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

March 29, 2024

Drew Snyder
Executive Director
550 High St, Suite 1000
Jackson, Mississippi 39201

Dear Executive Director Snyder:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Mississippi Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #50 "Interim Evaluation Report" of the section 1115 demonstration, "Healthier Mississippi" (Project No: 11-W-001854). The demonstration was approved on September 28, 2018, and is effective through September 30, 2024. The Interim Evaluation Report covers the period from October 2018 through September 2021. CMS is accepting the Evaluation Report, submitted originally in October 2022, and revised on December 29, 2022, and January 19, 2024.

While the state used primarily descriptive statistics for quantitative analysis, the Interim Evaluation Report showed that the number of hospitalizations decreased by 25.9 percent and emergency department visits decreased by 25.8 percent among beneficiaries under age 75 during the demonstration evaluation period. The evaluation report also indicated that 86 percent of beneficiaries reported being satisfied or very satisfied with the services provided by the demonstration. The report additionally surmises that several demonstration goals were not reached due to implications from the COVID-19 Public Health Emergency.

CMS expects, and the state agrees, that the limitations in the Interim Evaluation Report will be addressed in the Summative Evaluation Report, including aligning the evaluation report with the approved Evaluation Design. Consistent with the approved Evaluation Design, the Summative Evaluation Report is due to CMS within 18 months of the end of the demonstration period. We appreciate the state's cooperation and commitment to monitoring and evaluation of its section 1115 demonstration.

In accordance with STC #53 "Public Access," the accepted Interim Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Report on Medicaid.gov.

We look forward to our continued partnership on the Healthier Mississippi section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2024.03.29 09:16:25 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Tandra Hodges, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

MISSISSIPPI
Section §1115 Interim Evaluation
Healthier MS Waiver

January 19, 2024

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

Submitted by:
Mississippi Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

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

Interim Evaluation

Table of Contents

Executive Summary 3
General Background Information 3
Evaluation Questions and Hypotheses 4
Methodology 6
- Evaluation Design 6
- Target and Comparison Populations 6
- Evaluation Period 7
- Evaluation Measures 7
- Data Sources 8
- Analytic Methods 8
- Other Additions 8

Methodological Limitations 16
Results 16
Conclusions 23
Interpretations, Policy Implications and Interactions with Other State Initiatives 24
Lessons Learned and Recommendations 25
Attachment A: Healthier Mississippi Waiver Evaluation Design 26

EXECUTIVE SUMMARY

The Healthier Mississippi Waiver (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.

The results of this interim evaluation proved that the state's main goal of reducing hospitalizations and ED utilization among HMW beneficiaries was successful. There was a slight increase in the percentage of beneficiaries receiving ambulatory/preventive visits over time, but the target was not met. The most likely attributing factor of the decrease in the number of preventive screenings and follow up care for beneficiaries with diabetes was the COVID-19 pandemic. More community outreach may be needed to inform beneficiaries that preventive visits and screenings are available and will not count toward the physician visit limit of sixteen (16) per state fiscal year.

GENERAL BACKGROUND INFORMATION

In the 2004 legislative session, the Mississippi Legislature voted to discontinue Medicaid coverage for the optional Poverty Level Aged and Disabled (PLAD) group effective July 1, 2004. Concerned that this population was at risk for costly adverse events, including institutional placement, if medical regimens were not maintained, the state applied and received approval for a section 1115 demonstration to continue coverage for this population. The demonstration was predicated on the assumption that continued access to medical care by the PLAD population will delay deterioration in health status, which drives hospitalization and/or institutionalization in a nursing facility. The HMW Demonstration Program waiver 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. Under the 2010 renewal, the state requested, and CMS approved an increase in the enrollment limit from 5,000 to 5,500. Under the 2015 renewal, CMS approved two changes: increasing the enrollment limit from 5,500 to 6,000 and adding to the benefit package podiatry, eyeglasses, dental, and chiropractic services, which were previously excluded. Currently, the demonstration's special terms and conditions (STCs) are approved from October 1, 2018, through September 30, 2023.

There were no changes in the eligibility requirements or covered services from the previous demonstration. The population groups impacted by the HMW include Mississippi residents that are 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.

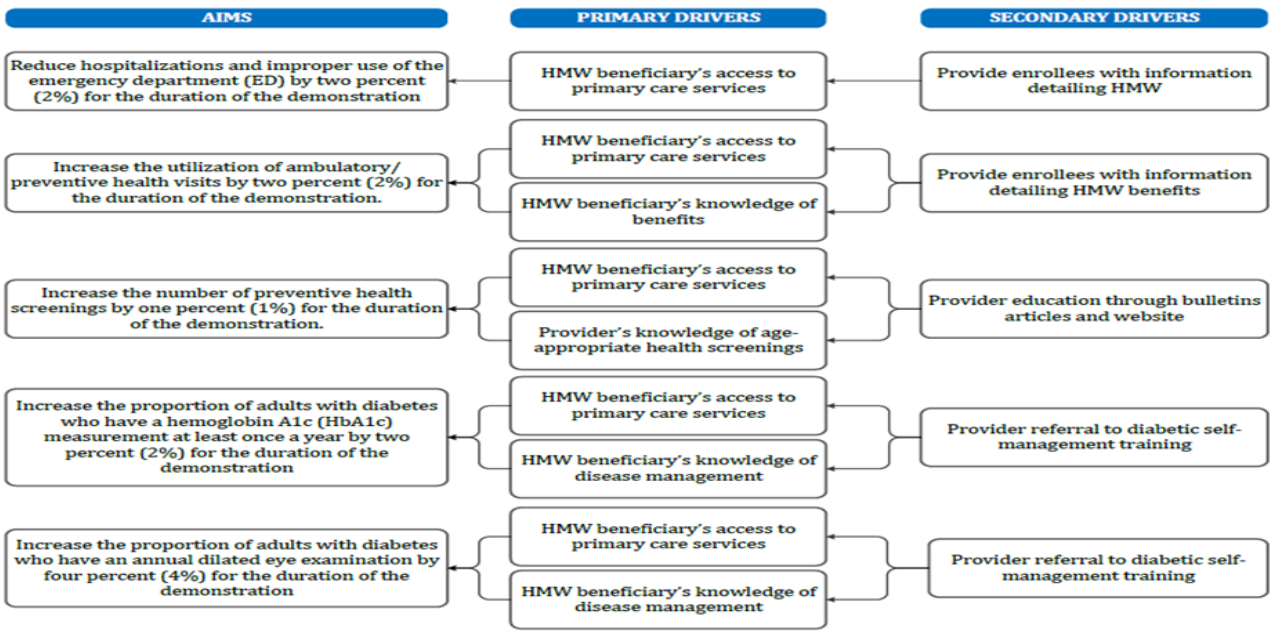
EVALUATION QUESTIONS AND HYPOTHESES

Mississippi examined the relationship between services available and utilization of those services among the population to analyze the performance of the demonstration through the goals and quantifiable target percentages, listed below and outlined in the CMS approved STCs.

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

A driver diagram was developed to identify primary and secondary drivers of how the state projected the goals could be obtained with the available resources to beneficiaries.

Healthier Mississippi Waiver Driver Diagram



The hypotheses and research questions listed below were derived from the state's goals to promote the objectives of Title XIX by allowing Medicaid coverage for medical assistance provided to low-income aged, blind, or disabled individuals not eligible for Medicaid or Medicare, and providing access to needed medical services.

Table 1: Hypotheses and Research Questions

Hypotheses	Research Questions
H 1 The rates of hospitalization and improper use of the emergency department visits will fall among HMW beneficiaries over time, and the HMW beneficiaries will have fewer hospitalizations and emergency department visits after accessing ambulatory and preventive services.	Q 1.1 How do the rates of inpatient hospitalization and non-emergent use of emergency department visits evolve over time among the HMW beneficiaries?
	Q 1.2 Will HMW beneficiaries who access ambulatory and preventive services have fewer hospitalizations and emergency department visits?
H 2 HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits.	Q 2 Will providing benefits under the HMW demonstration lead to an increase in the utilization of ambulatory/preventive health visits among HMW beneficiaries?
H 3 HMW beneficiaries with access to benefits will have an increase in the utilization of age-appropriate preventive screenings.	Q 3 Will providing benefits under the HMW demonstration result in an increase in age-appropriate preventive screenings?
H 4 HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.	Q 4 Will providing benefits under the HMW demonstration increase the number of annual HbA1c tests among HMW beneficiaries diagnosed with diabetes?
H 5 HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.	Q 5 Will providing benefits under the HMW demonstration increase the number of annual dilated eye examinations among HMW beneficiaries diagnosed with diabetes?
H 6 HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.	Q 6 Are HMW beneficiaries satisfied with the demonstration services?

METHODOLOGY

Evaluation Design

This evaluation will assess the performance of the demonstration goals using a one-group posttest-only design of HMW beneficiaries and their utilization of available services provided under the HMW benefit plan. Also, the trend analysis will incorporate appropriate statistical testing to show if changes over time are statistically significant. Qualitative findings from three groups and key informant interviews were utilized to complement and contextualize the descriptive quantitative analyses.

Target and Comparison Populations

The target population includes individuals that are aged, blind, or disabled who are not eligible for Medicare or Medicaid, not in a long-term care institution, and whose:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple calculated using a methodology based on the SSI program, as well as income exclusions approved under the State Plan under the authority of Section 1902(r)(2) of the Social Security Act, and
- Resources are below $4,000 for an individual and $6,000 for a couple.

