MISSISSIPPI DIVISION OF MEDICAID

MISSISSIPPI
Section §1115 Annual Report
Healthier MS Waiver

Demonstration Year XX, October 1, 2023, through September 30, 2024

December 30, 2024

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

Submitted by:

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

Demonstration Year 20
Annual Report
October 1, 2023, through September 30, 2024

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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

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. The state initiated the unwinding process for the continuous enrollment condition and began processing redeterminations. Members that were no longer eligible for the HMW were removed which caused a decrease in enrollment numbers.

Effective September 1, 2024, DOM secured the services of National Strategic Planning and Analysis Research Center (NSPARC), Mississippi State University, 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 (DY).

Policy or Administrative Difficulties

There were no policy or administrative difficulties reported during DY 20.

Grievances and Appeals

There were no grievances or appeals reported during DY 20.

Denial of Services

There were no denials of requested services reported during DY 20 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 DY 20.

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,
   - Reside in a long-term care facility,
   - Reside 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

Table 1 shows enrollment and member months for the last five demonstration years (DYs 16-20). For the most recent two years (DY 19 and DY 20), enrollment numbers reflect a 7.4% increase in enrollees[1] and a 0.3% increase in participants[2].

Total member months decreased by over 37%, dropping from 90,696 in DY 19 to 56,781 in DY 20, with a four-month decrease in average member months. This decrease was driven by a significant rise in disenrollments alongside a more moderate increase in new enrollments in DY 20, as shown in Table 2. Between DY 19 to DY 20, new enrollments grew by 37.4%, while disenrollments surged by approximately 185%.

Table 1: HMW Annual Enrollment

DY	Enrollees	Participants	Total Member Months	Average Member Months
16	7,618	7,040	61,932	8
17	7,291	6,607	71,932	10
18	8,095	5,083	80,374	10
19	9,176	7,605	90,696	10
20	9,854	7,628	56,781	6

Data Source: HMW Member Months data, extracted in December 2024.

Table 2: HMW Annual Disenrollment and New Enrollment

Enrollment Period	Disenrollment	New Enrollment
DY 16	2,139	2,923
DY 17	1,164	1,812
DY 18	1,008	1,970
DY 19	2,288	2,099
DY 20	6,514	2,884

Data Source: HMW Membership data, extracted in November 2024.

The numbers reported for DY 16 to DY 19 in the tables above vary from those reported on previous annual reports because this annual report utilizes updated HMW membership data extracted in November and December 2024. HMW members are eligible to request retroactive coverage for up to three months during the application process. These retroactive eligibility determinations can affect previously reported enrollment across demonstration years (DYs). Consequently, the enrollment data and associated metrics for DY 16 through DY 19 presented in this report differ from those in previous annual reports.

While these differences are minimal for DY 16, DY 17, and DY 19, DY 18 shows a significant discrepancy. This larger variation in DY 18 numbers is due to two factors: retroactive eligibility adjustments and a CMS policy change that required DOM to reinstate coverage of the original HMW category status. During DY 18 (10/01/2021 – 09/30/2022), the state initially allowed members to be transferred to different eligibility categories. However, CMS issued a notice to all

[1] Enrollees are defined as individuals who were enrolled at a time during the demonstration year.
[2] Participants are defined as enrollees who utilized at least one service during the demonstration year.

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. This required the restoration of all members to their original HMW category statuses. This policy was implemented after the DY 18 annual report was initially generated. As a result, there is a substantial discrepancy in DY 18 numbers between this report and previous annual reports, which were based on data originally produced in late 2022.

UTILIZATION

During DY 20, there were 7,628 unique HMW participants who accessed services evaluated in this report under the HMW. This is a 0.3% increase from DY 19, where there were 7,605 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 38 community events held during DY 20.

The Public Forum was held at 10:00 a.m. to 11:00 a.m. on Thursday, July 11, 2024, at the Central High School Auditorium, 259 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, are systematically denied.

INTERIM 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:

Hospitalizations

As shown in Table 3, while the number of beneficiaries under age 75 increased from DY 16 to DY 19, the number of those with hospitalizations continually declined. The percentage of these beneficiaries with hospitalizations dropped from 19.2% to 7.7%.

