

# Centering Health Equity in Medicaid Section 1115 Demonstrations: A Roadmap for 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup>

While addressing structural racism in healthcare requires collaborative and sustained efforts across state agencies, local governments, communities, and other stakeholders, many states are looking to Medicaid as a critical lever for advancing health equity. Medicaid has a large coverage footprint in all states and, across the nation, broad coverage of Black, Latino(a), and other people of color. States have multiple tools and authorities in Medicaid to advance health equity through coverage and benefit policy, delivery system and payment reform, and innovations that impact the social drivers of health (SDOH). States seeking to test new or innovative ideas related to health equity in their Medicaid programs are tapping Section 1115 demonstrations as one key strategy.

States are advancing health equity via Section 1115 demonstrations by: incorporating equity components in Section 1115 demonstration renewals; developing entirely new, equity-focused Section 1115 demonstrations; and evaluating the impacts of existing Section 1115 demonstrations on health equity, regardless of whether the demonstration explicitly centers or incorporates equity. Across all demonstrations, including those that may not identify specific policies to advance health equity, state policymakers have an opportunity and imperative to center health equity at each stage in the demonstration lifecycle.

**Systemic or structural racism** refers to the complex system, rooted in historical and current realities of differential access to power and opportunity for different racial groups. This system is embedded within and across laws, structures, and institutions in a society or organization. This includes laws, inherited disadvantages (e.g., the intergenerational impact of trauma) and advantages (e.g., intergenerational transfers of wealth), and standards and norms rooted in racism.

**Health equity** means that everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, socioeconomic status, geography, or any other social factor or potential barrier. When focusing on racial equity in health, advancing health equity means dismantling the systemic racism that underlies differences in the opportunity to be healthy, including addressing social and economic barriers to positive health outcomes. Since we have never had a truly equitable healthcare system, progress toward the goal of health equity is often benchmarked by measuring reductions in health disparities.

**Health disparities** are avoidable differences in health outcomes experienced by people with one characteristic (race, gender, sexual orientation) as compared to the socially dominant group (e.g., White, male, cis-gender, heterosexual).

*For more tools on language and health equity, please see the State Health and Value Strategies Health Equity Language Guide for State Officials.*

This issue brief examines Medicaid’s role in promoting health equity and describes ways states can center and advance health equity and address structural racism through each Section 1115 demonstration lifecycle stage, which include planning, implementation and monitoring, and evaluation. A companion issue brief, *Centering Health Equity in Medicaid: Section 1115 Demonstration Strategies*, provides insights into specific, innovative policies to advance health equity that states can implement through Section 1115 demonstrations. The insights and recommendations found in both documents are informed by recent interviews with federal and state policymakers, as well as secondary research and analysis.

## Role of Medicaid in Advancing Health Equity<sup>i</sup>

Medicaid is an important lever for advancing health equity because of the size, scale, and demographics of its coverage footprint. Medicaid covers more than 80 million individuals,<sup>4</sup> accounts for almost one fifth of national health expenditures,<sup>5</sup> and is the single largest payer in many states. Medicaid covers nearly half of all births in the United States,<sup>6</sup> nearly one in two children,<sup>7</sup> and over half of total institutional and community-based long-term care costs.<sup>8</sup> 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,<sup>9</sup> though they constitute less than half of the U.S. population.<sup>10</sup> As a result, Medicaid is a critical tool for addressing racial and ethnic health inequities in access, quality of care, and outcomes in healthcare. While states vary in their thinking about the relationship between the Medicaid program and health equity, many are evaluating how to reduce structural inequities that disproportionately impact people of color within their Medicaid programs, and considering how they might use Medicaid to address long-standing health inequities across their populations.

States have a range of Medicaid administrative and legal authorities to advance health equity priorities. Not all pathways and legal authorities apply to all state strategies and multiple mechanisms are needed to advance health equity. Key Medicaid administrative authorities include:

- **State regulation**, which can be used to implement, interpret, or further define Medicaid policies, procedures, and requirements.
- **Managed care contracts**, which set the terms between the state Medicaid program and managed care organizations (MCOs) for the delivery of services to members, and which allow states to legally require or encourage MCOs to perform certain activities.<sup>11</sup>

Key Medicaid legal authorities include:

- **State Plan authority**, which defines the scope of services covered for Medicaid enrollees, provider payment rates (in fee-for-service), and administration, consistent with permissible options and flexibility available under federal law.
- **Section 1915 waivers**, which are specialized waivers that add to the options otherwise available to states to provide long-term care services and supports in home and community-based settings, rather than in nursing homes or other institutional settings.
- **Section 1115 demonstrations**, which allow states to use Medicaid funds for initiatives and services that extend beyond Medicaid benefits available and otherwise allowable through the State Plan or other federal authorities.

