

## EXECUTIVE SUMMARY

Medicaid is a jointly funded federal-state program and overarching federal regulations structure much of the eligibility and coverage options available to states as they operate their state-specific Medicaid programs. In terms of coverage for long-term care services, historical Medicaid regulations have funded long-term care provided in institutional settings such as Nursing Facilities (NFs) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR). However, in recent years significant changes in Medicaid long-term care policy and funding options have occurred. As a result most states find themselves in the process of rebalancing their delivery of Medicaid long-term care services between institutional settings and community-based settings. Mississippi is no exception.

It is only relatively recently in the overall history of the Medicaid program that community-based services are being funded by Medicaid in a significant manner and in most instances states are still required to obtain a Medicaid waiver (a waiver of Medicaid regulations) to provide such community-based services. States may apply to the Centers for Medicare and Medicaid Services (CMS) for Medicaid waivers for community-based services. There are eight major types of HCBS waivers: MR/DD, aged, aged/disabled, physically disabled, children, HIV/AIDS, mental health and traumatic brain and spinal cord injuries. Waiver programs can provide a combination of medical services and non-medical services (i.e., respite, case management, transportation, environmental modifications). States can make waiver services only available to people at risk of institutionalization and not to other Medicaid beneficiaries. States can also use the income and resource rules for institutionalized Medicaid beneficiaries for the community-based waiver. Waiver programs don't have to be statewide. States specify the total number of participants in the waiver for CMS approval and can change the number of participants through an amendment to CMS for approval. States are in various stages of rebalancing activities which take advantage of these waivers and other CMS initiatives that promote home and community-based activities.

Rebalancing of long-term care delivery systems means reducing reliance on institutional care and developing increased community-based long-term care opportunities, thus developing a greater range of options for individuals to receive long-term care support services. As mentioned above, a waiver of federal Medicaid regulations is required to provide long-term care services in the community. It is only in the past decade that these waiver programs have covered more than a small number of people and in most states nursing facilities are still the primary sources of Medicaid long-term care services to the elderly. Although CMS has offered states more opportunities to expand community-based long term care services in recent years, states have found that it is a long, multi-year process to rebalance their long-term care delivery system. There are several underlying factors. Some of these factors stem from the design of Medicaid regulations, which do not place community long term care services on equal footing with institutional long-term care services. For example, nursing facility services for individuals 21 or over are mandated Medicaid services and access to these services is therefore an entitlement. This is not true of community long-term care services offered through waivers. As a result, many states find it difficult to shift funds from institutional long-term care settings to community long-term care settings. Limited Medicaid funds are often directed toward those services which are entitlements and waiver services experience waiting lists due to lack of available funding. In Mississippi, for example, funding is not currently available to fund all of the CMS approved waiver "slots" that could be used to provide additional home and community-based services. In

addition, reimbursement for institutional services may favor institutional providers in some states. For example, Mississippi's cost-based, case mix adjusted nursing home reimbursement system may also affect the ability to shift limited funds toward community-based long-term care services. Another factor that should be noted is that rebalancing options being pursued by states often are built upon concepts and infrastructure/operational needs which vary significantly from historical operation of Medicaid programs and therefore new or additional staffing support or skills may be necessary to support significant expansions in Medicaid home- and community-based programs.

Our review of the current Mississippi Medicaid program structure for providing long-term care services found that Mississippi offers a number of long-term care services, including Nursing Facilities, ICF/MR, Home Health, Personal Care, and Home and Community-Based Waivers. Mississippi has been actively rebalancing its long-term care delivery system to include more community options, and during this process has increased home and community-based services (HCBS) expenditures as a percentage of its total Medicaid long-term care spending from 3.8% in 2000 to 10.5% in 2005. This represents an annual compound rate of growth in HCBS expenditures of 35.2% over this time period. Currently there are five long-term care community-based waivers through which Medicaid covers long-term care services in community settings:

- The Elderly and Disabled waiver
- The Assisted Living waiver
- The Independent Living waiver
- The Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver
- MR/DD waiver

In terms of covered populations and services, these waivers are similar to the number and type of waivers found in comparison states and provide a solid foundation for the provision of community-based long-term care services in Mississippi.

In addition to operating these waiver programs, Mississippi has other efforts that reflect ongoing changes in Medicaid policy to rebalance the delivery of long-term care services:

- The Division of Medicaid is in the process of developing a comprehensive pre-admission screening process that, among other things, provides for comparable eligibility criteria for nursing facility services and Medicaid waiver HCBS. Specifically, the new pre-admission screening process and instrument are being designed to fill two primary functions: 1) determine eligibility for Medicaid long-term care across both institutional and HCBS service settings; and 2) facilitate informed choices by persons applying for services. This new pre-admission process is scheduled for implementation October 1, 2007. Under the process being established, all persons seeking long-term care services will be assessed for clinical eligibility using a common instrument and screening criteria, regardless of where they apply. The screening process will require that individuals provide information to be used in facilitating an informed choice of service settings.

In terms of assessing the strengths and gaps in the current Mississippi Medicaid long-term care program, EPP reviewed the demographics of Mississippi and the current Medicaid long-term care program structure. We examined the Mississippi program over time and then also

compared it to Medicaid long-term programs in comparison states.