While the overall trend showed a steady decline, the most substantial reduction occurred between DY 17 and DY 18, where the percentage hospitalized dropped by more than five points. This larger-than-average decline in DY 18 is likely associated with the impact of COVID-19, including social distancing policies, reduced access to medical visits, staff shortages at treatment facilities, closures or reductions in available facilities, and limited transportation options.

To evaluate whether the observed decline in hospitalizations is statistically significant, a Cochran-Armitage trend test was conducted using SAS 9.4. The results show a statistically significant negative trend ($p<0.001$) at a significance level of 0.01 (confidence level $\alpha = 0.01$), indicating that the percentage of beneficiaries under age 75 hospitalized for acute care decreased as the demonstration progressed from DY 16 to DY 20.

Table 3: HMW Beneficiaries under Age 75 with Hospitalization

DY	# of Beneficiaries	# of Beneficiaries with Hospitalizations	% of Beneficiaries with Hospitalizations
16	7,599	1,461	19.2%
17	7,265	1,115	15.3%
18	8,074	811	10.0%
19	9,155	760	8.3%
20	9,736	754	7.7%

Data Sources: HMW Membership data and hospitalization records, extracted in November 2024.

While the number of beneficiaries under age 75 increased by 28 percent between DY 16 and DY 20, the number of hospitalizations among these beneficiaries decreased by 50 percent. This was primarily due to a 28% drop between DY 17 and DY 18. This significant reduction is likely associated with the impact of COVID-19, as previously discussed. Among these hospitalizations, approximately 50% to 60% were preceded by preventive or primary care visits. While the percentage of preventive or primary care visits before hospitalization decreased from DY 16 to DY 19, it increased by 9.4 percentage point from DY 19 to DY 20.

To determine whether this increase represents an anomaly or a statistically significant trend, a Cochran-Armitage trend test was conducted. The test shows a statistically significant negative trend ($p<0.001$) at a significance level of 0.01 (confidence level $\alpha = 0.01$), indicating that the percentage of preventive or primary care visits before hospitalizations for beneficiaries age under 75 has generally declined over the years of the demonstration, despite an increase from DY 19 to DY 20 that might indicate a U-type relationship.

Table 4: Preventive/Primary Care Visits before Hospitalizations among HMW Beneficiaries under Age 75

DY	# of Hospitalizations	# of Preventive or Primary Care Visits before Hospitalizations	% of Preventive or Primary Care Visits before Hospitalizations
16	2,467	1,472	59.7%
17	1,891	1,094	57.9%
18	1,361	704	51.7%
19	1,245	587	47.1%
20	1,251	707	56.5%

Data Sources: HMW Membership data and hospitalization records, extracted in November 2024.

To obtain a better understanding of who did not use preventive or primary care before hospitalization, two groups of beneficiaries under age 75 were compared—those with preventive or primary care visits and those without. Table 5 highlights significant differences in age, gender, and race between beneficiaries under age 75 who used preventive or primary care before hospitalizations and those who did not. Beneficiaries who utilized preventive or primary care were approximately four years older and were more likely to be black or white females.

Table 5: Demographic Characteristics of Beneficiaries Under Age 75 with Hospitalizations (With vs. Without Preventive/Primary Care before Hospitalizations)

Characteristics	With Preventive or Primary Care Visits	Without Preventive or Primary Care Visits	*t* Test Difference
Age	54.57 (9.46)	50.38 (12.21)	13.52***
Gender			
Male	0.46 (0.50)	0.63 (0.48)	-12.28***
Female	0.54 (0.50)	0.37 (0.48)	12.28***
Race			
Black	0.47 (0.50)	0.44 (0.50)	2.14*
White	0.47 (0.50)	0.42 (0.49)	2.96**
Other races	0.06 (0.24)	0.14 (0.34)	-8.67***
Observations	2,713	2,188	

*Notes: Standard deviations in parentheses. *p<0.05, **p<0.01,***p<0.001 (two-tailed test).*
Data Sources: HMW membership data and hospitalization records, extracted in November 2024.

Emergency Department Visits

ED visits can be classified as either emergent or non-emergent. Non-emergent ED visits do not require immediate medical attention and are often avoidable with preventive or primary care services. Such visits are commonly associated with the inappropriate utilization of emergency department resources.