<sup>i</sup> The authors note that while this issue brief is focused on racial and ethnic health disparities and inequities in Medicaid, and 1115 demonstration considerations related to addressing them, structural inequities and related health disparities also exist for individuals of various genders, sexual orientations, disability status, economic status, immigration status, and geography.

Section 1115 of the Social Security Act permits states to waive certain Medicaid statutory requirements through demonstration projects that test innovative policies in Medicaid. Demonstrations must be approved by the Secretary of Health and Human Services, 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 demonstrations to test a range of new policies, including Medicaid managed care, delivery system and payment reform initiatives, and eligibility or benefit design features.<sup>12</sup> Section 1115 authority is a powerful tool that states can use to advance health equity, in combination with other authorities, including through policy and expenditure authority related to eligibility, benefit design, affordability, and payment and delivery system reform. For any policy innovation, states have the opportunity to implement strategies that center and advance health equity at each stage of the Section 1115 demonstration lifecycle: planning, implementation and monitoring, and evaluation. Using this staged framework, states can center and advance equity from the conceptualization to the design and execution of Section 1115 demonstrations.

The effectiveness of the design and implementation of Section 1115 demonstrations to advance health equity is predicated upon partnership and communication with those directly impacted. States are increasingly recognizing that true community engagement is not simply a “check the box” step in demonstration development and implementation, but rather a critical and sustained partnership with the community to design, implement, and evaluate innovative policy to advance health equity. “Community” in this context is defined as individuals enrolled in or eligible for the Medicaid program and their families and caregivers, with an emphasis on those people most impacted by inequities and proposed Medicaid policies to address those inequities. “Community” also extends to community-based providers, trusted advocates, and messengers (e.g., consumers, local providers of health and social services, faith leaders, other community-based organizations, and community leaders). Meaningful community engagement requires state Medicaid agencies to build trust, transparency, and capabilities to develop continuous and sustained partnerships and bi-directional communication with these critical stakeholders. States have not historically exhibited these skills and capacity, meaning success relies upon sustained investment of time and financial resources to develop and grow these capabilities. As the Oregon Health Authority states in its framework to advance health equity: “While conducting community and stakeholder engagement is important, it is critical to consider to whom are we listening, for what purpose the engagement happens, for whom is the engagement meaningful, and what action is taken with the information gathered.”<sup>13</sup>

## Roadmap to Center Health Equity Through the Section 1115 Demonstration Lifecycle

### Roadmap to Center Equity Through the Section 1115 Demonstration Lifecycle

#### 1.0. Strategies to Center Health Equity in 1115 Demonstration Planning and Design

1.1. Use Data-Driven Analysis to Identify Health Equity Priorities

1.2. Identify Policies to Address Health Equity Priorities

1.3. Identify Policies that Require 1115 Demonstration Authority

*Engage Community Stakeholders in Planning and Design*

#### 2.0. Strategies to Center Health Equity in 1115 Demonstration Implementation and Monitoring

2.1. Ensure that the Implementation Team Understands Health Equity Goals of the Demonstration

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*Engage Community Stakeholders in Implementation and Monitoring*

#### 3.0. Strategies to Center Health Equity in 1115 Demonstration Evaluation

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3.2. Invest in Data Needed to Evaluate Health Equity and Disparities in Medicaid

*Engage Community Stakeholders in Evaluation*

## 1.0. Strategies to Center Health Equity in 1115 Demonstration Planning and Design

Early planning can help states implement focused policy solutions that best address the needs of Medicaid enrollees. In partnership with communities, states can assess and prioritize health inequities experienced by Black, Indigenous, Latino(a), and other people of color using available data; craft strategies to address their health equity priorities; and determine how to best use Medicaid to advance those strategies, whether through Section 1115 demonstrations or other legal authorities.

### Strategy 1.1. Use Data-Driven Analysis to Identify Health Disparities and Establish Equity Priorities

States must be able to identify disparities and understand the underlying issues confronting Medicaid enrollees of varied racial and ethnic backgrounds in terms of coverage, access, quality, and health outcomes, as well as SDOH that influence health and wellbeing. Data-driven analysis early in the planning process will provide insights on the magnitude and scale of the health inequities observed across a Medicaid population—by race, ethnicity, gender, age, geography, and other factors—allowing the state to prioritize issues and shape actionable responses. Recognizing current data limitations, investments by states and the federal government to improve the quality of Medicaid and human services data will further enhance the ability of Medicaid agencies and their community partners to identify and set these priorities.