Subgroups of the target population include:

- Enrolled female beneficiaries age 50-74 to examine mammogram screenings;
- Female beneficiaries age 21-64 to examine cervical cancer screenings;
- Enrolled beneficiaries age 50-75 to examine colorectal cancer screenings;
- Beneficiaries age 20 or older receiving ambulatory/preventive services;
- Beneficiaries under age 75 utilizing the ED, excluding injury, poisoning, and certain other consequences of external causes; and
- Beneficiaries under age 75 with inpatient hospitalizations, excluding injury, poisoning, and certain other consequences of external causes

The survey target population consisted of 90 HMW participants with 12 consecutive months of coverage who accessed at least one (1) service under the demonstration. There were approximately 900 eligible beneficiaries that met the 12 consecutive months of coverage who accessed at least one (1) service under the demonstration. The Advisory Team decided that the sample size to whom the letters would be sent notifying them of the upcoming interviews and asking for participation should be 10% of the eligible population, or 90 beneficiaries. After adjusting for incorrect addresses, incorrect phone numbers, or declined participation, 44 participants were surveyed for response analysis.

Evaluation Period

The interim evaluation was conducted for demonstration years 15 – 17 during the period of October 1, 2018, through September 30, 2021.

Evaluation Measures

Metric	Description	Numerator/Denominator
Inpatient hospitalization rate	Beneficiaries under age 75 who had at least one acute care hospitalization during the measurement year	Number of HMW beneficiaries under age 75 with at least one inpatient hospitalization during the measurement year/Number of beneficiaries under age 75 during the measurement year
Non-emergent use of emergency department	Beneficiaries under age 75 who had at least one non-emergent ED visit during the measurement year	Number of HMW beneficiaries under age 75 with at least one non-emergent ED visit during the measurement year/Number of beneficiaries under age 75 during the measurement year
Inpatient hospitalization rate for beneficiaries who access ambulatory and preventive services	Number of hospitalizations for beneficiaries under age 75 who had at least one acute care hospitalization, who also accessed ambulatory and preventive services during the measurement year	Number of hospitalizations for HMW beneficiaries under age 75 that accessed ambulatory and preventive services during the measurement year/Number of hospitalizations for HMW beneficiaries under age 75 during the measurement year
Emergency department rate for beneficiaries who access ambulatory and preventive services	Number of ED visits for beneficiaries under age 75 who accessed ambulatory and preventive services during the measurement year	Number of ED visits for beneficiaries under 75 that accessed ambulatory and preventive services during the measurement year/Number of ED visits for HMW beneficiaries under age 75 during the measurement year
Ambulatory/Preve ntive Health Visits	Percentage of beneficiaries age 20 years and older who had at least one ambulatory or preventive care visit per year	Number of beneficiaries 20 and older who had at least one ambulatory or preventive care visit during the measurement year/Number of HMW 20 and older during the measurement year
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more Pap test to screen for cervical cancer	Number of HMW women, ages 21-64, who received screenings for cervical cancer during the measurement year/Number of HMW women 21-64 years of age during the measurement year
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to	Number of HMW women, ages 50-74, who had a mammogram during the measurement

	screen for breast cancer once during the measurement year	year/ Number of women, ages 50-74, during the measurement year
Colorectal Cancer Screening	Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer	Number of HMW beneficiaries, ages 50-75, who received screenings for colorectal cancer during measurement year/ Number of HMW beneficiaries, ages 50-75 during the measurement year
Comprehensive Diabetes Care: Eye Exam	Percentage of beneficiaries 18-75 years of age with diabetes who had a retinal or dilated eye exam during the measurement period	Number of HMW beneficiaries, ages 18 – 75, with diabetes who had a retinal or dilated eye exam during the measurement period/Number of HMW beneficiaries ages 18 - 75 with diabetes during the measurement year
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	The percentage of beneficiaries 18-75 years of age with diabetes who received an HbA1c test during the measurement year	Number of HMW beneficiaries, ages 18-75, with diabetes who received an HbA1c test during the measurement year/Number of HMW beneficiaries ages 18-75 with diabetes during the measurement year

Data Sources

The data will come from Medicaid claims, which are housed in the Medicaid Management Information Systems (MMIS) and Division Support System (DSS).

Additionally, telephone interviews were used to learn more in-depth information about the beneficiary experience of the HMW.

Analytic Methods

The evaluation was completed by utilizing a quantitative Cochran-Armitage trend test design analysis and a qualitative survey to monitor satisfaction and to identify potential areas of quality improvement and impact of the HMW.

Other Additions – Satisfaction Survey Information

The sample target consisted of 90 HMW participants with 12 consecutive months of coverage who accessed at least one (1) service under the demonstration. There were approximately 900 eligible beneficiaries from the total population of 6,377, that met the 12 consecutive months of coverage who accessed at least one (1) service under the demonstration criteria. The Advisory Team decided that the sample size to whom the letters would be sent notifying them of the upcoming interviews and asking for participation should be 10% of the eligible population, or 90 beneficiaries. The participants were surveyed to monitor satisfaction and to identify potential areas of quality improvement. After adjusting

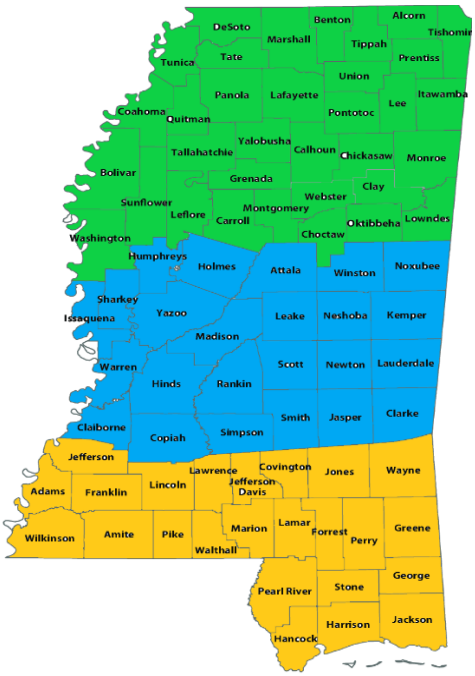
for incorrect addresses, incorrect phone numbers, or declined participation, 44 participants were surveyed for response analysis.

Based on the descriptive analyses in Table 2, the interview results incorporated a total of 44 participants who responded to the questions (N = 44). Randomly selected from three regions according to the proportion as in the table, the study sample was divided into 65.9 % of females and 34.1 % of males. The average age of the sample was 57.4 years old (SD = 7.3).

Table 2: Descriptive Statistics

Variable	Frequency (N)	Percent	
Northern Region	16	36.4%	
Central Region	14	31.8%	
Southern Region	14	31.8%	
Gender	**Frequency (N)**	**Percent**	
Male	29	65.9%	
Female	15	34.1%	
Variable			**Mean (SD)**
Age			57.41 (7.30)

Data source: *HMW Group Participation Data*



Mississippi Regional County Selection

Northern Region

Bolivar, Carroll, Coahoma, DeSoto, Grenada, Lafayette, Leflore, Marshall, Montgomery, Panola, Sunflower, Tallahatchie, Tate, Tunica, Washington, Yalobusha, Alcorn, Benton, Calhoun, Chickasaw, Choctaw, Clay, Itawamba, , Lee, Lowndes, Monroe, Oktibbeha, Pontotoc, Prentiss, Quitman, Tippah, Tishomingo, Union, Webster

Central Region
Claiborne, Copiah, Hinds, Holmes, Humphreys, Issaquena, Madison, Rankin, Sharkey, Simpson, Warren, Yazoo, Attala, Clarke, Jasper, Kemper, Lauderdale, Leake, Neshoba, Newton, Noxubee, Scott, Smith, Winston

Southern Region
Adams, Amite, Franklin, Jefferson Davis, Jefferson, Lawrence, Lincoln, Marion, Pike, Walthall, Wilkinson, Wayne, Covington, Forrest, George, Greene, Hancock, Harrison, Jackson, Jones, Lamar, Pearl River, Perry, Stone

Based on participant responses in Table 3, 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 answered, "very unsatisfied." The beneficiary's dissatisfaction was due to not being able access comprehensive dental services. State Plan benefits have limitations on dental services for adults. 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).

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 screenings, 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)

Based on the descriptive analyses in Table 2, the interview results incorporated a total of 44 participants who responded to the questions (N = 44). Randomly selected from three regions according to the proportion as in the table, the study sample was divided into 65.9 % of females and 34.1 % of males. The average age of the sample was 57.4 years old (SD = 7.3).

Table 3: Participant Survey Responses

Q1: What is your satisfaction level with Healthier MS Waiver?			
Response Choices	**Frequency (N)**	**Percent**	**Mean (SD)**
Very Unsatisfied	1	2.4%	4.41 (0.84)
Unsatisfied	0	0%	
Neutral	5	7.3%	
Satisfied	14	34.1%	
Very Satisfied	23	56.1%	
	*1 respondent declined to answer		
Q2: What is your perceived overall physical health?			
Response Choices	**Frequency (N)**	**Percent**	**Mean (SD)**
Very Poor	2	4.5%	3.05 (0.86)
Poor	7	15.9%	
Neutral	24	54.5%	
Good	9	20.5%	
Very Good	2	4.5%	
Q3: What is your perceived overall mental or emotional health?			
Response Choices	**Frequency (N)**	**Percent**	**Mean (SD)**
Very Poor	1	2.3%	3.45 (0.99)
Poor	5	11.4%	
Neutral	19	43.2%	
Good	11	25%	
Very Good	8	18.2%	
Q4: In the last 3 months, have you gone to an emergency room?			
Response Choices	**Frequency (N)**	**Percent**	
Yes	6	13.6%	
No	38	86.4%	
Q5: In the last 3 months, have you gone to the doctor just to get a check-up?			
Response Choices	**Frequency (N)**	**Percent**	
Yes	36	81.8%	
No	8	18.2%	
Q6: In the last 3 months, did you use preventive health screenings?			
Response Choices	**Frequency (N)**	**Percent**	
Yes	21	48.8%	
No	22	51.2%	
	*1 respondent's answer did not get recorded		
Q7: For cohorts who have diabetes. In the last 3 months, have you had a dilated eye exam or a hemoglobin A1c test?			
Response Choices	**Frequency (N)**	**Percent**	
A1c Only	8	40%	
Both	5	25%	
No	7	35%	

Data Collection

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 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. All beneficiaries chose the individual interview by telephone option.

