DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

State Demonstrations Group

May 14, 2025

Cindy H. Bradshaw
Executive Director
Division of Medicaid
Mississippi Department of Human Services
550 High Street Suite 1000
Jackson, MS 39201-1325

Dear Executive Director Bradshaw:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Final Report for the Managed Care Risk Mitigation COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Healthier Mississippi" (Project No: 11-W-001854), approved on January 18, 2022. This report covers the demonstration period from April 1, 2020, through June 30, 2021. CMS determined that the Final Report, submitted on November 7, 2024, is in alignment with the requirements set forth in the demonstration's Special Terms and Conditions (STCs), and therefore approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website within 30 days, per 42 CFR 431.424(c). CMS will also post the approved Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration amendment. We look forward to continuing our partnership on the IWP 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: 2025.05.14 10:21:56 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

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

MISSISSIPPI DIVISION OF
MEDICAID

Healthier Mississippi Project

Section 1115 Demonstration

Project Number 11-W-00185/4

Evaluation Design

March 20, 2025

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.

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

Evaluation Design
March 20, 2025

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, 2024 through September 30, 2029. 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, Research Questions and Evaluation Hypotheses

On September 24, 2024, the demonstration was extended for five years through September 30, 2029, with no programmatic changes. During this extension period, Mississippi expects to achieve the following goals and objectives with quantifiable target percentages:

Goal: To prevent hospitalizations and increase access to ambulatory and preventive healthcare by providing insurance coverage, for individuals who are aged, blind or disabled, not eligible for Medicare and do not qualify for Medicaid.

Objective 1: Decrease hospitalizations by two percent for the duration of the demonstration.

Objective 2: Increase the utilization of ambulatory/preventive health visits by two percent each demonstration year.

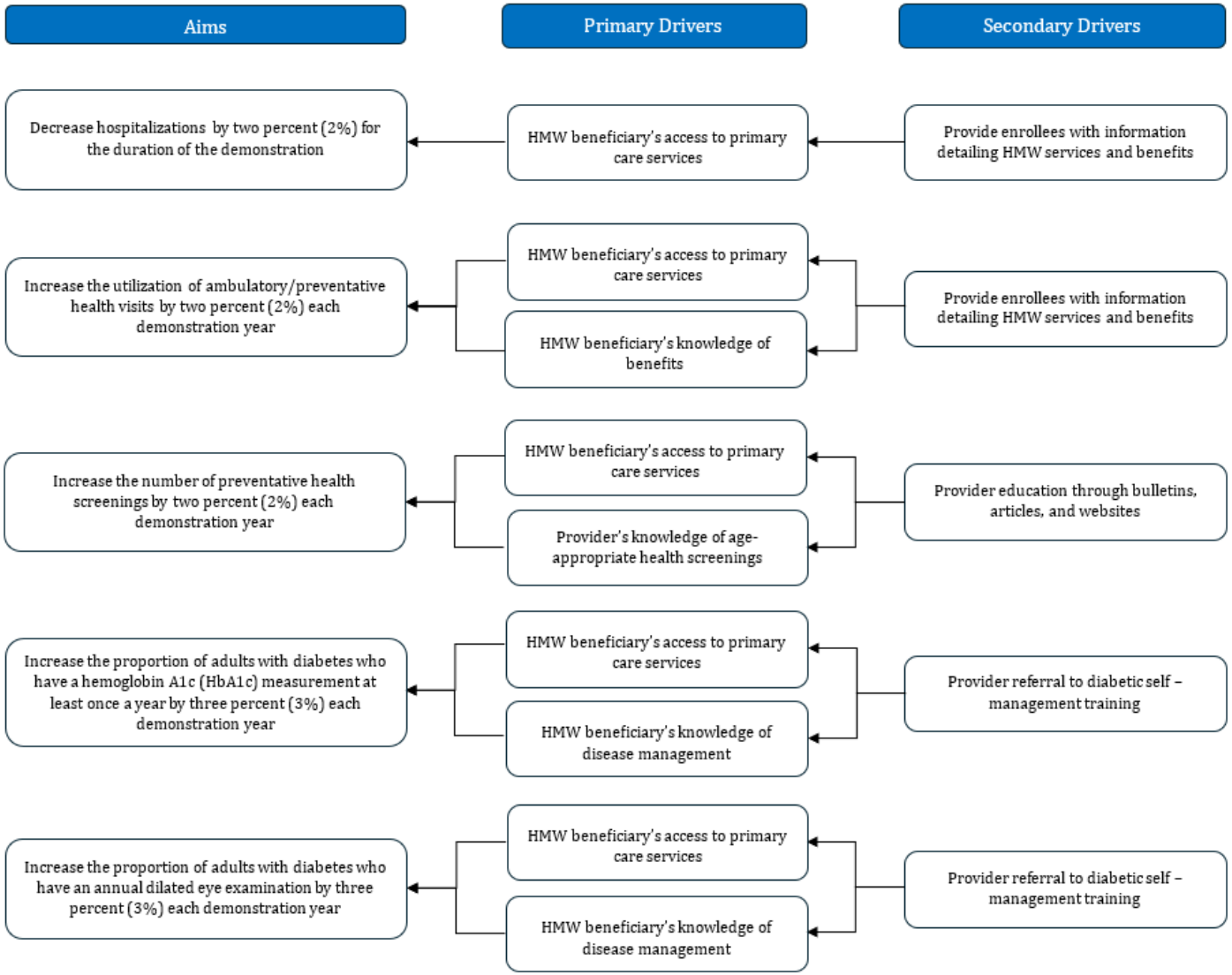
Objective 3: Increase the number of preventive health screenings by two percent each demonstration year.

Objective 4: Increase the proportion of adults with diabetes who have a hemoglobin A1c (HbA1c) measurement at least once a year by three percent each demonstration year.

Objective 5: Increase the proportion of adults with diabetes who have an annual dilated eye examination by three percent each demonstration year.

The rationale for achieving these five objectives is illustrated in Figure 1.

Figure 1: Healthier Mississippi Waiver Driver Diagram



The evaluation questions and hypotheses are designed to measure the program's performance in achieving its stated goals and objectives, ensuring alignment with the broader objectives of Titles XIX and XXI, which include:

- Providing financial support to medical assistance to low-income individuals who are aged, blind, or disabled and are not eligible for Medicaid or Medicare; and
- Providing access to preventive and necessary medical services for the low-income population.

Medicaid intends to measure the performance of the demonstration goals through the following quantitative evaluation questions:

Evaluation Question 1: How does the hospitalization rate among HMW beneficiaries change over time? Specifically, do hospitalizations decline as the duration of HMW enrollment increases? Additionally, do beneficiaries who utilize ambulatory and preventive services experience fewer hospitalizations compared to those who do not?

- **Hypothesis 1**: Beneficiaries who receive ambulatory and preventive care will have lower hospitalization rates than those who do not utilize these services. As HMW provides access to these services, hospitalizations among HMW beneficiaries are expected to decrease over time.