States can use data-driven analysis to measure disparities experienced by Black, Indigenous, Latino(a), and other people of color enrolled in their Medicaid programs, indicate potential systemic issues driving observed disparities, and prioritize strategies for addressing them in collaboration with the community, including defining specific actions and setting clear and measurable timelines and goals. Nationally, there are a wide range of observed disparities between people of color and non-Hispanic White individuals across coverage, access, quality of care, and health outcomes. For example:

- **Coverage and Access:** Nationally, uninsured rates for the nonelderly were highest among people of color in 2019; the uninsurance rate was 22 percent for people who are American Indian/Alaska Native, 20 percent for people who are Latino(a), and 11 percent for people who are Black, compared to only 8 percent for people who are non-Hispanic White.<sup>14</sup>
- **Quality of Care:** Across about 40 percent of quality measures focused on person-centered care, patient safety, healthy living, effective treatment, and care coordination, individuals who are Black or American Indian/Alaska Native were shown to have received worse care than those who are non-Hispanic White.<sup>15</sup>
- **Outcomes:** 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 infants born to Black, Latino(a), and other people of color are at higher risk for mortality compared to those born to non-Hispanic White women.<sup>16</sup>

States can use existing Medicaid administrative and clinical data to identify disparities—though they often confront data limitations in doing so. Lack of investment in data collection and sharing by states and the federal government has resulted in race, ethnicity, and language (REL) data gaps related to obtaining REL data that are complete, accurate, and consistently collected. States may enhance REL data collection by requiring standardized acquisition through Medicaid and human services programs and related contractors (e.g., Medicaid managed care plans); providing training for state and county workers, and other organizations and staff on the ground working to collect REL data; developing educational materials and programming to help patients understand why the information is being collected and how it will be used; and supporting new data sharing arrangements across state agencies and with state or regional health information exchanges to support demographic data exchange. For example, Connecticut passed legislation requiring REL data collection to support the identification of disparities, and specifically required collaboration across consumer advocates, health equity experts, healthcare providers, and state agencies on the implementation and data sharing approach.<sup>17</sup> While states invest and build capacity for self-reported data, the gold standard for REL,<sup>18</sup> they may need to rely on other indirect methods on a time-limited basis, such as population-based REL imputation using other available individual-level information (e.g., address, surname,

familial relations) to, in aggregate, identify populations and areas with the most pressing needs. When identifying health equity priorities, states should also incorporate qualitative data from community members and community-based organizations, drawn from focus groups and other forms of community outreach, to bring the perspective of the people being served, and understanding of the quantitative data through a lens other than the status quo, culturally dominant viewpoint.

In addition to healthcare access, quality, and outcomes data, states can collect and incorporate SDOH data sources that provide broader context around the social, economic, and environmental factors that influence health outcomes. Structural racism has resulted in divergent access to home ownership, asset accumulation, clean air and water, affordable and healthy foods, employment, and educational attainment among people of color. These SDOH are powerful influences on where and how individuals live and the health risks to which they are exposed. Many states are using their Medicaid programs to support whole person care, identifying barriers individuals may face to maintain their health—including where additional housing, transportation, employment, and food supports may be needed. Similar to data challenges around healthcare access, quality, and outcomes data, SDOH data is often limited and incomplete, and states have opportunities to enhance collaboration among agencies to improve this data. For example, California recently launched the “Data Exchange Framework,” which seeks to address cross-agency data sharing barriers, including barriers around social and economic data sharing.<sup>19</sup>

### **Strategy 1.2. Identify Policies to Address Health Equity Priorities**

Once states identify and prioritize the health inequities they intend to address, they can develop strategies and policies to address these issues. For example, if a state identifies significant disparities in rates of health insurance coverage among people of color, the state might consider expanding Medicaid eligibility or implementing coverage affordability initiatives broadly or in a targeted fashion (for more detail on these potential coverage opportunities through Section 1115 demonstrations, see the companion issue brief, *Centering Health Equity in Medicaid: Section 1115 Demonstration Strategies*). States could also streamline enrollment or renewal processes through targeted strategies that address barriers experienced by people of color. States that identify disparities in maternal and infant health outcomes might pursue policies to ensure people who are pregnant have access to full Medicaid benefits during pregnancy and the postpartum period. Specific strategies to identify and design policy solutions with a focus on equity include:

