ACHI
INSPIRING HEALTHY ACTS

Arkansas Medicaid Work and Community Engagement Requirement: Community Response

Report
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Executive Summary

Arkansas has been the only state to implement a work and community engagement requirement (WCER) under a Section 1115 demonstration waiver that operates as a condition of eligibility for Medicaid expansion enrollees. Prior to the halting of the WCER in Arkansas by a federal judge in March 2019, enrollees in Arkansas's Medicaid expansion program — the Arkansas Works premium assistance program — who were ages 19–49 and were receiving coverage through individual qualified health plans (QHP) were subject to the WCER. Of those, approximately 100,000 Arkansas Works enrollees ages 30-49 became subject to the WCER in 2018 under the state's phased implementation approach. By December 2018, there were 18,164 enrollees whose coverage ended due to non-compliance with the WCER. Others met the WCER through work, training, or other qualifying activities, or were exempt from reporting obligations.

This report seeks to answer the following questions about the early experience of Arkansas as the first state to implement a WCER for Medicaid expansion enrollees:

- How are communities (providers, volunteer organizations, etc.) responding to assist enrollees?
- What are communities' observations on enrollees' barriers to meeting the WCER?
- How are state officials monitoring and reporting publicly about the WCER?
- What modifications, if any, to WCER operational processes did state officials make in early implementation?

Our assessment focuses on the role of support organizations specifically identified by Arkansas Medicaid as resources for enrollees in an effort to better understand their awareness of and ability to assist enrollees in meeting the WCER. The report includes the following findings based on publicly available information and key interviews with support organizations and QHPs serving Medicaid:

- Consistent with previous practices in the premium assistance model adopted by Arkansas, the state relied on QHPs for enrollee engagement regarding the WCER within a coordinated outreach strategy by the Arkansas Department of Human Services (DHS), which houses Medicaid; the Arkansas Foundation for Medical Care (AFMC), a Medicaid vendor; and the Arkansas Department of Workforce Services (DWS). DHS, AFMC, DWS, and the QHPs together made 230,307 phone calls; sent 592,102 letters, 311,934 emails, and 38,766 text messages; and made 918 social media posts from April through December of 2018 as part of the coordinated strategy.
- DHS offered webinars and in-person training about the WCER for stakeholders — engaged organizations that would have potential contact with enrollees — and developed a SharePointe site with resources including county-specific guides for enrollees to locate employment and volunteer opportunities, education and training, and quality of life resources (e.g., shelters, food pantries), as well as information on accessing available public computers and/or Wi-Fi.

- DHS initiated the following modifications to WCER programmatic features from May 2018 through December 2018:
    - In May 2018, DHS established a process to authorize “registered reporters” to assist enrollees with WCER reporting and extended call center hours to correspond with the online portal hours of 7 a.m.–9 p.m.
    - In December 2018, DHS changed its policy to allow enrollees to report WCER activity by phone using the DHS Helpline, initiated calls using Helpline staff to those who had logged activities but needed more hours to comply with the WCER, and announced a paid advertising campaign to reach enrollees.
- QHP interviewees reported the following outreach efforts, approaches, and results:
    - QHPs worked with DHS to use consistent terminology for enrollee communications and employed avenues of outreach similar to those used by DHS, opting not to use radio or TV for outreach in an effort not to confuse enrollees not subject to the WCER.
    - The most successful communication routes were by phone, text, or email, although these methods reached only a small group of enrollees with available and valid phone numbers and emails. QHPs anticipated communication challenges due to historical experience with the Arkansas Works population, which they indicated frequently changed addresses.
    - There was significant confusion among enrollees regarding the WCER, including how to navigate the online portal, whether the WCER applied to them, and how to meet the requirement, although the availability of the DHS Helpline for reporting WCER activities by phone helped as an alternative to the online portal. Literacy within the Arkansas Works population was also a challenge for QHPs, resulting in changes to written communications.
- Of 100 community organizations selected for interviews from a DHS list of county-level enrollee resources, 68 contact attempts were not successful for various reasons, such as disconnected or incorrect phone numbers, non-responsiveness, or interview refusals.
- Of the 32 interviews with community organizations successfully conducted, the following results were observed:
    - Fewer than 10 organizations reported capacities to provide assistance in calling the Medicaid helpline or health plan, assist with website navigation, help with education, or assist with WCER exemption documentation. However, few organizations indicated that they had received requests for assistance.
    - Organizations that were previously involved with populations receiving coverage from Medicaid and/or Supplemental Nutrition Assistance Program enrollees were more likely to have knowledge of the WCER.
    - Organizations in more rural areas reported greater barriers to employment or volunteer options due to a lack of opportunity. Some interviewees, particularly those in more

urban areas, expressed strong opinions that individuals seeking employment would be able to find it.

    - Lack of understanding about the WCER and the technical interface for reporting was perceived as a barrier for enrollees.

- With respect to reporting on the WCER implementation, DHS provided monthly reporting including information about the number of enrollees subject to the WCER, the number DHS determined were meeting or exempt from the WCER, the number who reported satisfying the WCER, the number who reported an exemption, and the number who failed to satisfy WCER reporting. This was accompanied by overall enrollment and expenditure reports for the Arkansas Works program and the traditional Medicaid program.

Our assessment bolsters previous findings about enrollee awareness of WCER in Arkansas but also provides additional insight into the awareness and ability of community organizations in rural and urban areas to assist enrollees in complying with the WCER.

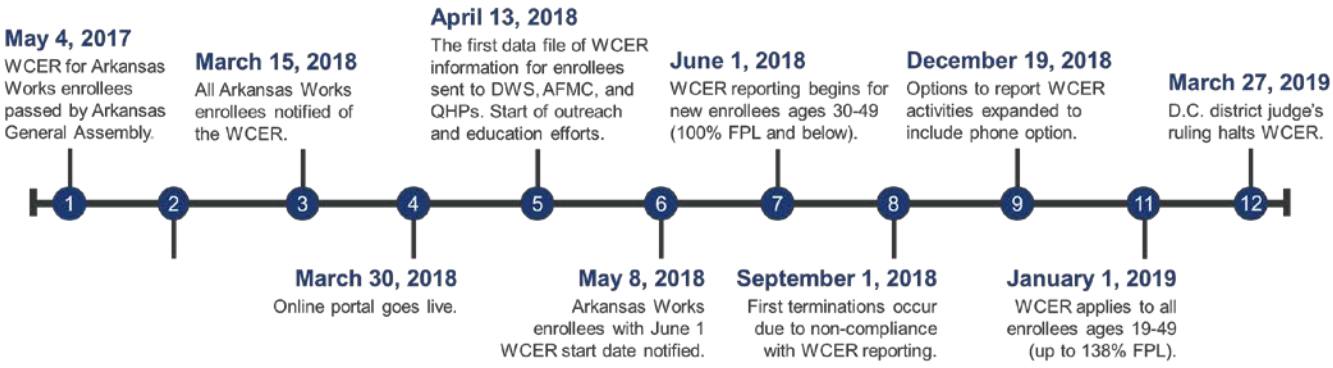
Background

In 2013, Arkansas opted to expand healthcare coverage to low-income adults earning up to 138% of the federal poverty level (FPL) through the Patient Protection and Affordable Care Act (ACA). Rather than pursue expanded healthcare coverage through the state's traditional Medicaid fee-for-service program, Arkansas sought and received approval from the Centers for Medicare and Medicaid Services (CMS) for a Section 1115 demonstration waiver under the Social Security Act to expand coverage through premium assistance. Colloquially known as the "Private Option," the Health Care Independence Program (HCIP) used federal funds allotted for Medicaid expansion under the ACA to purchase qualified health plans available in the Arkansas Health Insurance Marketplace (AHIM). QHP coverage is available for non-medically frail individuals eligible under the ACA's Medicaid expansion. Medically frail individuals receive coverage directly through Medicaid.[i]