Protocols, Materials, Questions, and Incentives

Certain protocols for creating a comfortable, receptive environment were suggested, an explanation script was drafted, and an introduction letter was developed. The questions for the individual interview were identified by the advisory group. A survey instrument was developed and approved by the Advisory Team. It was concluded that incentives were not necessary to generate the needed participation.

Implementation of Data Collection Plan

The criteria utilized to identify the sample target consisted of HMW participants with 12 consecutive months of coverage who accessed at least one (1) service under the demonstration. There were approximately 900 eligible beneficiaries from the total population of 6,377 that met the 12 consecutive months of coverage who accessed at least one (1) service under the demonstration criteria. The Advisory Team decided that the sample size to whom the letters would be sent notifying them of the upcoming interviews and asking for participation should be 10% of the eligible population, or 90 beneficiaries.

After the sample target was determined and identified, a letter from the Division of Medicaid (HMW) notifying the beneficiaries that they had been randomly selected to take part in an individual interview or a small group discussion (focus group) was mailed to each of the 90 potential participants approximately one week before being contacted. The letter also indicated that someone from the Parham Group would be contacting them to ask if they wanted to participate, and if so, did they prefer a group or individual setting. All beneficiaries who were contacted and agreed to participate chose the individual interview route.

Table 4: Group Contact

Variable	Northern Region	Central Region	Southern Region	Total
Total Number of letters mailed	30	30	30	90
Total returned to sender for no such address, not deliverable, or insufficient addresses	5	2	4	11
Total number who received notice letter				79
Successful Contact/Interview	15 (9 female/6 male)	14 (7 female/7 male)	15 (10 female/5 male)	44 (26 female/18 male)
Bad Telephone Numbers	8	7	8	23
No Answers (4 attempts each)	6	6	6	18
Declined to participate	1	2	1	4
Deceased	0	1	0	1

Data Source: *Group Contact Results*

Advisory Committee
An advisory group of key informants made recommendations to the evaluation team, including:

- Eligibility criteria
- Participant selection method and protocol plan
- Interview/ group protocols
- Appropriate support materials if needed (explanation script for why we are calling and what we are wanting, data collection form that guides the interview, etc.)
- Specific questions needed to facilitate a conversation and gain insight regarding the beneficiaries' satisfaction with program services
- If incentives should be utilized
- Timeline for activity completion

Eligible Population
The eligible population consisted of individuals who had been a HMW beneficiary for 12 consecutive months and for whom at least one service has been provided under the demonstration.

Participant Selection Methodology
A total target sample size is from 36 to 45. There are three regions for HMW programs as Northern, Central, and Southern regions by counties. Table 5 reflects almost the same proportion for each group: 33.5%, 31.5%, and 33.8%. Therefore, each region will have same number of study sample for the group study.

To pursue the similar proportion of the demographic variables such as Gender, Simplified Race, and Age Group in the total sample, descriptive statistics were considered as in Table 15. The original Race variable has too many categories; therefore, they were re-categorized as three groups: Caucasian, African American, and Others which have 40.9 %, 55.2 %, and 3.9 % respectively. Also, Age variable was divided into four groups according to quartile values as (1) 51 years or younger, (2) 52 to 58 years old, (3) 59 to 62 years old, and (4) 64 years old or older groups.

Table 6 showed no difference in Gender by Regions. Therefore, we can select participants by Gender as 56 % vs. 44% (Female: 7 vs. Male: 5 for N = 36 and Female: 9 vs. Male: 6 N = 45 respectively). After considering this, we randomly select the potential participants to reach out along with the Race and Age group ratios in each region.

Table 5: Descriptive Statistics of Whole Population (N=6,377)

Variable	Categories	N (%)	Mean (SD)
Gender	Female	3,612 (56.6%)	
	Male	2,765 (43.4 %)	
Age	5 ~ 90 years old		55.79 (10.85)
Race -simplified	Caucasian	2,608 (40.9 %)	
	African American	3,519 (55.2 %)	
	Others	250 (3.9 %)	
Age Group	51 years old or younger	1,494 (23. 4%)	
	52 to 58 years old	1,538 (24.1 %)	
	59 to 63 years old	1,654 (25.9 %)	
	64 years old or older	1,691 (26.5 %)	
Region	Northern	2,139 (33.5 %)	
	Central	2,008 (31.5 %)	
	Southern	2,153 (33.8 %)	
	Other *	77 (1.2 %)	

*****Although these beneficiaries live in Mississippi, the mailing address is in another state.

Table 6: Demographic Variables by Region

Variable	Categories by Regions	N (%)	Test Statistic *p*
Gender	Northern		
	Female	1,212 (56.7 %)	Chi-square Homogeneity Test = 0.026 (p = 0.987)
	Male	927 (43.3 %)	
	Central		
	Female	1,134 (56.5 %)	
	Male	874 (43.5 %)	
	Southern		
	Female	1,221 (56.7 %)	
	Male	932 (43.3 %)	
Race	Northern		
	Caucasian	867 (40.5 %)	Chi-square Homogeneity Test = 252.594 (p < 0.001)
	African American	1,220 (57.0 %)	
	Others	52 (2.4 %)	
	Central		
	Caucasian	585 (29.1 %)	
	African American	1,344 (66.9 %)	
	Others	79 (3.9 %)	
	Southern		
	Caucasian	1,106 (51.4 %)	
	African American	935 (43.4 %)	
		112 (5.2 %)	
Age Group	Northern		
	51 years old or younger	518 (24.2 %)	Chi-square Homogeneity Test = 23.840 (p = 0.001)
	52 to 58 years old	568 (26.6 %)	
	59 to 63 years old	513 (24.0 %)	
	64 years old or older	540 (25.2 %)	
	Central		
	51 years old or younger	490 (24.4 %)	
	52 to 58 years old	450 (22.4 %)	
	59 to 63 years old	515 (25.6 %)	
	64 years old or older	553 (27.5%)	
	Southern		
	51 years old or younger	458 (21.3 %)	
	52 to 58 years old	507 (23.5 %)	
	59 to 63 years old	611 (28.4%)	
	64 years old or older	577 (26.8 %)	

Table 7 shows the combination of these demographic variables' proportion for each region. Using random number generation for each split in the total sample, the following numbers were selected.

Table 7: Target Number of Sample from the Split Data

Region	Gender	Race	Note
Northern (n = 30)	Female (n = 19)	Caucasian (n = 8) AAF (n = 11) Other (n = 0)	The total number in the sample was divided into four groups evenly since age group is homogeneous according to other demographic groups. Then we took a random sample from each group. Next, we checked to see if the sample is evenly divided into four age groups. If not, we chose the next person in that group. We repeated the process until we reached the target number of sample as planned.
	Male (n = 11)	Caucasian (n = 5) AAF (n = 6) Other (n = 0)	
Central (n = 30)	Female (n = 19)	Caucasian (n = 6) AAF (n = 12) Other (n = 1)	
	Male (n = 11)	Caucasian (n = 4) AAF (n = 7) Other (n = 0)	
Southern (n = 30)	Female (n = 19)	Caucasian (n = 10) AAF (n = 8) Other (n = 1)	
	Male (n = 11)	Caucasian (n = 6) AAF (n = 5) Other (n = 0)	
Total (N = 90)			

Table 8: Minimum number of participants of from each group

Region	Gender	Race	Note
Northern (n = 12)	Female (n = 7)	Caucasian (n = 3) AAF (n = 4) Other (n = 0)	If we reached the numbers from this table for each group, then we stopped to recruit more from that group. Note: if we cannot recruit any from other race, it is fine since we have very small percentage of Other category in Race.
	Male (n = 5)	Caucasian (n = 2) AAF (n = 3) Other (n = 0)	
Central (n = 12)	Female (n = 7)	Caucasian (n = 2) AAF (n = 5) Other (n = 0)	
	Male (n = 5)	Caucasian (n = 2) AAF (n = 3) Other (n = 0)	
Southern (n = 12)	Female (n = 7)	Caucasian (n = 3) AAF (n = 3) Other (n = 1)	
	Male (n = 5)	Caucasian (n = 2) AAF (n = 3) Other (n = 0)	
Total (N = 36)			

METHODOLOGICAL LIMITATIONS

Individuals normally become ineligible for HMW benefits within two (2) years because most of this population becomes eligible for Medicare (and thus ineligible for HMW), which limits the state's ability to evaluate the long-term impact of the demonstration. Additionally, no existing data is available for these beneficiaries prior to their enrollment in the HMW to perform a pre-post comparison assessment. DOM was also unable to find a comparable population that had the same eligibility criteria as the HMW population. Reflecting on these limitations the state faced with the HMW population, a one-group posttest only design method was conducted and utilized. The limitation of a non-controlled population hinders a more rigorous and experimental evaluation.

RESULTS

Parham Group, LLC serves as the Independent Evaluator of Mississippi's HMW. Parham Group, LLC and sub-contractor, Dr. Hwanseok Choi, utilized quantitative Cochran-Armitage trend test design analysis and a qualitative survey to conduct an interim evaluation of the impact of the HMW. The following results are organized by the questions and hypotheses as outlined in the evaluation proposal.

Objective 1: Reduce hospitalizations and improper use of the emergency department (ED) by two percent (2%) for the duration of the demonstration.
Evaluation Question 1: How do the rates of inpatient hospitalization and non-emergent use of emergency departments evolve over time among the HMW beneficiaries? Will HMW beneficiaries who access ambulatory and preventive services have fewer hospitalizations and emergency department visits?
Hypothesis 1: The rates of hospitalization and improper use of the emergency department visits will fall among HMW beneficiaries over time, and the HMW beneficiaries will have fewer hospitalizations and emergency department visits after accessing ambulatory and preventive services.