- Get a clear sense of the problem from all sources, putting a premium on the experience of the people who are most directly impacted.
- Identify best practices in responding to the health inequity or disparity from the literature or other state Medicaid programs.
- Structure demonstration design teams to include individuals with lived experience that reflect communities disproportionately impacted by health inequities.
- Solicit and incorporate community stakeholder perspectives in the design process.
- Collaborate with and eliminate silos across state agencies to ensure alignment between Medicaid and other state agency policies and implementation efforts (e.g., collaborate with Department of Housing when designing Medicaid policies to address homelessness).
- Design with an eye to monitoring and evaluation (i.e., think ahead to what successful implementation will look like and how it can be evaluated).

States have an imperative to use both quantitative and qualitative data to model potential health equity implications of policies—whether positive, negative, or neutral and regardless of whether potential policies are explicitly equity-focused. Such considerations include examining the projected timeframe for the Medicaid agency to accomplish demonstration goals, as well as the projected impacts of the policy on different population groups (e.g., stratified by race and ethnicity, rural versus urban geographies).

### **Strategy 1.3. Identify Policies that Require 1115 Demonstration Authority**

After states determine their health equity priorities and identify potential policy solutions, they can determine the mechanism through which they will pursue those solutions (i.e., the authority by which they can implement changes). As part of this process, states will determine where Section 1115 demonstration authority is required to advance key policy approaches, and how these demonstrations will relate to and interact with other authorities that the state identifies to advance health equity priorities in Medicaid.

### **Engage Community Stakeholders in Planning and Design**

Beginning engagement and partnership with community members prior to the development of a Medicaid health equity strategy and designing an 1115 demonstration will promote equity-centered program design and community buy-in. Recognizing the challenges associated with obtaining meaningful stakeholder engagement, states should set aside ample time in the 1115 demonstration planning process to identify and engage a representative range of community members to review evidence of disparities in order to inform and deepen state policymakers' understanding of the causes and impacts of these disparities and to identify impactful and appropriate policy solutions. Through early and ongoing engagement, including bi-directional communication, states can build mutual trust with the community to support the development of more informed and effective policy solutions.

This type of engagement might be accomplished through small community forums organized in partnership with trusted community-based organizations, facilitated focus groups with consumers and providers, the formation of regional health equity community advisory groups (of consumers, local providers such as federally qualified health centers, and health and social service community organizations) or a combination of these engagement tactics. It is crucial for states to implement these types of engagement activities in a manner that facilitates participation, including holding meetings and focus groups after work and school hours, holding in-person meetings at convenient, community locations, providing technology for virtual participation, and, where appropriate, compensating community members for the time they devote to informing the state's health equity strategy. In demonstration concept papers and applications, states can reflect how they are leveraging meaningful community input to shape their Medicaid health equity strategies overall, and with respect to their particular demonstrations.

## **2.0. Strategies to Center Health Equity in 1115 Demonstration Implementation and Monitoring**

If policies to drive health equity are not implemented appropriately (e.g., with cultural sensitivity and humility, with a person-focused approach, informed by engagement with communities impacted by the policies), and monitored in real-time to gauge their impact, the demonstration may not achieve the policy goals set forth in the planning process. Key strategies to incorporate equity in implementation and monitoring of Section 1115 demonstrations include:

### **Strategy 2.1. Ensure that the Implementation Team Understands the Health Equity Goals of the Demonstration**

Often, the Medicaid agency team working on demonstration design and planning is different than the team charged with implementation. Strategies to facilitate effective implementation of Section 1115 demonstrations to advance equity include:

- Ensuring the implementation team is included in demonstration design conversations and brought along in the planning process so that implementers understand the emphasis on equity, rationale for specific design features, and can provide critical input regarding the feasibility of certain elements (e.g., collection of particular data points or assigning necessary reimbursement codes).
- Structuring implementation teams to include individuals with lived experience reflecting communities disproportionately impacted by health inequities to the extent possible.

