Healthier Mississippi Waiver

Section 1115 Annual Report

Demonstration Reporting Period:

Demonstration Years: 1-12 (10/01/2004 – 9/30/2016)
Federal Fiscal Year 2016 (10/01/2015 – 09/30/2016)

Introduction:

The Healthier Mississippi Waiver (HMW) Demonstration Program, Section 1115, 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. Since then, the demonstration was approved for renewal and under a series of temporary approvals for an additional five (5) year period beginning October 1, 2009, through July 23, 2015. Currently the demonstration has been approved for renewal effective July 24, 2015, through September 30, 2018 with the following changes: (1) an increase in the enrollment limit from 5,500 to 6,000 and (2) coverage of podiatry, eyeglasses, dental, and chiropractic services which were excluded from previous demonstration years.

The HMW Demonstration Program allows Mississippi 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 to individuals with income up to one hundred and thirty five percent (135%) of the federal poverty level (FPL) who are aged or disabled, are not eligible for Medicare, and are not eligible under the Medicaid state plan. The Mississippi Division of Medicaid (DOM) expects to achieve the following to promote the objectives of Title XIX:

- Increase access to primary and preventive services to reduce hospitalizations, premature nursing facility placements, and improper use of the emergency department, and
- Slow the deterioration of health status for the demonstration population.

<u>Accomplishments</u>

Through the HMW, DOM ensured access to services for 7,750 beneficiaries during federal fiscal year (FFY) 2016. Without the HMW the 7,750 beneficiaries, not eligible for Medicare and do not qualify for Medicaid, would not have received medically necessary services.

Coverage of podiatry, eyeglasses, dental, and chiropractic services, excluded from the previous demonstration years, ensures access to services to treat conditions caused by other disease processes, particularly diabetes.

<u>Project Status</u>

At the end of FFY 2016 there were 4,669 beneficiaries enrolled in the HMW. Current enrollment is well below the 6,000 beneficiary enrollee limit. During the past two (2) years of the renewal, the financial/budget neutrality reporting format was revised to only report Population 1 (Medicaid only) and not Population 2 (prior enrollees). The demonstration

met the budget neutrality for demonstration year 12 with actual expenditure of $832,608,978 compared to a cumulative budget neutrality expenditure limit of $1,178,961,321.

Quantitative and case study findings

Objective 1: Access to medical services will reduce the rate of inpatient hospitalization admissions for participants with specific ambulatory sensitive conditions that can often be managed in an outpatient setting.

In FFY15 there were 555 preventable inpatient hospitalizations. In FFY16 there were 812 preventable inpatient hospitalizations. Access to preventive and primary care services in the outpatient setting resulted in an increase in beneficiary inpatient hospital admissions for preventable conditions in FFY16. Although the actual percentage rate increased for preventable stays, there was a decrease in total expenditures of $5,441,581.88 for FFY16 compared to FFY15.

Federal Fiscal Year	Number of Beneficiaries with Inpatient Hospitalization	Number of Beneficiaries with Preventable Inpatient Hospitalization	Percent of Beneficiaries with Preventable Inpatient Hospitalization	Number of Inpatient Hospitalizations	Number of Preventable Hospitalizations	Costs Attributable to Preventable Hospitalizations	Preventable Hospitalization Rate	Preventable Hospitalization Rate Increase or Decrease?	Rate of Increase/Decrease	Actual Inpatient Expenditures
FFY15	1,758	555	31.57%	2,900	664	$4,896,949.46	22.90%			$29,875,167.38
FFY16	1,559	812	52.08%	2,541	1,020	$7,488,961.38	40.14%	Increase	75.28%	$24,433,585.50

Objective 2: Access to medical services will reduce the rate of admissions to long-term care nursing facilities for participants with specific ambulatory sensitive conditions that can often be managed in an outpatient setting.

For beneficiaries requiring nursing facility admissions, there was a decrease in the number of nursing facility admissions from 79 in FFY15 to 73 in FFY16. Although there was a decrease in beneficiaries requiring long-term care stays, the costs attributable to preventive stays increased from $386,325.80 in FFY15to $697,719.42 in FFY16.