In this evaluation, non-emergent visits are defined as ED visits with primary diagnosis codes from the International Classification of Diseases, 10th Revision (ICD-10), classified as low-acuity, non-emergent (LANE) diagnosis codes or aftercare visit codes (ICD-10 codes beginning with "Z"). The list of low-acuity diagnosis codes used in this evaluation was published by New Jersey Medicaid (NJMMIS). Table 6 shows non-emergent ED visits accounted for approximately 24% to 26% of all ED visits of HMW beneficiaries under age 75 from DY 16 to DY 20.

Table 6: Emergency Department Visits of HMW Beneficiaries under Age 75

DY	# of ED Visits	# of Non-Emergent ED Visits	% of Non-Emergent ED Visits
16	5,236	1,360	26.0%
17	3,722	898	24.1%
18	2,965	711	24.0%
19	3,296	803	24.4%
20	3,301	844	25.6%

Data Sources: HMW membership data and emergency department visits, extracted in November 2024.

As shown in Table 7, the percentage of beneficiaries under age 75 with non-emergent ED visits consistently declined from 12.3% in DY 16 to 6.1% in DY 20. The most significant decreases occurred during the first two years of this period, with the rate of decline gradually slowing after DY 18.

This consistent downward trend aligns with the results of a Cochran-Armitage trend test conducted. The test shows a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of beneficiaries under age 75 with non-emergent ED visits decreased as the demonstration progressed from DY 16 to DY 20.

Table 7: HMW Beneficiaries under Age 75 with Non-Emergent ED Visits

DY	# of Beneficiaries	# of Beneficiaries with Non-Emergent ED Visit(s)	% of Beneficiaries with Non-Emergent ED Visit(s)
16	7,599	935	12.3%
17	7,265	679	9.3%
18	8,074	525	6.5%
19	9,155	597	6.5%
20	9,736	590	6.1%

Data Sources: HMW membership data and emergency department visits, extracted in November 2024.

The results reported in Table 8 show that the number of non-emergent ED visits decreased from 1,360 in DY 16 to 711 in DY 18, followed by a slight increase to 803 in DY 19 and 844 in DY 20. Among these non-emergent ED visits, the percentage preceded by preventive or primary care visits consistently declined from DY 16 onward, with the exception of a modest increase of 0.8 percentage points from DY 19 to DY 20.

To assess whether this increase represents an anomaly or a potential trend, a Cochran-Armitage trend test was conducted. The results show a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of preventive or primary care visits before non-emergent ED visits for beneficiaries under age 75 has generally declined over the years of the demonstration, despite the small increase observed between DY 19 and DY 20.

Table 8: Preventive/Primary Visits before Non-Emergent ED Visits among HMW Beneficiaries under Age 75

DY	# of Non-Emergent ED Visits	# of Preventive or Primary Care Visits before Non-Emergent ED Visits	% of Preventive or Primary Care Visits before Non-Emergent ED Visits
16	1,360	900	66.2%
17	898	588	65.5%
18	711	462	65.0%
19	803	484	60.3%
20	844	516	61.1%

Data Sources: HMW membership data and emergency department visits, extracted in November 2024.

To better understand the characteristics of beneficiaries under age 75 who did not utilize preventive or primary care before non-emergent ED visits, two groups were compared. Table 9 highlights significant differences in age, gender, and race between beneficiaries who used preventive or primary care before non-emergent ED visits and those who did not. Beneficiaries who utilized preventive or primary care were, on average, approximately five years older and more likely to be black females.

Table 9: Demographic Characteristics of Beneficiaries Under Age 75 with Non-emergent ED Visits (With vs. Without Preventive/Primary Care before Non-emergent ED Visits)

Characteristics	With Preventive or Primary Care Visits	Without Preventive or Primary Care Visits	*t Test Difference*
Age	54.58 (9.32)	49.31 (12.62)	13.68***
Gender			
Male	0.34 (0.47)	0.48 (0.50)	-8.01***
Female	0.66 (0.47)	0.52 (0.50)	8.01***
Race			
Black	0.55 (0.50)	0.52 (0.50)	1.88!
White	0.38 (0.49)	0.0 (0.49)	-0.84
Other races	0.06 (0.25)	0.08 (0.28)	-2.05*
Observations	2,168	1,158	

*Notes: Standard deviations in parentheses. !p<0.1,*p<0.05, **p<0.01,***p<0.001 (two-tailed test).*
Data Sources: HMW membership data and emergency department visits, extracted in November 2024.