Based on this review, we found that even with the large increase in Medicaid funding of HCBS in recent years, the overarching gap in the delivery of Medicaid long-term care services is in the relative portion of resources available to HCBS programs. It appears that the long-term care service delivery in Mississippi continues to reflect the historical institutional emphasis of the federal Medicaid program. For example:

- Mississippi ranks 11<sup>th</sup> in its Medicaid nursing home expenditures as a percentage of the total Medicaid long-term care expenditures at 65.1%, well above the national average of 50.0%
- Mississippi ranks 7th in its Medicaid ICF/MR expenditures as a percentage of its total Medicaid long-term care spending at 22.2%, well above the national average of 12.8%.
- Mississippi ranks last in terms of all community-based services as a percentage of its total Medicaid long-term care expenditures. Mississippi dedicates 12.7% of its Medicaid long-term care expenditures to community-based care, which is significantly lower than the national average of 36.9% of long-term care expenditures spent on community-based services.
- When compared to the following states (Arkansas, Florida, Georgia, Louisiana and South Carolina), Mississippi still appears to have a relatively greater reliance on institutional care within its Medicaid long-term care delivery system. In terms of Medicaid HCBS expenditures as a percentage of total Medicaid long-term care spending Mississippi ranks lower than any of the comparison states. Only two of the comparison states have Medicaid HCBS expenditures less than 20% of total Medicaid long-term care expenditures. Arkansas, at 16.8%, and Louisiana, at 17.9% use less than 20% of their total Medicaid long-term care expenditures towards HCBS.
- While Mississippi spends significantly more than the comparison states and the US average for nursing home care, Mississippi only spends a third of the national average on HCBS waiver expenditures. Other states, including the comparison states have been more successful in substituting community-based care and HCBS waivers for nursing home expenditures than Mississippi.

In addition to rebalancing funding allocations between institutional and community-based settings, as states have rebalanced their long-term care systems, CMS has encouraged and states are increasingly taking advantage of options to incorporate less traditional Medicaid concepts into their program design, such as consumer-direction. Mississippi's current waiver programs incorporate many of the building blocks of consumer-direction, including person-centered planning, consumer choice and decision making. However, as part of their long-term care system rebalancing, a number of state Medicaid programs have included a broader consumer-direction design, including the ability for people to select, supervise and dismiss their own direct care workers, the ability to hire non-agency direct care support staff, including family members, and the ability to have increased flexibility to spend long-term care services funds on things other than services. All of the comparison states in our study had at least one self-

direction option within their community-based waiver programs. Although a relatively new concept, the speed at which consumer-directed Medicaid programs have grown across the country will increasingly lead to the lack of a consumer-directed option being considered a gap in Mississippi's long-term care system.

At a more detailed level, additional gaps in Mississippi's long-term care system are more targeted gaps in terms of populations, services and/or service settings. As mentioned above, the existing Medicaid waivers provide a strong foundation of community-service coverage. It may be noted that Mississippi has a MR/DD waiver and an Assisted Living waiver which covers Alzheimer's and dementia but no other waivers pertaining to mental health. Some other states have waivers for Community Mental Health Services, Persons with Mental Illness, Severe Emotional Disturbances, and Children's Mental Health.

As noted above, the State has recently been awarded a grant for use in developing alternatives to institutions for children with mental illness. The State has identified the need for more community settings and has recently pursued grant funds to develop adult foster care as an additional community setting. This setting has increasingly been used with success in other states.

Given that the relative lack of rebalancing toward community services was identified as the most significant gap in the State's Medicaid long-term care system, we examined potential barriers to Mississippi's ability to address rebalancing:

- ❑ The variation in coverage of prescription medications in nursing facilities versus community settings is a barrier to rebalancing services and in some ways is a "gap" in the long-term care system that may represent a barrier to rebalancing. Currently, federal Medicaid policy requires unlimited coverage of prescription medication in nursing facilities. However, each state may determine coverage for prescription drugs for non-institutionalized adults. Currently in Mississippi, waiver participants are limited to specified state plan prescription benefits (five prescriptions per month). With the expansion of Medicare's prescription drug coverage, the potential impact of this differential is less than in the past. However, for many people with only Medicaid coverage, the unlimited prescription coverage in institutions may discourage them from transitioning to community-based care, limiting their choice.
- ❑ A greater barrier to rebalancing stems in part from the lack of equal capacity across nursing facility and home and community-based services settings. A barrier to Mississippi being able to further rebalance its Medicaid long-term care system is the inadequate funding compared to demand which leads to waiting lists that exist for some of the community-based waivers. Mississippi is not alone in having waiting lists for community services. As of 2005 the Kaiser Commission on Medicaid and the Uninsured found that only 15 of the responding states reported zero people on waiting lists for Medicaid 1915(c) HCBS waivers. (Four states reported having an unknown number of individuals on waiting lists and 21 states reported having fewer than 500 individuals on waiting lists. The remaining states reported having more than 500 individuals on waiting lists.) The average waiting time for HCBS waivers nationally was reported as 20 months. Currently Mississippi has a waiting list of approximately 6,500 – 7,000 people for the

Elderly and Disabled waiver. The Assisted Living, TBI/SCI and Independent Living waivers have waiting lists of 56, 44 and 899 individuals respectively.

