MISSISSIPPI
Section §1115 Annual Report
Healthier MS Waiver
Demonstration Year XIX, October 1, 2022, through September 30, 2023

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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
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Demonstration Year 19
Annual Report
October 1, 2022, through September 30, 2023

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INTRODUCTION

The Healthier Mississippi Waiver (HMW) Demonstration Program operates under the authority of an 1115(a) waiver 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. Mississippi received CMS approval with the July 24, 2015 extension of the demonstration, 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.

Goals 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 Updates

Eligible HMW beneficiaries remained on the HMW due to the maintenance of effort (MOE) requirements under the Families First Coronavirus Response Act, which required DOM to provide continuous eligibility through the end of the month in which the PHE ends for those enrolled as of March 18, 2020, or at any time thereafter during the PHE period, unless the person ceases to be a state resident or requests a voluntary coverage termination. Effective

June 30, 2021, the Mississippi DOM ended the following temporary Section 1135 waiver flexibilities:

1. Prior Authorization (PA) Requirements: The temporary suspension was lifted, and proper notice was given to beneficiaries with pre-existing prior authorizations.

2. Waiver of Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II Assessment Requirements: Standard practices was restored to those in effect prior to the PHE, and proper notice was given to providers.

3. Flexibility to Temporarily Delay Scheduling of Medicaid Fair Hearings and Issuing Fair Hearing Decisions during the Emergency Period: Extensions were no longer provided.

4. Alternative Settings: This flexibility was ended, and proper notice was given to providers.

5. Emergency Medical Treatment and Labor Act (EMTALA): This flexibility was ended, and proper notice was given to providers.

6. Critical Access Hospitals: This flexibility was ended, and proper notice was given to providers.

7. HIPAA Regulations: The following HIPAA flexibilities were ended with proper notice to providers:

    a. Obtaining a patient's agreement to speak with family or friends,
    b. Honoring a patient's request to opt out of the facility directory,
    c. Distributing a notice of privacy practices, or
    d. The patient right to request confidential communications.

8. Telehealth Security Requirements/HIPAA: DOM discontinued this flexibility under the authority of Section 1135 of the Social Security Act. To ensure continued access to telehealth service without risk of a HIPAA penalty, DOM continued to allow providers to operate under the enforcement discretion provided by the Office for Civil Rights (OCR at the U.S. Department and Human Services (HHS) on March 17, 2020, for the remainder of the PHE.

The U.S. Department of Health and Human Services Public Health Emergency for COVID-19 (PHE) declared by the Secretary of Health and Human Services expired May 11, 2023.

Significant Program Changes from Previous Demonstration Years

There were no significant program changes from previous demonstration years.

Policy or Administrative Difficulties

There were no policy or administrative difficulties reported during demonstration year (DY) 19.

Grievances and Appeals

There were no grievances or appeals reported during demonstration year (DY) 19.

Denial of Services

There were no denials of requested services reported during DY 19 by beneficiaries or providers.

Provider Audits/Medical Reviews, Investigations or Lawsuits

There were no audits, medical reviews, investigations, or lawsuits filed against DOM that impacted the demonstration during demonstration year (DY) 19. However, on March 7, 2023, CMS issued a notice to all state Medicaid agencies, pursuant to the nationwide preliminary injunction, issued by a federal judge in the U.S. District Court on January 31, 2023, ordering the Department of Health and Human Services (HHS) to stop enforcing the November 2020 Interim Final Rule (IFR), which allowed state Medicaid agencies to shift Medicaid enrollees to a reduced coverage group if they became Medicare-eligible during the PHE. DOM was required to reinstate coverage for individuals terminated after March 18, 2020 and suspend any terminations already scheduled to occur during the PHE. This caused coverage for HMW beneficiaries to be reinstated back to the date of termination, which impacted enrollment.

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

At the end of DY 18 there were 7,391 beneficiaries enrolled in the HMW, which exceeded the enrollment limit of 6,000. The increased enrollment was due to the injunction previously explained under the Provider Audits/Medical Reviews, Investigations or Lawsuits section of this report.

The enrollment numbers depict a 93% increase in the number of enrollees, and a 25% increase in the number of participants from DY 18 to DY 19. Participants are defined as enrollees who utilized at least one state plan service during the DY. The table below depicts enrollees and member month data for the last five demonstration years (DYs 15-19).