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:

As reported in Table 10, the percentage of beneficiaries with ambulatory/preventive visits has declined, from 77% in DY 16 to 60% in DY 20. Initially, the percentage increased slightly from 77% in DY 16 to 78.3% in DY 17 but then dropped substantially to 49% in DY 18. This drop was followed by an increase to 66.9% in DY 19 and a decline to 60.0% in DY 20. This substantial decline experienced in DY 18 is most likely attributable to the impact of COVID-19, as previously discussed.

To determine if the observed trend in the percentage of beneficiaries aged 20 or older receiving ambulatory/preventive visits is significant, a Cochran-Armitage trend test was conducted. The test results show that there is a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of ambulatory/preventive visits of HMW beneficiaries aged 20 or older decreased as the demonstration progressed from DY 16 to DY 20.

Table 10: HMW Beneficiaries Aged 20 or Older with Ambulatory/Preventive Visits

DY	# of Beneficiaries	# of Beneficiaries with Ambulatory/Preventive Visit	% of Beneficiaries with Ambulatory/Preventive Visit
16	7,599	5,852	77.0%
17	7,265	5,685	78.3%
18	8,074	3,958	49.0%
19	9,155	6,126	66.9%
20	9,736	5,838	60.0%

Data Sources: HMW membership data and ambulatory or preventive care records, extracted in November 2024.

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:

Mammogram

As reported in Table 11, the percentage of female beneficiaries aged 50 to 74 receiving mammograms continuously decreased from 20.0% in DY 15 to 9.5% in DY 20. A significant drop occurred between DY 17 and DY 18, where the percentage fell from 17.6% to 12.1%, despite an increase in the total number of female beneficiaries aged 50 to 74 from 3,155 to 3,514.

This significant decline in both the number and percentage of female beneficiaries aged 50 to 74 receiving mammograms is likely associated with the effects of the COVID-19 pandemic, as previously discussed. However, the continued decline after DY 18 may also be affected by additional factors that would require further study, such as interviews with affected beneficiaries.

A Cochran-Armitage trend test was performed to analyze the trend in the percentage of beneficiaries aged 50 to 74 receiving mammograms. The test shows that there was a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of HMW female beneficiaries aged 50 to 74 receiving mammograms decreased as the demonstration progressed from DY 16 to DY 20.

Table 11: HMW Female Beneficiaries Aged 50 to 74 Receiving Mammograms

DY	# of Female Beneficiaries	# of Female Beneficiaries Receiving Mammogram	% of Female Beneficiaries Receiving Mammogram
16	3,179	636	20.0%
17	3,155	556	17.6%
18	3,514	424	12.1%
19	3,978	389	9.8%
20	4,077	387	9.5%

Data Sources: HMW membership data and mammogram records, extracted in November 2024.

Cervical Cancer Screening

As reported in Table 12, the percentage of female beneficiaries aged 21 to 64 who received cervical cancer screenings showed a continuous downward trend, decreasing from 7.5% in DY 16 to 6.1% in DY 17, and a further drop to 4.3% in DY 18. Despite an increase in the total number of female beneficiaries from 3,752 to 3,857, the number of female beneficiaries receiving cervical cancer screenings decreased significantly, from 230 in DY 17 to 164 in DY 18. This significant decline in both the number and percentage of female beneficiaries receiving cervical cancer screenings is likely associated with the effects of the COVID-19 pandemic, as previously discussed.

As the impact of the pandemic diminished, the number and percentage of female beneficiaries receiving cervical cancer screenings increased slightly from DY 18 to DY 19. However, both declined again from DY 19 to DY 20, despite a slight increase in the total number of female beneficiaries aged 21 to 64 in DY 20 compared to DY 19.

A Cochran-Armitage trend test was performed to analyze the trend in the percentage of beneficiaries aged 21 to 64 receiving cervical cancer screening. The results show a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of beneficiaries aged 21 to 64 who had cervical cancer screening as the demonstration progressed from DY 16 to DY 20.