- An additional barrier many states face during rebalancing is the difficulty in moving money from nursing facility services to home and community-based services without an increase in overall state Medicaid expenditures. This is true for two reasons. The first factor is that as people move from nursing facilities to community settings, those nursing facility beds that have just become vacant are filled with a new person in need of long-term care services. This is often referred to as “backfilling of beds.” The second reason is that because of the case mix adjusted cost-based nature of reimbursement for nursing facility services in Mississippi as well as some other states, the Medicaid program has less flexibility to adjust nursing home reimbursement than it does with respect to reimbursement of community-based services.
- The new or additional staffing, staffing skills and/or additional infrastructure to support major rebalancing efforts may also be a barrier to large scale rebalancing efforts. For example, states often support consumer-directed service programs through the use of a fiscal intermediary (FI). Since 2002 more than 15 states have implemented programs utilizing FIs. The FI provides technical assistance to waiver participants who hire and supervise their own direct care staff to help assure that appropriate taxes and fees are deducted and funds are disbursed appropriately. The full range of services varies for each state waiver. The initial wave of states using fiscal intermediary services has resulted in a number of innovative ideas. For example, South Carolina has an FI contractor who collects information about in-home services through an electronic monitoring system it operates for the state. The monitoring system is telephone-based and requires the provider to telephone a dedicated number indicating his arrival at the customer’s location. In the event that the provider does not arrive at the consumer’s location, the consumer telephones a different number which indicates that the provider has not arrived. The monitoring system helps track provider absenteeism rates and allows the fiscal intermediary to assist the consumer in locating and procuring replacement services. This is just one example of how rebalancing efforts in many states are incorporating a great degree of technology for informing people about Medicaid long-term care services, tracking enrollment, delivering services and/or monitoring quality.
- In their Money Follow the Person Demonstration Grant awards, a number of states are training peer counselors to provide intensive transitional support before discharge and continuing into the community and adding home and community-based demonstration services such as service animals and adaptive devices to help modify the enrollee’s environment. These are new programs so there is no information on their effect on the number of transitions or impact on state budgets.

As Mississippi moves forward in its rebalancing efforts, such as the Aging and Disability Resource Center and comprehensive pre-admission screening initiatives, it will be important to identify and evaluate further initiatives to address the above barriers.

Recent legislation has been adopted addressing the development of additional options for Medicaid members in need of long term care services. However, as is often the case, creating

more options has implications for the system that must be considered. For example, Section 43-11-1 of the Mississippi Code of 1972 (as amended by 2007 Senate Bill 2416) authorizes the Division of Medicaid to apply for waivers for adults to receive care in Adult Foster Care settings. However, Adult Foster care is created under the category of group living arrangements for four (4) or more people, which then limits the flexibility of the Adult Foster Care option and is in contrast with the philosophy underlying CMS' Money Follows the Persons grants, which limits eligible living arrangements to four (4) people *or fewer*. Section 43-13-107 of the Mississippi Code of 1972 (as amended by House Bill 528), which authorizes the transfer of funds allocated for nursing facility services for eligible residents to cover the cost of waiver services, reflects a direction many states are pursuing to rebalance their long term care delivery systems. Often such initiatives are combined with other initiatives in order to keep the overall system budget neutral. Such initiatives may include changes in nursing home reimbursement methodology, the creation of incentives for nursing home beds to be reduced and overall uniform budgeting initiatives across all long-term care services. Without a combination of approaches, it is likely that additional funds will transfer to the community setting without a reduction in nursing facility expenditures. The result will be a rebalancing of services to the extent that additional dollars are devoted to community settings; however, the rebalancing is likely to be accompanied with an overall increase in the amount of funds devoted to long term care services.

Mississippi's demographics highlight the importance of the State's long-term care delivery system. Mississippi's demographic information shows that while the State's population is growing at a slower rate than the U.S. population overall, the portion of Mississippi residents between the ages of 65 and 74 is the single age group in the state growing at a rate faster than the U.S. average. In addition, a review of available information on chronic conditions shows that Mississippi's population also has a higher rate of disability than the national average, especially among the elderly. Given these demographic patterns, the structure of the long-term care delivery system will take on added importance as the population ages.

## **SECTION I: OVERVIEW OF CURRENT MISSISSIPPI MEDICAID PROGRAM**

Section I presents descriptions of the elderly and disabled population in Mississippi and recent trends. The overview of current long-term care service design discusses Mississippi state plan options and waivers. The entry into the long-term care systems summarizes the points of entry in Mississippi, the Long Term Care Alternatives Program and the upcoming Aging and Disability Resource Center. Current long term care utilization rates are also analyzed.

The elderly population in Mississippi is projected to grow faster than the national average and have a high disability rate, leading to a higher demand for long-term care services.

Mississippi has five major long term care waivers which have different points of entry:

- ❑ The Elderly and Disabled waiver
- ❑ The Assisted Living waiver
- ❑ The Independent Living waiver
- ❑ The Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver
- ❑ MR/DD waiver

The Long Term Care Alternatives Program contacts nursing home applicants and/or their families to discuss community-based alternatives. The Aging and Disability Resource Center will create a single coordinated system of information. In recent years Mississippi has increased the number of individuals participating in HCBS waivers by nearly 400% but Mississippi still has among the lowest HCBS expenditures as a percentage of long-term care spending.