Table 1: HMW Annual Enrollment

DY	Enrollees	Participants	Member Months
15	8,498	7,779	61,748
16	7,445	6,853	62,498
17	7,072	6,438	61,000
18	4,735	4,351	35,291
19	9,157	5,453	92,616

Data Source: HMW Member Month Data Report-Cognos

There were 2,138 beneficiaries disenrolled from the HMW during DY 19. Table 2 depicts disenrollment data for DYs 15-19.

Table 2: HMW Annual Disenrollment

Enrollment Period	Disenrollment Count
DY 15	3,789
DY 16	1,919
DY 17	3,674
DY 18	1,857
DY 19	2,138

Data Source: Enrollment Report-Cognos

UTILIZATION

During DY 19, there were 5,453 unique HMW participants who accessed services under the HMW. This is a 25% increase from DY 18, where there were 4,351 unique HMW participants who accessed services.

PROGRAM OUTREACH AWARENESS AND NOTIFICATION

DOM provides eligibility and coverage information regarding the HMW through flyers, workshops, health fairs, virtual events, and DOM's public website. DOM's Outreach Coordinators provided HMW information at 51 community events held during DY 19.

The Post-Award Forum was held at 10:00 a.m. to 11:00 a.m. on Thursday, July 13, 2023, in room 145 at the Woolfolk Building, 501 N. West Street, Jackson, MS 39201, with the option of teleconference. 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:
As shown in Table 3 below, the raw number of beneficiaries under age 75, who accessed hospitals for acute care has decreased from 1,353 in DY 15 to 1,138 in DY 16, which is 15.9%. In DY 17, the raw number of beneficiaries who accessed hospitals for acute care declined again by around 12% (11.9%) from DY 16. This number dramatically dropped from 1,003 to 596 which is 40.6% in DY 18. This decrease continued in DY 19. The frequency dropped from 596 to 543, which is an 8.9% reduction from the previous year. In sum, from DY 15 to DY 19 there was a 59.9% reduction, from 1,353 to 543, of hospitalization visits by beneficiaries under 75 years old with acute care.

As shown in Table 3 below, the raw number of beneficiaries under 75, who had at least one emergency department visit steadily decreased from DY 15 to DY 19. The raw number dropped by from 2,635 in DY 15 to 2,155 in DY 16 or 18.2%, to 1,887 in DY 17 (12.4%), to 1,302 in DY 18 (31%) and to 1,257 in DY 19 (3.5%). Overall, compared with the frequency in DY15, the number of beneficiaries under 75 years old with non-emergent emergency department visits in DY 19 dropped by 52.3%, from 2,635 to 1,257.

Although steadily decreasing over the study period, the significant drop in the number of acute hospitalizations and number of non-emergent emergency department visits during DY 18 was impacted by Covid-19 and the lingering Covid effect (people getting used to staying in more, not going to medical visits, loss of staffing at treatment facilities, reduced number of treatment facilities, limited transportation options, etc.).

Table 3: Hospitalizations and Emergency Department

	DY 15	DY 16	DY 17	DY 18	DY 19
# of beneficiaries under 75 with acute care hospitalizations	1,353	1,138	1,003	596	543
# of beneficiaries under 75 with Emergency department visit(s)	2,635	2,155	1,887	1,302	1,257

To identify if there is a trend in the percentage of preventive/primary care visits before inpatient stay among beneficiaries, Cochran-Armitage trend test was performed using SAS 9.4. The frequencies and percentages in Table 4 below were used to determine if there is a positive trend at $\alpha = 0.05$. Even though the frequency was dropped from DY 15 to DY 19, the test results showed that there is no statistically significant trend ($z = 0.94$, $p = .173$). In addition, the Spearman rho correlation test was performed to verify the direction of the relationship at the significance level, 0.05. The results showed a negative relationship between the years and the relative frequency ($\gamma = -0.014$, $p = .01$), but it seems that there is a U-type relationship in the percentages.