Evaluation Question 2: How does the rate of ambulatory or preventive health visits change over time? Specifically, does utilization of these services increase as the duration of HMW enrollment increases? Additionally, does the utilization of ambulatory and preventive health visits vary across different age groups of beneficiaries?

- **Hypothesis 2**: As HMW provides access to ambulatory and preventive healthcare services, their utilization among HMW beneficiaries is expected to increase over time. Additionally, utilization rates may differ across age groups.

Evaluation Question 3: Does the number of HMW beneficiaries receiving age-appropriate preventive screenings (e.g., mammograms, cervical cancer screenings, and colorectal cancer screenings) increase over time? Does the proportion of HMW beneficiaries receiving preventive screenings increase as beneficiaries age? Does this proportion increase as the duration of HMW enrollment increases?

- **Hypothesis 3**: As HMW provides access to preventive screenings, the number of HMW beneficiaries receiving recommended preventive screenings will increase over time. Additionally, older HMW beneficiaries are more likely to receive preventive screenings compared to younger beneficiaries. Furthermore, beneficiaries are more likely to receive preventive screening as the duration of enrollment increase.

Evaluation Question 4: Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual HbA1c test increase over time? Specifically, does this proportion increase as the duration of HMW enrollment increases? Additionally, does the utilization of annual HbA1c testing vary by gender and race?

- **Hypothesis 4**: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual HbA1c test are expected to increase over time. Additionally, beneficiaries with diabetes are more likely to receive annual HbA1c test as the duration of enrollment increase. Furthermore, the utilization of annual HbA1c testing may differ across gender and race groups.

Evaluation Question 5: Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual dilated eye examination increase over time? Specifically, does this proportion increase as the duration of HMW enrollment increases? Additionally, does the utilization of annual dilated eye examinations vary by gender and race?

- **Hypothesis 5**: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual dilated eye examination will increase over time. Additionally, beneficiaries with diabetes are more likely to receive an annual dilated eye examination as the duration of enrollment increase. Furthermore, the utilization of annual dilated eye examinations may differ across gender and race groups.

To gain further insights into the challenges affecting program performance, an additional quantitative evaluation question related to beneficiary satisfaction will be included:

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.

To improve the HMW program and ensure it meets its intended goals and objectives, four qualitative evaluation questions will also be included:

Evaluation Question 7: What factors prevent some HMW beneficiaries from receiving age-appropriate preventive screenings?

Evaluation Question 8: What factors prevent some HMW beneficiaries with diabetes from receiving an annual HbA1c test or an annual dilated eye examination?

Evaluation Question 9: Among HMW beneficiaries who report dissatisfaction with the program, what are the primary reasons for their dissatisfaction?

Evaluation Question 10: What improvement do HMW beneficiaries think would make the program more helpful for them?

These evaluation questions and hypotheses align with the program's goal of preventing hospitalizations and increasing access to ambulatory and preventive healthcare. The evaluation results will assess whether the program meets its target objectives, including reducing hospitalizations, increasing preventive care utilization, and improving chronic disease management.

By analyzing healthcare utilization trends, reductions in avoidable hospitalizations, and beneficiary satisfaction, this evaluation will provide data-driven insights to inform policymakers, helping the demonstration meets its intended objectives while contributing to a more effective and sustainable healthcare system.

III. Methodology

Evaluation Design

This evaluation will assess the effectiveness of the HMW demonstration in achieving its stated objectives by employing a one-group posttest-only design complemented by trend analysis, longitudinal analysis, and subgroup comparisons.

Trend analysis will be used to track changes in hospitalization rates, ambulatory and preventive healthcare utilization, and chronic disease management over the demonstration period to determine whether changes over time are statistically significant.

Longitudinal analysis will be used to examine healthcare utilization patterns among beneficiaries enrolled for at least two consecutive demonstration years, comparing their service utilization in the first and second years.

Subgroup analysis will be used to assess potential disparities in healthcare utilization by age, gender, and race, helping to identify differences in access and outcomes.

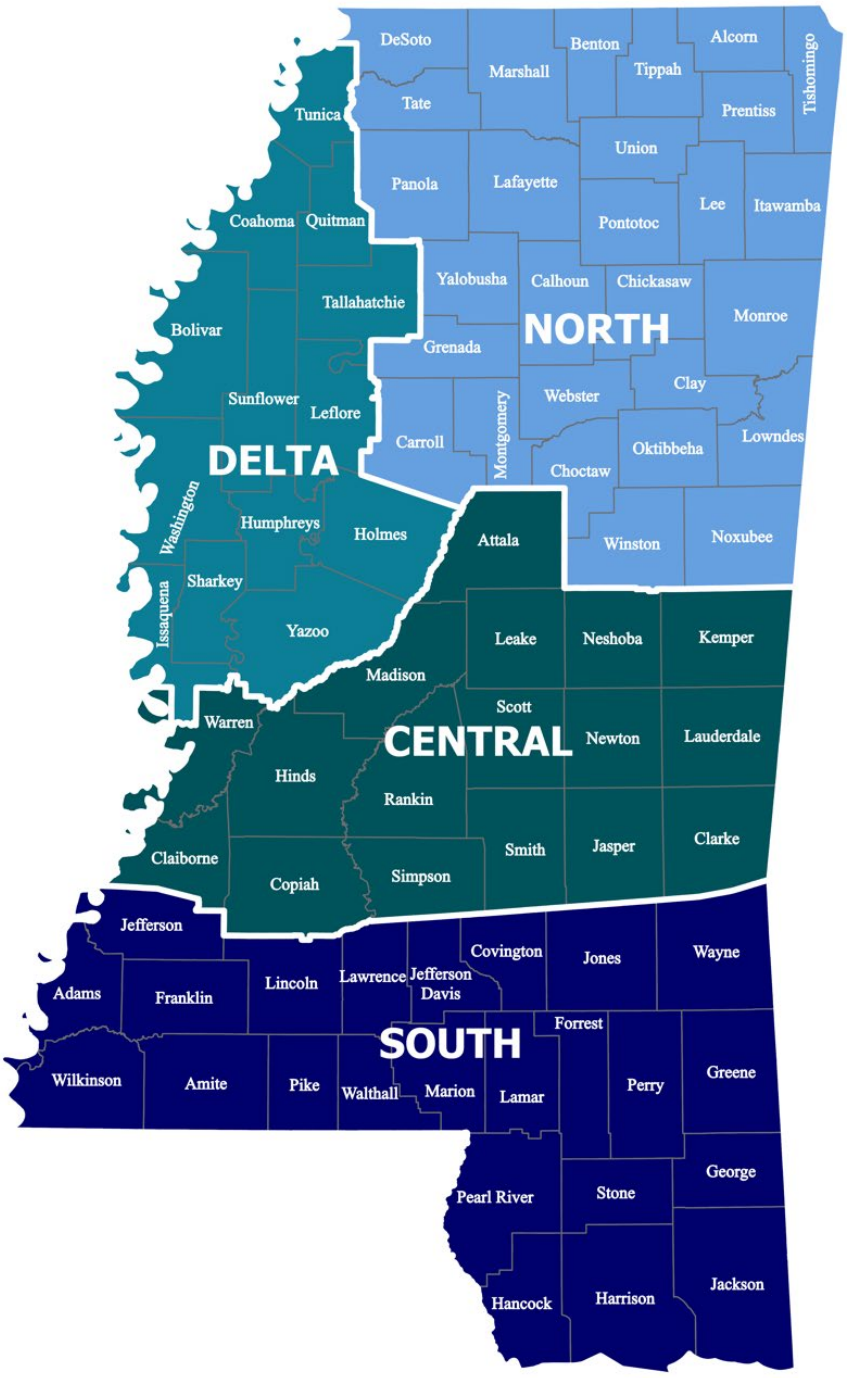
Analyses will be conducted at both the statewide and regional levels. Following the Mississippi Public Health region map issued by Mississippi Department of Human Services (MDHS), the state will be divided into four regions: Central, Delta, North, and South (shown in Figure 2).