### **A. Overview of Mississippi Population and Trends**

The purpose of this section is to provide background information on the demographics of Mississippi's population to help understand the increasing role that long-term care services will play in upcoming decades. Population trends indicate that the population of Mississippi is going to shift toward older demographics. According to the Bureau of Labor Statistics, the overall population in Mississippi is predicted to increase 8.7% between 2000 and 2030. The largest increase will be the number of Mississippi residents age 45 and older. As shown in the table on the next page, the population of Mississippi residents between the ages of 45 and 64 is expected to increase by 27.5% while the population of individuals age 65 and older is expected to increase by 84.6%. The remaining age groups are predicted to decrease.

In 2000 the elderly were 12.1% of the total population in Mississippi, ranking it below the national average and 35<sup>th</sup> among the states. By 2030, the elderly will be 20.5% of the total population in Mississippi, ranking it above the national average and 23<sup>rd</sup> among the states. The elderly population is projected to grow faster in Mississippi than the national average. More than half (54.3%) of the elderly population in Mississippi were disabled in 2005, significantly higher than the 40.5% disability rate for U.S. elderly overall. The increase in the elderly who are also more likely to be disabled in Mississippi will require more long-term care services.

## Population Projection for Mississippi, By Age, 2000-2030<sup>1</sup>

Years	2000	2005	2010	2015	2020	2025	2030	Percentage Change
0-4	204,364	217,735	211,215	202,636	194,779	194,814	199,382	-2.4%
5-13	391,577	376,323	379,548	382,488	369,146	355,740	351,103	-10.3%
14-17	179,246	177,357	168,687	167,423	173,129	167,486	161,537	-9.9%
18-24	310,974	294,575	282,092	272,093	267,469	277,630	270,323	-13.1%
25-44	807,170	789,914	769,623	755,792	740,800	711,937	701,189	-13.1%
45-64	607,804	705,509	781,222	800,549	800,299	788,270	774,809	27.5%
65+	343,523	354,283	379,025	433,428	499,190	573,543	634,067	84.6%
<b>Total</b>	<b>2,844,658</b>	<b>2,915,696</b>	<b>2,971,412</b>	<b>3,014,409</b>	<b>3,044,812</b>	<b>3,069,420</b>	<b>3,092,410</b>	<b>8.7%</b>

### Elderly Population

From 1994 to 2004 the population in Mississippi grew at a rate lower than the national average. The only Mississippi population that grew at a faster rate than the national average was for ages 65-74, which increased by 4.3%. This is well above the 1.0% increase for the same age group nationally. However, during this same period of time, Mississippi experienced a much lower rate of increase than the national average for residents ages 75 and above. Mississippi's 9.7% increase was well below the 24.2% increase nationally.

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<sup>1</sup> Bureau of Labor Statistics, "Interim Projections of the Population by Selected Age Groups for the United State and States: April 1, 2000 to July 1, 2030", Released April 2005.

### Population Rates of Increase, 1994 – 2004<sup>2</sup>

	MS Population		Percent Change 1994-2004	
	1994	2004	MS	US
<b>Total Population</b>	2,663,450	2,902,966	9.0%	12.8%
<b>Males</b>	1,275,967	1,408,733	10.4%	13.8%
Under Age 18	385,585	382,712	-0.7%	7.8%
Ages 18-64	760,420	882,687	16.1%	16.7%
Ages 65-74	79,103	85,589	8.2%	1.6%
Ages 75 and Over	50,859	57,745	13.5%	28.8%
<b>Females</b>	1,387,483	1,494,233	7.7%	11.9%
Under Age 18	369,279	366,587	-0.7%	8.1%
Ages 18-64	817,365	917,843	12.3%	14.6%
Ages 65-74	105,520	106,929	1.3%	-3.6%
Ages 75 and Over	95,319	102,604	7.6%	19.6%
<b>Total by Ages</b>	2,663,450	2,902,966	9.0%	12.9%
Under Age 18	754,864	749,299	-0.7%	8.0%
Ages 18-64	1,577,785	1,800,530	14.1%	15.7%
Ages 65-74	184,623	192,518	4.3%	-1.0%
Ages 75 and Over	146,178	160,349	9.7%	24.2%

#### Disabled Population

The percentage of Mississippians with disabilities is above the national average for all age groups. This is especially true for residents age 65 and older. According to the 2005 American Community Survey reported by the U.S. Bureau of Labor Statistics, more than one-half of all Mississippi residents age 65 and older live with a disability, significantly higher than the U.S. average of 40.5%. Mississippi ranks number one among states as having the highest percentage of elderly with a disability. The table on the following page, *Disability Status of the Civilian Non-Institutionalized Population*, highlights the difference between the disabled population in Mississippi versus the rest of the country.