Federal Fiscal Year	Number of Beneficiaries with Nursing Home Stay	Number of Beneficiaries with Preventable Nursing Home Stay	Percent of Beneficiaries with Preventable Nursing Home Stay	Number of Nursing Home Stays	Number of Preventable Stays	Costs Attributable to Preventable Stays	Preventable Stay Rate	Preventable Stay Rate Increase or Decrease?	Rate of Increase/Decrease	Actual Nursing Home Expenditures
FFY15	79	24	30.38%	79	24	$386,325.80	30.38%			$1,588,853.65
FFY16	73	34	46.58%	74	34	$697,719.42	45.95%	Increase	51.25%	$2,029,686.57

Objective 3: Access to medical services will reduce the rate of emergency room (ER) visits for participants with specific ambulatory sensitive conditions that can often be managed in an outpatient setting.

Access to preventive and primary care services in the outpatient setting resulted in a decrease in ER visits from 6,744 in FFY15 to 6,649 in FFY16. Although there was a $480,397.72 increase in expenditures for preventable conditions in the ER, the actual number of beneficiaries receiving ER services decreased by 151 beneficiaries.

Federal Fiscal Year	Number of Beneficiaries with ER Visits	Number of Beneficiaries with Preventable ER Visits	Percent of Beneficiaries with Preventable ER Visits	Number of ER Visits	Number of Preventable ER Visits	Costs Attributable to Preventable ER Visits	Preventable ER Rate	Preventable ER Rate Increase or Decrease?	Rate of Increase/Decrease	Actual Inpatient Expenditures
FFY15	3,149	1,290	40.97%	6,744	1,952	$1,002,424.83	28.94%			$3,279,476.64
FFY16	2,998	1,595	53.20%	6,649	2,663	$1,482,822.55	40.05%	Increase	38.39%	$3,569,705.36

Interim Evaluation Findings

Goal #1: Provide Medicaid coverage to certain individuals who will no longer be covered under the Mississippi Medicaid State Plan.

On average, from October 1, 2015- through-September 30, 2016, the approximate enrollment in the HMW was 4,733 beneficiaries. This is an average decrease of 162 individuals from DY11.

Goal #2: Demonstrate budget neutrality based on an aggregate dollar cap that cannot exceed the cumulative target of $1,520,279,231.

As of September 30, 2016, the cumulative expenditure amount as reported on the CMS 64 Report was $832,608,978, as compared to the budget neutrality limit of $1,178,961,321, yielding a cumulative variance of $346,352,343.

Utilization data

In FFY16, 7,750unique HMW beneficiaries accessed preventive and primary services. Fifteen hundred fifty-nine (1,559) beneficiaries had an inpatient hospital admission, 2,998 beneficiaries had an emergency department visit, and 73 beneficiaries had an admission to a long-term care nursing facility.

Policy and administrative difficulties in the operation of the demonstration

There were no reported policies or administrative difficulties in the operation of the demonstration during FFY16.

Enrollment Information

Enrollment counts are person counts, not member months. The enrollment limit is 6,000.

Participant Populations	Number of Enrollments during FFY 2016	Number of Voluntary Disenrollments during FFY 2016	Number of Involuntary Disenrollments during FFY 2016
Population 1 – Medicaid Only	7,750	644	2,835

Outreach/Innovative Activities

DOM publishes flyers and other outreach materials which include a description of the HMW eligibility criteria and benefits. Flyers are made available to the public in various sites throughout the state and are posted on the DOM website. During the FFY 2016, DOM's Outreach Coordinators provided HMW information at over 150 community events to 22,155 attendees.

Operational/Policy Developments/Issues
For DY12, there were no operational or policy issues reported.

Demonstration Population 1 "Medicaid Only"
Aged or disabled individuals enrolled in the demonstration with income up to one hundred and thirty five percent (135%) of the FPL who are not eligible for Medicare, and are not eligible under the Medicaid state plan.

Consumer Issues
There have been no reported consumer issues. For eligibility issues, appeals will be granted in the same manner as all ongoing eligibility decision for non-waiver coverage.

Appeals of denials, terminations or other adverse changes are granted by the DOM upon receipt of written request, provided the appeal is requested within the specified deadline of thirty (30) days.