During the life of the waiver, the HCIP underwent modifications in response to amendments to the enabling legislation, including limitations on use of non-emergency transportation and the introduction of Health Independence Accounts (HIAs) to incorporate personal responsibility. Prior to expiration of the HCIP on December 31, 2016, Arkansas sought and received approval for a waiver extension to continue the premium assistance model, renamed Arkansas Works. The five-year waiver extension included premium payment requirements for individuals earning between 101% and 138% of the FPL and an employer-sponsored health insurance premium assistance program.[ii]

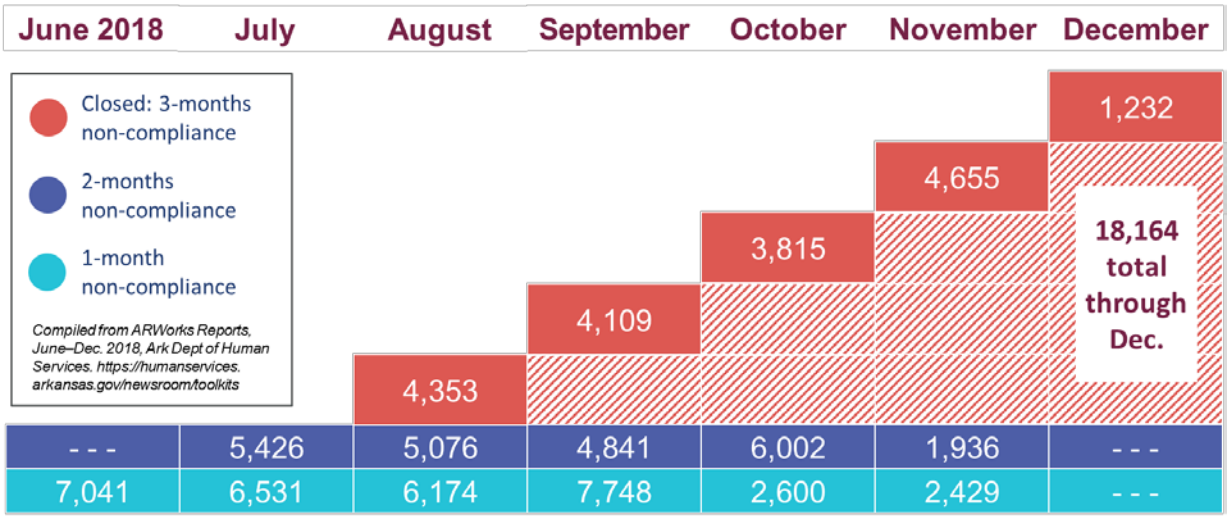
In 2017, the state Legislature enacted additional modifications to Arkansas Works, including incorporation of a work and community engagement requirement as a condition of eligibility and limitations on retroactive eligibility.[iii] In March 2018, Arkansas became the third state to receive approval from the U.S. Department of Health and Human Services (HHS) to implement a WCER for Medicaid adults, following the department's approval of WCERs submitted by Kentucky and Indiana. While other states have received approval to implement WCERs, on June 1, 2018, Arkansas became the first, and so far only, state to implement such a policy. However, a federal judge halted the WCER in Arkansas in March 2019, and the case is currently on expedited appeal.[iv] Figure 1 shows the WCER approval and implementation timeline.

FIGURE 1: WORK AND COMMUNITY ENGAGEMENT REQUIREMENT (WCER) APPROVAL AND IMPLEMENTATION TIMELINE



Arkansas Works enrollees ages 30–49 were impacted by the WCER in 2018, and the state added the WCER for enrollees aged 19–29 in 2019. Approximately 100,000 enrollees at or below 100% of the FPL became subject to the WCER in 2018. Figure 2 shows a total of 18,164 enrollees whose coverage ended in 2018 due to non-compliance with the WCER.

FIGURE 2: ENROLLEES NOT MEETING WCER IN 2018 (PER REPORTING PERIOD)



The purpose of this report is to capture the results of key interviews and answer the following research questions about the early experience of Arkansas as the first state to implement a WCER for Medicaid enrollees:

- How are state officials monitoring and reporting publicly about the WCER?
- What modifications, if any, to WCER operational processes did state officials make in early implementation?
- How are communities (providers, volunteer organizations, etc.) responding to assist enrollees?
- What are communities' observations on enrollees' barriers to meeting the WCER?

This report will complement quantitative analyses to assess any changes in the risk and demographic profiles of the Arkansas Works population in early implementation of the WCER, ascertain any differential effects of the WCER on populations in counties with higher unemployment rates, and analyze the rate of reenrollment following termination due to the WCER.

Prior Assessments

Other research and advocacy organizations (both in Arkansas and nationally) have sought to gauge the impact of the WCER on Arkansas Works enrollees, including the role of support organizations to assist enrollees. In October 2018, Musumeci et. al. examined early experience with implementation of WCER in Arkansas. These analyses included publicly available data along with interviews with state officials, health plans, providers, and enrollee advocates conducted in August and September 2018. Findings from the study suggest that many enrollees were not successfully contacted during initial stages of outreach efforts, that ongoing implementation efforts would necessitate complex data matching and sharing efforts from the state, and that coverage losses could result in coverage gaps and increase the uninsured rate/uncompensated care costs for providers. [v] An update from Musumeci et. al. was published in December 2018 and added to previous analyses to incorporate enrollee and provider perspectives regarding the WCER. This included the addition of focus groups with 31 Arkansas Works enrollees conducted in November 2018 in Little Rock and Monticello, Arkansas. Findings from the focus group engagement highlighted in the report found that enrollees were unaware/confused about new Arkansas Works requirements and experienced difficultly navigating the online portal, and that the WCER did not seem to provide additional incentive to work (and instead, heightened reported stress) and negatively impacted enrollees with high health needs and vulnerable populations. [vi]

A January 2019 issue brief from the Center on Budget and Policy Priorities (CBPP) also examined the implementation of the Arkansas Medicaid WCER and discussed efforts by other states to implement a similar requirement. The issue brief cites a number of outreach barriers and findings from previous studies assessing the validity of work requirements in public assistance programs such as Temporary Assistance for Needy Families (TANF). Citing the Muscumeci (October 2018) report, the authors note difficulties expressed by Arkansas health plans and the state's Medicaid agency in conducting outreach efforts targeting Arkansas Works enrollees, including outreach efforts through mailings, texts, emails, online videos, and phone calls. [vii]

In an Urban Institute study from May 2019, Karpman sought to understand the impact of the Arkansas WCER on enrollees seeking sustained employment. Using a sample of 15,031 nondisabled adults ages 19–64 who participated in September 2018 and March 2019 rounds of the Health Reform Monitoring Survey, this study sought to gauge/examine work patterns and potential barriers to employment among Medicaid enrollees likely to be subject to the WCER based on standards proposed in Arkansas and Kentucky and compared the group with both Medicaid enrollees who would likely be exempt and privately insured adults. Findings from the Karpman report found that enrollees potentially subject to the WCER faced significant employment barriers (e.g., lack of high school degree, health problems); that fewer than one in six potentially non-exempt enrollees reported working at least 20 hours per week in the prior year; that half of the non-exempt enrollees reported issues in obtaining employment (e.g., restricted work schedules); and that over one-quarter of non-exempt enrollees cited health reasons as a barrier to employment. [viii]

Musumeci (June 2018) published an updated issue brief which found enrollee disability and technical issues presented barriers to enrollees' ability to meet the WCER. Specifically, the report

looks at four safeguards implemented and intended to protect enrollees with disabilities and others who should not have been subject to the WCER. The report analyzed the impact of these measures and utilized data from Arkansas's 2018 annual waiver report to CMS and data released monthly by the state (while the program was still in effect). The report found that the four safeguards intended to protect coverage for those with disabilities (and other non-exempt enrollees) were very complex; few enrollees utilized the safeguard process; enrollees with disabilities were particularly vulnerable to losing coverage under the WCER reporting requirements; and administrative processes (such as reporting requirements) also created barriers to eligible enrollees beyond the disabled.[ix]