For the American Community Survey, the U.S. Census Bureau defined a disability as:

*...a long-lasting sensory, physical, mental, or emotional condition. This condition can make it difficult for a person to do activities such as walking, climbing stairs, dressing, bathing, learning, or remembering. It can impede a person from being able to go outside the home alone or to work at a job or business, and it includes persons with severe vision or hearing impairments.*

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<sup>2</sup> Baer, David, *State Handbook of Economic, Demographic, and Fiscal Indicators, 2006*, AARP Public Policy Institute, 2006

The U.S. Census Bureau used six (6) disability items to determine an individual’s disability status. These are:

- ❑ Sensory Limitations
- ❑ Physical Limitations
- ❑ Limitations in Cognitive Functioning (“Mental Disability”)
- ❑ Self-Care Limitations
- ❑ Going-Outside-Home Limitations
- ❑ Employment Limitations

Individuals aged 16-64 were classified by the U.S. Census Bureau as having a disability if they reported at least one of the above six conditions. Children aged 5-15 were classified as having a disability if they reported any one of the following four conditions: sensory limitations, physical limitations, limitations in cognitive functioning, or self-care limitations. Individuals over age 65 were classified as having a disability if they reported any one of the following five conditions: sensory limitations, physical limitations, limitations in cognitive functioning, self-care limitations, or going-outside-home limitations.

**Disability Status of the Civilian Non-Institutionalized Population<sup>3</sup>**

	Mississippi Estimate	U.S. Estimate
<b>5-15 Years</b>		
Population	448,770	44,586,147
With Disability	35,336	2,886,534
<i>% with Disability</i>	<i>7.9%</i>	<i>6.5%</i>
<b>16-64 Years</b>		
Population	1,818,313	188,041,309
With Disability	329,726	22,790,299
<i>% With Disability</i>	<i>18.1%</i>	<i>12.1%</i>
<b>65 Years and Over</b>		
Population	337,462	34,760,527
With Disability	183,161	14,063,876
<i>% With Disability</i>	<i>54.3%</i>	<i>40.5%</i>

**B. Overview of Current Long-Term Care Service Design**

The purpose of this section is to provide information about the long-term care services that are being provided through Mississippi’s Medicaid program. As is common across states, a portion of Mississippi’s Medicaid long-term care services are operated by the state’s Medicaid agency, the Division of Medicaid, while other programs are operated by sister agencies that have a

<sup>3</sup> U.S. Census Bureau, “2005 American Community Survey, Selected Social Characteristics in the United States”, 2005

memorandum of understanding with the Division of Medicaid. It should also be noted that the Medicaid program is a jointly funded federal-state program. The state dollars toward funding Medicaid are called “state match dollars.” In Mississippi some of these state match dollars are within the Division of Medicaid’s legislatively approved budget while other legislative funds are in sister agency budgets.

Under the Medicaid program, there are mandatory services and optional services that may be offered through the program. Mandatory and optional services are determined by federal regulation. For example, coverage of nursing facility services for those under age 21 is an optional service but is offered by all 50 states. The State Plan is the document in which each state describes its Medicaid coverage and payment methodologies for federal approval. Mississippi covers optional long-term care services under its State Plan including home health services and nursing facility services for individuals under age 21 and ICF/MR. Federal Medicaid regulations also allow states to apply for and receive a “waiver” of specific regulations. The majority of home and community-based long term care services must be provided under a Medicaid waiver program. States may apply to the federal Centers for Medicare and Medicaid Services (CMS) for Medicaid waivers for community-based services. There are two broad categories of waivers, a 1915(c) home and community based waiver and an 1115 research and demonstration waiver that states have used to implement community long-term care programs. It should be noted that CMS approved waivers have a specific approval period (3 – 5 years) and then must be renewed. In addition, waiver programs must not cost more than the coverage would have cost without the waiver (referred to as budget neutrality).

- ❑ **1915c Waivers:** These waivers are often referred to as "Home and Community-Based Service" waivers because of their focus on waiving portions of federal requirements for community-based treatment.
- ❑ **1115 Waivers:** These are also referred to as "Research and Demonstration" waivers. These waivers are often used for broader more complex program designs that require multiple Medicaid requirements to be waived. The 1115 waivers are for demonstration projects of system reform and are approved for five years.

Mississippi has multiple Medicaid waiver programs, including five waiver programs targeted for community-based long-term care services. At the present time Mississippi has CMS approved waiver “slots” that cannot be fully used due to lack of funding. Over the course of a year more individuals may be served in total than there are approved slots, this is because of turnover in the program. At any given time there are fewer participants in some of Mississippi’s HCBS waivers than the total number approved by CMS due to lack of available full funding.

### State Plan Options

Mississippi’s long-term care support system provides institutional and home and community-based services. Services are provided through the State Plan, and through waivers. Mississippi

offers the following optional Medicaid Services under its State Plan:<sup>4</sup>

- ❑ Targeted Case Management Services
- ❑ Chiropractic Services
- ❑ Christian Science Sanatoria
- ❑ Clinic Services (ambulatory surgical centers, birthing centers, and freestanding dialysis centers)
- ❑ Dental Services
- ❑ Disease Management Services
- ❑ Durable Medical Equipment (DME) and Supplies
- ❑ Emergency Hospital Services
- ❑ Eyeglasses
- ❑ Extended Services to Pregnant Women
- ❑ Home Health Services for Individuals Under Age 21
- ❑ Hospice Care
- ❑ Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
- ❑ Inpatient Psychiatric Facility Services for Individuals Under Age 21
- ❑ Nurse Practitioner Services
- ❑ Nursing Facility Services for Individuals Under Age 21 (NF Over Age 21 is mandatory)
- ❑ Other Diagnostic, Screening, Preventive, and Rehabilitation Services (Mental Health Services)
- ❑ Physician Assistant Services
- ❑ Podiatrist Services
- ❑ Prescribed Drugs

These services do not include services that are also covered under the State's various home and community-based waivers. Also, since Mississippi provides nursing facility services to beneficiaries under 21, home health services are mandatory. However, since nursing facility services to beneficiaries under 21 are optional, home health for this population is listed as an optional service.

State Plan Amendment (SPA) 2005-011, effective date July 1, 2005, was filed to allow the Division of Medicaid (DOM) to: (1) reduce the number of home health service visits from 60 to 25 per year; (2) remove the skill requirement for nursing aides; (3) retain consistency between SPA and agency policies related to medical supplies through home health services; and (4) delete physical therapy and speech pathology as covered services through the home health program.<sup>5</sup> State Plan Amendment 2005-0006 allows the Division of Medicaid to eliminate the optional category of eligibility for hospice individuals under 300% of the SSI limit as required by House Bill 1104.<sup>6</sup>

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<sup>4</sup>Analysis of the Mississippi Medicaid Program, Report Two of Two, submitted to the Mississippi Joint Legislative Committee on Performance Evaluation and Expenditure Review (PEER), submitted November 5, 2002.

<sup>5</sup> Mississippi Division of Medicaid Web site, [http://www.dom.state.ms.us/ltc\\_alternative/ltc\\_alternative.html](http://www.dom.state.ms.us/ltc_alternative/ltc_alternative.html) Accessed August 10, 2006.

<sup>6</sup> Ibid.

## Waivers Options

Mississippi currently has the following Medicaid waivers in place:

- ❑ Mississippi Non-Emergency Transportation 1915(b) This waiver provides for an in-house broker model to oversee group and individual transportation providers in 32 service regions.
- ❑ Mississippi Family Planning 1115 The primary objective of the demonstration is to reduce State and Federal maternity care expenditures by reducing the number of births resulting from unintended pregnancies. Subsequent to the initial design of the proposal, provisions to include access to primary care services have also been included.
- ❑ Healthier Mississippi 1115 Demonstration to cover a portion of an optional Medicaid eligibility group (called the “Poverty Level Aged and Disabled” (PLAD) group) that was eliminated from the State Plan.
- ❑ Independent Living Home & Community –Based Services Waiver 1915(c) This waiver is intended to provide case management, personal care and special medical equipment and supplies to individuals with severe orthopedic and/or neurological impairments, disabled age 21-64.
- ❑ Elderly & Disabled HCBS Waiver 1915 (c) This waiver provides case management, homemaker, respite, adult day care, home health, home delivered meals and escorted transportation to aged and disabled individuals.
- ❑ MR/DD 1915 (c) This waiver provides support coordination, respite care, habilitation (residential, day, prevocational and supported employment), specialized med equip & supplies, attendant care, Physical Therapy (PT), Occupational Therapy (OT), Speech, Hearing, and Language Therapy (SHL), behavior support & intervention services.
- ❑ Assisted Living 1915 (c) This assisted living waiver provides case management, adult residential care and assisted living services to individuals 21 and over who are disabled and require assistance with at least three activities of daily living services or have a diagnosis of Alzheimer’s Disease or another type of dementia and require substantial human assistance with two or more activities of daily living.
- ❑ TBI/SCI 1915(c) This waiver provides case management, in-home and institutional respite, attendant care, environmental modifications and specialized medical equipment and supplies for individuals with TBI or spinal cord injury.
- ❑ Mississippi Hurricane Katrina Relief Program 1115 Katrina Waivers The demonstration waivers and expenditure authorities designated as 1115 Katrina Waivers and accompanying state specific Special Terms and Conditions will assist each state in providing Medicaid and SCHIP coverage for evacuees who have been

displaced as a result of Hurricane Katrina.

Five of these waivers are 1915(c) waivers that serve people who would otherwise reside in a Nursing Facility or other institutional settings. They are:

- ❑ The Elderly and Disabled waiver
- ❑ The Assisted Living waiver
- ❑ The Independent Living waiver
- ❑ The Traumatic Brain Injury/ Spinal Cord Injury (TBI/SCI) waiver

The Bureau of Mental Health Services Division (Special Mental Health Initiatives Division) administers the Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration Grant (CA-PRTF) to create home and community-based alternatives for children currently institutionalized for serious emotional disturbance. Alternatives include 24-hour support and crisis intervention in the community setting, training for families and respite care. Mississippi plans to conduct the CA-PRTF demonstration in conjunction with a CMS 1915 (c) waiver (application submitted in May 2007).

Each of these waiver programs is described below.<sup>7</sup>

#### *Elderly and Disabled Waiver*

The Elderly and Disabled (E/D) waiver program was implemented in its current form in 2002 (it was originally implemented in 1986). It provides home and community-based services to individuals over the age of 21 who meet applicable financial and medical criteria. The following services are available under the waiver: case management, adult day health care, home delivered meals, homemaker (which includes assistance with activities of daily living (ADLs)), escorted transportation, institutional respite, in-home respite, and extended home health.

The Elderly and Disabled waiver program is administered by Division of Medicaid's (DOM) Home and Community-Based Services (HCBS) Division, and case management services are provided by the Area Agencies on Aging (AAA) within the Planning and Development Districts (PDDs). The entry point for the waiver is the PDDs. Individuals are referred to the PDDs by various entities, including the DOM regional offices, health care providers, social service agencies, advocacy groups, and other state agencies. Within five business days of receiving the referral information, the PDD case management team (consisting of a registered nurse and a licensed social worker) contacts the person to gather additional information and makes an initial determination regarding medical eligibility. If the person meets the initial qualifications, the case management team arranges a visit with the individual. At that visit, generally in the person's home, the team conducts an assessment and completes various forms, including a plan of care, and authorization to release health/medical information. After the home visit the team contacts the person's physician to complete the physician certification form.

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<sup>7</sup> Source for information on waiver programs: Mississippi 1915(c) waiver applications, website, CMS website, and conversations with DOM and MDRS staff.

Individuals must meet both Medicaid financial and waiver medical criteria to receive waiver services. To meet the financial criteria individuals must qualify for one of the following Medicaid eligibility categories: SSI or 300% of SSI. In order to be medically eligible the person must require the level of care provided in a nursing facility and must have deficits in at least three of their ADLs. Medical eligibility is determined by physician certification. If a physician completes the form certifying that the person needs assistance with three ADLs and meets the medical criteria for nursing facility care, the person is medically eligible for the waiver. Once the PDD has completed and collected the necessary forms, these forms are sent to the HCBS Division for review. A Registered Nurse at the Division reviews the paperwork to verify that all required forms are included and completed properly. The nurse also reviews the assessment and plan of care to ensure that the proposed services are appropriate. In general, if the paperwork is correct and the services are appropriate, the nurse sends the PDD a cover letter along with other documents (e.g., the approved plan of care). The case management team then notifies the consumer that services can begin.

If the person is not a Medicaid beneficiary the nurse notifies the PDD via a letter that the person is medically eligible for the waiver but is not eligible for Medicaid. The PDD then notifies the applicant and helps them complete the Medicaid application. If the person is determined eligible for Medicaid, the regional office sends written notification to the consumer as well as the nurse, and the standard process continues (the nurse sends a cover letter, etc.). If the person is not eligible for Medicaid, the regional office issues a notice of ineligibility to the consumer and notifies the nurse, and the nurse notifies the PDD in writing.

Once the person is financially and medically eligible, the case management team coordinates and monitors services. Monitoring includes monthly, quarterly, and annual visits. The team updates the plan of care as necessary, but at least quarterly. Also, as part of the annual recertification process the team conducts a recertification needs assessment and obtains a new physician certification that the person meets the medical criteria. As with the initial application, the assessment, plan of care and physician certification are sent to the HCBS Division for review by a Registered Nurse.

If everything is in order, the nurse sends the PDD team a cover letter with attachments. If the person is eligible for Medicaid through the 300% of SSI category, the nurse also sends a notice to the regional office so that Medicaid eligibility continues. If the person is no longer medically eligible, the nurse notifies the PDD, who notifies the consumer. If the person is eligible for Medicaid through the 300% of SSI category, but no longer medically eligible for the waiver, then the nurse notifies the Medicaid regional office, and the regional office will determine if the person is otherwise eligible for Medicaid.

### *Assisted Living Waiver*

The Assisted Living waiver was implemented in 2000 in seven counties. In July, 2003 the State received authority to remove the seven county restriction. The Assisted Living waiver provides case management and assisted living services to individuals 21 years of age or older who meet the applicable financial and medical criteria. The financial criteria are the same as for the Elderly and Disabled waiver. In order to be medically eligible the person must meet the nursing facility level of care and either (1) require assistance with at least three activities of daily living

(ADLs), or (2) have a diagnosis of Alzheimer's or another type of dementia and require assistance with two or more activities of daily living. As with the Elderly and Disabled waiver, a physician must certify that a person meets the medical criteria. Assisted living services can be provided in licensed Assisted Living personal care homes, community residential care facilities, or in a congregate housing services program that meet the criteria to be designated as an Assisted Living provider.

The Assisted Living waiver is also administered by DOM's HCBS Division with case management provided by DOM licensed social workers. The process for entry into the waiver is very similar to that for the Elderly and Disabled waiver. The HCBS Division is the point of entry, and individuals are referred to the division by various entities. However, the most common referral source is an assisted living personal care provider. Once the division case manager receives a referral, they contact the individual within five working days and make an initial determination as to whether the person meets the medical criteria. If the initial qualifications are met, the case manager visits the person (generally at the facility) to conduct an assessment and completes the same forms required for the Elderly and Disabled waiver and some additional forms that are specific for Assisted Living. As with the Elderly and Disabled waiver, these forms are sent to the division for review by a registered nurse. The process from nurse review to notice to the consumer regarding eligibility is the same as for the Elderly and Disabled waiver (see above) except that the division case manager is substituted for the PDD.

Once it is determined that the person meets the financial and medical criteria, the case manager monitors service provision, including monthly, quarterly, and annual visits. Also, as with the Elderly and Disabled waiver, the case manager assists with the annual recertification process. The steps in this process are the same as for the Elderly and Disabled waiver, except that the division case manager is substituted for the PDD.

### *Independent Living Waiver*

The Independent Living (IL) waiver program was implemented in 1994 and was amended in 1999 to remove the age restriction and allow deinstitutionalized people to be served. It provides case management, personal care, and specialized medical equipment and supplies to individuals who meet applicable financial and medical criteria.

The financial criteria are the same as for the Elderly and Disabled waiver except that individuals eligible for Medicaid under Temporary Assistance for Needy Families (TANF) may also participate. To be medically eligible a person must: (1) meet the nursing facility level of care; (2) have severe orthopedic and/or neurological impairments that render the individual dependent upon others, assistive devices, and/or other types of assistance to accomplish the activities of daily living; (3) be certified as medically stable by their primary care physician; and (4) be able to communicate effectively with caregivers and providers.

In conjunction with DOM, the Department of Rehabilitation Services, Office of Special Disability Programs (OSDP) administers the Independent Living waiver. OSDP also provides case management services using teams consisting of a Registered Nurse and a rehabilitation counselor. OSDP is the entry point, and individuals are referred to OSDP by various entities. Once the case management team receives a referral, they contact the individual within 14

working days and collect referral information. All referrals are entered into the referral module in OSDP's case management system. The next several steps in the process are similar to the Elderly and Disabled (E/D) waiver except that the OSDP case management team is substituted for the PDD and some of the forms are different – the team meets with the consumer to conduct an assessment and complete various forms, obtains the physician certification form, and sends required forms to the HCBS Division for review by a nurse. Unlike in the E/D waiver, the physician certification alone is not sufficient to meet the level of care. The recipient must be able to communicate effectively with caregivers, personal care attendants, case managers, and others involved in their care. The DOM/long term care nurse must determine that the other medical criteria are met. Once the nurse reviews the packet notifying the consumer of their eligibility, the process is the same as for the Elderly and Disabled waiver (see above) except that the OSDP case management team is substituted for the PDD. Once it is determined that the person meets the financial and medical criteria, the case management team assists the consumer in selecting a personal care attendant and completing the employment forms, coordinates services, and monitors service provision. Monitoring includes monthly contact and at least quarterly face to face visits for plan of care updates. Also, as with the E/D waiver, the case management team assists with the annual recertification process. The steps in this process are the same as for the Elderly and Disabled waiver, except that the OSDP case management team is substituted for the PDD.

#### *TBI/SCI Waiver*

The Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver program was implemented in 2001. It provides home and community-based services to individuals who meet applicable financial and medical criteria. The financial criteria are the same as for the IL waiver. To be medically eligible a person must: (1) meet the nursing facility level of care; (2) have a traumatic (defined as an insult to the skull, brain, or its covering resulting from external trauma) brain injury which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficit OR a spinal cord injury (defined as a traumatic injury to the spinal cord or cauda equina) with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction (the lesions must have significant involvement with two of the above three); and (3) be certified as medically stable by their primary care physician.

Services available under the waiver are: case management, in-home nursing respite, in-home companion respite, institutional respite, attendant care, environmental accessibility adaptations, and specialized medical equipment and supplies.

The TBI/SCI Waiver is administered in conjunction with DOM by OSDP in the Department of Rehabilitation Services. As in the Independent Living waiver, OSDP also provides case management services using teams consisting of a registered nurse and a rehabilitation counselor. Individuals may be referred to OSDP by various entities. Individuals may be referred to OSDP by various entities and once the case management team receives a referral, the remaining steps are the same as for the Independent Living waiver.

## *MR/DD Waiver*

The MR/DD Waiver provides services to individuals with mental retardation and developmental disabilities who would require placement in an ICF/MR without the provision of home and community-based service. Individuals must qualify for the program through one of the following eligibility categories:

- ❑ SSI
- ❑ TANF
- ❑ Disabled Child Living at Home
- ❑ Or Income up to 300% of the SSI Federal benefit rate

The MR/DD is administered by the Division of Medicaid and the Department of Mental Health through an interagency agreement. All individuals eligible for the MR/DD Waiver receive Support Coordination services. Waiver Support Coordinators are responsible for arranging assessment of individuals referred for the Waiver Program. They develop the written plan of care for each eligible individual, and assist him/her in locating and gaining access to all services on the plan of care whether it is a waiver service or not. They are also responsible for ongoing evaluation of the continued effectiveness and appropriateness of identified services

The following services are offered under the MR/DD Waiver:

- ❑ Habilitation
- ❑ Behavior Support Intervention
- ❑ Respite Care
- ❑ Support Coordination
- ❑ Attendant Care Services
- ❑ Specialized Medical Services
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Speech, Hearing and Language Therapy

There are currently waiting lists for enrolling in some of the waiver programs. There are 56 on the waiting list for the Assisted Living waiver and 1,200 on the waiting list for the MR/DD waiver. The Elderly and Disabled waiver has a waiting list of 6,500 to 7,000. The TBI/SCI waiver has 44 people on a waiting list and the IL waiver has 899 people on a waiting list.

### **C. Entry into Long-Term Care Systems**

There are different points of entry for the various waiver programs. The Long Term Care Alternatives program contacts nursing home applicants and their families to provide information about community-based alternatives.

### Point of Entry<sup>8</sup>

The Area Agencies on Aging (AAAs) of the Planning Development Districts (PDD), which also administer various non-Medicaid services, are the single point of entry for the Elderly and Disabled waiver. DOM is the single point of entry for the Assisted Living waiver. The Department of Rehabilitative Services (MDRS) is the single point of entry for its services, including the Independent Living and TBI/SCI waivers and three non-Medicaid programs.

### