MISSISSIPPI
Section §1115 Annual Report
Healthier MS Waiver
Demonstration Year XV, October 1, 2018 through September 30, 2019

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Submitted to:
U.S. Department of Health & Human Services
For Medicare and Medicaid Center for Medicaid and State Operations

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Healthier MS Waiver Program
§1115 Wavier No. 11-W-00185/4

Demonstration Year 15
Annual Report
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Table of Contents

INTRODUCTION

The Healthier Mississippi Waiver (HMW) Demonstration Program, Section 1115, was initially approved by the Centers for Medicare & Medicaid Services (CMS) for a five (5) year period beginning on October 1, 2004, through September 30, 2009. The demonstration has been consistently extended since that date. The HMW was originally implemented to provide healthcare coverage for the Poverty Level Aged & Disabled (PLAD) Medicaid population, an optional category of eligibility (COE) that was discontinued during the Mississippi 2004 Legislative Session. With the July 24, 2015 extension of the demonstration, the state received CMS approval to increase the enrollment limit from 5,500 to 6,000 and add coverage of podiatry, eyeglasses, dental, and chiropractic services which were excluded from previous demonstration years.

EXECUTIVE SUMMARY

Demonstration Population

The HMW Demonstration allows Mississippi Medicaid to provide all state plan services, except for long-term care services (including nursing facility and home and community based waivers), swing bed in a skilled nursing facility, and maternity and newborn care. Individuals who are eligible for the HMW must be aged, blind, or disabled, with incomes at or below 135 percent of the federal poverty level (FPL), and not eligible for Medicare or other Medicaid coverage.

Goal of Demonstration

Under this demonstration, the Mississippi Division of Medicaid (DOM) expects to achieve the following goals by providing access to preventive and primary care services for the targeted population:

1. Reduce hospitalizations, and improper use of the emergency department (ED);
2. Increase the utilization of ambulatory/preventive health visits each demonstration year;
3. Increase the number of preventive health screenings each demonstration year;
4. Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year each demonstration year; and
5. Increase the proportion of adults with diabetes who have an annual dilated eye examination each demonstration year.

Program Highlights

Healthier MS Waiver participants now receive increased benefits. The following State Plan Amendments were approved by CMS:

- State Plan Amendment (SPA) 18-0020 Physician Visit Limit Increase was approved to allow DOM to increase the physician office and outpatient hospital visit limit from twelve (12) to sixteen (16) per state fiscal year for both psychiatric and non-

psychiatric services, effective January 1, 2019. These are two (2) separate service limits and both were increased.

- State Plan Amendment (SPA) 19-0004 Prescription Drug Limit Increase was approved to allow the DOM to increase the prescription drug limit from five (5) to six (6) per month, effective July 1, 2019.

DOM secured the services of the Parham Group, LLC, to serve as the independent evaluator for the HMW.

Significant Program Changes From Previous Demonstration Years
There were no significant program changes from previous demonstration years other than the increase in State Plan Benefits listed under Program Highlights.

Policy or Administrative Difficulties
There were no policy or administrative difficulties reported during demonstration year (DY) 15.

ENROLLMENT

Eligibility Information
Individuals eligible to enroll in the HMW must meet the following criteria:

1. Be aged, blind, or disabled and not:
   - Eligible for Medicare;
   - Residing in a long term care facility;
   - Residing in a skilled nursing facility (swing bed);
   - Pregnant; or
   - Eligible for Medicaid under State Plan Benefits.

2. Have an income at or below 135% of the FPL for an individual or couple, calculated using a methodology based on the supplemental security income program, as well as income exclusions approved in the state plan under the authority of Section 1902(r)(2) of the Social Security Act; and

3. Have resources below $4,000 for an individual and $6,000 for a couple.

Enrollment and Disenrollment Information

The table below depicts enrollees and member month data for DYs 12-15.

Table 1: HMW Annual Enrollment

Demonstration Year (DY)	Enrollees	Participants	Member Months
12	8,731	8,013	61,852
13	8,745	7,910	62,211
14	8,720	8,002	64,362
15	8,498	7,779	61,748

Data Source: HMW Enrollment and Member Month Data Report-Congos

There was a 2.55% decrease in the number of enrollees, and a 2.79% decrease in the number of participants from DY 14 to DY 15. Participants are defined as enrollees who utilized at least one state plan service during the DY.