Table 4: Preventative/Primary Hospitalizations

Beneficiaries under age 75, who accessed Preventative Care Visit before the initial Inpatient Stay			
DY	**Number of Preventative or Primary Care Visit before the Inpatient Stay**	**Total Number of Beneficiaries with Inpatient Stay**	**Percentages of Primary visits before Inpatient Stay among total number of Beneficiaries**
15	803	1,353	59.3%
16	708	1,138	62.2%
17	631	1,003	62.9%
18	360	596	60.4%
19	298	543	54.9%

Table 5 below shows the numbers and percentages of preventive/primary care visits precede Emergency visit for every year among beneficiaries. The Cochran-Armitage trend test results showed that there is no statistically significant trend found ($z = 0.95$, $p = .17$) at $\alpha = 0.05$. One of the reasons might be this percentages show U-type pattern again. The percentages increased from 63.5% to 68.2%, and then dropped to 63.3%. To verify whether there is any linear association, we need additional data.

Table 5: Preventative/Primary Emergency Department

Beneficiaries under age 75, who accessed Preventative Care Visit before the initial Non-emergent Emergency Department Visit			
DY	**Number of Preventative or Primary Care Visit before the ED visit**	**Total Number of Beneficiaries with ED visit**	**Percentages of Primary visits before ED Visit among total number of Beneficiaries**
15	1,673	2,635	63.5%
16	1,401	2,155	65.0%
17	1,287	1,887	68.2%
18	863	1,302	66.3%
19	796	1,257	63.3%

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 visits has been decreasing since DY 15 from 6,664 to 5,830 in DY 16, to 5,614 in DY 17, and to 3,587 in DY 18. The total number of beneficiaries enrolled in the HMW age 20 years or older also dropped with a similar pattern. Resulting in the percentages of the beneficiaries aged 20 or older receiving preventative visits have been slightly increasing from 79.8% to 81.0%, and then in DY 18, the percentage dropped to 72%. The number of beneficiaries enrolled in HMW ages 20 or older and received ambulatory/preventive visits increased by 779 in DY 19 when compared to DY 18, it increased from 3,587 to 4,366, but the percentage dropped dramatically to 48.7%. This abnormal trend was caused by a significant increase in the total number of beneficiaries in the same population group from 4,981in DY 18 to 8,960 in DY 19. It is possible that the drop in both numbers and percentage were associated with the lingering Covid-19 effect (people getting used to staying in more, not going to medical visits, loss of staffing at treatment facilities, reduced number of treatment facilities, limited transportation options, etc.). An interview with beneficiaries who did not have preventive care visits may also be helpful in providing additional insight into the significant drop.

To identify if there is a trend in the percentage of beneficiaries aged 20 or older receiving ambulatory/preventive visits, the Cochran-Armitage trend test was performed using SAS 9.4. The test results reflect that there is now a negative trend ($z = -47.11$, $p < .001$) at $\alpha = 0.05$. In addition, Spearman rho correlation test also showed the negative relationship with statistically significance ($\gamma = -0.24$, $p = .005$). Therefore, the number of ambulatory/preventive visits has been decreasing statistically significantly.

Table 6: Ambulatory/Preventive Visits

DY	# of Beneficiaries Age 20 or Older Receiving Ambulatory/Preventive Visits	# of Beneficiaries Enrolled Age 20 or Older	Percentage of total Beneficiaries Age 20 or Older Receiving Ambulatory/Preventive Visits
15	6,664	8,350	79.8%
16	5,830	7,271	80.2%
17	5,614	6,928	81.0%
18	3,587	4,981	72.0%
19	4,366	8,960	48.7%

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, the percentage of beneficiaries enrolled in the HMW, aged 50 to 74, receiving mammograms slightly decreased from 21.9% in DY15, to 21.1% in DY 16, and to 18.8% in DY 17. Although the number of preventive screenings dropped in DY 18, the percentage received increased to 20.7% among the population. Notably, this percentage decreased significantly in DY 19, falling to 10.2%. The recommended once every two (2) years frequency for breast cancer screenings and the limited time beneficiaries are enrolled in the HMW, which is an average of about two (2) years, may also contribute to the decline.

In comparison to the initial frequency of female beneficiaries enrolled in the HMW, aged 50-74, who underwent mammograms in DY 15, the count decreased by 54.0%, from 746 to 403. A Cochran-Armitage trend test was performed using SAS 9.4 to analyze the trend in the percentages, specifically the percentage of beneficiaries aged 50-74 receiving mammograms. At = 0.05, the data indicated a statistically significant negative trend ($z = -12.86$, $p < .001$).

