDNOTES

23. Anchor institutions are "large, usually nonprofit organizations tethered to their communities [… that] have significant economic and social impact on their communities, and […] also have an economic self-interest in making sure these communities are healthy and safe," as defined by "Communities in Action: Pathways to Health Equity" published by the National Academies of Sciences, Engineering, and Medicine (2017).
24. At the direction of the Legislature, Montana submitted a waiver amendment to terminate the 12-month continuous eligibility provision.
25. Utah provides 12 months continuous coverage for childless adults ages 19-64 with incomes <5% of the FPL who are chronically homeless or in need of SUD or mental health treatment including justice-involved populations.

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ABOUT MANATT HEALTH

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