Table 2 below depicts the enrollment and disenrollment data for DYs 12-15.

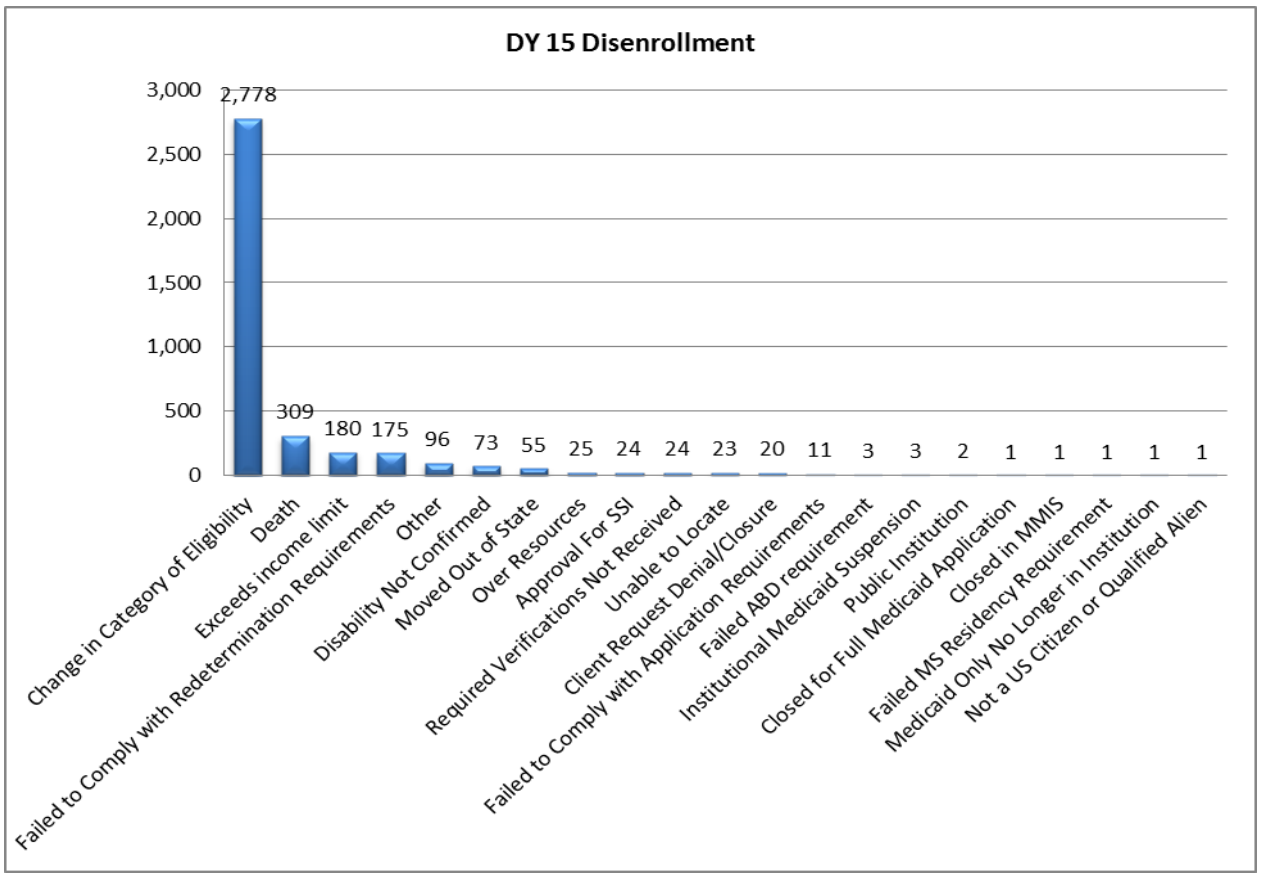
Table 2: HMW Annual Enrollment/Disenrollment

Enrollment Period	Number of Enrollments	Number of Voluntary Disenrollments	Number of Involuntary Disenrollments
DY 12	8,731	644	2,835
DY 13	8,745	915	2,884
DY 14	8,720	975	2,757
DY 15	8,498	1,011	2,778

Data Source: Enrollment and Member Month Report-Cognos

There was a 2.5% decrease in enrollment from DY 14 to DY 15. Voluntary disenrollment increased by 3.7% and involuntary disenrollment increased by 0.8%. The primary reason for disenrollment was attributed to a change in category of eligibility. Reasons for disenrollment are listed in Graph 1.