In addition to quantitative methods, a qualitative evaluation will be conducted through structured telephone surveys. These surveys will provide insights into beneficiary satisfaction, perceived barriers to care, and potential program improvements. The survey will be conducted twice during the current demonstration extension period. The first survey will take place within two months after the end of the first demonstration year, with its findings incorporated into the first annual evaluation report for this extension. The second survey will be administered within two months following the conclusion of the third demonstration year, and its results will be included in the DY 23 annual report.

The survey script and questions for the initial survey have been developed based on quantitative findings from the Demonstration Year (DY) 20 Annual Report (See Attachment V). The script and questions for the second survey will be refined based on insights from the first (DY 21) and second (DY 22) annual reports of the current extension period.

Findings from both surveys will be integrated with other quantitative analyses in the Interim Evaluation Report and Summative Report, providing a comprehensive assessment of beneficiary experiences and program effectiveness. All quantitative and qualitative analyses will be benchmarked against the quantifiable target goals outlined in the demonstration objectives, ensuring alignment with federal and state evaluation standards.

Figure 2: Regions of Healthier Mississippi Waiver Program



Target and Comparison Populations

The primary target population for this evaluation consists of HMW beneficiaries enrolled in the program during the measurement demonstration year. These beneficiaries include individuals who are aged, blind, or disabled, are not eligible for Medicare or Medicaid, are not inpatients in a long-term care facility, and meet the following financial eligibility criteria:

- 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.
- Resources are below $4,000 for an individual and $6,000 for a couple.

Although the state can identify a subset of HMW beneficiaries who previously qualified for Medicaid through SSI, this group is not considered a suitable comparison population. Since HMW provides the same healthcare services as Medicaid—except for swing bed care in a skilled nursing facility, long-term care services, and maternity and newborn care—the transition from Medicaid to HMW is not expected to result in significant changes in healthcare utilization. Therefore, beneficiaries who previously qualified for SSI-based Medicaid will not be used as a comparison group.

Additionally, for HMW beneficiaries who did not qualify for Medicaid through SSI before enrolling in HMW, no pre-enrollment healthcare utilization data is available. As a result, a pre/post comparison is not feasible. Given these constraints, the evaluation will adopt a post-only assessment design, using historical data from demonstration years 15 through 20 (Federal Fiscal Years 2019–2024) as the baseline to analyze utilization trends over time. In this approach, the comparison group will consist of HMW beneficiaries enrolled in prior demonstration years, allowing for an assessment of changes in healthcare utilization, preventive screenings, and chronic disease management throughout the demonstration period.

Furthermore, for HMW beneficiaries enrolled in both the measurement demonstration year and the preceding demonstration year, their service utilization in the measurement year will be compared to that in the preceding year. This longitudinal analysis will assess changes in healthcare utilization as beneficiaries become more familiar with HMW services over time.

Lastly, to evaluate whether HMW beneficiaries who utilize ambulatory and preventive healthcare services are less likely to experience hospitalization (a key sub-research question under Research Question 2), the target population will be HMW beneficiaries enrolled for at least six months who accessed ambulatory or preventive services at least once during the measurement demonstration year. The comparison group will consist of HMW beneficiaries enrolled for at least six months who did not access ambulatory or preventive services during the measurement year. This subgroup analysis will provide insights into the potential impact of preventive care on hospitalization rates.

This evaluation framework ensures a methodologically sound approach to assessing HMW's impact on healthcare utilization, leveraging historical trends, longitudinal comparisons, and subgroup analyses to derive meaningful insights.

Evaluation Period

The evaluation will cover the demonstration period from October 1, 2024, through September 30, 2029. Additionally, historical utilization data from demonstration years 15–20 (October 1, 2019 – September 30, 2024) will be included to analyze utilization trends over time.

Evaluation Measures

The evaluation measures included in the quantitative analysis of the evaluation are presented in Table 1.

Table 1: Quantitative Evaluation Outcomes Measures

Metric	Description	Numerator/Denominator
Hospitalization Rate	The percentage of beneficiaries who had at least one acute care hospitalization during the measurement demonstration year. The percentage will be conducted at both the statewide and regional levels.	Number of HMW beneficiaries with at least one hospitalization during the measurement demonstration year/Total number of HMW beneficiaries during the measurement demonstration year
Average Hospitalization Reduction Rate Over Two Demonstration Years	The average percentage change in hospitalizations between the first and second demonstration years among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year. The average percentage change will be calculated at both the statewide and regional levels.	Step 1: Calculate individual hospitalization reduction rate using the follow formula: (Number of hospitalizations in the measurement demonstration year − Number of hospitalizations in the previous demonstration year)/ Number of hospitalizations in the measurement demonstration year Step 2: Average hospitalization reduction rates among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year
Hospitalization Rate Among Beneficiaries Who Accessed Ambulatory and Preventive Services	The percentage of beneficiaries enrolled in HMW for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year and were subsequently hospitalized within the same measurement demonstration year. The percentage will be calculated at both the statewide and regional levels.	Number of HMW beneficiaries enrolled for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year and were subsequently hospitalized within the same measurement demonstration year/Number of HMW beneficiaries enrolled for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year
Hospitalization Rate Among Beneficiaries Who Did Not Access Ambulatory and Preventive Services	The percentage of beneficiaries enrolled in HMW for at least six months who did not access ambulatory and preventive services during the measurement demonstration year and were hospitalized within the same	Number of HMW beneficiaries enrolled for at least six months who did not access ambulatory and preventive services and were hospitalized during the measurement demonstration year/Number of HMW beneficiaries enrolled for at least six