Table 9

DY	Number of beneficiaries under age 75 with at least one inpatient hospitalization	Total Number of Beneficiaries Under age 75	Hospitalization rate of beneficiaries under age 75
15	1,432	8,753	16.36%
16	1,214	7,607	15.96%
17	1,061	7,289	14.55%

Data source: *Cognos HMW Inpatient Visit Analysis Report*

Hospitalization Outcome: The data revealed the number of beneficiaries with hospitalizations decreased by 25.9% (1,432 to 1,061) for demonstration years 15 through 17 as shown in Table 9. To determine if there is a trend in the percentage of beneficiaries

with hospitalizations, a Cochran-Armitage trend test was performed using SAS 9.3. The test results showed that there is a strong trend of reducing number of beneficiaries under age 75 with hospitalizations, (z = -3.08, p = .001) at α = 0.05.

In Table 10, among the total number of beneficiaries under age 75, the number of acute hospitalizations (at least one inpatient stay) for the beneficiaries who had Preventative/Primary care visit before the hospitalizations has decreased from 758 (8.66%) in DY 15 to 699 (9.19%) in DY 16 and to 632 (8.67%) in DY 17. During the three demonstration years, there was a 16.6% reduction from 758 to 632. However, the Cochran-Armitage trend test does not have statistically significant result that there is a negative trend in these percentages (z = 0.09, p = .46) at α = 0.05.

The group of beneficiaries who did not have Preventative/Primary care visit before the hospitalizations also decreased from 674 (7.70%) in DY 15 to 515 (6.77%) in DY 16 and to 429 (5.89%) in DY 17. During the three demonstration years, there was a 36.4% reduction from 674 to 429. Another Cochran-Armitage trend test showed that there is a statistically significant decreasing trend in this group (z = -4.54, p < .001) at α = 0.05. It appears thus far that primary care visits have little or no impact on acute hospitalization reduction. It is possible that the lingering effects of COVID-19 (habit of people staying in more, loss of staffing at treatment facilities, reduced number of treatment facilities because of closings, etc.), has had a prevalent impact on the outcome data for the HMW population. An interview with beneficiaries may be helpful in providing additional insight into what is truly generating the data.

Table 10

DY	Total Number of beneficiaries aged 75 or younger	Number of beneficiaries aged 75 or younger had at least one Inpatient Stay	Preventative/Primary Care Visit before Inpatient Stay	
			Percentage of beneficiaries who had at least one Inpatient Stay over total number of beneficiaries aged 75 or younger for Primary Care Visit group (n_1)	Percentage of beneficiaries who had at least one Inpatient Stay over total number of beneficiaries aged 75 or younger for non-Primary Care Visit group (n_2)
15	8,753	1,432	8.66% (758)	7.70% (674)
16	7,607	1,214	9.19% (699)	6.77% (515)
17	7,289	1,061	8.67% (632)	5.89% (429)

Data source: *Cognos HMW Inpatient Analysis Report*

Emergency Department Outcome: The data in Table 11 below revealed the number of beneficiaries under age 75 with ED utilization decreased by 28.5% (2,689 to 1,923) for demonstration years 15 through 17. To determine if there is a trend in the percentage of beneficiaries with ED visits, a Cochran-Armitage trend test was performed using SAS 9.3. The test results showed that there is a strong trend of decreasing number of beneficiaries under age 75 with ED visits, (z = -6.05, p < .001) at α = 0.05.

Table 11

DY	Number of beneficiaries Under age 75 with at least one ED visit	Total Number of beneficiaries Under age 75	Non emergent ED visit rate of beneficiaries Under age 75
15	2,689	8,753	30.72%
16	2,175	7,607	28.59%
17	1,923	7,289	26.38%

Data source: *Cognos HMW ER Visit Analysis Report*

Table 12 below reflects that the number of ED visits (at least one visit) for the beneficiaries who had Preventative/Primary care visit before the ED visit has decreased from 1,578 (17.87%) in DY 15 to 1,451 (18.92%) in DY 16 and to 1,331 (18.10%) in DY 17. During the three demonstration years, there was a 15.6% reduction from 1,578 to 1,331. The Cochran-Armitage trend test confirmed that there is no statistically significant negative trend in percentages (z = 0.48, p = .32) at α = 0.05.

The group of beneficiaries who did not have Preventative/Primary care visit before the ED visit also decreased from 981 (11.1%) in DY 15 to 724 (9.44%) in DY 16 and to 592 (8.05%) in DY 17. Another Cochran-Armitage trend test showed that there is a statistically significant decreasing trend in the non-primary visit group (z = -6.59, p < .001) at α = 0.05.

Although the number of ED visits after a primary visit decreased by 15.6% over the period, the number of ED visits for those without a primary care visit remains larger for all three demonstration years. Again, there was no statistically significant negative trend in the percentages for the Primary visit group according to the Cochran-Armitage test results whereas for the non-primary visit group, we found a decreasing pattern in ED visit percentages which is statistically significant. Again, according to the data, primary care visits do not seem to have an impact on acute hospitalization reduction. It is possible that the lingering effects of COVID-19 (habit of people staying in more, loss of staffing at treatment facilities, reduced number of treatment facilities because of closings, etc.), has had a prevalent impact on the outcome data for the HMW population. An interview with beneficiaries may be helpful in providing additional insight into what is truly generating the data.

Table 12

DY	Total Number of beneficiaries aged 75 or younger	Number of beneficiaries aged 75 or younger had at least one ED visit	Preventative/Primary Care Visit before ED visits	
			Percentage of beneficiaries who had at least one ED Visit over total number of beneficiaries aged 75 or younger for Primary Care Visit group (n_1)	Percentage of beneficiaries who had at least one ED Visit over total number of beneficiaries aged 75 or younger for Non-Primary Care Visit group (n_2)
15	8,753	2,689	17.87% (1,578)	11.11% (981)
16	7,607	2,175	18.92% (1,451)	9.44% (724)
17	7,289	1,923	18.10% (1,331)	8.05% (592)

Data source: *Cognos HMW ER Visit Analysis Report*

Objective 2: Increase the utilization of ambulatory/preventive health visits by two percent (2%) for the duration of the demonstration.
Evaluation Question 2: Will providing benefits under the HMW demonstration lead to an increase in the utilization of ambulatory/preventive health visits among HMW beneficiaries?
Hypothesis 2: HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits.
Ambulatory/Preventive Outcome: The data revealed the percentage of ambulatory/preventive care visits by beneficiaries compared to the total beneficiary population, age 20 or older, increased 0.7% (79.1% to 79.8%) for demonstration years 15 through 17.

Table 13

DY	Number of Beneficiaries Aged 20 or Older Receiving Ambulatory/Preventive Visits	Total Population	Percentage of Population
15	6,938	8,645	80.25%
16	6,049	7,520	80.44%
17	5,867	7,247	80.96%

Data source: *Cognos HMW Ambulatory Preventive Health Visit Report*

To determine if there is a trend in the percentage of receiving ambulatory/preventive visit among beneficiaries aged 20 or older recorded in Table 13, Cochran-Armitage trend test was performed using SAS 9.3. The test results showed that there is no statistically significant trend (z = 1.10, p = .14) at α = 0.05. The data revealed the percentage of ambulatory/preventive care visits by beneficiaries compared to the total beneficiary population, age 20 or older, increased around 0.7% (80.25% to 80.96%) for demonstration years 15 through 17.

Objective 3: Increase the number of preventive health screenings by one percent (1%) for the duration of the demonstration.
Evaluation Question 3: Will providing benefits under the HMW demonstration result in an increase in age-appropriate preventive screenings?
Hypothesis 3: HMW beneficiaries with access to benefits will have an increase in the utilization of age-appropriate preventive screenings.
Preventive Screenings Outcome: To see whether there is any specific pattern in various exam participants among the beneficiaries during DY 15 through DY 17 with demographic variables, we performed Chi-square tests of independence for categorical variables such as Race and Gender and two independent sample t test for continuous variable, Age. If the equal variance assumption is not satisfied, then Satterthwaite unequal variance t test was performed at α = .05 level. All three DYs data were merged into one dataset to execute these analyses.

Table 14 shows the bivariate analyses for females age 21-64 with cervical cancer screenings. As shown in the table, there are statistically significant relationship between race and screening groups ($\chi^2 = 13.01$, $p < .001$). African American group and Other racial group shows very similar percentages of screening, 6.53% and 6.46% respectively, but Caucasian group has lower screening percentages (4.43%), which makes this statistically significant. Also, cervical cancer screening group is younger than not-getting screening group; 52.53 years old and 54.50 years old respectively ($t = 3.93$, $p < .001$). It is strongly suggested to find solutions to improve Cervical cancer screening percentages of Caucasian female group.

Table 14

Variable	Cervical cancer Screen n (%)/ Mean (SD)		Comparison Test Statistic	*p*
	Yes	No		
Race				
African American	247 (6.53%)	3,534 (93.47%)	$\chi^2 = 13.01$	<0.001 *
Caucasian	113 (4.43%)	2,438 (95.57%)		
Others	37 (6.46%)	536 (93.54%)		
Age	52.53 (10.96)	54.50 (9.61)	$t = 3.93$	<0.001 *

Data source: *Cognos HMW Mammogram, Cervical Cancer, or Colorectal Cancer Screening Report*

Table 15 shows the bivariate analyses for female beneficiaries age 50-74 receiving Mammogram screenings. As shown in the table, there are statistically significant relationship between race and screening groups ($\chi^2 = 11.04$, $p = .004$). African American group and Other racial group shows very similar percentages of screening, 14.98% and 15.29% respectively, but Caucasian group has lower screening percentages (10.40%), which makes this statistically significant. It is strongly suggested to find solutions to improve Mammogram screening percentages of Caucasian female group.

Table 15

Variable	Mammogram n (%)/ Mean (SD)		Comparison Test Statistic	*p*
	Yes	No		
Race				
African American	505 (14.98%)	2,364 (85.02%)	$\chi^2 = 11.04$	0.004 *
Caucasian	283 (10.40%)	2,438 (89.60%)		
Others	74 (15.29%)	410 (84.71%)		
Age	58.96 (4.35)	59.09 (4.30)	$t = 0.82$	0.40

Data source: *Cognos HMW Mammogram, Cervical Cancer, or Colorectal Cancer Screening Report*

Table 16 shows the bivariate analyses for beneficiaries age 50-75 receiving colorectal cancer screenings. As shown in the table, there are statistically significant relationship between race and screening groups ($\chi^2 = 120.26$, $p < .001$). African American group and Caucasian group shows very similar percentages of screening, 10.26% and 11.57% respectively, but other racial group has very low screening percentages (4.67%), which makes this statistically

significant. For the gender variable, male has lower percentages (7.27%) than the female group (9.99%), which makes this significant (χ^2 = 14.03, p = .009). Age does not show any difference.