Table 7: Mammogram

DY	# Female Beneficiaries Age 50-74	# of Female Beneficiaries Age 50 -74 Receiving Mammogram	% of Beneficiaries Age 50 – 74 Receiving Mammogram
15	3,411	746	21.9%
16	3,104	654	21.1%
17	3,042	573	18.8%
18	2,137	442	20.7%
19	3,957	403	10.2%

According to Table 8 below, the trend in the percentage of individuals who received cervical cancer screening among beneficiaries enrolled in the HMW, aged 21 to 64, is remarkable. It was 9.0% in DY 15, 7.8% in DY 16, 6.5% in DY 17, and 6.4% in DY 18. A more significant drop was observed in DY 19, dropping the percentage down to 4.6%. The results from the prior

year are surprising; despite a shift of roughly 2%, the reduction is more significant than in previous years. The recommended once every three (3) years frequency for cervical cancer screenings and the limited time beneficiaries are enrolled in the HMW, which is an average of about two (2) years, may also contribute to the decline.

A Cochran-Armitage trend test was performed using SAS 9.4 to validate the observed negative trend in the percentage of beneficiaries aged 21-64 receiving cervical cancer screening. At = 0.05, the data indicated a significant negative trend ($z = -8.40$, $p < .001$). Despite the steady decline in the number of female beneficiaries aged 21 to 64, it is evident that cervical cancer screening is also dropping. Beginning in DY 15, the percentage of beneficiaries aged 20 to 64 who had cervical cancer screening dropped from 9.0% to 4.6%, a 4.4% decline.

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
15	4,455	402	9.0%
16	3,976	310	7.8%
17	3,630	236	6.5%
18	2,595	167	6.4%
19	4,151	189	4.6%

According to Table 9 below, the percentage of beneficiaries enrolled in the HMW, aged 50 to 75, who had colorectal cancer screening varied. It slightly decreased from 10.0% in DY 15, to 9.6% in DY 16, and to 7.1% in DY 17. But this was changed to 8.3% in DY 18 suddenly. In DY 19, the total number of beneficiaries increased to 7,012 while the number of receiving colorectal cancer screening dropped to 284, which is 4.1%. This reflects a 5.9% decrease from the initial year, DY 15. The recommended once every five (5) to ten (10) years frequency for colorectal cancer screenings and the limited time beneficiaries are enrolled in the HMW, which is an average of about two (2) years, may also contribute to the decline.

To identify if there is a trend in proportion, the percentage of receiving colorectal cancer screening among beneficiaries aged 50 – 75, the Cochran-Armitage trend test was performed using SAS 9.3. The test results showed statistically significant evidence of a negative trend ($z = -13.31$, $p < .001$) at $\alpha = 0.05$. As we observed in the table, the downward trend is obvious.

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
15	6,234	625	10.0%
16	5,510	526	9.6%
17	5,395	383	7.1%
18	3,864	319	8.3%
19	7,012	284	4.1%

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, the percentage of beneficiaries with diabetes receiving an annual HbA1c test, aged 18 to 75, demonstrated a consistent downward trend from 72.2% in DY 15, to 71.2% in DY 16, and again decreased to 65% in DY 17. In DY 18, there was a 1.3% incline in the percentage of diabetic beneficiaries having annual HbA1c tests. Notably, in DY 19, the proportion fell dramatically to 43.5%, a 28.7% decline from the beginning year, DY 15. Despite an increase in beneficiaries from 1,297 to 1,833, HbA1c tests among these cohorts declined from 866 to 797. It is possible that the drop in both number of beneficiaries aged 18-75 with Diabetes Receiving A1C Test and percentage among beneficiaries A1c tests receiving were associated with the lingering Covid-19 effect (people getting used to staying in more, not going to medical visits, loss of staffing at treatment facilities, reduced number of treatment facilities, limited transportation options, etc.). An interview with beneficiaries who did not have preventive care visits may also be helpful in providing additional insight into the significant drop.

To identify if there is a trend in proportion, the percentage of A1c tests among beneficiaries with Diabetes age 18 – 75, Cochran-Armitage trend test was performed using SAS 9.4. Even accounting for the downward trend over the past 2 years, the test results showed that there is a statistical positive trend ($p = .022$) at $\alpha = 0.05$. Additional years are needed to see if this trend continues.