Graph 1: HMW Disenrollment Reasons for Demonstration Year 15



Data Source: HMW Enrollment Report

UTILIZATION

During DY 15, there were 7,779 unique HMW participants who accessed services under the HMW.

PROGRAM OUTREACH AWARENESS AND NOTIFICATION

DOM provides eligibility and coverage information regarding the HMW through flyers, workshops, health fairs and DOM's public website. DOM's Outreach Coordinators provided HMW information at 94 community events held during DY 15.

The Post-Award Forum was held at 10:00 a.m. on Tuesday, April 16, 2019, in room 145 at the Woolfolk Building, 501 N. West Street, Jackson, MS 39201. There were no comments recorded for this forum.

PROGRAM EVALUATION AND MONITORING

DOM State Quality Assurance Monitoring

DOM's Office of Eligibility continues to monitor the waiver enrollment process to ensure only beneficiaries meeting the qualifications for the HMW are enrolled. There is a specific category of eligibility for beneficiaries enrolled in the HMW. Claims submitted for services excluded under the HMW or for individuals who are no longer eligible, systematically deny.

INTERMIM EVALUATION

Goal 1: Reduce hospitalizations and improper use of the emergency department (ED) by two percent (2%) for the duration of the demonstration.

Hypothesis: Beneficiaries who access ambulatory and preventive services will have a lower number of hospitalizations and ED visits.

Interim Analysis:
The raw number of beneficiaries, under age 75, who accessed hospitals for acute care, has slightly increased (average 2.7%/year) from DY 12 to DY 14. In DY 15 however, the raw number of beneficiaries who accessed hospitals for acute care declined by nearly 15% from DY 14.

The raw number of beneficiaries, under 75, who had at least one ED visit steadily increased from DY 12 to DY 14, but remained at a relatively flat rate (percentage) of the population. In DY 15, the raw number dropped by nearly 8.0%.

Table 3: Hospitalizations and Emergency Department

	DY 12	DY 13	DY 14	DY 15
# of beneficiaries under 75 with acute care hospitalizations	1501	1541	1589	1353
# of beneficiaries under 75 with Emergency department visit(s)	2772	2842	2854	2635

Further analysis is needed to identify and compare the relationship between accessing preventive services offered through HMW and reducing acute care hospital visits and ED utilization. The proposed test statistics and p-values are reported in the tables below. For example, among the overall cohorts, the number of inpatient stays is different between two groups. For the last four years, the difference of the percentage of inpatients has been growing at a statistically significant rate. The difference of the percentage of recipient also has been growing, but statistically significant difference only started from 2017. The two-sample proportion z test for each year comparing "yes" with "no" revealed the following information in Tables 4 and 5 below:

Table 4: Preventative/Primary Hospitalizations

	Did Preventative or Primary Care Visit Precede Inpatient Stay?		% of Preventative /Primary Care Visit before inpatient Stay		Test Statistic (p)	Number of recipients		% of the recipient to total		Test Statistic (p)
DY	**Yes**	**No**	**Yes**	**No**		**Yes**	**No**	**Yes**	**No**	
12	1,263	1,065	54.3	45.7	**6.70 (< .001**	802	767	53.4	51.1	**1.56 (0.12)**
13	1,306	1,158	53.0	47.0	**4.82 (< .001)**	807	806	52.4	52.3	**0.07 (0.40)**
14	1,377	1,107	55.4	44.6	**8.70 (< .001)**	868	802	54.6	50.5	**2.87 (0.01)**
15	1,287	907	58.7	41.3	**13.19 (< .001)**	803	637	59.3	47.1	**7.95 (<.001)**