Table 16

Variable	Colorectal cancer Screen n (%)/ Mean (SD)		Comparison Test Statistic	*p*
	Yes	No		
Race				
African American	348 (10.26%)	3,044 (89.74%)	χ^2 = 120.26	< 0.001 *
Caucasian	303 (11.57%)	2,316 (88.43%)		
Others	184 (4.67%)	3,749 (95.32%)		
Gender				
Female	503 (9.99%)	4,874 (90.01%)	χ^2 =14.03	0.009 *
Male	332 (7.27%)	4,234 (92.73%)		
Age	58.39 (4.41)	58.31 (4.39)	t = 0.49	0.62

Data source: *Cognos HMW Mammogram, Cervical Cancer, or Colorectal Cancer Screening Report*

Objective 4: Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year by two (2%) for the duration of the demonstration.

Evaluation Question 4: Will providing benefits under the HMW demonstration increase the number of annual HbA1c tests among HMW beneficiaries diagnosed with diabetes?

Hypothesis 4: HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.

Hemoglobin A1c Outcome: Table 17 shows the bivariate analyses for beneficiaries age 18-75 with diabetes receiving A1C screenings. As shown in the table, there are statistically significant relationship between race and screening groups (χ^2 = 12.71, p = .002). African American group and Caucasian group shows very similar percentages of screening, 65.55% and 67.22% respectively, but other racial group has relatively low screening percentages (59.11%), which makes this statistically significant. For the gender variable, male has lower percentages (61.27%) than the female group (68.39%), which makes this significant (χ^2 = 35.07, p < .001). The screening group is almost one year older than non-screening group is, and the result shows statistically significant (t = 5.71, p < .001).

Table 17

Variable	A1C Screen n (%)/ Mean (SD)		Comparison Test Statistic	*p*
	Yes	No		
Race				
African American	2,451 (65.55%)	1,288 (34.45%)	χ^2 = 12.71	0.002 *
Caucasian	1,528 (67.22%)	745 (32.78%)		
Others	318 (59.11%)	220 (40.89%)		

Gender				
Female	2,728 (68.39%)	1,261 (31.61%)	χ^2 = 35.07	< .001 *
Male	1,569 (61.27%)	992 (38.73%)		
Age	55.60 (8.02)	54.73 (8.83)	t = 5.71 ł	< .001 *

Data source: *Cognos HMW Diabetes and A1c Test or Eye Exam Report*

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

Evaluation Question 5: Will providing benefits under the HMW demonstration increase the number of annual dilated eye examinations among HMW beneficiaries diagnosed with diabetes?

Hypothesis 5: HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.

Dilated Eye Examination Outcome: Table 18 shows the bivariate analyses for beneficiaries age 18-75 with diabetes receiving dilated eye examinations. As shown in the table, there are statistically significant relationship between race and eye exam groups (χ^2 = 18.21, p < .001). African American group and Other racial group show very similar percentages of exam, 31.53% and 29.74% respectively, but Caucasian group has very low exam percentage (26.35%), which makes this statistically significant. For the gender variable, male has lower percentages (24.37%) than the female group (32.94%), which makes this significant (χ^2 = 55.05, p < .001). Age does not show any significance.

Table 18

Variable	**Eye Exam n (%)/ Mean (SD)**		**Comparison Test Statistic**	***p***
	Yes	**No**		
Race				
African American	1,179 (31.53%)	2,560 (68.47%)	χ^2 = 18.21	< .001 *
Caucasian	599 (26.35%)	1,674 (73.65%)		
Others	160 (29.74%)	378 (70.26%)		
Gender				
Female	1,314 (32.94%)	2,675 (67.06%)	χ^2 = 55.05	< .001 *
Male	624 (24.37%)	1,937 (75.63%)		
Age	55.85 (8.03)	55.44 (8.45)	t = 1.79	0.074

Data source: *Cognos HMW Diabetes and A1c Test or Eye Exam Report*

ł: Satterthwaite unequal variance t test was performed.

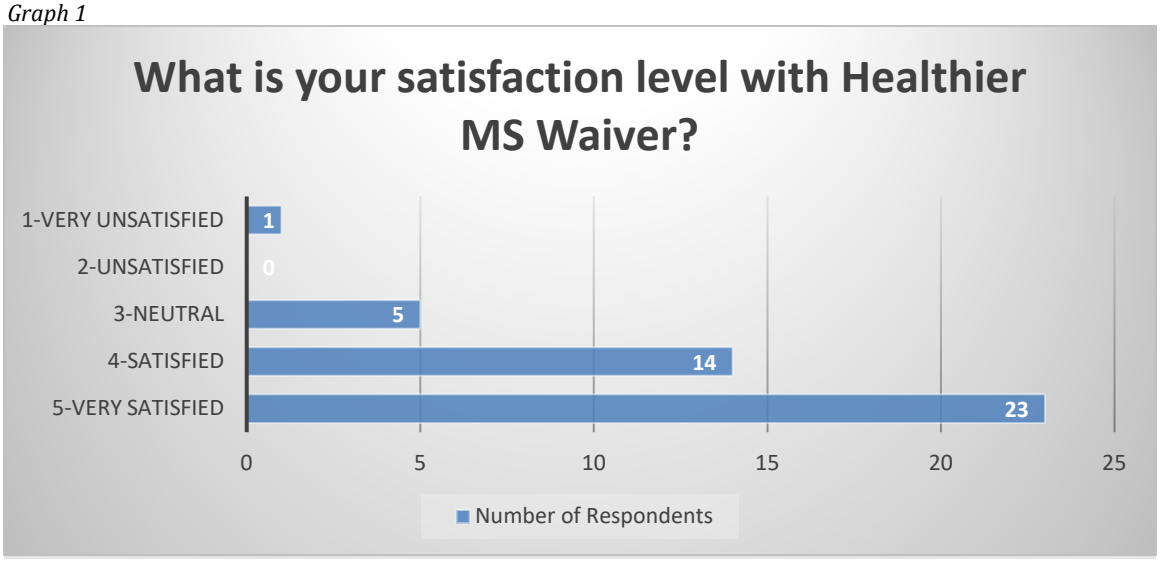
*: At 0.05 significance level, the test result is statistically significant.

Frequencies and percentages were reported for all the outcome variables which are descriptive statistics for categorical variables. Continuous variables such as blood pressure, body temperature, etc., were not available to report mean and standard deviation. The outcome variables are all categorical variables.

Evaluation Question 6: Are HMW beneficiaries satisfied with the demonstration services?
Hypothesis 6: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.

Beneficiary Satisfaction Outcome: The 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 access comprehensive dental services. State Plan benefits have limitations on dental services for adults. Overall, 86% of respondents answered to this question either satisfied or very satisfied with the waiver services/supports.

Graph 1



CONCLUSIONS

The goal of reducing hospitalizations and ED utilization among HMW beneficiaries was successful, however being able to meet the goals of increasing the utilization of ambulatory/preventive health visits, increasing preventive screenings and follow up treatment for chronic conditions, were drastically reduced by the COVID-19 pandemic. Fear of contracting the virus and stay at home orders resulted in a delay or cancelation of less urgent services.

Table 17: Interim Conclusions

Objectives	Outcomes	Goal Status
Reduce hospitalizations and improper use of the emergency department (ED) by two percent (2%) for the duration of the demonstration.	Hospitalizations decreased by 25.9% and ED visits decreased by 28.5% over the demonstration period.	Successful
Increase the utilization of ambulatory/preventive health visits by two percent (2%) for the duration of the demonstration.	The percentage of ambulatory/preventive care utilization increased by 0.7% over the demonstration period.	Unsuccessful
Increase the number of preventive health screenings by one percent (1%) for the duration of the demonstration.	Female beneficiaries who received cervical cancer screenings decreased, female beneficiaries who received mammogram testing for breast cancer decreased, and beneficiaries who received colorectal cancer screenings decreased over the demonstration period.	Unsuccessful
Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year by two percent (2%) for the duration of the demonstration.	The percentage of beneficiaries with diabetes who have a dilated eye exam decreased over the evaluation period.	Unsuccessful
Increase the percentage of beneficiaries with diabetes who have a dilated eye exam by four percent (4%) over the demonstration period.	The percentage of adults with diabetes who received an annual dilated eye exam did not significantly increase over the demonstration period.	Unsuccessful

INTERPRETATIONS, POLICY IMPLICATIONS AND INTERACTIONS

Mississippi's interpretations from the interim evaluation conducted are as follows:

1. The enrollment for the demonstration has experienced a continued decline as discovered during the interim assessment.

2. The state recognizes a major contributing factor of not meeting the goal of increasing age-related preventive screenings and improving the targeted percentages over time might be the recommended frequency of the screenings and the limited time beneficiaries are enrolled in the HMW, which is an average of two (2) years. The recommend frequency for breast cancer screening is once every two (2) years, cervical cancer screening once every three (3) years, and colorectal screening once every five (5) to ten (10) years.

There are no policy implications identified that would impact the demonstration. The HMW demonstration is the state's approach to providing comparable benefits and access to care to individuals who would not qualify for traditional state plan benefits.

LESSONS LEARNED AND RECOMMENDATIONS

Achieving the goal of increasing preventative screenings at this time is unlikely. Most of the age-related screenings are recommended every 2 to 3 years or more, and the majority of the HMW population are awaiting Medicare eligibility and will most likely not be enrolled in the program more than 2 years. Additionally, the number of HMW Waiver enrollees continues to decline, which may be attributed to limited community outreach during the public health emergency and general lack of awareness about the waiver including what services are provided and who is eligible.

We anticipate that the lingering effect of COVID-19 (habit of people staying in more, not going to necessary preventive treatments, loss of staffing at treatment facilities, reduced number of treatment facilities because of closings, etc.), has had a prevalent impact on the outcome data for the HMW population. An interview with beneficiaries who did not have a preventive care visit, for example, also may be helpful in providing additional insight into what is truly generating the data.

ATTACHMENT A

Healthier Mississippi Project

Section 1115 Demonstration

Project Number 11-W-00185/4

Evaluation Design

April 15, 2020

550 High Street, Suite 1000
Jackson, Mississippi 39201
Website: medicaid.ms.gov

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

Table of Contents

I. Historical Background of the Demonstration 28

II. Demonstration Goals and Evaluation Hypotheses and Research Questions 29

Methodology 32

Evaluation Design 6

Target and Comparison Populations 6

Evaluation Period 7

Table 1: Evaluation Outcomes Measures 33

Data Sources 35

Analytic Methods 36

IV. Methodological Limitations 41

V. Special Methodological Considerations 41

Attachment I: Independent Evaluator 42

Attachment II: Evaluation Budget 43

Attachment III: Timeline and Major Milestones 44

Attachment IV: Healthier Mississippi Waiver Baselines 45

Attachment V 46

Healthier Mississippi Project
Section 1115 Demonstration
Project Number 11-W-00185/4

Evaluation Design
April 15, 2020

I. Historical Background of the Demonstration

Legislation passed during the Mississippi 2004 Legislative Session discontinued the optional Poverty Level Aged & Disabled (PLAD) category of eligibility, effective June 30, 2004. Due to concerns that this population was at risk for costly adverse events, such as institutional placement if medical regimens were not maintained, the state applied and received approval for a section 1115 demonstration to continue coverage for this population. The Healthier Mississippi Waiver (HMW) was originally 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 HMW demonstration continued to operate under a series of temporary approvals for an additional five (5) years from October 1, 2009 through July 23, 2015. The Division of Medicaid received an approval for a five (5) year extension for the period of July 24, 2015 through September 30, 2018. Beginning with the July 24, 2015 through September 30, 2018 extension, the HMW enrollment limit increased from 5,500 to 6,000 and provided coverage for podiatry, eyeglasses, dental, and chiropractic services which were excluded from previous demonstration years. Currently, the demonstration's special terms and conditions (STCs) are approved from October 1, 2018 through September 30, 2023. There were no changes in the eligibility requirements or covered services from the previous demonstration.

Eligibility for the Healthier Mississippi demonstration is limited to aged, blind, or disabled individuals who are not eligible for Medicare, do not qualify for Medicaid, and are not in a long-term care institution, and whose:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple calculated using a methodology based on the Supplemental Security Income (SSI) program, as well as income exclusions approved under the State Plan under the authority of Section 1902(r)(2) of the Social Security Act, and
- Resources are below $4,000 for an individual and $6,000 for a couple.

Children (ages 0 through 20) enrolled in the demonstration receive all Medicaid state plan benefits, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT). Adults (ages 21 and older) enrolled in the demonstration receive all services covered under the

Medicaid state plan with the same service limits with the exception of the following services:

- Long-term care services (nursing facility, home and community-based waiver, and Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) services),
- Swing bed services in a skilled nursing facility, and
- Maternity and newborn care services.

HMW beneficiaries who require long-term care, swing bed services in a skilled nursing facility, or maternity and newborn care services would qualify for Medicaid and, therefore, would be deemed ineligible for the waiver. HMW enrollees are assigned to a specific category of eligibility (045) to ensure the population is easily identifiable and to ensure the number of enrollees does not exceed the cap of 6,000.

II. Demonstration Goals and Evaluation Hypotheses and Research Questions

Mississippi Medicaid intends to measure the performance of the demonstration goals through the following quantifiable target percentages. These percentages were determined by using the percent change for demonstration years 12 through 14 (fiscal years 2016-2018):

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

The hypotheses and research questions listed below promote the objectives of Title XIX by:

- Providing payments for medical assistance to low-income aged, blind, and disabled individuals, not eligible for Medicaid or Medicare; and
- Providing access to needed medical services.

Evaluation Question 1: How do the rates of inpatient hospitalization and non-emergent use of emergency department visits evolve over time among the HMW beneficiaries? Will

HMW beneficiaries who access ambulatory and preventive services have fewer hospitalizations and emergency department visits?

Hypothesis 1: The rates of hospitalization and improper use of the emergency department visits will fall among HMW beneficiaries over time, and the HMW beneficiaries will have fewer hospitalizations and emergency department visits after accessing ambulatory and preventive services.

Evaluation Question 2: Will providing benefits under the HMW demonstration lead to an increase in the utilization of ambulatory/preventive health visits among HMW beneficiaries?

Hypothesis 2: HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits.

Evaluation Question 3: Will providing benefits under the HMW demonstration result in an increase in age-appropriate preventive screenings?

Hypothesis 3: HMW beneficiaries with access to benefits will have an increase in the utilization of age-appropriate preventive screenings.

Evaluation Question 4: Will providing benefits under the HMW demonstration increase the number of annual HbA1c tests among HMW beneficiaries diagnosed with diabetes?

Hypothesis 4: HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.

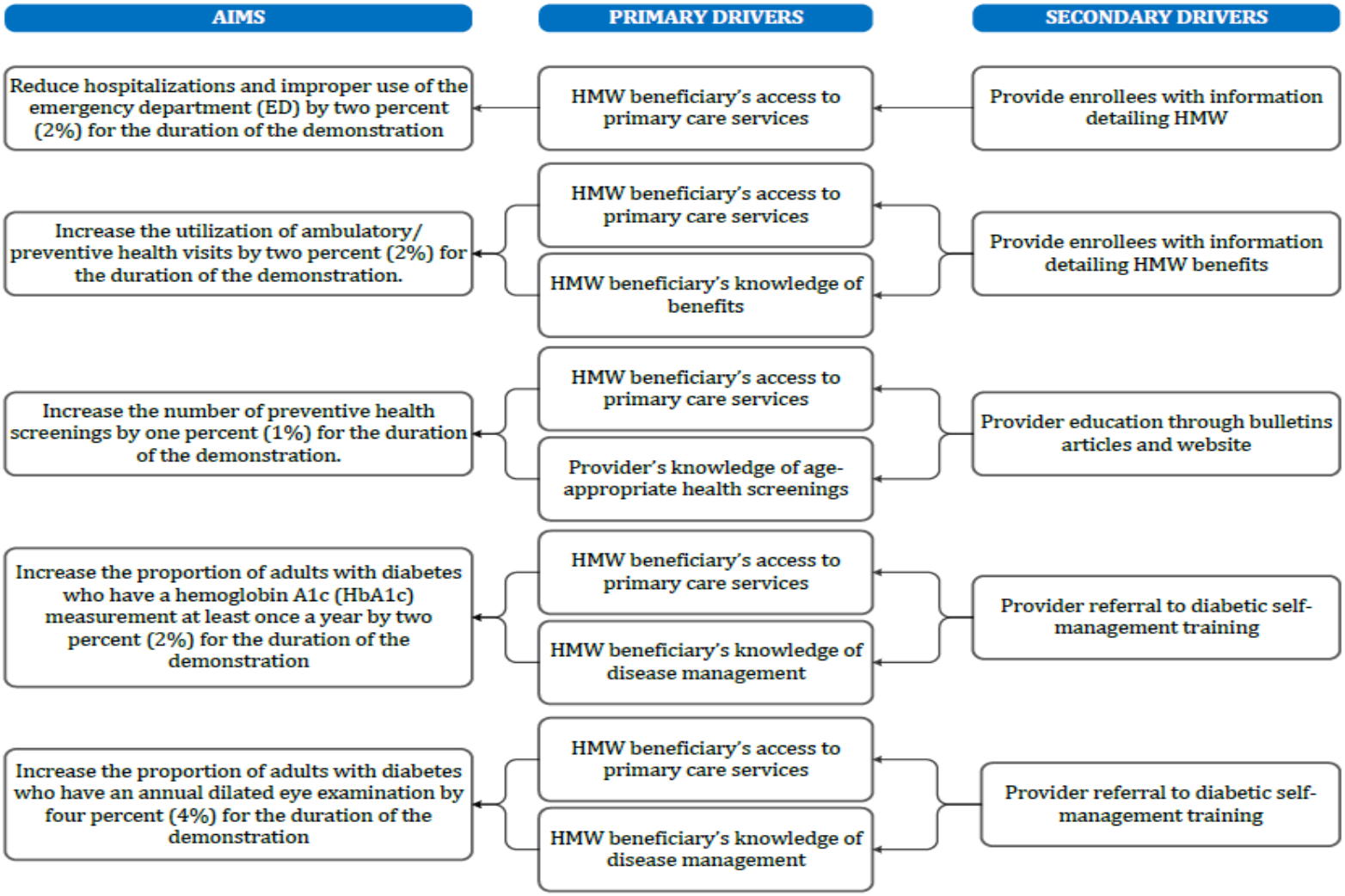
Evaluation Question 5: Will providing benefits under the HMW demonstration increase the number of annual dilated eye examinations among HMW beneficiaries diagnosed with diabetes?

Hypothesis 5: HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.

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

Hypothesis 6: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.

III. Healthier Mississippi Waiver Driver Diagram



Methodology

Evaluation Design

This evaluation will assess the performance of the demonstration goals using a one-group posttest-only design of HMW beneficiaries and their utilization of the available services provided under the HMW benefit plan. Also, the trend analysis will incorporate appropriate statistical testing to show if changes over time are statistically significant. Qualitative findings from three focus groups and key informant interviews will be used to complement and contextualize the descriptive quantitative analyses.

All findings over the period of the demonstration will be assessed against the target goals for changes in service utilization outlined under the objectives of the demonstration for the current period of performance in Section II above.