Table 12: HMW Female Beneficiaries Aged 21 to 64 Receiving Cervical Cancer Screenings

DY	# of Female Beneficiaries	# of Female Beneficiaries Receiving Cervical Cancer Screening	% of Female Beneficiaries Receiving Cervical Cancer Screening
16	4,069	306	7.5%
17	3,752	230	6.1%
18	3,857	164	4.3%
19	4,210	187	4.4%
20	4,339	184	4.2%

Data Sources: HMW membership data and cervical cancer screening records, extracted in November 2024.

Colorectal Cancer Screening

As reported in Table 13, although the number of beneficiaries aged 50 to 75 gradually increased from DY 16 to DY 20, both the number and percentage of beneficiaries aged 50 to 75 receiving colorectal cancer screening continuously decreased. Although COVID-19 may cause the substantial drop from DY 17 to DY 19, there may be additional factors that driving the continuous drop in subsequent years that could be identified through further research, such as interviews affected beneficiaries.

To identify if the observed trend in the percentage receiving colorectal cancer screening among beneficiaries aged 50 to 75 is significant, the Cochran-Armitage trend test was performed. The test results show that the decline observed from DY 16 to DY 20 is significant.

Table 13: HMW Beneficiaries Aged 50 to 75 Receiving Colorectal Cancer Screenings

DY	# of Beneficiaries	# of Beneficiaries Receiving Colorectal Cancer Screening	# of Beneficiaries Receiving Colorectal Cancer Screening
16	5,695	511	9.0%
17	5,626	380	6.8%
18	6,316	302	4.8%
19	7,091	275	3.9%
20	7,278	274	3.8%

Data Sources: HMW membership data and colorectal cancer screening records, extracted in November 2024.

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:

As reported in Table 14, the percentage of diabetic beneficiaries aged 18 to 75 receiving an annual HbA1c test showed a consistent downward trend from 52.5% in DY 16 to 50.4% in DY 17 and declined more steeply to 31.6% in DY 18. Despite an increase in the total number of beneficiaries from 2,876 to 3,106, the number of beneficiaries receiving HbA1c tests decreased, from 1,449 in DY 17 to 981 in DY 18. This decline in both the number and percentage of beneficiaries receiving HbA1c tests is likely associated with the effects of the COVID-19 pandemic, as previously discussed.

As the impact of the pandemic diminished, this decline gradually reversed. From DY 18 to DY 19, both the number and percentage of beneficiaries receiving HbA1c tests increased, continuing the upward trend into DY 20. While the total number of beneficiaries aged 18 to 75 with diabetes slightly decreased in DY 20 compared to DY 19, the number of those receiving HbA1c tests increased, accompanied by a 2.1% rise in the percentage of diabetic beneficiaries receiving this essential care.

To identify whether the increase from DY 18 to DY 20 represents an anomaly or a statistically significant trend, a Cochran-Armitage trend test was conducted. The results show a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of beneficiaries aged 18 to 75 with diabetes who received HbA1c test significantly decreased over the years of the demonstration.

Table 14: HMW Beneficiaries Aged 18 to 75 with Diabetes Receiving Hemoglobin A1c (HbA1c) Tests

DY	# of Beneficiaries	# of Beneficiaries Receiving HbA1c Test	% of Beneficiaries Receiving HbA1c Test
16	2,999	1,573	52.5%
17	2,876	1,449	50.4%
18	3,106	981	31.6%
19	3,404	1,167	34.3%
20	3,294	1,200	36.4%

Data Sources: HMW membership data and HbA1c test records, extracted in November 2024.

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:

As reported in Table 15, the percentage of beneficiaries with diabetes, aged 18 to 75, that received an annual eye exam showed a downward trend, declining from 25.4% in DY 16 to 13.5% in DY 20. Although the percentage initially increased from 25.4% in DY 16 to 26.4% in DY 17, it dropped significantly to 14.7% in 2018. Once again, given the year involved, this significant decline in DY 18 is most likely attributable to the impact of COVID-19. After DY 18, the percentage slightly increased but then decreased again, with a 3.3% percentage point drop from DY 19 to DY 20. This decline between DY 19 and DY 20 may be influenced by other factors that would require further study, such as interviews with the affected beneficiaries.