In June 2019, Sommers et al. published a study in the New England Journal of Medicine exploring the impact of the WCER on Arkansas Works enrollees. The authors conducted a telephone survey to compare beneficiary outcomes for Arkansans ages 30–49, both before and after implementation of the WCER. The sample also included individuals with reported family incomes up to 138% of the FPL. Responses from these individuals were compared with Arkansans ages 19–29 and ages 50–64, and with adults in three comparisons states which included Kentucky, Louisiana, and Texas. Findings from the study showed that implementation of the WCER increased the uninsured rate of 30–49-year-olds in Arkansas (10.5% in 2016 to 14.5% in 2018), and that employment did not increase among this population when compared to the other groups. Additionally, survey results found that many respondents were unaware or confused by the reporting requirements, and that 95% of individuals subject to the program already met the requirement or should have received an exemption. The authors cite a number of study limitations, including a lower response rate than that of government surveys; a lack of baseline data on employment, necessitating asking respondents about past employment (with potential for recall bias); the limitation of the study to a single state implementing a WCER with approximately 6,000 respondents; and that the study was non-randomized. [xx]

These prior assessments provide important insight on WCERs. Our assessment bolsters findings about enrollee awareness of WCER and online portal reporting issues but also provides an opportunity to ascertain the role of support organizations specifically identified by Arkansas Medicaid as resources for Arkansas Works enrollees. In particular, we included community organizations operating in rural areas of the state with higher unemployment, seeking to better understand their awareness of and ability to assist enrollees in meeting the WCER.

Work and Community Engagement Requirement Outreach and Education Efforts

From the outset of the premium assistance approach used for Medicaid expansion in Arkansas, the state has relied upon the marketplace qualified health plans (QHPs) for enrollee engagement. The rationale for such reliance was multi-faceted:

- The state wanted Medicaid expansion enrollees to be treated like commercial insurance enrollees, thereby reducing stigma associated with being a Medicaid enrollee.

- The state wanted to minimize communications from multiple entities which could create confusion among enrollees or send mixed messages.
- The QHP premiums included 20% administrative costs and profit in the medical-loss ratio calculations (requiring QHPs to spend at least 80% of the premium on medical costs), and the state wanted to avoid the administrative expense and shift the cost of enrollee engagement to the QHPs.

This heavy reliance on the QHPs for enrollee engagement continued throughout the life of the Health Care Independence Program (2014–2016) and into its successor, Arkansas Works.

As part of a coordinated outreach strategy for the WCER, the Arkansas Department of Human Services — which houses Medicaid — established ongoing workgroup meetings with DWS, AFMC, the QHPs, and other stakeholders beginning in the summer of 2017. These workgroups assisted in the development of outreach plans for educating enrollees about the WCER; streamlining the communication that enrollees would receive about the WCER from DHS, DWS, AFMC, and QHPs; and compiling resources to help enrollees navigate the online portal for reporting work and community engagement activity or exemptions. To enable a more targeted outreach and education approach, DHS also sent a weekly data file to DWS, AFMC, and QHPs. The files included information such as enrollee contact information, exemption status and type, renewal month, and months of non-compliance.[xi] According to a December 2018 DHS report, DHS, AFMC, DWS, and the QHPs together made 230,307 phone calls; sent 592,102 letters, 311,934 emails, and 38,766 text messages; and made 918 social media posts from April through December of 2018 as part of the coordinated strategy.

DHS

Outreach efforts began in March 2018, shortly after federal waiver approval, with official notices sent to Arkansas Works enrollees on March 15, 2018.[xii] As discussed in DHS' 2018 annual waiver report and approved enrollment and eligibility monitoring plan to CMS, outreach efforts during the year included correspondence with enrollees through paper mail, phone calls, text messages, and emails; educational postcards for physician offices and emergency rooms; social media posts and videos shared on Facebook and Twitter; and webinars and in-person training for stakeholders and advocacy groups.[xiii] In an effort to reach enrollees through broad community-wide efforts, DHS engaged many organizations that would have potential contact with enrollees. Some of the stakeholders and advocacy groups with whom DHS communicated included substance abuse providers, the Arkansas Hospital Association, Community Health Centers of Arkansas, crisis stabilization units, Arkansas Community Action Agencies Association, Goodwill Industries of Arkansas, Central Arkansas Homeless Coalition, Arkansas Community Colleges, Our House Homeless Shelter, Community Mental Health Centers, Arkansas Department of Corrections, Rural Community Alliance, and the Central Arkansas Library System. DHS also informed and provided educational materials to retail locations such as Fun Wash laundry centers, Edwards Food Giant grocery stores, and Best Rent-to-Own North Little Rock.[xiv]

DHS also developed a SharePoint site with resources for enrollees including flyers, notices sent to enrollees, videos, and interactive computer training videos on the WCER (e.g., steps for

creating an online portal account, calculating qualifying student work activity hours). The SharePoint site also included a resource dashboard with county-specific guides for enrollees to locate employment and volunteer opportunities, education and training, and quality of life resources (e.g., shelters, food pantries), as well as information on accessing available public computers and/or Wi-Fi.

In response to early criticism about the online portal being the sole mechanism through which enrollees could report work activity and exemptions, DHS established in May 2018 a process through which individuals, called "registered reporters," could be authorized to assist enrollees with work activity reporting.[xv] Using Arkansas geographic information system (GIS) mapping technology, DHS analyzed the distance "at risk" enrollees resided from a public computer access site and found that 92% of enrollees expected to be subject to the WCER were within 10 miles of a site. Enrollees who lived over 20 miles away from a public computer site were sent a letter and email informing them of the registered reporter process.[xvi] During the same month, DHS also extended its call center hours after receiving reports that enrollees' calls were not being answered in a timely manner. Originally, the call center hours were Monday through Friday from 8 a.m. to 4:30 p.m., but they were extended to seven days a week between the hours of 7 a.m. and 9 p.m. to correspond with the online portal's hours.[xvii]

Initially, enrollees were required to report work activity only through the online portal. However, DHS announced a change in policy allowing enrollees to report work activity by phone using its newly established DHS Helpline beginning December 19, 2018. To facilitate work activity reporting, DHS Helpline staff also began making calls to enrollees who had logged work activities but still needed more hours to meet the WCER.

While DHS previously leveraged existing avenues for outreach, the agency also announced in December that it would be launching a paid advertising campaign to reach enrollees through "traditional and social media outlets, online sites, and local transportation organizations." Additionally, DHS announced it planned to work with higher education institutions to promote student awareness of school hours counting as work and community engagement activities.[xviii]

AFMC

AFMC, a DHS vendor for Medicaid enrollee relations, conducted phone outreach and education beginning in May 2018 for Arkansas Works enrollees who were subject to the WCER.[xix] Existing enrollees who became subject to the WCER were contacted by phone 30 days prior to their WCER start date. AFMC attempted to contact new enrollees who were subject to the WCER during the first 12 days after receipt of program eligibility approval. Outreach and education included provision of information about the WCER to enrollees by phone, portal reporting instruction, and referrals to DWS, SNAP Employment and Training providers, and other resources.

Thousands of calls were made by AFMC each month, ranging from 5,511 to 47,367 calls between May 2018 and December 2018 to enrollees beginning the WCER in the following month. However, the phone outreach yielded low contact rates. In May, June, July, August, and

December, the percentage of enrollees successfully contacted was below 33.2 percent.[xx] Figure 3 is a table from DHS' 2018 annual waiver report submitted to CMS showing results of AFMC's outreach and education efforts from May 2018 through December 2018 to enrollees subject to the WCER beginning the following month.