Target and Comparison Populations

The target population is individuals that are aged, blind, or disabled who are not eligible for Medicare or Medicaid, not in a long-term care institution, and whose:

- Income is at or below 135% of the Federal Poverty Level (FPL) for an individual or a couple calculated using a methodology based on the SSI program, as well as income exclusions approved under the State Plan under the authority of Section 1902(r)(2) of the Social Security Act, and
- Resources are below $4,000 for an individual and $6,000 for a couple.

The state was unable to determine a population that was comparable to the HMW population; therefore, the state is using data from demonstration years 12 through 14 (FY 16-18) to analyze trends.

Evaluation Period

The evaluation will be conducted for the demonstration period of October 1, 2018, through September 30, 2023.

Table 1: Evaluation Outcomes Measures

Metric	Description	Numerator/Denominator
Inpatient hospitalization rate	Beneficiaries under age 75 who had at least one acute care hospitalization during the measurement year	Number of HMW beneficiaries under age 75 with at least one inpatient hospitalization during the measurement year/Number of beneficiaries under age 75 during the measurement year
Non-emergent use of emergency department	Beneficiaries under age 75 who had at least one non-emergent ED visit during the measurement year	Number of HMW beneficiaries under age 75 with at least one non-emergent ED visit during the measurement year/Number of beneficiaries under age 75 during the measurement year
Inpatient hospitalization rate for beneficiaries who access ambulatory and preventive services	Number of hospitalizations for beneficiaries under age 75 who had at least one acute care hospitalization, who also accessed ambulatory and preventive services during the measurement year	Number of hospitalizations for HMW beneficiaries under age 75 that accessed ambulatory and preventive services during the measurement year/Number of hospitalizations for HMW beneficiaries under age 75 during the measurement year
Emergency department rate for beneficiaries who access ambulatory and preventive services	Number of ED visits for beneficiaries under age 75 who accessed ambulatory and preventive services during the measurement year	Number of ED visits for beneficiaries under 75 that accessed ambulatory and preventive services during the measurement year/Number of ED visits for HMW beneficiaries under age 75 during the measurement year
Ambulatory/Preventive Health Visits	Percentage of beneficiaries age 20 years and older who had at least one ambulatory or preventive care visit per year	Number of beneficiaries 20 and older who had at least one ambulatory or preventive care visit during the measurement year/Number of HMW 20 and older during the measurement year
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more Pap test to screen for cervical cancer	Number of HMW women, ages 21-64, who received screenings for cervical cancer during the measurement year/Number of HMW women 21-64 years of age during the measurement year
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer once during the measurement year	Number of HMW women, ages 50-74, who had a mammogram during the measurement year/ Number of women, ages 50-74, during the measurement year
Colorectal Cancer Screening	Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer	Number of HMW beneficiaries, ages 50-75, who received screenings for colorectal cancer during measurement year/ Number of HMW beneficiaries, ages 50-75 during the measurement year
Comprehensive Diabetes Care: Eye Exam	Percentage of beneficiaries 18-75 years of age with diabetes who had a	Number of HMW beneficiaries, ages 18 – 75, with diabetes who had a retinal or dilated eye exam during the measurement

	retinal or dilated eye exam during the measurement period	period/Number of HMW beneficiaries ages 18 - 75 with diabetes during the measurement year
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	The percentage of beneficiaries 18-75 years of age with diabetes who received an HbA1c test during the measurement year	Number of HMW beneficiaries, ages 18-75, with diabetes who received an HbA1c test during the measurement year/Number of HMW beneficiaries ages 18-75 with diabetes during the measurement year

Data Sources

The data will come from Medicaid claims, which are housed in the Medicaid Management Information Systems (MMIS) and Division Support System (DSS). DOM will carefully review claims data to ensure the best available data is used for reporting purposes. Data for the evaluation will be processed and validated throughout the demonstration period.

Additionally, to contextualize and support the quantitative data analysis, we plan to use focus groups as a means to learn more in-depth about the beneficiary experience of the Healthy Mississippi Waiver. This will help gauge information on participant perception of their health, how they think the demonstration is helping with their specific health issues, and their experience with service delivery and access to care. The participants will be recruited accounting for geographic, race/ethnicity, age, tenure, and other relevant diversity criteria. A complete account of the participant selection criteria and recruitment protocol will be included in the demonstration's interim and summative evaluation reports.

To ensure the validity of the findings, our effort will adhere to the key principles of focus group methodology:

(1) Remain neutral and unbiased in recruitment, questions development, and analysis;
(2) Design strategies maximize the diversity of experiences represented;
(3) Maintain consistency throughout the focus group process; and
(4) Adhere to ethical obligation of confidentiality and informed consent.

The use of focus groups as a research tool to explore a particular topic by gathering the experiences and perceptions of a selected target population has certain advantages over other information gathering methods, such as (a) producing results more quickly, (b) group interaction is generally more comfortable for participants, (c) offers increased flexibility allowing the participant to individualize responses and researchers to probe deeper on particular points, (d) results are generally easier to understand than statistical findings, and (e) they complement more structured quantitative data.[1]

In order to facilitate the focus group activities, we plan to ask key informants, such as Medicaid administrators, service/support providers, advocates, and perhaps family members, to constitute a focus group advisory committee. The committee will help to:

(1) Refine the scope of the focus groups for clear project description;

[1] Ward, Helen and Atkins, Julie. 2002. "From Their Lives: A Manual on How to Conduct Focus Groups of Low-Income Parents." University of Southern Maine. Accessed on March 22, 2020 at: https://digitalcommons.usm.maine.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1100&context=facbooks.

(2) Draft questions needed to facilitate participant discussion around the goals;
(3) Recommend a recruitment protocol and plan;
(4) Develop appropriate support materials (scripts for recruitment and question delivery, consent, registration, and other forms, etc.);
(5) Identify appropriate focus group scheduling options;
(6) Determine if and what incentives should be utilized; and
(7) As key informants, to provide insightful feedback supporting Interpretations of both the quantitative findings and the information gathered from the focus groups.

Approximately two weeks after a sufficient number of the target population has successfully been recruited, the first focus group will be implemented. To facilitate convenience and thus, attendance, there will be in-person focus groups in three locations (north, central, and south) in the state. Approximately 14-16 participants will be recruited and confirmed for each group with the goal of having approximately eight beneficiaries participating in each. Staffing each focus group will be a primary facilitator, secondary facilitator, and a designated note-taker (that supports the electronic recording). A total of approximately 8-9 engagement, exploratory, and exit questions will be used to help participants get comfortable, acquire useful information, and solicit any additional comments. It is anticipated that each focus group session will last 60 - 90 minutes. A staff debriefing will occur after each session to provide guidance for subsequent sessions and identify any departures from protocol and to assess the group process. A final report of focus group findings will be drafted, analyzed, and included in the evaluation report for the demonstration. Progress of focus group activities and a summary of key findings will also be incorporated in the relevant monitoring reports due to CMS. If recommended by the advisory committee and authorized by the state, we plan to use an incentive (gift card or such) to promote and facilitate participation in the focus groups.

To better contextualize the quantitative data analysis, we plan to conduct the focus groups after we have initial indications of our quantitative findings. This way, we will be able to refine the scope and questions for focus groups further. It is anticipated that the focus group activities will begin in the first quarter of 2022, take approximately seven months to complete, and findings made part of the Interim Evaluation Report due in September later that year. A tentative timeline is illustrated in Attachment V of this document.

Analytic Methods

Proposed methods for addressing the evaluation questions and hypotheses of the demonstration are described in the following table.

The effects of the demonstration are isolated from other initiatives occurring in the state, as there are no other initiatives in Mississippi for this population. Enrollees in the HMW are not eligible for Medicaid.

Table 2: Summary of Evaluation Hypotheses, Research Questions, Outcome Measures, Population, Data Sources, and Analytic Approaches

Research Question	Outcome Measure(s)	Population	Data Sources	Analytic Approach
Hypothesis 1: The rates of hospitalization and improper use of the emergency department visits will fall among HMW beneficiaries over time, and the HMW beneficiaries will have fewer hospitalizations and emergency department visits after accessing ambulatory and preventive services.				
How do the rates of inpatient hospitalization and non-emergent use of emergency department visits evolve over time among the HMW beneficiaries? Will HMW beneficiaries who access ambulatory and preventive services have fewer hospitalizations and emergency department visits?	Emergency department visit and inpatient hospitalization Emergency department visit and inpatient hospitalization for beneficiaries who access ambulatory and preventive services	• Beneficiaries under age 75 • Beneficiaries under age 75 who access ambulatory and preventive services at least once during the past six months	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (Central tendency measures such as mean and median; variability measures, such as standard deviation and range) Also, include subgroup analysis; compare beneficiaries under age 75 who had used ambulatory and preventive services at least once during the measurement year and those that did not. Regression adjusted trend analysis to show whether there is any noticeable pattern during the span of the demonstration.
Hypothesis 2: HMW beneficiaries with access to benefits under the HMW demonstration will have an increase in the utilization of ambulatory/preventive health visits.				

Research Question	Outcome Measure(s)	Population	Data Sources	Analytic Approach
Will providing benefits under the HMW demonstration lead to an increase in the utilization of ambulatory/ preventive health visits among HMW beneficiaries?	Percentage of beneficiaries ages 20 and older who had at least one ambulatory/preventive visit during the measurement year	HMW beneficiaries ages 20 and older	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measures such as mean and median; variability measures, such as standard deviation and range) Statistical tests will include (1) McNemar test Cochran-Armitage test for trends), or regression adjusted trend analysis to show whether there is any noticeable pattern during the span of the demonstration.

Research Question	Outcome Measures	Population	Data Sources	Analytic Methods
Hypothesis 3: HMW beneficiaries with access to benefits will have an increase in the utilization of age-appropriate screenings.				
Will providing benefits under the HMW demonstration result in an increase in age appropriate screenings?	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer once during the measurement year	HMW women 50-74 years of age	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measure, such as mean and median; variability measures, such as standard deviation and range) Statistical tests will include McNemar test or multiple regression.
	Percentage of women 21-64 years of age received one or more Pap test to screen for cervical cancer	HMW women 21-64 years of age		
	Percentage of beneficiaries 50-75 years of age who had appropriate screening for colorectal cancer	HMW beneficiaries 50-75 years of age		
Hypothesis 4: HMW beneficiaries diagnosed with diabetes are more likely to have an annual HbA1c test performed as a result of having access to HMW benefits.				