## **Strategy 2.2. Center Health Equity in Demonstration Implementation and Monitoring Protocols**

In addition to the Section 1115 demonstration's Special Terms and Conditions (STCs), the Centers for Medicare & Medicaid Services (CMS) requires that states provide additional detail regarding their implementation and monitoring approaches through separate implementation protocols or plans.<sup>20</sup>

Implementation protocols include operational detail around key program features, including operational design decisions, steps for and approach to ensuring implementation readiness, strategies for communicating new policies to Medicaid enrollees, and timelines for meeting milestones associated with the policies, among other details. For example, a state implementing a new housing or employment support service through its demonstration would need to describe in detail how it would identify members who are eligible for and need the service, how the service will be defined, and what steps the state will take to develop these program details prior to implementation. The state may identify as a key implementation step engaging with community members who may require the service to inform the service definition and eligibility criteria, or consider how service definitions should differ for rural and urban populations. Ensuring that health equity considerations are embedded in these protocols, for waivers centered around health equity and those that address other policy priorities, will support successful implementation of demonstrations and achievement of the equity goals the state is trying to advance (and help the state avoid unintended, negative health equity impacts related to demonstration implementation).

Monitoring protocols outline the key metrics through which states will track demonstration progress toward implementation milestones and goals. An important purpose of monitoring 1115 demonstrations is to identify trends that suggest the need for course correction, including changes to demonstration policy or implementation approach to improve demonstration performance and protect enrollees. Demonstration monitoring metrics typically rely on Medicaid administrative data and can include information related to enrollment and eligibility, grievances and appeals, encounter and claims experience, and quality measures. Ensuring that health equity considerations are embedded into these protocols, both for waivers centered around health equity and those that address other policy priorities, is essential. This includes analyzing and reporting demonstration monitoring metrics by racial, ethnic, and language demographics to inform state and CMS understanding of whether demonstrations are achieving equity goals the state is trying to advance, or, conversely, potentially creating or exacerbating disparities in coverage, access, or quality. In the example of the state implementing a new housing or employment support benefit, racial and ethnic disparities in eligibility determinations for the new benefit may indicate policy or implementation problems that the state needs to correct.

### **Engage Community Stakeholders in Implementation and Monitoring**

States should maintain engagement with the community to inform implementation and monitoring of the demonstration. States can continue to hold forums and focus groups to get input on how programs should be implemented—including, as noted above, informing prerequisites for implementation, making program design decisions, such as eligibility criteria or services, and identifying monitoring metrics. Ongoing engagement with community members can also provide real-time and critical feedback on implementation—including challenges, successes, and problems that those impacted by the demonstration may be encountering. Indeed, this type of qualitative data gathering will be essential to correcting course if demonstrations are having unintended, adverse impacts. As part of these efforts, states may consider funding community-based organizations to track and report on demonstration implementation progress.

## **3.0. Strategies to Center Health Equity in 1115 Demonstration Evaluation**

Federal statute and regulation require states to develop approaches for evaluation of Section 1115 demonstrations to examine the impacts on members, providers, health plans, and states.<sup>21</sup> Given that efforts to center and advance health equity in Section 1115 demonstrations are relatively new, states and the federal government will be keenly interested in evaluating and assessing the impact of these demonstrations. As noted previously, centering health equity in demonstration evaluation is critical regardless of whether the demonstration or specific policy flexibilities put

forward are equity-focused. In equity-focused demonstrations, states can focus evaluation on the key question, “Is this demonstration accomplishing the goals and having the anticipated impact to reduce inequities?” In demonstrations focused on other areas, a guiding question could be, “How is this demonstration impacting different population groups stratified by race and ethnicity?” Key strategies to advance equity in Section 1115 demonstration evaluations include:

### **Strategy 3.1. Center Health Equity in Demonstration Evaluation Design**

States have a range of opportunities to center and incorporate health equity in Section 1115 demonstration evaluation design, including:

- Requiring state evaluation contractors to propose an evaluation methodology that incorporates health equity;
- Requiring evaluation contractors to have a team member or members who are expert in health equity and health disparities, including in evaluation design;
- Requiring evaluation contractors to have an evaluation team that is racially and ethnically diverse;
- Developing specific evaluation measures that measure progress against any equity specific demonstration hypotheses;
- Designing evaluation approaches that combine qualitative and quantitative data and information collection;
- Incorporating contingencies for course correction if a particular strategy is not having the intended impact or is harming a population (similar to a drug trial when drugs are pulled from the market if they are demonstrating harm to individuals); and
- Broadly sharing evaluation findings with state providers, managed care plans, plan enrollees and other stakeholders, as well as national audiences, to inform and improve future demonstration proposals and implementation practices.