Figure 3: AFMC Outreach and Education Results in DHS' 2018 Annual Waiver Report[xxi]

AFMC Outreach Beneficiaries Required to Report WCE Activities Following Month (May-December 2018)				
Month	**Beneficiaries in Target Audience**	**Number of Calls Placed**	**Beneficiaries Successfully Educated**	**Referrals to WCE activity resources**
January	*	*	*	*
February	*	*	*	*
March	*	*	*	*
April	*	*	*	*
May	11,547	39,328	2,511	247
June	8,905	47,367	2,023	221
July	7,883	34,984	1,850	624
August	9,040	28,144	2,149	1,066
September	837	5,511	837	785
October	1,024	5,903	559	1,155
November	889	6,029	442	1,170
December	5,702	18,913	1,893	1,134

DWS

Prior to the start of the WCER in June 2018, Arkansas Works enrollees were referred by DHS to DWS for job search assistance and training opportunities, as required by state law. DWS has a website and physical locations in 32 of the 75 counties at which enrollees can access these services. Building upon this existing process, DWS began sending follow-up letters and emails to enrollees subject to the WCER about the services available to them.[xxii]

In a November 19, 2018, news article, DWS indicated that 1,366 of the 21,841 Arkansas Works enrollees subject to the WCER had received assistance at a workforce center as of November 14, 2018. DWS also said that based on the New Hire Registry, 2,887 enrollees subject to the WCER had obtained full-time employment. Although there is indication that some enrollees were able to find full-time employment, the data do not differentiate between enrollees searching for employment due to the WCER and enrollees already searching for a job. DWS currently does not collect this information from enrollees.[xxiii]

Summary of QHP Interviews on Outreach and Education Efforts[xxiv]

ACHI conducted interviews with key staff from the QHPs serving Medicaid enrollees in an effort to better understand their outreach and education efforts and communication barriers experienced during their efforts.

QHP staff reported weekly meetings with DHS and use of the weekly data file from DHS and other data sources to obtain contact information for outreach. QHPs worked with DHS to ensure consistent terminology was used in notices and to develop language explaining to enrollees that they have coverage through the QHP, are part of the Arkansas Works program, and must also meet the new WCER. QHPs employed avenues of outreach similar to DHS to reach enrollees, including social media posts on Facebook and Twitter, some paid advertising (e.g., ads on buses), and correspondence through paper mail, phone calls, emails, and if enrollees opted in, through text messages. The QHPs also developed consumer-facing web pages with WCER information and links to the online portal and DWS website. One QHP reported that its web page received nearly 2,500 hits a month and that the most common request was for help complying with the WCER. As Arkansas Works enrollees are not their only membership, QHPs refrained from using radio or TV in their outreach efforts to avoid confusion among their entire membership, instead using a more targeted approach.

One QHP mailed notices to enrollees every time they attested to completing a work activity and to those who did not report any activity or exemption. The QHP also sent emails monthly to enrollees, and if enrollees opted in for text communication and/or reminder calls, they also received reminder texts and/or calls each month. During phone interactions, enrollees had access to live agents for assistance with logging their WCER activity.

QHPs had designated staff who were certified as registered reporters to help answer questions, report work activity, and track outreach data (e.g., enrollees reached and not reached). One QHP also trained staff to help enrollees find work or volunteer opportunities and established an outreach team that travelled to community events and locations, such as food banks and bus stations, to provide in-person assistance with the WCER. Another QHP indicated that approximately 240 staff were certified as registered reporters, and each of its retail location across the state had registered reporters available for assistance.

Of all the channels used for outreach, QHPs reported that the most successful communication method was by phone, text, or email. However, this was only successful among a small group of enrollees with available and valid phone numbers and emails. “We were constantly outreaching,” one QHP said. “The first thing we did when we would get someone on the phone was ask them if this was the best way to reach them, as well as collect email addresses. It’s really hard to quantify the success of print materials because we can get much better statistics on phone and open rates on email. The best way for us to reach our members has always been through email or phone, if we have those. But we have challenges because the state does not provide us email addresses and sometimes the phone numbers are inaccurate. We don’t have as many of those as we do physical addresses.” Another QHP reported that the click-through rate for text messages (the percentage of individuals who opened a link sent via text) was higher for its Arkansas Works population who were subject to the WCER than for its commercial population.

Prior to WCER implementation, the QHPs had anticipated communication challenges due to historical experience attempting to communicate with the Arkansas Works population, which they indicated frequently changed addresses. QHPs faced difficulty in receiving quality demographic and contact information for their Arkansas Works enrollees. QHPs reported some confusion among members who did not realize they were enrollees in the Arkansas Works program: "There is a ton of confusion around health insurance. DHS will send them a letter telling them that they need to do something regarding eligibility to keep their coverage and some of our members will disregard the letter because they think they do not have DHS Medicaid [Arkansas Works]."

A large amount of mail sent to Arkansas Works enrollees who were subject to the WCER was returned. One QHP reported that only about 10% to 15% of the mail sent to enrollees reached its intended recipient. With respect to maintaining contact with enrollees, one QHP also noted that "the key is to find the main decision maker in the household. However, it is very challenging to do."

Literacy was also a challenge for QHPs. While one QHP generally wrote its communications at the eighth grade level, it found that written communication at a fourth grade level was more appropriate for this population.

In general, QHPs reported significant confusion among enrollees regarding the WCER, including how to navigate the online portal, whether the WCER applied to them, and how to meet the requirement. One QHP noted that availability of the DHS Helpline for reporting WCER activities by phone helped as an alternative to the online portal.

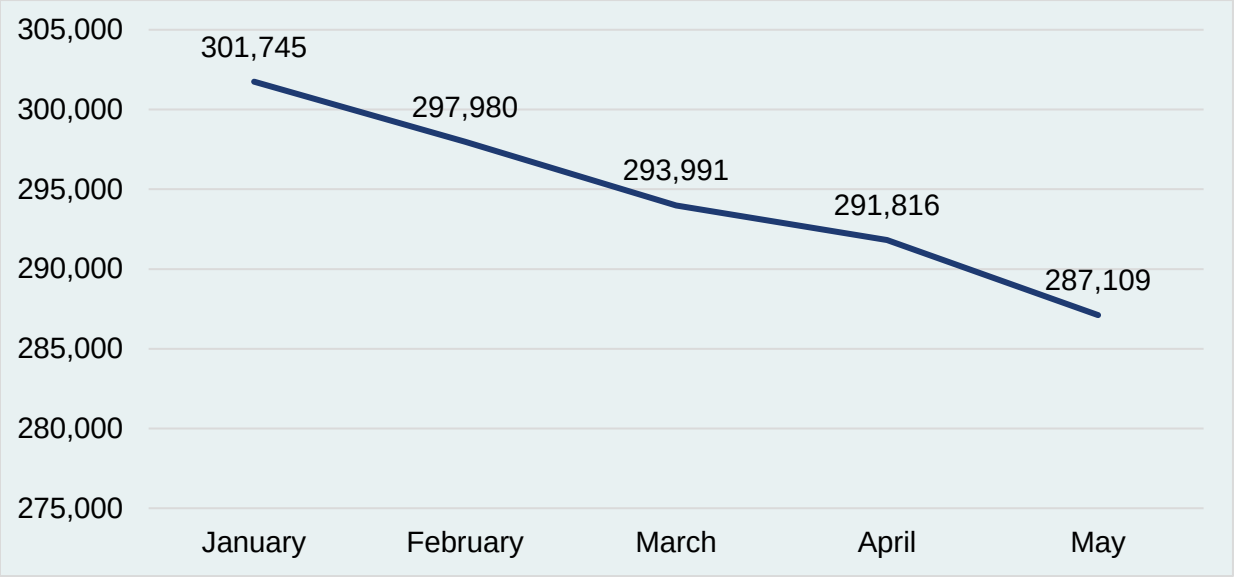
The QHPs also reported often hearing about transportation and health issues related to having multiple chronic conditions, but not qualifying for a medically frail designation, as barriers for enrollees in meeting the WCER.

Finally, QHPs reported that the enrollees whose coverage ended due to WCER non-compliance were considerably healthier, younger, and had lower utilization than those who maintained coverage. These enrollees may have had less incentive to maintain coverage or competing priorities leading to non-compliance.