	measurement demonstration year. The percentage will be calculated at both the statewide and regional levels.	months who did not access ambulatory and preventive services during the measurement demonstration year
Ambulatory/Preventive Health Visit Rate	The percentage of beneficiaries who had at least one ambulatory or preventive care visit during the measurement demonstration year. This percentage will also be calculated for different age groups of beneficiaries at both the statewide and regional levels.	Number of HMW beneficiaries who had at least one ambulatory or preventive care visit during the measurement demonstration year/Total number of HMW beneficiaries during the measurement demonstration year
Average Change Rate in Ambulatory/Preventive Health Visits Over Two Demonstration Years	The average percentage change in ambulatory and preventive health visits between the first and second demonstration years among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year. This average percentage change will be calculated at both the statewide and regional levels.	Step 1: Calculate individual ambulatory or preventive health visit change ate using the follow formula: (Number of ambulatory or preventive health visits in the measurement demonstration year − Number of ambulatory or preventive health visits in the previous demonstration year)/ Number of ambulatory or preventive health visits in the measurement demonstration year Step 2: Average change rates in ambulatory or preventive health visits among HMW beneficiaries who were enrolled in HMW during both the measurement demonstration year and the preceding year
Average Ambulatory/Preventive Health Visits	The average number of ambulatory/preventive health visits per beneficiary, calculated separately for different age groups (<18, 18-44, 45-64, 65-75, >75) and for the four different regions.	For each age group, the average number of ambulatory and preventive health visits is calculated as follows: Total number of ambulatory or preventive health visits during the measurement demonstration year/ Total number of beneficiaries in the age group
Cervical Cancer Screening Rate	The percentage of female beneficiaries aged 21-65 who received a cervical cancer screening during the measurement demonstration year. This metric will also be calculated separately for the 21–29 and 30–	Number of female HMW beneficiaries aged 21-65 who received a cervical cancer screening during the measurement demonstration year/Total number of female HMW beneficiaries aged 21-65 during the measurement demonstration year

	65 age groups, and for the four different regions.	For each age group, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective age group.
Change in Cervical Cancer Screening Rate Over Two Demonstration Years	The difference in the percentage of female beneficiaries aged 21–65 who received a cervical cancer screening between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be analyzed at both the statewide and regional levels.	Cervical cancer screening rate in measurement demonstration year − Cervical cancer screening rate in preceding demonstration year
Breast Cancer Screening Rate	The percentage of female beneficiaries aged 40-74 who received a mammogram during the measurement demonstration year. This metric will also be calculated separately for the following age groups: 40–44, 45–54, 55–64, and 65–74, and for the four regions.	Number of female HMW beneficiaries aged 40-74 who received a mammogram during the measurement demonstration year/Total number of female HMW beneficiaries aged 40-74 during the measurement demonstration year For each age group, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective age group.
Change in Breast Cancer Screening Rate Over Two Demonstration Years	The difference in the percentage of female beneficiaries aged 40-74 who received a mammogram between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	Breast cancer screening rate in measurement demonstration year − Breast cancer screening rate in preceding demonstration year
Colorectal Cancer Screening Rate	The percentage of beneficiaries aged 45-75 who received a colorectal cancer screening during the measurement demonstration year. This metric will also be calculated for the 45–64 and 65–75 age groups, and for the four regions.	Number of HMW beneficiaries aged 45-75 who a colorectal cancer screening during measurement demonstration year/Total number of HMW beneficiaries aged 45-75 during the measurement demonstration year

		For each age group, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective age group.
Change in Colorectal Cancer Screening Rate Over Two Demonstration Years	The difference in the percentage of female beneficiaries aged 45-75 who received a colorectal cancer screening between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	Colorectal cancer screening rate in measurement demonstration year − Colorectal cancer screening rate in preceding demonstration year
Diabetes Care: Hemoglobin A1c (HbA1c) testing Rate	The percentage of beneficiaries with diabetes who received an HbA1c test during the measurement demonstration year. This metric will also be calculated by gender race, and region.	Number of HMW beneficiaries with diabetes who received an HbA1c test during the measurement demonstration year/Total number of HMW beneficiaries with diabetes during the measurement demonstration year For each gender and racial subgroup, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective subgroup.
Change in Hemoglobin A1c (HbA1c) testing Rate Over Two Demonstration Years	The difference in the percentage of beneficiaries with diabetes who received an HbA1c test between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	Hemoglobin A1c (HbA1c) testing rate in measurement demonstration year − Hemoglobin A1c (HbA1c) testing rate in preceding demonstration year
Diabetes Care: Dilated Eye Examination Rate	The percentage of beneficiaries with diabetes who received a dilated eye examination during the measurement period. This metric will also be calculated by gender, race, and region.	Number of HMW beneficiaries with diabetes who received a dilated eye examination during the measurement demonstration year/Total number of HMW beneficiaries with diabetes during the measurement demonstration year For each gender and racial subgroup, the percentage will be calculated using the same formula, with both the numerator and denominator adjusted to reflect the respective subgroup.

Change in Dilated Eye Examination Rate Over Two Demonstration Years	The difference in the percentage of beneficiaries with diabetes who received a dilated eye examination between the measurement demonstration year and the preceding demonstration year, among those enrolled in HMW during both years. This metric will be calculated at both the statewide and regional levels.	Dilated eye examination rate in measurement demonstration year − Dilated eye examination rate in preceding demonstration year
Beneficiary Satisfaction Rate	The percentage of beneficiaries who report satisfaction with the demonstration services among those who responded to the telephone survey.	Number of HMW beneficiaries who reported satisfaction with the demonstration services during the telephone survey/ Total number of HMW beneficiaries who responded to the telephone survey

Data Sources

HMW Enrollment Data and Medicaid Fee for Services Claim Data

This evaluation mainly utilizes HMW enrollment data and Medicaid Fee for Service (FFS) claims data to conduct quantitative analysis. HMW enrollment data will be used to identify eligible beneficiaries and their demographic information, and track their enrollment history, while Medicaid FFS claims data will be used to capture critical healthcare utilization metrics. These two data will be provided by Medicaid, 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.

Beneficiary Satisfaction Telephone Survey

In addition to analyzing claims and enrollment data, a structured telephone survey will be conducted to assess HMW beneficiaries' satisfaction with demonstration services, as well as to identify perceived barriers to access and service utilization. This survey will provide qualitative insights into beneficiary experiences, complementing the quantitative findings derived from claims and enrollment data.

The survey sample will be selected through a rigorous methodology to ensure that responses are representative of the HMW beneficiary population. Participants will be drawn from a survey pool consisting of HMW beneficiaries who were enrolled for at least 12 consecutive months prior to survey administration and had utilized at least one demonstration service during the measurement demonstration year. To ensure that the survey results are statistically reliable, a randomized sampling approach will be employed. Eligible participants will be randomly selected from the survey pool of each region. The number of selected participants will be determined based on the percentage of beneficiaries in each region (Central, Delta, North, and South) relative to the total number of beneficiaries at the state level. HMW enrollment and Medicaid claims data will be utilized to verify participant eligibility and ensure the validity of the random selection process.

