**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
**7500 Security Boulevard, Mail Stop S2-25-26**
**Baltimore, Maryland 21244-1850**


**State Demonstrations Group**

November 1, 2018

Dawn Stehle
Medicaid Director
Arkansas Department of Human Services
700 Main Street, Suite 201
Little Rock, Arkansas 72201

Dear Ms. Stehle:

The Centers for Medicare & Medicaid Services (CMS) has reviewed Arkansas's evaluation design for its community engagement initiative against the demonstration's Special Terms and Conditions (STCs) for the period of March 5, 2018 through December 31, 2021, dated March 5, 2018, as well as CMS's standardized evaluation guidance (shared with the state on June 30, 2018, also available on Medicaid.gov at the following link: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/developing-the-evaluation-design.pdf). We appreciate your submitting the evaluation design, as required in the STCs.

The state's community engagement (CE) evaluation design partially addresses the requirements for evaluation described in the STCs. CMS notes that the CE evaluation design should complement the evaluation design currently approved for the premium contributions amendment, which CMS approved in January 2017, and should assure that all of the waivers and expenditure authorities approved in AR be examined, including the waiver of retroactive eligibility, which is not currently included in either evaluation design.

The attached feedback provides information on areas that should be better articulated and strengthened in the design in order to assure the state's independent evaluator conducts a rigorous evaluation. Those areas include developing a robust set of measureable outcomes, identifying appropriate comparison groups, providing specific data sources mapped to specific analyses, and incorporating quantitative analyses including subgroup analyses. CMS and its evaluation technical assistance contractor, Mathematica Policy Research, is available to provide further technical assistance if the state would find that helpful.

The state may provide a revised evaluation design to address CMS comments as a next step. The state may also wish to incorporate CMS comments into the state's request for proposals (RFP) for an independent evaluator. This latter approach may help the state to ensure the proposals it receives address CMS expectations for evaluation of the demonstration. CMS also encourages

the state to remain active in the CMS sponsored CE learning collaborative to support learning and diffusion of best practices.

Of note, CMS is developing draft evaluation guidance for states with CE demonstrations. The evaluation guidance will be a resource for states, and will highlight important hypotheses, evaluation questions, and impact analyses. The guidance is currently undergoing internal review and comment. Key draft hypotheses and evaluation questions in the evaluation guidance focus on changes in employment, income, transitions to employer sponsored insurance, and health outcomes (among other areas of interest). Additionally, the draft evaluation guidance addresses incorporating comparison groups in order to understand the impact of the demonstration on the population of interest. The evaluation guidance also highlights the importance of tracking beneficiaries longitudinally, particularly after beneficiaries leave Medicaid, in order to assess the long-term goals of the demonstrations. The CE evaluation guidance is expected to be available for states in January 2019. We encourage the state to continue collaborating with CMS to ensure alignment with the CE evaluation design guidance.

If you have any questions, please contact your CMS project officer, Ms. Rachel Nichols. Ms. Nichols can be reached at (410) 786-6269 or by email at Rachel.Nichols@cms.hhs.gov. We look forward to our continued partnership with you and your staff on the Arkansas Works section 1115 demonstration.

Sincerely,

/s/

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Bill Brooks, Associate Regional Administrator, CMS Dallas Regional Office
Stacey Shuman, State Lead, CMS Dallas Regional Office

**Arkansas Community Engagement Section 1115 Demonstration**
**Evaluation Design: CMS feedback**
**November 1, 2018**

As noted in CMS' letter to the state (dated November 1, 2018), CMS looks forward to continuing to work with the state on its community engagement evaluation design. Specific recommendations to complete and improve the evaluation design follow below.

**1. Evaluation outcomes are not well defined and outcome measures are not specified.** The state has broadly defined expected outcomes of the demonstration, but most outcomes are not quantifiable or measurable. Outcomes such as "culture of work," "personal life stability," and "decreased perception of challenges in life," (p. 9) are not well defined for evaluation purposes. The evaluation design should specify quantifiable outcomes for each research question as well as valid, reliable measures for each outcome.[1] The state should consider outcomes which can be achieved in the evaluation period (March 2018 through December 2021). Intermediate outcomes (such as obtaining and maintaining employment, or receipt of preventative care), or health outcomes which respond relatively quickly to treatment (such as diabetes control) could also be helpful to explore. The state should ensure the data are available, and are valid, reliable measures for each of the outcomes identified. The draft design does include some measures for expected employment outcomes (80+ hours per month, increased earnings) and health insurance coverage outcomes (transition to private insurance); the state should expand on this list. Specification of quantifiable outcomes and corresponding measures is necessary to assess the adequacy of other elements of the evaluation design—including data sources, comparison groups, and quantitative methods. In addition, the hypotheses should focus on measureable outcomes, and each hypothesis should relate to a specific subset of outcomes.

> *Recommendation 1*: Revise the evaluation design to include a list of quantifiable evaluation outcomes and specific measures to address each research question. Outcome measures should capture important features of expected outcomes such as increased employment (measures could include hours worked, wages, and benefits) and improved health (e.g.: self-reported physical/mental health, other measures of health care utilization). The state could also consider ways to measure education as an intermediate outcome toward independence (enrollment in degree-seeking or certificate programs), new employment, and transitions off public assistance (from Medicaid to private insurance, transitioning off SNAP and TANF). Additionally, the revised evaluation design should include an assessment of outcomes for individuals who are never enrolled, or are disenrolled from the program for failure to comply with the community engagement requirements, including the impact of the lockout policy. For example, is disenrollment for noncompliance with community engagement requirements (including failure to meet the requirements as well as failure to report) associated with poorer health outcomes? The evaluation design should specify the data source for each outcome measure.