Table 5: Preventative/Primary Emergency Department

	Did Preventative or Primary Care Visit Precede ED visit?		% of Preventative /Primary Care Visits before ED Visit		Test Statistic (p)	Number of recipients		% of the recipient to total		Test Statistic (p)
DY	**Yes**	**No**	**Yes**	**No**		**Yes**	**No**	**Yes**	**No**	
12	3,332	2,481	57.3	42.7	**18.38 (< .001)**	1,651	1,321	59.6	47.7	**11.75 (<.001)**
13	3,396	2,515	57.5	42.5	**19.03 (< .001)**	1,675	1,384	58.9	48.7	**10.19 (<.001)**
14	3,612	2,290	61.2	38.8	**28.38 (< .001)**	1,743	1,315	61.1	46.1	**14.98 (<.001)**
15	3,514	2,011	63.6	36.4	**33.39 (< .001)**	1,673	1,165	63.5	44.2	**18.60 (<.001)**

Once we collect the individual data, we can provide (1) descriptive statistics (Central tendency measures such as mean and median; variability measure, such as standard deviation and range will identify the spread of a variable(s) increase or decrease) and (2) independent sample t-test between a control group who access ambulatory and preventive services more than a certain frequency and the default group (less than that frequency). These will provide an opportunity for better analysis of the groups and will eventually identify who are still inappropriately using emergency departments and why.

Goal 2: Increase the utilization of ambulatory/preventive health visits by two percent (2%) for the duration of the demonstration.

Hypothesis: HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits each year.

Interim Analysis:
According to table 6 below, the number of beneficiaries enrolled in HMW ages 20 or older, and received ambulatory/preventive visit has been increasing since DY 12 from 6,752 to 6,847 in DY 13 to 6,929 in DY 14. For DY 15, this number decreased to 6,664, but because the population was down as a whole, the number still represents a slight increase in the rate (79.8%). Once individual data is accessed we can better assess the utilization rates of ambulatory/preventive care and the connection between access to and utilization of preventive health care.

Table 6: Ambulatory/Preventive Visits

DY	# of Beneficiaries Age 20 or Older Receiving Ambulatory/Preventive Visit	Total Population	Percentage of total
12	6,752	8,570	78.8%
13	6,847	8,739	78.3%
14	6,929	8,735	79.8%
15	6,664	8,350	79.8%

Analysis Plan: Once the individual data is accessed, we can provide descriptive statistics, such as central tendency measures and variability measures, which will identify the spread of a variable's change for the individual data. Based on these results, we should be able to perform the needed statistical tests including (1) McNemar test and/or (2) multiple regressions.

Goal 3: Increase the number of preventive health screenings by one percent (1%) for the duration of the demonstration.

Hypothesis: HMW beneficiaries with access to benefits will have an increase in the utilization of age appropriate preventive screenings.

Interim Analysis:
According to table 7 below, we can observe that the percentage of beneficiaries ages 50 to 74, who received an annual Mammogram has increased from 20.1% in DY 12 to 22.0% in DY 13 but stayed the same for next two years.

Table 7: Mammogram

DY	# Female Beneficiaries Age 50-74	# of Female Beneficiaries Age 50 -74 Receiving Mammogram	% of Beneficiaries Age 50 – 74 Receiving Mammogram
12	3,549	712	20.1
13	3,636	800	22.0
14	3,626	793	21.9
15	3,411	746	21.9

According to table 8 below, we can observe that the percentage of people who received Cervical Cancer screening among the beneficiaries enrolled in 045, ages 21 to 64, decreased from 9.5% in DY 12 to 8.9% in DY 13. The percentage increased to 9.4% in DY 14 and then decreased again in DY 15 to 9.0%.

It remains unclear if access to HMW benefits prompts a utilization of cervical cancer screenings among female beneficiaries ages 21-64. When we connect this information into the individual data, however, we can better analyze the resulting numbers, percentages, trends, and connection between access to and utilization of preventive health screenings.

Table 8: Cervical Screening

DY	# Female Beneficiaries Age 21-64	# of Female Beneficiaries Age 21-64 Receiving Cervical Cancer Screening	% of Receiving Cervical Cancer Screening among Beneficiaries Age 21-64
12	4,618	440	9.5
13	4,723	421	8.9
14	4,682	440	9.4
15	4,455	402	9.0

According to table 9 below, we can observe that the percentage of people who received Colorectal Cancer screening among the beneficiaries, ages 50 to 75 has been increasing from 10.4% in DY 12 to10.7% in DY 14, but dropped to 10.0% in DY 15.