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
15	2,208	1,594	72.2%
16	2,001	1,425	71.2%
17	1,978	1,285	65.0%
18	1,297	866	66.8%
19	1,833	797	43.5%

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, the percentage of beneficiaries with diabetes, aged 18 to 75, receiving an annual eye exam were steady from 31.3% in DY 15, 31.8% in DY 16, 31.1% in DY 17, and 29.8% in DY 18. However, the percentage just changed surprisingly in DY 19 dropping percentages to 20.3%. Compared with the starting year, DY 15, the percentages decreased from 31.3% to 20.3%, dropping to 11.3% during the last five demonstration years. Despite an increase in beneficiaries from 1,297 to 1,833, the number of people receiving eye exams reduced from 386 to 372. Once again, given the years involved, the decreasing number of beneficiaries aged 18-74 with diabetes having eye exams most likely is a result of lingering impact of Covid-19 as described earlier. The current year's drop in percentage of beneficiaries receiving eye exams, however, could be prompted by other factors that may be uncovered through an interview with the beneficiaries in that population group.

To identify if there is a trend in proportion to the percentage of eye exams among beneficiaries with Diabetes aged 18 – 75, the Cochran-Armitage trend test was performed using SAS 9.4. The test results showed that there is a negative trend ($z = -7.24$, $p < .001$) which is statistically significant at $\alpha = 0.05$. The Spearman rho correlation test was added to verify this trend. The test results confirmed this negative trend (ɣ = - 0.07, $p = .01$).

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
15	2,208	690	31.3%
16	2,001	624	31.8%
17	1,978	615	31.1%
18	1,297	386	29.8%
19	1,833	372	20.3%

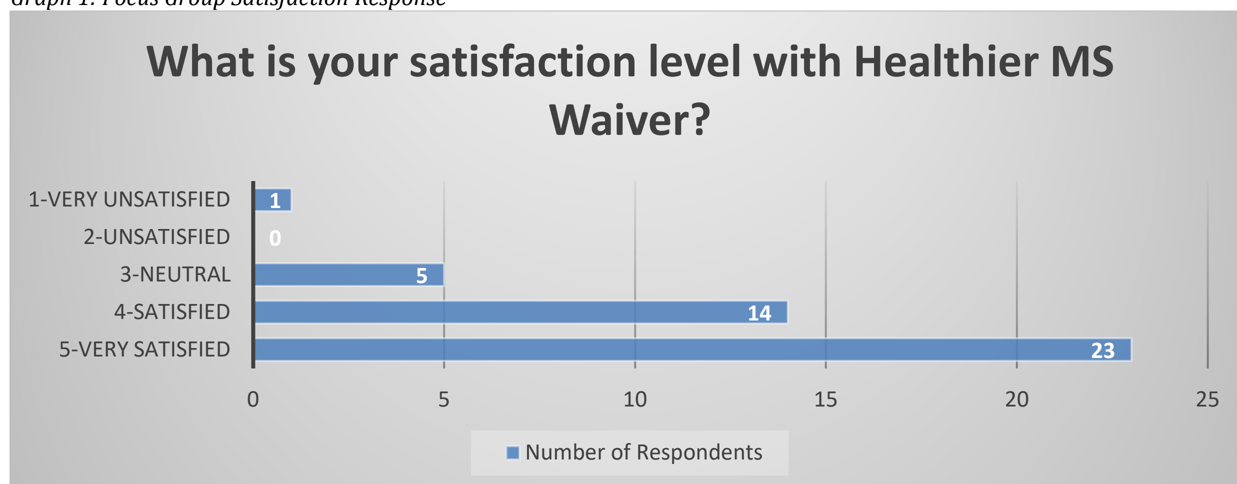
During DY 16, the final Evaluation Design was completed and approved by CMS. The final design included a collaborative agreement for identifying and answering evaluation question 6 and hypothesis 6 below.

Evaluation Question 6: Are HMW beneficiaries satisfied with the demonstration services?

Hypothesis 6: HMW beneficiaries are more likely to report being satisfied with the benefits under the demonstration than being dissatisfied with the benefits.