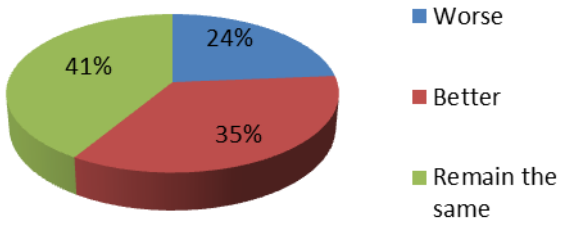
DOM sampled approximately ten percent (10%) of the HMW beneficiaries who accessed at least one (1) service during DY12. DOM sampled the beneficiaries to monitor beneficiary satisfaction and to identify potential areas of quality improvement. Five hundred (500) beneficiaries were randomly selected from DOM data. After adjusting for incorrect addresses, 464 beneficiaries received surveys. DOM received 105 responses to the survey which resulting in a cooperation rate of 21%. After eliminating incomplete surveys and surveys with no responses, 99 surveys were available for analysis.

- 40 out of 97 (40.4%) responded they feel their health status remain the same.
- 92 out of 97 (93%) responded did see their doctor.
- 57 out of 97 (57.6%) responded they did not spend time in the hospital.
- 58 out of 97 (58.6%) responded they did visit the emergency room.
- 52 out of 97 (53.6%) responded there was a time they needed to see a doctor but could not because they could not pay.
- 61 out of 97 (62.9%) responded there was a time when they did not get the medicine they needed because they could not pay for it.
- There were 91 responses they have been told by a doctor they have asthma, cancer, diabetes, end stage renal disease, or any other chronic condition.
- 14 out of 97 (14.4%) responded they did get a new pair of glasses or contact paid for by Mississippi Medicaid.
- 7 out of 97 (7.2%) responded they did get services from a foot doctor.
- 9 out of 97 (9.3%) responded they did get services from a chiropractor.
- 10 out of 97 (10.3%) responded they did get dental care.
- 81 out of 97 (83.5%) responded they get a check-up.
- 59 out of 97 (60.8%) responded they are very satisfied with their overall medical coverage.

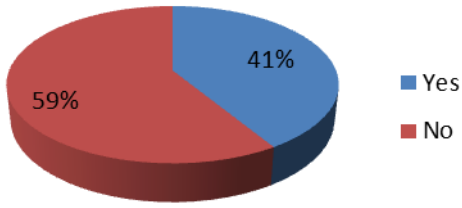
- 87 out of 97 (89.9%) responded they describe their race as Black or African-American or White; 10 out of 97 (10.3%) described their race as American Indian or Alaskan Native, Asian, or another race.

Key questions and answers on the survey related to the HMW objectives are listed below.

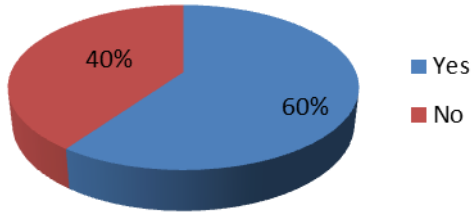
Since being on the HMW, do you feel your health became worse, better, or remained the same?



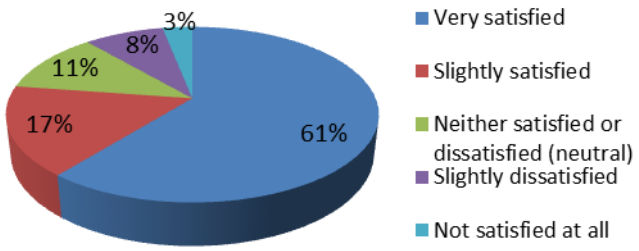
Did you spend time in the hospital?



Did you go to the emergency room?



What is your overall satisfaction with your medical coverage?



Quality Assurance/Monitoring Activity

The Office of Eligibility staff continues to monitor the waiver enrollment process to ensure only beneficiaries meeting the qualifications for the HMW are enrolled.

Financial/Budget Neutrality Development/Issues

CMS provided revised budget neutrality cumulative targets for the current renewal (see below). Also, DOM revised its financial/budget neutrality reporting format to provide statistics for the distinct population defined in the demonstration.

In accordance with the "Special Terms and Conditions", Section VIII, *Monitoring Budget Neutrality*, CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. The following table includes the reporting of expenditures for those currently enrolled in the waiver.

Demonstration Year	Cumulative Budget Neutrality Expenditure Limit	Expenditures for current enrollees and those disenrolled within one year
Years 1 – 5	$350,250,000	$213,905,091
Year 6	$448,787,000	$289,909,421
Year 7	$552,743,535	$377,640,601
Year 8	$662,417,679	$473,168,820
Year 9	$778,123,901	$575,717,085
Year 10	$893,830,123	$690,331,933
Year 11	$1,029,989,323	$754,466,330
Year 12	$1,178,961,321	$832,608,978

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