It remains unclear if access to preventive care services through HMW prompts the use of age-appropriate colorectal cancer screenings. When this information is connected into the individual data, however, we can better assess/analyze the resulting numbers, percentages, trends, and connection between access to and utilization of preventive health screening.

Table 9: Colorectal Screening

DY	# Beneficiaries Age 50-75	# of Beneficiaries Age 50-75 Receiving Colorectal Cancer Screening	% Receiving Colorectal Cancer Screening among Beneficiaries Age 50 -75
12	6,422	665	10.4
13	6,524	676	10.4
14	6,532	701	10.7
15	6,234	625	10.0

Goal 4: Increase the percentage of beneficiaries diagnosed with diabetes that have a hemoglobin A1c (HbA1c) measurement at least once a year by two percent (2%) for the duration of the demonstration.

Hypothesis: HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.

Interim Analysis:
According to table 10 below, we can observe that the percentage of beneficiaries with diabetes, who receive an annual HbA1c, ages 18 to 75, has been steadily increasing each demonstration year from 68.0% in DY 12, to 70.3% in DY 13, to 70.5% in DY 14, to 72.2% in DY15.

It appears that access to preventive care services through HMW benefits does seem to prompt the use of annual HbA1c tests for beneficiaries with diabetes with a growth rate of 3% from the initial year. When this information is connected into the individual data, however, we can better assess/analyze the resulting numbers, percentages, trends, and connection between access to and utilization of preventive health screenings.

Table 10: Diabetes-A1c

DY	# of Beneficiaries Age 18-75 with Diabetes	# of Beneficiaries Age 18-75 with Diabetes Receiving A1C Test	% of Receiving A1C Test among Beneficiaries Age 18-75 with Diabetes
12	2,285	1,553	68.0
13	2,344	1,648	70.3
14	2,310	1,628	70.5
15	2,208	1,594	72.2

Goal 5: Increase the percentage of adults with diabetes who have an annual dilated eye examination by four percent (4%) for the duration of the demonstration.

Hypothesis: HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.

Interim Analysis:
According to table 11 below, we can observe that the percentage of beneficiaries with diabetes, ages 18 to 75, who receive an annual eye exam has been increasing from 26.0% in DY 12 to 27.9% in DY 13, to 29.4% in DY 14, to 31.3% in DY 15.

It appears that access to preventive care services through HMW benefits does seem to prompt the use of annual eye exams with a growth rate of 20% from the initial year. When this information is connected into the individual data, however, we can better assess/analyze the resulting numbers, percentages, trends, and connection between access to and utilization of preventive health screenings.

Table 11: Diabetes-Eye Examination

DY	# of Beneficiaries Age 18-75 with Diabetes	# of Beneficiaries Age 18-75 with Diabetes Receiving Eye Exam	% of Eye Exam among Beneficiaries with Diabetes Age 18-75
12	2,285	593	26.0
13	2,344	655	27.9
14	2,310	678	29.4
15	2,208	690	31.3

To assess beneficiary perception of improved health benefits, we will be utilizing a recently developed survey instrument to be mailed to a valid sample of beneficiaries. The survey is designed for ease of understanding, use, and submission. Results of the survey will be

recorded, tallied, and analyzed to help identify beneficiary perception of health benefits and their satisfaction with HMW. Survey results will be reported to CMS in the next annual report.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

Annual Expenditures

Table 12: Service Expenditures

	Service Expenditures as reported on the CMS-64		Administrative Expenditures as reported on the CMS-64		Expenditures as requested on the CMS-37	Total Expenditures as reported on the CMS-64
	Total Computable	Federal Share	Total Computable	Federal Share		
DY 12	$88,861,839	$65,980,196	N/A	N/A	N/A	$88,861,839
DY 13	$83,756,973	$62,535,073	N/A	N/A	N/A	$83,756,937
DY 14	$92,763,297	$70,195,889	N/A	N/A	N/A	$92,763,297
DY 15	$100,141,854	$76,520,249	N/A	N/A	N/A	$100,141,854

Source Data: Schedule C: CMS 64 Waiver Expenditure Report

Budget Neutrality Development

DOM completed and submitted the Budget Neutrality Workbook using the new design format and is awaiting CMS approval.

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