The survey will be administered via telephone interviews using Voxco, a professional telephone survey system designed to support large-scale telephone-based research. Structured questionnaires will be carefully developed to accommodate individuals with a reading level no higher than the recommended 6th-grade level, ensuring clarity, accessibility, and consistency in data collection (See Attachment V). Additionally, all interviewers will be trained to maintain a neutral and unbiased approach throughout the survey administration. To accommodate non-English-speaking beneficiaries, bilingual interviewers will be available as needed.

A minimum response rate of 10% will be required to ensure statistical reliability. To improve response rates, follow-up attempts will be made for beneficiaries who do not respond to the initial outreach. Additionally, newly enrolled beneficiaries will be notified about the telephone survey in the welcome mail package sent by Medicaid. Once data collection is complete, survey

responses will be converted into structured datasets and then be analyzed alongside quantitative claims data.

To enhance the credibility and reliability of survey findings, several methodological safeguards will be implemented. Randomized selection of survey participants will minimize selection bias, and validated survey instruments will be used to align with industry-standard methodologies such as Medicaid's Consumer Assessment of Healthcare Providers and Systems (CAHPS). Prior to full-scale implementation, the survey will undergo pilot testing to refine the wording of questions and ensure clarity.

Ethical considerations will be strictly followed throughout the survey process. All participants will provide informed consent, ensuring that they fully understand the purpose of the survey and their right to withdraw at any time. Confidentiality will be maintained by anonymizing all responses, protecting participant privacy, and ensuring compliance with data protection regulations.

Findings from the telephone survey will be triangulated with Medicaid claims and enrollment data to validate trends observed in the quantitative analysis. This integration will help determine whether lower utilization rates correlate with reported utilization and lower satisfaction, identify areas for program improvement, and provide insights that are not captured through claims-based analyses alone.

By incorporating multiple data sources—including HMW enrollment records, Medicaid claims, and qualitative beneficiary survey responses—this evaluation will provide a comprehensive and evidence-based assessment of the HMW demonstration's impact on healthcare utilization, preventive care, chronic disease management, and the place to improve.

Analytic Methods

Table 2 provides details on the quantitative research questions, hypotheses, measures, related populations, and data sources, as well as the specific analytic approaches.

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

Research Question	Outcome Measure(s)	Population	Data Sources	Analytic Approach
Hypothesis 1: Beneficiaries who receive ambulatory and preventive care will have lower hospitalization rates than those who do not utilize these services. As HMW provides access to these services, hospitalizations among HMW beneficiaries are expected to decrease over time.				
• How does the hospitalization rate among HMW beneficiaries change over time? • Do hospitalizations decline as the duration of HMW enrollment increases? • Do beneficiaries who utilize ambulatory and preventive services experience fewer hospitalizations compared to those who do not?	• Hospitalization rate • Average hospitalization reduction rate over two demonstration year • Hospitalization rate among beneficiaries who accessed ambulatory and preventive services • Hospitalization rate among beneficiaries who did not access ambulatory and preventive services	• All beneficiaries in the measurement demonstration year • Beneficiaries enrolled in HMW during both the measurement demonstration year and the preceding year • Beneficiaries enrolled in HMW for at least six months who accessed ambulatory and preventive services at least once during the measurement demonstration year • Beneficiaries enrolled in HMW for at least six months who did not access ambulatory and	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: calculate hospitalization rates for each demonstration year over the past 6-10 years[1] and perform statistical trend analysis (e.g., Cochran-Armitage trend test) to assess overall patterns in hospitalization rates over time. • Longitudinal Analysis: track hospitalization rates among beneficiaries enrolled for two consecutive demonstration years and analyze changes in hospitalization trends between the first and second enrollment years. • Subgroup Analysis: conduct subgroup analysis to compare hospitalization rates between beneficiaries who utilized ambulatory or preventive services at least once during the demonstration year and those who did not. T-tests or Chi-square tests will be used to assess differences in hospitalization rates and demographic characteristics between the two groups. Relevant summary statistics will also be provided to present the analysis results. • All the analyses mentioned above will be conducted at both the statewide and regional levels.

[1] This will include previous 6 demonstration years and the first four demonstration years of the current period.

		preventive services during the measurement demonstration year		
Hypothesis 2: As HMW provides access to ambulatory and preventive healthcare services, their utilization among HMW beneficiaries is expected to increase over time. Additionally, utilization rates may differ across age groups.				
• How does the rate of ambulatory or preventive health visits change over time? • Does utilization of these services increase as the duration of HMW enrollment increases? • Does the utilization of ambulatory and preventive health visits vary across different age groups of beneficiaries?	• Ambulatory/preventive health visit rate • Average change rate in ambulatory/preventive health visits over two demonstration years • Average ambulatory/preventive health visits for different age groups (<18, 18-44, 45-64, 65-75, >75) of beneficiaries	• All beneficiaries in the measurement demonstration year • Beneficiaries enrolled HMW in both the measurement demonstration year and the preceding year • Beneficiaries in the measurement demonstration year categorized by age group (<18, 18-44, 45-64, 65-75, >75)	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: calculate the rate of ambulatory and preventive health visits over the past 6-10 years[2] and conduct statistical trend analysis (e.g., Cochran-Armitage trend test) to evaluate overall patterns in utilization over time. • Longitudinal Analysis: track the ambulatory or preventive health visits among beneficiaries enrolled for two consecutive demonstration years and analyze changes in visits between the first and second enrollment years. • Subgroup Analysis: compare the average number of ambulatory and preventive health visits across different age groups. T-tests or Chi-square tests will be conducted to assess differences in visit rates and demographic characteristics between age groups. Relevant summary statistics will also be provided to present the analysis results. • All the analyses mentioned above will be conducted at both the statewide and regional levels.
Hypothesis 3: As HMW provides access to preventive screenings, the number of HMW beneficiaries receiving recommended preventive screenings will increase over time. Additionally, older HMW beneficiaries are more likely to receive preventive screenings compared to younger beneficiaries. Furthermore, beneficiaries are more likely to receive preventive screening as the duration of enrollment increase.				
• Does the number of HMW beneficiaries receiving age-	• Cervical cancer screening rate, calculated for all			• Trend Analysis: calculate the preventive screening rates for each demonstration year over

[2] This will include previous 6 demonstration years and the first four demonstration years of the current period.