State Monitoring and Reporting

As part of its monitoring and reporting process, DHS publishes monthly enrollment and expenditure reports for the Arkansas Works program, as well as for other Medicaid programs and the Children's Health Insurance Program (CHIP). As shown in Figure 4 and Appendix A, enrollment in Arkansas Works had been on the decline since the beginning of 2018 and prior to the implementation of the WCER in June 2018, with enrollment dropping from 301,745 at the end of January 2018 to 287,109 by the end of May 2018.

FIGURE 4: ARKANSAS WORKS ENROLLMENT FROM JANUARY 2018 THROUGH MAY 2018[xxv]



Expenditures were similarly on the decline for the same period, dropping from $677.73 per member per month (PMPM) in January 2018 to $570.23 PMPM in May 2018, as shown in Appendix B.

Beginning in July 2018, DHS began publishing a separate, new report describing the number of enrollees subject to the WCER by month; the number of enrollees who did not meet the WCER by month; types of exemptions; reasons why enrollees' cases were closed; outreach efforts; types of WCER activities enrollees reported; good-cause requests; and numbers of hours reported for all enrollees by activity type. Appendix C shows a sample page of the published report for September 2018. To provide context for the number of closures due to non-compliance with the WCER relative to closure for other reasons, DHS also included in the report the pie chart shown in Appendix D.

Summary of Findings from Key Interviews

To better understand how community organizations were assisting enrollees with the WCER and to capture their observations on enrollees' success in complying with the WCER to maintain coverage, ACHI utilized Rapid Qualitative Analysis (RQA) strategies to collect qualitative data elements from the interview process with selected community stakeholders. Using DHS published county-level resource guides, ACHI selected 100 different organizations representing community organizations, healthcare providers, and education resources to contact for key informant interviews. A two-level screening call script was developed to solicit responses from selected organizations for interview purposes. Thirty-two organizations a level 2 in-depth interview. Rapid analytic methods — including template analysis, matrix analysis, and critical case studies — were used to produce qualitative findings. A more detailed explanation of the methods utilized can be found in Appendix E.

Below are the results for each of the domains described in the methods section — resources offered to assist enrollees with the WCER; knowledge of the WCER; reported volume of requests for assistance received from enrollees; observations of the success of enrollees in meeting the WCER; observations on job opportunities; and observations on integration of WCER assistance with core business functions.

CALL OUTCOMES FOR SURVEY

As noted in the methods section, three separate call attempts were made to each of 100 organizations identified for this study. Thirty-two of the 100 call attempts led to in-depth interviews, but 68 of the contact attempts did not proceed beyond level 1 screening. A breakout of the call outcomes for all organizational outreach attempts is provided in Appendix F.

Many organizations were not responsive to multiple phone call attempts, referred the interviewer to someone outside of their office, hung up, or declined the interview altogether. Nine of the 68 organizations had numbers that were disconnected, or an incorrect phone number had been published in the county resource guides.

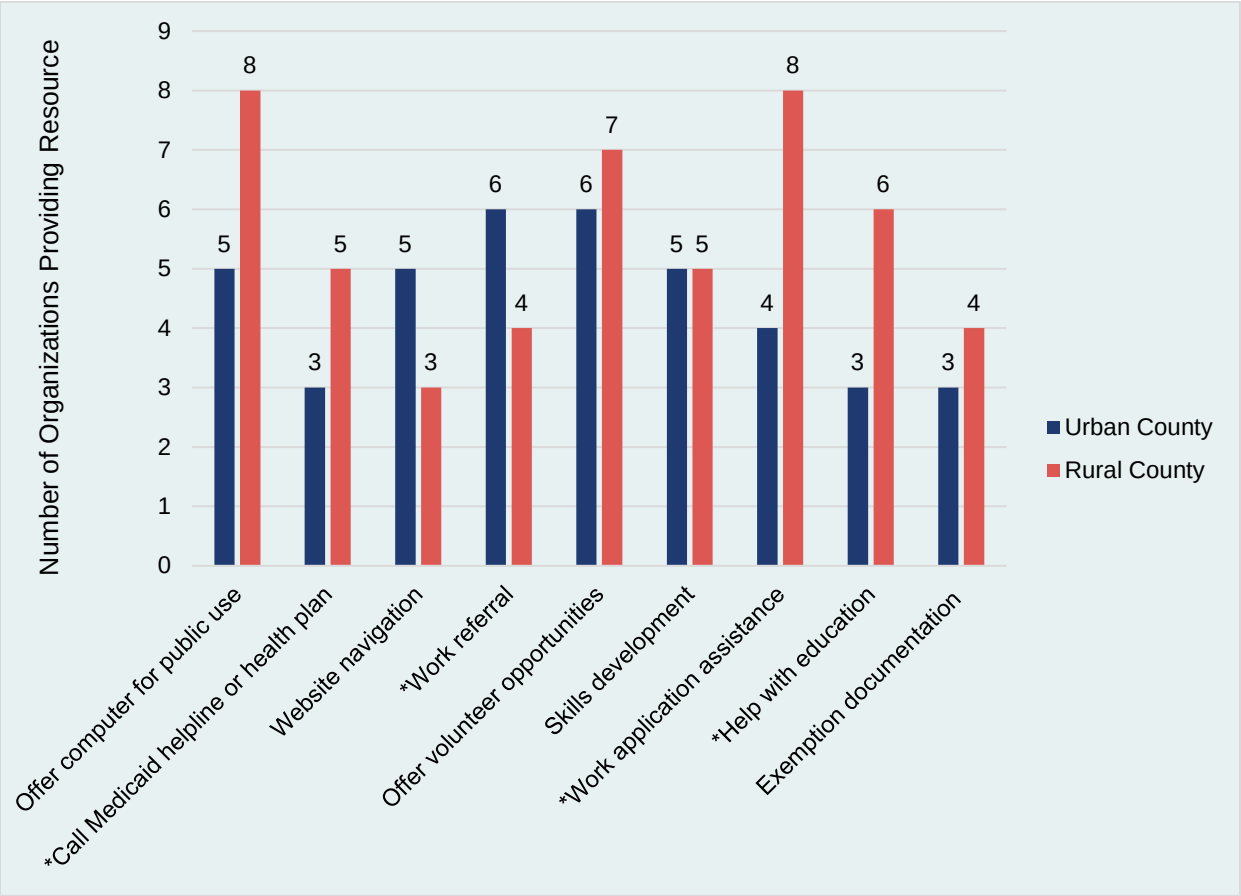
Food pantries and religious organizations were particularly difficult to reach, possibly due to a mostly volunteer staff and limited hours of operation. Additionally, staff answering the phone from large organizations such as colleges/universities, hospital systems, and recreational facilities were often unsure of the purpose of the call or whom to transfer the call to for an in-depth interview. While there were multiple reasons why the level 1 screening calls did not proceed to in-depth interviews, these results suggest a lack of capacity to assist potential enrollees who may reach out to these organizations for assistance with the WCER.

RESOURCES OFFERED TO ASSIST ENROLLEES WITH THE WCER

The organizations with more in-depth interviews (n=32) noted various resources that were available to enrollees to meet the WCER. Figure 5 below lists the number of organizations offering these resources to enrollees based on whether the organization was in an urban or rural county.[1] In total, fewer than 10 organizations reported capacities to provide assistance in calling the Medicaid helpline or health plan, assist with website navigation, help with education, or assist with WCER exemption documentation, as shown in Figure 5.

[1] Urban counties are defined as counties having a city with a population of 10,000 residents or more, while rural counties are defined as counties not having a city of 10,000 residents or more.

FIGURE 5: RESOURCES OFFERED TO ASSIST ENROLLEES WITH THE WORK AND COMMUNITY ENGAGEMENT REQUIREMENT (N=32)



*Call Medicaid helpline or health plan: Two organizations noted capacity to assist in facilitating direct contact with Medicaid. One organization stated a conference room is made available on a monthly basis where a Medicaid representative can meet with the community members it serves.
Work referral: Organizations with the specific mission of providing adult education or job placement assistance reported additional capacities to provide work referral and training opportunities to enrollees.
Work application assistance: While 12 organizations reported the capacity to provide this service, very few reported receiving actual requests for assistance from enrollees.
Help with education: One organization noted providing education around the WCER to both its employees and enrollees it serves.