Research Question	Outcome Measures	Population	Data Sources	Analytic Methods
Will providing benefits under the HMW increase the number of annual HbA1c tests among HMW beneficiaries diagnosed with diabetes?	Percentage of beneficiaries 18-75 years of age with diabetes (Type 1 and Type 2) who received an HbA1c test during the measurement year.	HMW beneficiaries 18-75 years of age with a diabetes diagnosis	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measures such as mean and median; variability measures, such as standard deviation and range). Statistical tests will include McNemar test/ Cochran-Armitage tests for trends or multiple regression.
Hypothesis 5: HMW beneficiaries diagnosed with diabetes are more likely to have an annual dilated eye examination as a result of having access to HMW benefits.				
Will providing benefits under the HMW demonstration increase the number of annual dilated eye examinations among HMW beneficiaries diagnosed with diabetes?	Percentage of beneficiaries 18-75 years of age with diabetes who had a retinal or dilated eye exam during the measurement year	HMW beneficiaries 18-75 years of age with a diabetes diagnosis	Medicaid Fee for Service (FFS) claims data Enrollment data	Descriptive statistics (central tendency measures such as mean and median; variability measures, such as standard deviation and range). Statistical tests will include McNemar test/ Cochran-Armitage tests for trends.
Hypothesis 6: HMW beneficiaries are more likely to report being satisfied than not with the benefits under the demonstration.				
Are HMW beneficiaries satisfied with the demonstration services?	Beneficiary experience with demonstration services and benefits	HMW beneficiaries who participate in focus groups	Focus group findings and key informant interviews	Transcribed reports of focus group comments, systematic, manually-driven analysis of focus group findings supported by key informant interviews.

IV. Methodological Limitations

The HMW was designed to provide health care coverage to ABD individuals that do not qualify for Medicaid State Plan or Medicare. Within two (2) years, the majority of this population becomes eligible for Medicare (and thus ineligible for HMW), which limits the state's ability to evaluate the long-term impact of the demonstration. Additionally, no existing data is available for these beneficiaries prior to their enrollment in the HMW to perform a pre-comparison assessment. DOM was also unable to find a comparable population that had the same eligibility criteria as the HMW population. Reflecting on these limitations the state faces with the HMW population, a one-group posttest only design method will be conducted and utilized.

It is planned to use results from beneficiary focus groups to complement and contextualize the quantitative findings.

V. Special Methodological Considerations

DOM would like CMS to take into consideration the limitations listed above when reviewing the evaluation draft for scientific and academic rigor. DOM will rely on a non-experimental design because of the following reasons:

- There is no comparison group for this population that has been identified for this evaluation;
- A cause and effect relationship among HMW beneficiaries cannot be demonstrated; and
- Due to the lack of control population, DOM can only rely on interpretation and observations to draw a conclusion about the effectiveness of the HMW demonstration over time.

Attachment I: Independent Evaluator

As a result of a recent request for quotes, the Division of Medicaid (DOM) has secured the services of an independent evaluator and executed a professional services contract on June 18, 2019 with the Parham Group, LLC, and its sub-contractor, Dr. Hwanseok Choi.

The contractor has worked specifically with the evaluation and analysis of Federal and State programs for 17 years, including evaluation and support services with the DOM waiver-related programs: MYPAC, Money Follows the Person (B2i), and Person-centered Practices Training for waiver providers. Dr. Choi is an Associate Professor in the School of Health Professions at the University of Southern Mississippi and holds a Ph.D. in Applied Statistics from the University of Alabama. For over 16 years, Dr. Choi has participated in the design, data entry design, data coding, data editing, analysis, and statistical reporting on nearly 100 studies using multiple statistical packages such as SAS, SPSS, STATA, and ArcGIS.

DOM has measures in place to assure that the independent evaluator will conduct a fair and impartial evaluation, prepare an objective evaluation report and that there is no conflict of interest. The primary means employed by the State to accomplish these goals are the contract and contract monitoring process. DOM will ensure compliance through the use of carefully crafted contractual language outlining benchmarks, report due dates, and the use of approved methods. With these measures in place, DOM will be able to monitor the independent evaluator's progress while maintaining a "no conflict of interest" status. DOM has also specified that any subcontractor who is involved in the demonstration will have to be approved by DOM. DOM has approved both the contractor and sub-contractor for this project.

Attachment II: Evaluation Budget

We estimate the total cost of the evaluation for the waiver approval period at $59,500 for the demonstration. The staffing, data collection, and administrative costs are listed in the accompanying table and described below.

Line Item	Components of Budget	Line Item Cost
1	Estimated staff	$58,000
2	Focus Group implementation and other misc. administrative costs	$1,500
	Total Amount	$59,500

Staffing

Project Director
Project Director will have overall responsibility for the evaluation, including the developing the evaluation design and data collection instruments, overseeing evaluation staff and analysis of the claims and survey data, and preparing the annual reports.

Associate Project Director
Associate Project Director will provide guidance on the evaluation design and data collection instruments and will assist with data analysis and conceptualizing results for the annual report, based on their experience as the lead evaluator.

Statistical Analyst
Statistical Analyst will be responsible for data management, data cleaning and analyzing the enrollment, claims and survey data for the annual reports.

Dissemination/Special Project Coordinator
Dissemination/Special Project Coordinator will coordinate the administration of the annual surveys with a Survey Research Unit, prepare protocols for review, and assist with preparing the annual reports.

Focus Group Implementation
With significant input from a newly developed advisory committee (composed primarily of key informants) the independent evaluator team will organize, develop, and implement three planned beneficiary focus groups and provide a written report that synthesizes findings and analyzes results.

Attachment III: Timeline and Major Milestones

Deliverable	Timeline	Projected Submission Date
Annual Monitoring Report	Within 90 days following the end of each demonstration year	December 31, 2019
Draft Evaluation Design Plan	Within 120 days after the approval of the demonstration extension	January 25, 2019
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	Pending CMS Comment Period
Interim Evaluation Reports	With submission of a demonstration extension request.	September 30, 2022
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs.	March 31, 2025

Attachment IV: Healthier Mississippi Waiver Baselines

Criteria	FFY16	FFY17	FFY18	Average	Percent Change
Colorectal Screening (Age 50-75)					
Eligible	6,422	6,523	6,535	6,493	
No. Received	668	680	700	683	
% of Population Received Screening	10.4%	10.4%	10.7%	10.5%	0.96%
Cervical Screening (Females, Age 21-64)					
Eligible	4,619	4,726	4,692	4,679	
No. Received	440	422	439	434	
% of Population Received Screening	9.5%	8.9%	9.4%	9.3%	-0.35%
Mammogram (Females, Age 50-74)					
Eligible	3,550	3,639	3,626	3,605	
No. Received	634	802	793	284	
% Received Screening	17.9%	22%	21.9%	20.6%	7.45%
Ambulatory/Preventive Visit (Age ≥20)					
Eligible HMW Beneficiaries	8,570	8,738	8,742	8,683	
No. Received	6,752	6,846	6,916	6,838	
% Received Screening	78.8%	78.3%	79%	78.7%	0.08%
Diabetic & Annual A1c Test (Age 18-75)					
Eligible	2,285	2,344	2,305	2,311	
No. Received	1,552	1,648	1,626	1609	
% Received Test	68%	70.3%	71%	69.8%	1.47%
Diabetic & Annual Dilated Eye Exam (Age 18-75)					
Eligible	2,285	2,344	2,305	2,311	
No. Received	593	655	678	642	
% Received Exam	26%	28%	29%	27.7%	3.85%

Emergency Department (ED) Visits

0.47% Change	FFY 16 *(n=5,809)*		FFY 17 *(n=5,911)*		FFY 18 *(n=5,891)*	
≥1 Preventive/ Primary Care Visit	# Visits (% of Total Visits)	Recipient Count	# Visits (% of Total Visits)	Recipient Count	# Visits (% of Total Visits)	Recipient Count
Yes	3,330 (57.3)	1,651	3,396 (57.5)	1,675	3,611 (61.3)	1,746
No	2,479 (42.7)	1,320	2,515 (42.5)	1,385	2,280 (38.7)	1,313

Hospitalizations (HMW Beneficiaries <75)

1.93% Change	FFY 16 *(n=2,328)*		FFY 17 *(n=2,460)*		FFY 18 *(n=2,463)*	
≥1 Preventive/ Primary Care Visit	# of Inpatient Claims	Recipient Count	# of Inpatient Claims	Recipient Count	# of Inpatient Claims	Recipient Count
Yes	1,263 (54.3)	802	1,306 (53.1)	807	1,374 (55.8)	865
No	1,065 (45.7)	767	1,154 (46.9)	802	1,089 (44.2)	788

Attachment V

Estimated Timeline for Conducting Focus Group Activities

ACTIVITY	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Plan and Organize							
▪ Establish the project Adv. Com.							
▪ Identify goals							
▪ Identify project description							
▪ Develop 10-12 group questions							
▪ Establish operating protocols							
▪ Develop materials/forms							
Recruitment							
▪ Identify diverse sample							
▪ Establish procedure							
▪ Decide on if and what incentive							
▪ Develop recruitment script							
▪ Recruit 32-36 participants							
Implementation							
▪ Focus group script /protocol							
▪ Reminders sent out							
▪ Dry run through/tweak as needed							
▪ Staffing in place							
▪ Transportation set							
▪ Site preparation and set up							
▪ Electronic recording and manual note-taking in place							
▪ Conduct focus groups (3)							
▪ Staff debrief of meeting and adjust as needed							
Analysis and Reporting							
▪ With support from the Advisory Committee, prepare a manually-driven, written report that synthesizes findings and analyzes the results of the three focus groups.							
▪ Incorporate the focus group findings report into the interim evaluation report.							