[1] See "Best Practice in Causal Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations" (https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/causal-inference.pdf) for a discussion of these aspects of the evaluation planning process.

**2. Limitations of administrative data and need for beneficiary survey data.** As written, the draft evaluation design does not include sufficient detail on planned data sources or approaches to gathering data on individuals who have separated from Medicaid. Significant numbers of people may exit the Medicaid program because they successfully increase their income or fail to meet community engagement requirements. The state must track beneficiaries after they separate from Medicaid to understand employment, income, health status, and coverage transitions over time.

Strategies to passively follow individuals through administrative records, such as tax returns or the state's All Payer Claims Database, should be explored. However, based on known limitations in the Arkansas All-Payer Claims Data (APCD),[2] it may not be possible to track individuals across different types of insurance (Medicaid to private or vice versa). Likewise, individuals who earn below a certain threshold are not required to file taxes and will not appear in these databases, and it may be difficult to use such data for those who churn in and out of Medicaid.

Because administrative data are unlikely to be sufficient to evaluate the community engagement requirement, a beneficiary survey will be a particularly important data source. The state should plan to conduct a longitudinal survey that follows current and former beneficiaries for several years. Minimizing survey attrition in both of these populations is a challenging task, especially for those who have separated from Medicaid and may not be as motivated to respond.

> *Recommendation 2*: Revise the evaluation design to specify use of administrative data where possible, and acknowledge limitations in using this data. Describe the state's plan to conduct a survey of current and former beneficiaries. Provide details on the sampling strategy and estimated number of completed surveys, stratification by subgroups of particular interest, frequency and timing of data collection, and the method of data collection. The revised evaluation design should also provide identification of the concepts covered by the survey of current and former beneficiaries, and include beneficiary understanding of the demonstration policies. The evaluation design should present power calculations to demonstrate that the planned survey sample will be adequate to detect expected effects.
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> *Recommendation 3*: Describe how the state will meet challenges such as reaching hard-to-reach populations, achieving sufficient response rates, sample weighting for survey nonresponse, and avoiding survey attrition among beneficiaries, especially those disenrolled. The state and its independent evaluator should consider strategies to mitigate these challenges.

**3. Comparison group selection.** To evaluate the impact of the community engagement requirement on the treatment group, it is necessary to identify one or more appropriate comparison groups that are similar to the treated group in some ways, including labor force

[2] The June 2018 final evaluation report for the Arkansas Health Care Independence Program (the section 1115 demonstration preceding Arkansas Works) noted that evaluators were unable to track premium assistance beneficiaries into Marketplace coverage.

participation, education, and health status, but that are exempt from the requirement.[3] The draft evaluation design does not include any discussion of comparison groups.

*Recommendation 4:* Revise the evaluation design to identify comparison groups and describe how they will be included in the evaluation.

The state could specify within-state comparison groups made up of individuals not subject to the community engagement requirement. These could include, for example, eligibility groups that are not part of the demonstration, such as section 1931 parents, and/or certain individuals enrolled in the demonstration but exempt from CE requirements. The state and its evaluator should consider whether all potential within-state comparison groups are suitable based on labor force participation and other factors.

The evaluation design could also specify comparison groups in other states that can be identified or closely approximated in national survey data, such as the American Community Survey or the Behavioral Risk Factor Surveillance Survey. The evaluation design should focus on use of comparison states that are similar to Arkansas in terms of Medicaid eligibility for childless adults, population characteristics, and economic conditions but that have not implemented a community engagement requirement.

**4. Quantitative analysis**. The quantitative analysis described in the state's evaluation design is vague and requires more detail. The state and its evaluator should select the most rigorous possible analytic strategies based on the available comparison group(s) and data sources. Analytic approaches that use both pre-period data and comparison groups are preferred.

*Recommendation 5*: Revise the evaluation design to provide more detail on the quantitative analyses. Consider using the phase-in of the community engagement requirements as a source of quasi-random variation (similar to a stepped-wedge design in randomized controlled trials) for exploring short-term differences. Beneficiaries not yet subject to the community engagement requirement can serve as controls for those in earlier waves that are affected by the requirement.

*Recommendation 6:* Where it is possible to observe beneficiary information from the period before the implementation of the community engagement requirement, and where suitable within-state or out-of-state comparison groups are identifiable, difference-in-differences regression analysis is an appropriate way to estimate program effects.

**5. Subgroup analysis.** Depending on sample size and statistical power, the state and its evaluators should articulate plans to estimate the effect of CE requirements on various subgroups.

[3] See "Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations" (https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/comparison-grp-eval-dsgn.pdf) for a detailed discussion of best practices in comparison group selection.

*Recommendation 7*: Revise the evaluation design to incorporate subgroup analyses where appropriate. Subgroups can be analyzed by regional economic conditions, SUD status, disability status, racial/ethnic group, age group, or eligibility group.

**6. Logic model vs. driver diagram.** The logic model in the draft evaluation design is useful, because it outlines short- vs. long-term outcomes and highlights important confounding variables that will need to be adequately controlled for across treatment and comparison groups. The time horizon for outcomes is particularly important for understanding when it will be possible to observe hypothesized effects like improved health status. Because this logic model is more helpful than the state's driver diagram, the state may choose to include the logic model in place of the driver diagram. If the state chooses to include both, every effort should be made to ensure alignment and lessen confusion between the two conceptual frameworks.

*Recommendation 8*: Revise the logic model to organize and simplify it. For example, "enrollment churn" and "accurate income reporting" are two important limitations to any evaluation design, but they are not moderating factors that affect employment outcomes for beneficiaries. Increased employment is missing as a short-term outcome. In addition, "work history...", and "skills translate…" should be thought of as intermediate outcomes that potentially accrue after some time. Lastly, "Identify and track…" and "Provide the bridge…" are not policies.