KNOWLEDGE OF THE WORK REQUIREMENT

Knowledge of the WCER among respondents varied significantly. Organizations that were already engaged directly with Medicaid and/or SNAP enrollee outreach (e.g., homeless shelters, adult education centers) were more likely to have knowledge of the WCER. Additionally, libraries were more likely to report having an understanding of the WCER as many community members utilize their computer services. Medical clinics were the least likely to have knowledge of the WCER, along with food pantries and local cooperative extension offices. Twelve of the 32 organizations reported having no knowledge or understanding of the WCER.

REQUESTS FOR ASSISTANCE

Overall, very few organizations indicated that they had received requests for assistance from Arkansas Works enrollees in their community. One nonprofit organization respondent stated that a few requests had been received and that the organization was tracking these requests. One library respondent in rural Arkansas stated that requests for assistance were generated during the early stages of the WCER rollout, but that requests waned in later months.

SUCCESS OF ENROLLEES IN MEETING WORK REQUIREMENT

A majority of respondents had no observations about whether enrollees were successful in meeting the WCER. One food pantry respondent noted that enrollees served by their organization were not interested in the information offered about jobs and employment opportunities. Another food pantry respondent and a library respondent noted a significant amount of confusion among enrollees in meeting the WCER. A homeless shelter respondent reported that many of its clients were exempt from the WCER and indicated that those who were subject to the WCER were already working.

JOB OPPORTUNITIES

Some organizations were unsure about the extent to which enrollees were able to find jobs, while others asserted strong opinions that individuals seeking employment would be able to do so, especially in more urban areas. Organizations in more rural areas reported greater barriers to employment due to a lack of opportunity, or the need to travel to other towns or outside of the county to find employment.

ALIGNMENT OF ASSISTING ENROLLEE WITH CORE BUSINESS FUNCTIONS

Almost all organizations reported that assisting Arkansas Works enrollees aligned with the missions of their organizations, irrespective of their core functions. Community health clinics had a greater familiarity with serving Arkansas Works enrollees due to their involvement in clinical care for enrollees, while other community nonprofits indicated that helping low-income populations more broadly fit well within their organizational mission and objectives.

Barriers and Facilitators Associated with Work and Community Engagement Requirement

A summary of facilitators and barriers associated with perceived access to successful work requirement and community engagement by enrollees is provided below. This section contains

descriptions of issues and other key information obtained during interviews, along with select illustrative quotations.

In assessing barriers and facilitators, an important observation was discerned about the differences in organizations located in more rural versus urban counties. Fifteen of the 32 organizations for which an in-depth interview occurred are located in an urban county, while the remaining included 17 are in more rural counties.

FACILITATORS

- Being in a more urban area positively impacted perceptions about employment opportunities.
- Having prior engagement with organizations providing comprehensive services to low-income, vulnerable populations was perceived as beneficial to enrollees.

Illustrative Quotation:
"You can't drive around Jonesboro without seeing help wanted signs all over. I'm unsure what kind of jobs the clients are looking for because there are lots of jobs out there."

A key theme that emerged from the interviews was the impact of living in a rural versus urban part of Arkansas. Generally, organizations that were located in more urban areas of the state were more likely to indicate that enrollees would be able to find employment or volunteer opportunities.

Illustrative Quotation:
"The bulk of the clients we serve here are exempt [from the WCER] in one way or another. We serve a lot of families and so people who have dependents are exempt. People who are homeless are exempt. People who have disabilities are exempt.* And so, I think generally speaking, the clients we serve who are required to work to keep their benefits are working. So that's good. The main challenge, I think, has just been the interface. You know, understanding the interface, like the technical challenges related to it."

*Those who are deemed medically frail, which may include individuals experiencing homelessness or those with a disability, are exempt.

Another perceived facilitator was enrollee engagement with an organization prior to implementation of the WCER. Organizations that were already serving low-income, vulnerable populations (particularly homeless shelters, charitable service organizations, and community health clinics) were generally more knowledgeable about the WCER and were more likely to report assisting enrollees in completing WCER reporting activities.

BARRIERS

- Being in a rural area negatively impacted perceptions about employment opportunities.

- Lack of understanding about the WCER and the technical interface for reporting was perceived as a barrier for enrollees.

> **Illustrative Quotation:**
> "Here in Eudora, it is a very poverty stricken area and there are very few jobs. It is a very small town. So they have to go to other places. Sometimes they even have to go to Mississippi to get a job because we're close to Greenville. So, in this particular area, it would be pretty hard for them to find a job. Monticello probably is not as hard as it is here because they have more, you know, options and things and places you can potentially get a job. Eudora doesn't."

Organizations located in and serving clients in rural areas were more likely to indicate a lack of employment or volunteer opportunities that would be available to enrollees. This was a reoccurring theme, and a few organizations interviewed indicated that many people in their areas would have to travel to adjoining cities or counties to find employment.

> **Illustrative Quotation:**
> On observations about relative success of enrollees in meeting the WCER: "It's a complicated issue, and I do think there's a struggle to provide information to everyone who needs it."

Another barrier identified in multiple interviews from various organizations highlighted enrollee confusion about the WCER. As the quote above illustrates, many organizations observed that the WCER reporting requirements were complicated and difficult for their clients to understand and complete. In addition, a majority of the respondents interviewed had limited or no knowledge of the WCER activities to bring enrollees into compliance or assist with reporting exemptions, likely creating additional barriers for enrollees needing assistance in meeting the WCER.

Limitations

While our goal was to provide in-depth interviews representing multiple regions and counties throughout Arkansas, we were only able to obtain in-depth interviews from a total of 32 organizations. As such, caution should be taken against generalizing the results of these findings as some organizations with higher or lower levels of enrollee engagement may have not been contacted for this study. Also, because Arkansas's public policy debate on the waiver focused largely on the WCER, our ability to ascertain information on community engagement may have been limited.

Discussion

Findings from this study are consistent with findings in prior interview-based assessments of the WCER for Arkansas Works enrollees. Despite considerable enrollee outreach and education by DHS, its contractor AFMC, and the QHPs about the WCER through multiple avenues including direct mail, email, social media and phone calls, enrollees experienced a lack of awareness about the WCER. As reported by the QHPs, many Arkansas Works enrollees are transient, and this resulted in challenges communicating with enrollees about the WCER. The lack of awareness about the WCER extended to community organizations identified by DHS as being available resources for enrollees, even among provider organizations who have an incentive to ensure WCER compliance and thus continued program enrollment. This was true despite the availability of webinars and in-person trainings for stakeholders and advocacy groups. The short time frame from federal approval of the WCER to launch of the WCER and the absence of a mass media campaign that included radio and television outreach and education may have contributed to the lack of awareness.

If enrollees were aware of the WCER, there remained substantial confusion about the applicability of the WCER and pathways for compliance. Even though DHS attempted to notify enrollees about the WCER beginning several months prior to its implementation, enrollees were reportedly confused about the WCER's applicability. This is not surprising given that the QHPs have been the primary contact on communication efforts historically under the premium assistance approach to Medicaid expansion. Many enrollees view themselves as being privately insured rather than covered by Medicaid, an intentional feature of the program intended to combat stigma and promote access. Notable were observations by community organization respondents and QHPs regarding enrollee confusion about the technical interface to report WCER activity and exemptions. According to at least one QHP, the introduction of the DHS Helpline in late 2018 as an alternative to the online portal for WCER reporting was a valued addition for enrollee communication.

Local organizations noted distinct differences in the availability of work opportunities between urban and rural areas. Their observations are consistent with labor statistics showing that unemployment rates in some rural Arkansas counties are more than three times the rates in urban counties.[xxvi] Some other states that have proposed a WCER for Medicaid enrollees have exempted individuals in counties with high unemployment rates, which could be an option to address this concern.