The findings from the telephone interviews were identified and captured in DY 18 for the Interim Evaluation Report, which is prior to the current reporting year (DY 19), and thus do not explain or account for drastic decreases or increases in DY 19 noted in this annual report. The focus group survey data revealed the satisfaction level of the Healthier MS Waiver program is highly positive; the average satisfaction score is 4.41 out of 5.0 (SD = 0.84). Of the 43 that responded to the satisfaction question, there was only one respondent who answered, "very unsatisfied." The beneficiary's dissatisfaction was due to not being able to access comprehensive dental services. State Plan benefits have limitations on dental services for adults. Overall, 90.2% of respondents answered to this question either satisfied or very satisfied with the waiver services/supports.

Graph 1: Focus Group Satisfaction Response



Data Collection Process for Assessing HMW Beneficiary Satisfaction

In the approved Evaluation Design, Mississippi proposed to use focus groups as a research tool to contextualize the quantitative data and address question/hypothesis 6 relating to HMW beneficiary satisfaction. Given the restrictions and concerns resulting from the Covid-19 virus pandemic, the evaluation team decided to expand the options by which we collected this qualitative data to assess beneficiary satisfaction. In addition to offering selected beneficiaries to participate in one of three focus groups, we offered the option of participating in an individual interview as well. (CMS was notified of this data collection

modification.) All beneficiaries chose to participate via a telephone interview. A survey instrument was developed and approved by the Advisory Team (and sent to CMS for approval).

Eligible Population

Individuals who have been a Healthier Mississippi Waiver beneficiary for the 12 consecutive months and for whom at least one service type has been provided will be eligible to participate in the interview process. There were approximately 900 eligible beneficiaries. The Advisory Team decided that the sample size to whom letters would be sent notifying them of the upcoming interviews and asking for participation should be 10% of the eligible population, or 90 beneficiaries.

Participant Selection Methodology

There are three designated regions for Healthier Mississippi Waiver program (Northern, Central, and Southern). Beneficiaries to be interviewed were selected equally from each of the three regions, or approximately 30 from each region. Ultimately, interview results were collected from 44 beneficiaries. (N=44) Detailed description of the criteria, process, and demographic variables used to identify a valid sample of beneficiaries is available if requested (already submitted as part of the interim evaluation report).

Findings and Analysis Summary

The findings from the telephone interviews were identified and captured prior to the current year (DY 19) and thus do not explain or account for drastic decreases or increases in DY 19 noted in this annual report.

The completed surveys collected from the phone interviews were stored, analyzed, and presented to the HMW administrative staff. The satisfaction level of the Healthier MS Waiver program is highly positive; the average satisfaction score is 4.41 out of 5.0 (SD = 0.84). There is only one respondent who said, "very unsatisfied." * Overall, 86% of respondents answered to this question either satisfied or very satisfied with the waiver services/supports. (*Beneficiary's dissatisfaction was due to not being able to access comprehensive dental services.)

In this sample, the perceived overall physical health was in the neutral range (mean = 3.05, SD = 0.86) and 79.5 % of the respondents said they are neutral or positive (n = 44). The perceived overall mental or emotional health was some better (mean = .3.45, SD = 0.99). More than 80 % of the respondents answered they are neutral or positive (n = 44).

In the past three months, over 86% of respondents said that they did not have to go to an emergency room (n = 44), and the percentage of respondents who said they have gone to doctor's office for preventive care (regular checkups) in this timeframe was nearly 82% (n = 44).

In the past three months, nearly 49% of respondents said that they have used preventive health screening, such as mammograms, cervical cancer screening, and colon cancer screening. (n = 43)

In the past three months, 65% of the number of respondents who have diabetes said that they utilized dilated eye exams and had A1C tests regularly. (n = 20)

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 15	$100,141,854	$76,520,249	N/A	N/A	N/A	$100,141,854
DY 16	$83,884,122	$68,676,518	N/A	N/A	N/A	$83,884,122
DY 17	$67,165,808	$56,402,057	N/A	N/A	N/A	$67,165,808
DY 18	$51,603,474	$43,632,335	N/A	N/A	N/A	$51,603,474
DY 19	$44,316,173	$36,487,818	N/A	N/A	N/A	$44,316,173

Source Data: Schedule C: CMS 64 Waiver Expenditure Report

Budget Neutrality Development

DOM completed and submitted the Budget Neutrality Workbook to CMS on December 27, 2023.

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