To identify if this observed trend is statistically significant, a Cochran-Armitage trend test was performed. The results show a statistically significant negative trend ($p < 0.001$) at a significance level of 0.01 ($\alpha = 0.01$), indicating that the percentage of beneficiaries aged 18 to 75 with diabetes who received eye exams decreased over the years of the demonstration.

Table 15: HMW Beneficiaries Aged 18 to 75 with Diabetes Receiving Eye Examination

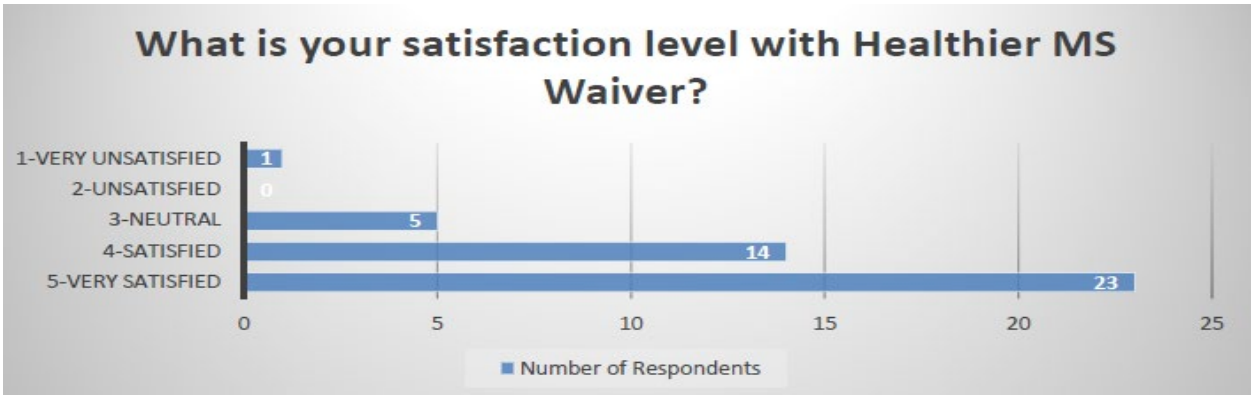
DY	# of Beneficiaries	# of Beneficiaries Receiving Eye Exam	% of Beneficiaries Receiving Eye Exam
16	2,999	763	25.4%
17	2,876	758	26.4%
18	3,106	457	14.7%
19	3,404	572	16.8%
20	3,294	445	13.5%

Data Sources: HMW membership data and eye examination records, extracted in November 2024.

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 two years prior to the current reporting year (DY 20), and thus do not explain or account for drastic decreases or increases in DY 20 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 at the time decided to expand the options for collecting qualitative data to assess beneficiary satisfaction. In addition to offering selected beneficiaries to participate in one of three focus groups, the option of participating in an individual interview

was offered 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 two years prior to the current year (DY 20) and thus do not explain or account for drastic decreases or increases in DY 20 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"[3]. Overall, 86% of respondents answered to this question either satisfied or very satisfied with the waiver services/supports.

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).

Over 86% of respondents said that they did not have to go to an emergency room (n = 44) in the last three months, 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).
Nearly 49% of respondents said that they have used preventive health screening in the last three months, such as mammograms, cervical cancer screening, and colon cancer screening. (n = 43)

65% of the number of respondents who have diabetes said that they utilized dilated eye exams and had HbA1c tests regularly in the last three months. (n = 20)

3 Beneficiary's dissatisfaction was due to not being able to access comprehensive dental services.

FINANCIAL REPORTING

Annual Expenditures

Table 16: 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 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	$54,755,942	$46,077,781	N/A	N/A	N/A	$54,755,942
DY 19	$50,345,046	$40,812,905	N/A	N/A	N/A	$50,345,046
DY 20	$56,215,977	$43,466,187	N/A	N/A	N/A	$56,215,977

Budget Neutrality Development

The Budget Neutrality Workbook document for the extension year (DY 20) was uploaded to the CMS Performance Metrics Database and Analytics (PMDA) site on December 30, 2024.

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