appropriate preventive screenings (e.g., mammograms, cervical cancer screenings, and colorectal cancer screenings) increase over time? • Does the proportion of HMW beneficiaries receiving preventive screenings increase as beneficiaries age? • Does this proportion increase as the duration of HMW enrollment increases?	female beneficiaries aged 21-65 and separately for different age groups (21-29 and 30-65) • Change in cervical cancer screening rate over two demonstration years • Breast cancer screening rate, calculated for all female beneficiaries aged 40–74 and by specific age groups (40–44, 45–54, 55–64, and 65–74). • Change in breast cancer screening rate over two demonstration years • Colorectal cancer screening rate, calculated for all beneficiaries aged 45–75 and by specific age groups (45–64 and 65–74). • Change in Colorectal Cancer Screening Rate Over Two Demonstration Years	• Female beneficiaries aged 21-65 • Female beneficiaries aged 21-65 enrolled HMW in both the measurement demonstration year and the preceding demonstration year • Female beneficiaries aged 40-74 • Female beneficiaries aged 40-74 enrolled HMW in both the measurement demonstration year and the preceding demonstration year • Beneficiaries aged 45-75 • Beneficiaries aged 45-75 enrolled HMW in both the measurement demonstration year and the preceding	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	the past 6-10 years.[3] Additionally, conduct a statistical trend analysis (e.g., Cochran-Armitage trend test) to evaluate whether screening rates have increased or decreased over time. • Longitudinal Analysis: track the preventive screenings among beneficiaries enrolled for two consecutive demonstration years and analyze changes in screening rates between the first and second enrollment years. • Subgroup Analysis: compare the preventive screening rates across different age groups. T-tests or Chi-square tests will be conducted to assess differences in screening rates and demographic characteristics between age groups. Relevant summary statistics will also be provided to present the analysis results. • All the analyses mentioned above will be conducted at both the statewide and regional levels.

[3] This will include previous 6 demonstration years and the first four demonstration years of the current period.

		demonstration year		
Hypothesis 4: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual HbA1c test are expected to increase over time. Additionally, beneficiaries with diabetes are more likely to receive annual HbA1c test as the duration of enrollment increase. Furthermore, the utilization of annual HbA1c testing may differ across gender and race groups.				
• Does the proportion of HMW beneficiaries diagnosed with diabetes who receive an annual HbA1c test increase over time? • Does this proportion increase as the duration of HMW enrollment increases? • Does the utilization of annual HbA1c testing vary by gender and race?	• Diabetes care: HbA1c testing rate, calculated for all beneficiaries with diabetes and stratified by gender (male and female) and race (black, white, and other). • Change in HbA1c testing rate over two demonstration years	• All beneficiaries with diabetes • Beneficiaries with diabetes who enrolled HMW in both the measurement demonstration year and the preceding demonstration year	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	• Trend Analysis: calculate the HbA1c testing rate for each demonstration year over the past 6-10 years.[4] Additionally, conduct a statistical trend analysis (e.g., Cochran-Armitage trend test) to evaluate whether screening rates have increased or decreased over time. • Longitudinal Analysis: track HbA1c testing among beneficiaries enrolled for two consecutive demonstration years and analyze changes in HbA1c testing rates between the first and second enrollment years. • Subgroup Analysis: compare HbA1c testing rates across gender and race groups. T-tests or Chi-square tests will be conducted to assess differences in screening rates and demographic characteristics between gender and racial subgroups. Relevant summary statistics will also be provided to present the analysis results. • All the analyses mentioned above will be conducted at both the statewide and regional levels.
Hypothesis 5: As HMW provides access to HbA1c test, HMW beneficiaries with diabetes receiving an annual dilated eye examination will increase over time. Additionally, beneficiaries with diabetes are more likely to receive an annual dilated eye examination as the duration of enrollment increase. Furthermore, the utilization of annual dilated eye examinations may differ across gender and race groups.				
• Does the proportion of HMW beneficiaries	• Diabetes care: dilated eye examination rate,	• All beneficiaries with diabetes		• Trend Analysis: calculate the dilated eye examination rate for each demonstration year

[4] This will include previous 6 demonstration years and the first four demonstration years of the current period.

diagnosed with diabetes who receive an annual dilated eye examination increase over time? • Does this proportion increase as the duration of HMW enrollment increases? • Does the utilization of annual dilated eye examinations vary by gender and race?	calculated for all beneficiaries with diabetes and stratified by gender (male and female) and race (black, white, and other). • Change in dilated eye examination rate over two demonstration years	• Beneficiaries with diabetes who enrolled HMW in both the measurement demonstration year and the preceding demonstration year	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data	over the past 6-10 years.[5] Additionally, conduct a statistical trend analysis (e.g., Cochran-Armitage trend test) to evaluate whether dilated eye examination rates have increased or decreased over time. • Longitudinal Analysis: track dilated eye examinations among beneficiaries enrolled for two consecutive demonstration years and analyze changes in the dilated eye examination rate between the first and second enrollment years. • Subgroup Analysis: compare dilated eye examination rates across gender and race groups. T-tests or Chi-square tests will be conducted to assess differences in screening rates and demographic characteristics between gender and racial subgroups. Relevant summary statistics will also be provided to present the analysis results. • All the analyses mentioned above will be conducted at both the statewide and regional levels.
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 Satisfaction Rate	• Beneficiaries who were enrolled in HMW for at least 12 consecutive months and utilized at least one demonstration service during the measurement demonstration year at the time of	• HMW Enrollment data • Medicaid Fee for Service (FFS) claims data • Survey data, collected via telephone	• Utilize HMW enrollment data and Medicaid FFS claims data to identify the survey pool, consisting of HMW beneficiaries who were enrolled for at least 12 consecutive months and utilized at least one demonstration service at the time of survey administration. • Randomly select beneficiaries from the survey pool of each region for participating in the survey.

[5] This will include previous 6 demonstration years and the first four demonstration years of the current period.

		survey administration	surveys conducted by the program evaluator during the measurement demonstration year	• Conduct telephone surveys using Voxco, a professional survey system. • Ensure that responses are collected from at least 10% of the survey pool to maintain statistical reliability. • Convert survey responses into structured data • Analyze survey results to assess beneficiary satisfaction with HMW services

IV. Methodological Limitations

While the evaluation is designed to be rigorous and methodologically sound, three limitations need to be acknowledged.

One limitation is the lack of pre-enrollment healthcare utilization data for HMW beneficiaries. Although a subset of HMW beneficiaries qualified for Medicaid through SSI prior to their enrollment in the HMW, Medicaid provides all healthcare services that HMW offers, making it difficult to determine whether access to care under HMW results in changes in healthcare utilization. For most HMW beneficiaries who were not eligible for Medicaid before enrolling in HMW, there is no available data on their healthcare utilization prior to enrollment. As a result, conducting a pre/post comparison for HMW beneficiaries will either lacking meaningful insights or unfeasible. To mitigate this issue, the evaluation will rely on historical trend analysis, comparing healthcare utilization across multiple demonstration years to assess patterns over time. Additionally, a longitudinal analysis will be conducted on beneficiaries enrolled in HMW for two consecutive demonstration years to track changes in healthcare utilization within the same individuals. The expectation is that utilization patterns will shift between the first year of enrollment, when beneficiaries are less familiar with the HMW benefits, and the second year, when they are more accustomed to the healthcare services provided.