DHS has offered timely reporting on the implementation of the WCER. Beginning in July 2018 — the month after enrollees became subject to the WCER — DHS issued a monthly report that included information about the number of enrollees subject to the WCER, the number DHS determined were meeting or exempt from the WCER, the number who reported satisfying the WCER, the number who reported an exemption, and the number who failed to satisfy WCER reporting. The monthly report also included information about exemption reasons, types of WCER activity reported, and requests for good-cause exemptions. The reports contextualized the information about those whose coverage ended due to non-compliance with the WCER within other reasons why Medicaid coverage might cease (e.g., increase in household income, failure

to return requested information). The monthly reports were accompanied by overall enrollment and expenditure reports showing per member per month costs for both the Arkansas Works and traditional Medicaid populations. Along with reports to federal officials about the extent of the state's outreach and education, these reports are critical for agency officials and policymakers to understand the impact of the WCER in a timely fashion. Even with this type of reporting, however, a robust and scientifically rigorous evaluation of the WCER policy is essential.

Appendices

APPENDIX A: ENROLLMENT DATA IN JUNE 2018 ARKANSAS WORKS MONTHLY REPORT[xxvii]

Enrollment at 1st Day of Month

	Arkansas Works	Traditional Adults	Medicaid & CHIP Children	Total
January 2019	234,400	239,755	404,733	878,888
February 2019	233,870	240,349	405,322	879,541
March 2019	235,962	236,870	409,545	882,377
April 2019	240,177	237,859	416,211	894,247
May 2019	239,558	236,389	410,856	886,803
June 2019				0
July 2019				0
August 2019				0
September 2019				0
October 2019				0
November 2019				0
December 2019				0

NOTE: Enrollment numbers are based on report ran on the first Monday after the claim cycle that includes in the first day of the month.

Enrollment as of the Last Day of the Month

	Arkansas Works	Traditional Adults	Medicaid & CHIP Children	Total
January 2019	245,857	243,819	418,424	908,100
February 2019	245,198	239,963	418,615	903,776
March 2019	247,631	240,876	423,870	912,377
April 2019	250,573	240,558	426,091	917,222
May 2019				0
June 2019				0
July 2019				0
August 2019				0
September 2019				0
October 2019				0
November 2019				0
December 2019				0

NOTE: Enrollment numbers are based on report ran on the first Monday after the claim cycle that includes in the first day of the month. January through March 2019 End of the Month Enrollment numbers were ran on April 17, 2019.

APPENDIX B: EXPENDITURES DATA IN JUNE 2018 ARKANSAS WORKS MONTHLY

Total Spend Per Month - Arkansas Works 1115 Demonstration Premium Assistance Program

	Arkansas Works	Arkansas Works Premiums	Arkansas Works Cost Sharing	Arkansas Works Wrap Services	Total Arkansas Works QHP Program	Arkansas Works PMPM QHP Program	Reconciliation Payments & Non-Claim Adjustments	Arkansas Works PMPM QHP Program After Reconciliations	Budget Neutrality Amount
January 2019	193,186	$87,787,873.55	$31,903,617.08	$676,746.66	$120,368,237.29	$623.07	($297,227.63)	$621.53	$625.39
February 2019	191,587	$86,734,810.88	$31,703,014.94	$686,112.77	$119,123,938.59	$621.77	($350,995.82)	$619.94	$625.39
March 2019	195,886	$88,558,636.23	$32,341,434.73	$701,381.96	$121,601,452.92	$620.78	$30,641,195.04	$777.20	$625.39
April 2019	201,439	$88,410,798.71	$32,307,564.91	$702,276.71	$121,420,640.33	$602.77	$10,587,542.38	$655.33	$625.39
May 2019									
June 2019									
July 2019									
August 2019									
September 2019									
October 2019									
November 2019									
December 2019									

NOTE: Arkansas Works program has reconciliations done on a periodic basis for cost sharing reduction payments and premium payments made for individuals above 100% FPL. These payments are not included in the claims processing payments due to the material impact on a per member per month amount in the month paid despite the payments being made for previous months. **March 2019 and April 2019 adjustment includes Annual Cost Sharing Reconciliations to QHP Carriers. These amounts are applied to budget neutrality figures for 2016 and 2017 and are not matched against budget neutrality for 2019.**

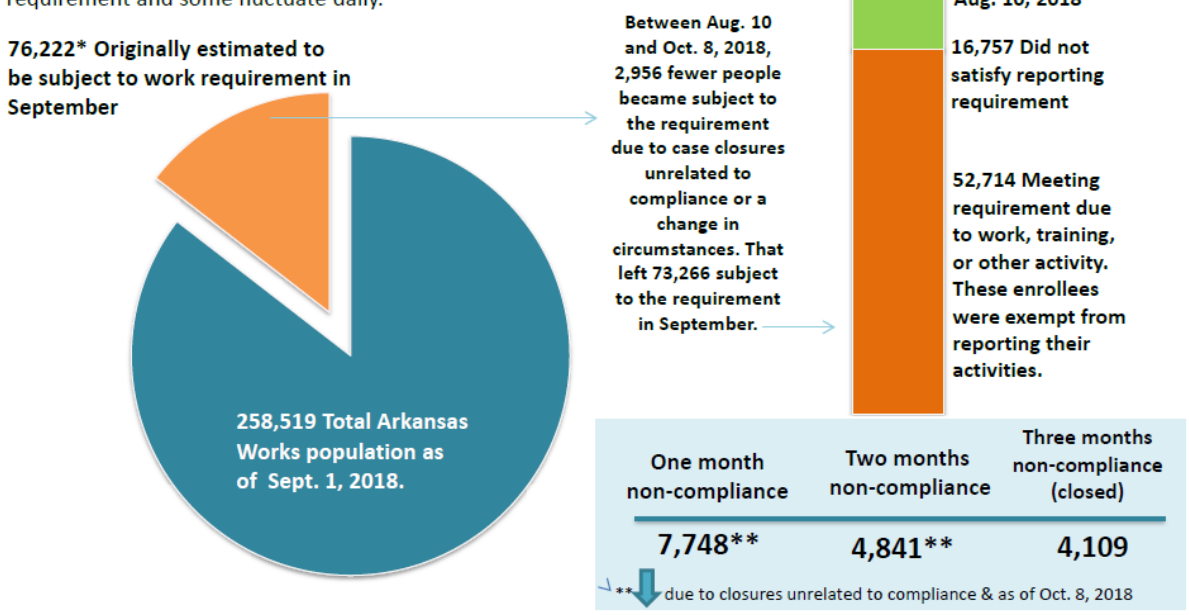
REPORT[xxviii]

APPENDIX C: SAMPLE PAGE FROM THE SEPTEMBER 2018 ARKANSAS WORKS MONTHLY REPORT[xxix]

Arkansas Works Program

September 2018 Report

As of August 10, DHS data showed just over 76,200 Arkansas Works enrollees were subject to the work requirement in September. Most are already meeting the requirement through work, school, or other life situations that made them exempt from reporting. Numbers below are a point-in-time snapshot of the requirement and some fluctuate daily.