### **Strategy 3.2. Invest in Data Needed to Evaluate Health Equity in Medicaid**

Data availability, completeness, and accuracy are barriers to evaluating the impact of demonstrations on health equity priorities. Many states lack complete, accurate, and standardized REL data to identify and evaluate solutions aimed at eliminating disparities. As a result, they must rely upon narrow and limited plan- and provider-based quality reporting or time-lagged surveys with data segmented by limited race and ethnicity classifications to gain insight into differences in outcomes.<sup>22</sup> States face challenges when relying on these data sources, due to incomplete data or use of methodologies that are implicitly biased. Half of Medicaid managed care plans lack race data for more than 50 percent of their membership, with ethnicity data even less available.<sup>23</sup> Measuring quality, evaluating service needs, or stratifying risk using incomplete or biased data sources will introduce or amplify underlying bias (e.g., absent other inputs, using existing claims data to determine future service needs amplifies bias, as non-Hispanic White patients have been prioritized in the health system over people of color and, as a result, have higher medical expenses and received more care than people of color).<sup>24</sup>

To ensure that demonstration evaluation (and monitoring) data can provide insights into health equity and disparity impacts, states will need to invest in improving data collection and reporting of REL data for program enrollees, and making that data available to evaluation researchers. In most states, this likely requires developing a thorough assessment of REL data gaps and developing a plan for addressing those gaps. Gap-filling strategies may include identifying new mechanisms for data collection, standardizing data collection across state health and human service programs, looking for opportunities to leverage federal race and ethnicity data sources, investing in new health information and data exchange infrastructure that allows for bi-directional communication (i.e., importing new race/ethnicity data from other sources as it is available), and, as a last resort and interim approach, using data imputation strategies when patient reported data is not available. States should also assess and seek to reduce bias in existing data sources and methodologies, including by investing in training for those collecting and analyzing the data, as well as helping evaluators and program teams understand how bias may be influencing observed trends.



## Engage Community Stakeholders in Evaluation

As in other stages of the demonstration lifecycle, evaluation design can and should include qualitative input from consumers, providers, and others impacted by demonstrations in addition to quantitative data collection and analysis. Qualitative data often provides the “how” or “why” behind quantitative reports. For example, if a Section 1115 demonstration included three strategies to address housing instability, and the evaluation report demonstrated a reduction in disparities, the qualitative stakeholder information would provide insight into which of the three strategies was most effective in closing this disparity and why. States could engage community-based organizations or require evaluation contractors to ensure sufficient qualitative feedback from the community.

## Conclusion

Section 1115 demonstrations are a powerful tool for states to advance health equity in Medicaid and across their populations. Demonstrations offer a broad range of flexibilities related to Medicaid eligibility, benefits, affordability, and payment and delivery system reform. Given these flexibilities, as well as the populations that Medicaid covers, Section 1115 demonstrations can be used to respond to health disparities and address health equity in a variety of ways. At the same time, innovative state demonstration policies—whether equity-focused or not—must be developed with an equity lens at every stage of the demonstration lifecycle.

As states make new efforts to center and advance health equity in Medicaid, including through 1115 demonstrations, the Biden administration will be a critical partner. CMS Administrator Brooks-LaSure has articulated six strategic pillars for CMS, including to “advance health equity by addressing health disparities that underlie our health system...[and] drive innovation to tackle our health system challenges...”<sup>25</sup> CMS could accelerate its vision and strategic focus by issuing guidance on equity-related considerations and requirements for demonstrations. Such guidance could include specific equity-related goals, implementation considerations or monitoring metrics, similar to guidance on substance use disorder demonstration implementation, monitoring, and protocols released by CMS in 2017 and 2018.<sup>26</sup>

Additionally, as states seek to remedy historic underinvestment in certain communities, services, or providers to address health disparities, Section 1115 demonstration budget neutrality policy will likely limit states’ options and flexibility for innovation. Throughout the demonstration negotiation process, CMS and the state develop estimates of what the state’s Medicaid program would have cost without the waiver for the purpose of ensuring Medicaid costs with the demonstration will not exceed “without waiver” costs. These estimates act as a cap on total spending during the demonstration; in other words, states must generate savings in their Medicaid programs to “pay for” new demonstration spending. This requirement limits states’ ability to innovate through Section 1115 demonstrations and make investments to address underlying structural inequities, particularly when a root cause of these structural inequities is underinvestment. States require fresh thinking and additional guidance from CMS related to budget neutrality considerations for equity-focused demonstrations.

For information on specific state innovations to advance health equity in Medicaid through Section 1115 demonstrations, see the companion issue brief, *Centering Health Equity in Medicaid: Section 1115 Demonstration Strategies*.

## ENDNOTES

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