Another limitation is the absence of a suitable comparison group. In theory, individuals who lack Medicaid benefits and are on the waiting list for HMW enrollment could serve as a comparable population due to their similar financial and health conditions. However, there is no existing data available for these individuals, making direct comparisons impossible. As an alternative, the evaluation will conduct subgroup analyses, examining variations in healthcare utilization across age, gender, and race to identify potential disparities and trends within the enrolled population.

A third limitation is potential response bias in self-reported data collected through the beneficiary satisfaction survey. Respondents may be inclined to overstate satisfaction with services or underreport challenges due to social desirability bias. To enhance the validity of survey findings, the evaluation will implement several measures, including randomized selection of participants, the careful design of survey questions to ensure neutrality and avoid leading language, and maintaining respondent anonymity to encourage honest feedback. Additionally, interviewers will undergo professional training to ensure they adopt a neutral and unbiased approach during survey administration, further minimizing the risk of response bias.

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. Due to these constrains, DOM will adopt non-experimental designs because of the following reasons:

- Lack of an external comparison group: There is no data available for the potential comparison group external to HMW program, preventing the use of matching techniques to compare HMW beneficiaries with non-HMW beneficiaries.
- Limited pre-enrollment healthcare utilization data: There is insufficient data on healthcare utilization before HMW enrollment, making a pre/post quasi-experimental analysis infeasible.

Despite these limitations, the evaluation will employ rigorous analytical methodologies and mitigation strategies to ensure the reliability and validity of the findings. The combination of trend analysis, longitudinal assessments, and subgroup comparisons will provide valuable insights into the impact of HMW on healthcare utilization, preventive care, and chronic disease management while acknowledging and accounting for the inherent challenges of evaluating the program's effectiveness.

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 August 7,2024 with the National Strategic and Planning Analysis Center (NSPARC) at Mississippi State University.

NSPARC is a trusted and experienced independent evaluator with over 15 years of expertise in conducting rigorous evaluations for federal and state programs, particularly in health, education, and workforce development. With a proven track record in assessing program impact, NSPARC has partnered with agencies such as DOM and the Mississippi Department of Employment Security (MDES), earning a reputation for delivering data-driven insights that inform policy and enhance program effectiveness.

NSPARC specializes in comprehensive evaluations, including survey design and deployment, focus group facilitation, data collection and analysis, and professional reporting with actionable insights to support evidence-based decision-making. Leveraging expertise in administrative records, longitudinal data systems, and advanced analytical techniques, the NSPARC team applies cutting-edge methodologies, including machine learning, to extract meaningful insights from complex data. This capability enables NSPARC to address the critical challenges faced by policymakers, employers, economic developers, and state agencies.

NSPARC's expertise aligns with the requirements for the Section 1115 Demonstration evaluation, which requires a comprehensive assessment of the demonstration's goals, hypotheses, methodologies, and outcomes. The NSPARC team will design and implement the evaluation, overseeing all aspects of data collection, cleaning, analysis, and reporting. Their extensive experience in evaluating large-scale health programs ensures that the evaluation meets both federal requirements and the program's specific objectives.

To ensure an objective, impartial evaluation with no conflict of interest, DOM has established robust oversight measures. The contract and contract monitoring process serve as the primary mechanisms for maintaining compliance. DOM enforces accountability through contractual provisions that define benchmarks, reporting deadlines, and approved methodologies. These measures allow DOM to monitor the independent evaluator's progress while upholding a conflict-free evaluation process.

Attachment II: Evaluation Budget

We estimate the total cost of the evaluation at $100,800. The staffing, survey tool license fees, and administrative costs are listed in the accompanying table and described below:

Line Item	Components of Budget	Line Item Cost
1	Estimated Cost of Staff	$80,000
2	Estimated administrative and other costs (such as administrative costs and annual telephone survey system licensing fee, etc.)	$20,800
	Total Amount	$100,800

Staffing

Project Director

Dr. Grice, a research professor and the executive director of NSPARC, will have overall responsibility for the evaluation, including developing the evaluation design and data collection instruments, overseeing staff, analyzing claims and survey data, and preparing annual reports. With over 30 years of experience in research and data analysis, Dr. Grice specializes in using data modeling and analytics to drive business intelligence and improve policymaking. He has secured over $130 million in research funding, serves as the Director of Mississippi's SLDS, and is the lead scientist for Mississippi Business Intelligence Research. Dr. Grice holds a Ph.D. in Sociology from Mississippi State University.

Associate Project Director

Dr. Taquino, a research professor and the deputy executive director for research and data analytics at NSPARC, will guide the evaluation design and data collection instruments, assist with data analysis, and conceptualize results for the annual report. With over 25 years of experience in social and economic impact research, labor market analysis, and workforce program evaluation, Dr. Taquino leads NSPARC's team of research scientists and data activities. He holds a Ph.D. in Sociology from Mississippi State University.

Statistical Analyst

Dr. Tang, associate director of research and applied science, and Dr. Wang, research project manager, will manage data cleaning and analysis for enrollment, claims, and survey data. Dr. Tang has extensive expertise in data-driven decision-making, predictive modeling, and machine learning, with advanced degrees in Statistics, Accounting, and Geography. Dr. Wang, holding a Ph.D. in Economic Analysis and Policy from Tulane University, specializes in program evaluation

using advanced analytical methodologies. Both bring over a decade of experience in statistical analysis and data management.

Dissemination/Special Project Coordinator

Dr. Wang will coordinate survey administration, prepare protocols for review, and assist in preparing annual reports. With a successful track record of evaluation projects for organizations like MDES and Mississippi DOM, she brings expertise in survey administration, data analysis, and report preparation, supported by five years of project coordination experience.

Telephone Survey Implementation Staff

The independent evaluation team is composed of highly experienced professionals with expertise in designing, developing, testing, and conducting telephone surveys. The team will utilize Voxco, a professional telephone survey platform, which will be operated under a one-time paid license to ensure seamless survey administration. Adhering to industry best practices, the team will uphold data integrity, reliability, and respondent confidentiality throughout the survey process.

Once data collection is complete, data analysts will systematically process survey responses, converting them into structured datasets for analysis. The responses will be evaluated alongside quantitative findings, and the results will be synthesized into a written report that provide a comprehensive evaluation of the effectiveness of the HMW program.