One month non-compliance	Two months non-compliance	Three months non-compliance (closed)
7,748**	4,841**	4,109

** due to closures unrelated to compliance & as of Oct. 8, 2018

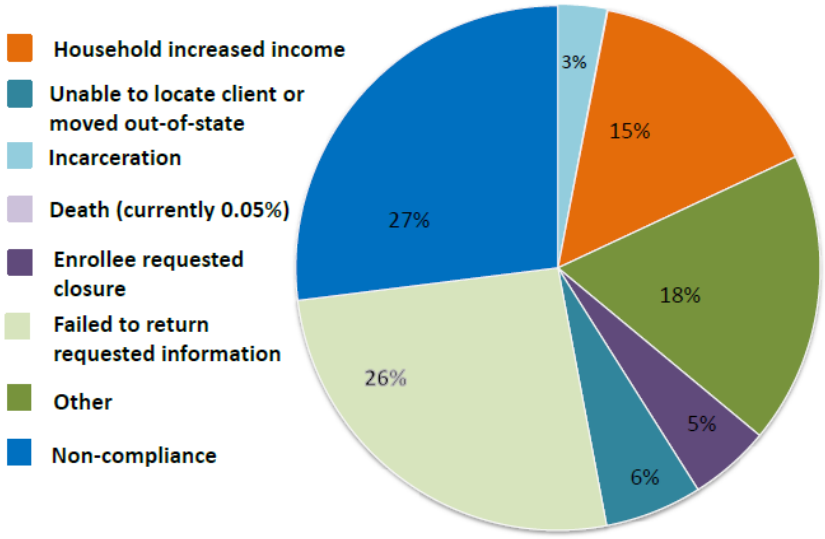
*Enrollees ages 30-49 are being phased into the requirement from June through September 2018. Those 19-29 will roll in starting January 2019.

APPENDIX D: CLOSURE REASONS FROM THE SEPTEMBER 2018 ARKANSAS WORKS MONTHLY REPORT[xiii]

Arkansas Works Program

September 2018 Report

Every Medicaid program has what is known as "churn," cases that close for various reasons. It is not uncommon for those individuals to take action and come back on a program after receiving a closure notice. The total number of Arkansas Works cases closed in September was 15,276. Of those, only 4,109 closed due to non-compliance with the work requirement. Below the closures are broken down by type.



Top four reasons people were exempt from reporting in September

Employed at least 80 hours a month	**25,368**
Already meeting SNAP requirement through work or exemption	**9,705**
Medically frail/disabled	**8,020**
At least one dependent child in the home	**7,432**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

APPENDIX E: METHODS

Sampling Frame and Recruitment

Arkansas DHS published resource guides available through an online SharePoint site for enrollee use to assist in finding local support and/or assistance in meeting the WCER. DHS published county-level guides which included local resources for employment, volunteering, educational opportunities, quality of life support (e.g., shelters, food pantries), and other county agencies.

To achieve understanding of local resources available to enrollees statewide, ACHI utilized the Arkansas Department of Health public health regions. In addition, to ascertain different availability for enrollees in rural areas, ACHI selected from each of the five ADH public health regions four counties — two with a city of more than 10,000 people and two with no city of more than 10,000 people. For each county, five organizations representing different resource types as identified by DHS in the resource guides were selected to contact for interviews.

TABLE 1: TYPES OF ORGANIZAITONS CONTACTED FOR INTERVIEWS

Providers	Education	Community Organizations
▪ Hospitals ▪ Community health centers	▪ Career and adult education centers ▪ Universities and community colleges ▪ Cooperative extension offices ▪ Public libraries	▪ Volunteer organizations ▪ Food pantries ▪ Shelters ▪ Substance abuse treatment centers

Qualitative Interview Saturation

Purposive sampling involves the intentional selection of participants based on a certain knowledge or an experience that is pertinent to the research question, and places primary emphasis on saturation.[xxx] Three call attempts on different days were undertaken to reach each targeted organizational representative.

Attempts to reach all organizations (20 organizations per each of the five public health regions) were captured and coded for high-level call outcomes data collection purposes. Call outcomes were grouped across the following categories:

- 1 - No answer on third call attempt
- 2 - Hung up
- 3 - Referred to someone outside of office
- 4 - Referred to someone within office on third call attempt

- 5 - Someone will call back
- 6 - Phone line disconnected
- 7 - Wrong number
- 8 - Declined interview
- 9 - In-depth interview occurred

Out of the 100 organizations contacted, in-depth interviews took place with a total of 32 organizations.

Data Collection

Data were collected using individual telephone surveys. A semi-structured interview guide was used in order to elicit the broadest possible range of experiences and perspectives related to the organization's interactions with Arkansas Works enrollees. The in-depth interviews ranged from 5 to 15 minutes in duration.

Specifically, a two-level screening call script was developed to solicit responses from selected organizations for interview purposes. The level 1 screening call script included an introduction about ACHI and the intent of the call. Questions in the level 1 screening call script included the following:

- Are you aware that your organization is listed as a resource by the Department of Human Services?
- Is there someone with whom I can speak about the work requirement?
- Do you mind if I record this call to make sure our notes accurately reflect what you say?

A level 2 in-depth interview also took place if an organization successfully passed the initial level 1 screening. These questions were open-ended and included the following questions:

- What resources do you offer to assist enrollees with the work requirement? Interviewer would then review a checklist of resources including the following: offer computers for public use, call Medicaid helpline or health plan, website navigation, work referral, offer volunteer opportunities, skills development, work application assistance, help with education, exemption documentation, and other for an open-ended response.
- What do you know about the activities or exemptions that would make an enrollee compliant with the work requirement?
- How many requests for assistance did/do you receive from enrollees?
- When do you generally receive requests for assistance?

- Do you have any observations about the relative success of enrollees in meeting the work requirement?
- To what extent are enrollees able to find jobs in your area?

Data Analyses

Rapid analytic methods — including template analysis, matrix analysis, and critical case studies — were used to produce qualitative findings. These methods were selected because they are more efficient than traditional qualitative methods (e.g., coding) and are better suited to qualitative analysis performed by one individual.

Prior to the initial interview, a prototype template (call script) was developed in a Word document. The template is a table containing domains drawn from an interview guide. Each of the questions developed in the level 2 screener corresponded to the following domains listed in Table 2.

- Template analysis — First, recordings from interviews (in which the interviewee agreed to an audio recording) were analyzed using templates. If an interviewee did not agree to an audio recording, the interviewer captured each response in the interview call script. Template analysis is a method for systematically summarizing and organizing descriptive qualitative data from interviews and focus groups.[xxxi]

TABLE 2: LEVEL 2 SCREENER QUESTIONS AND CORRESPONDING DOMAINS

Question	Domain
What resources do you offer to assist enrollees with the work requirement?	Resources offered to assist enrollees with work requirement
What do you know about the activities or exemptions that would make an enrollee compliant with the work requirement?	Knowledge of work requirement
How many requests for assistance did/do you receive from enrollees? (Volume)	Requests for assistance
When do you generally receive requests for assistance? (Timing)	Requests for assistance
Do you have any observations about the relative success of enrollees in meeting the work requirement?	Success of enrollees in meeting work requirement
To what extent are enrollees able to find jobs in your area?	Job opportunities
How does assisting enrollees integrate with your core business?	Alignment of assisting enrollees with core business

- Matrix analysis — Following template analysis, descriptive data captured from each of the individual interview templates were compiled in a participant-by-participant matrix. The use of matrices streamlines the process of identifying similarities, differences, and trends in responses from interviewees.[xxxii] Relevant comments from each of the in-depth interviews were aligned into the domain areas identified in the table above.
- Critical case studies — To better determine organizations' efforts in assisting eligible Arkansas Works enrollees in meeting the WCER, critical case studies were also developed. This process included reviewing in-depth interviews to find data which emerged throughout the course of the interviews into a coherent narrative regarding organizations' experience with outreach efforts. Illustrative quotations were selected for this report based on their richness and ability to illustrate intrinsic issues.

APPENDIX F: CALL OUTCOME RESULTS

	Central	Southeast	Southwest	Northeast	Northwest	Total
In-Depth Calls	**3**	**6**	**7**	**9**	**7**	**32**
All Others	**17**	**14**	**13**	**11**	**13**	**68**
1 - No answer on third call attempt	4	8	3	4	6	25
2 - Hung up	0	1	1	0	0	2
3 - Referred to someone outside of office	2	1	3	1	0	7
4 - Referred to someone within office on third call attempt	3	1	0	3	4	11
5 - Someone will call back	1	1	0	0	0	2
6 - Phone line disconnected	1	1	1	1	1	5
7 - Wrong number	1	0	0	1	2	4
8 - Declined interview	5	1	5	1	0	12
Total	**20**	**20**	**20**	**20**	**20**	**100**

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