Attachment III: Timeline and Major Milestones

Deliverable	Timeline	Projection Submission Date
Annual Monitoring Report	Within 90 days following the end of each demonstration year	December 31, 2025-2028
Draft Evaluation Design Plan	Within 180 calendar days after demonstration approval	March 23, 2025
Final Evaluation Design Plan	Within 60 days following receipt of CMS comments on Draft Evaluation Design	Pending CMS Comment Period
Draft Interim Evaluation Report	Within one year prior to the end of the demonstration or with submission of a demonstration extension request	September 30, 2028
Revised Interim Evaluation Report	Within 60 calendar days following receipt of CMS comments on the Draft Interim Evaluation Report	Pending CMS Comment Period
Summative Evaluation Report	Within 18 months following the end of the demonstration approval period identified in these STCs	March 31, 2031
Revised Summative Evaluation Report	Within 60 calendar days after receipt of CMS comments on the Draft Summative Evaluation Report	Pending CMS Comment Period

Attachment IV:
Draft Survey Script for the Initial Survey in the Current Demonstration Extension

[Introductory Script]

Hello, my name is **(Interviewer Name)** with (**firm or agency**), Are you (**Beneficiary Name**)? (If yes, proceed). I am calling on behalf of the Mississippi Division of Medicaid. Were you enrolled in the Healthier Mississippi Waiver program between October 1, 20XX September 30, 20XX? **(If Yes, proceed. If No, thank the respondent for his or her time and end the call.)**

We are conducting a brief survey to see how you feel about the health care services you have received through the Healthier Mississippi Waiver.

You do not have to take this survey if you do not want to, but your answers would help Mississippi Medicaid see how well our health care benefits are working or what can make it better. The survey is completely voluntary, takes about 10 minutes, and all responses will remain confidential.

Would you be willing to participate in this short survey? **(If Yes, Continue. If No, thank the respondent for his or her time and end the call.)**

[Survey Questions]

1. Overall, how satisfied are you with the healthcare services covered by the Healthier Mississippi Waiver program?
(Scale of 1 to 5, where 1 = Very Dissatisfied, 2=Dissatisfied, 3=Neutral, 4=Satisfied, and 5 = Very Satisfied)

2. Do you think having access to Medicaid made your health better, worse, or remain the same?

3. In the past 12 months, did you see a doctor?

4. Have you had any problems seeing your doctor or other health care providers through this program? *(Yes/No. If Yes, ask: please specify the challenges you faced: Cost, Transportation, trouble getting an appointment, or Other – please specify.)*

5. In the past 12 months, have you received any of the following preventive health screenings or tests?

- Mammogram (Yes/No)
- Colon cancer screening (Yes/No)
- Cervical cancer screening (Yes/No)

- Diabetes screenings (HbA1c test, dilated eye exam) (Yes/No)
  (If No, ask: What was the main reason? Cost, No transportation, Didn't know it was needed, Didn't know it was covered, Had trouble getting an appointment, or other—please specify.)

6. What do you think would make this program more helpful for you? *(Open-ended)*

[Closing Statement]

Thank you so much for your time and valuable feedback. If you have any additional comments or concerns, please feel free to share them. Have a great day!

Attachment V: Estimated Timeline for Conducting a Telephone Survey

Activity	Month 1	Month 2	Month 3	Month 4	Month 5
Plan and Preparation					
Design and develop survey information to be included in the welcome mail package for new enrollees.					
Begin distributing welcome mail packages containing survey details.					
Finalize survey questions and script to ensure clarity					
Prepare enrollment and claims data to identify the survey population.					
Process and analyze data to determine eligible survey participants (HMW beneficiaries enrolled for at least 12 months at the time of data processing).					
Compile contact phone numbers for identified survey populations.					
Randomly select survey participants from the identified survey population within each region					
Survey Implementation					
Obtain access to Voxco, a professional telephone survey tool					
Integrate survey questions into the Voxco Telephone Survey Tool					
Conduct test deployment to ensure survey functionality and reliability.					
Train survey interviewers on proper survey administration techniques, including maintaining neutrality and ensuring data integrity					
Launch the telephone survey and monitor progress					
Conduct follow-up outreach to maximize response rates					
Survey Response Processing and Analysis					
Convert survey responses into structured datasets					
Process and analyze survey responses					
Reporting and Integration					
Create a written report that synthesize findings and analyzes the results of the survey					
Integrate survey findings into the annual evaluation report					

Attachment VI: Baselines of Healthier Mississippi Waiver

Table A: HMW Beneficiaries under Age 75 with Hospitalization

DY	# of Beneficiaries	# of Beneficiaries with Hospitalizations	% of Beneficiaries with Hospitalizations
15	8,745	1,730	19.8%
16	7,599	1,461	19.2%
17	7,265	1,115	15.3%
18	8,074	811	10.0%
19	9,155	760	8.3%
20	9,736	754	7.7%

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

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

DY	# of Hospitalizations	# of Preventive or Primary Care Visits before Hospitalizations	% of Preventive or Primary Care Visits before Hospitalizations
15	3,136	1,828	58.3%
16	2,467	1,472	59.7%
17	1,891	1,094	57.9%
18	1,361	704	51.7%
19	1,245	587	47.1%
20	1,251	707	56.5%

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

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

DY	# of Beneficiaries	# of Beneficiaries with Ambulatory/Preventive Visit	% of Beneficiaries with Ambulatory/Preventive Visit
15	8,745	6,694	76.5%
16	7,599	5,852	77.0%
17	7,265	5,685	78.3%
18	8,074	3,958	49.0%
19	9,155	6,126	66.9%
20	9,736	5,838	60.0%

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

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

DY	# of Female Beneficiaries	# of Female Beneficiaries Receiving Cervical Cancer Screening	% of Female Beneficiaries Receiving Cervical Cancer Screening
15	4,603	403	8.8%
16	4,069	306	7.5%
17	3,752	230	6.1%
18	3,857	164	4.3%
19	4,210	187	4.4%
20	4,339	184	4.2%

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

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

DY	# of Female Beneficiaries	# of Female Beneficiaries Receiving Mammogram	% of Female Beneficiaries Receiving Mammogram
15	3,535	724	20.5%
16	3,179	636	20.0%
17	3,155	556	17.6%
18	3,514	424	12.1%
19	3,978	389	9.8%
20	4,077	387	9.5%

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

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

DY	# of Beneficiaries	# of Beneficiaries Receiving Colorectal Cancer Screening	# of Beneficiaries Receiving Colorectal Cancer Screening
15	6,469	624	9.6%
16	5,695	511	9.0%
17	5,626	380	6.8%
18	6,316	302	4.8%
19	7,091	275	3.9%
20	7,278	274	3.8%

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

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

DY	# of Beneficiaries	# of Beneficiaries Receiving HbA1c Test	% of Beneficiaries Receiving HbA1c Test
15	3,324	1,727	50.0%
16	2,999	1,573	52.5%
17	2,876	1,449	50.4%
18	3,106	981	31.6%
19	3,404	1,167	34.3%
20	3,294	1,200	36.4%

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

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

DY	# of Beneficiaries	# of Beneficiaries Receiving Eye Exam	% of Beneficiaries Receiving Eye Exam
15	3,324	866	26.1%
16	2,999	763	25.4%
17	2,876	758	26.4%
18	3,106	457	14.7%
19	3,404	572	16.8%
20	3,294	445	13.5%

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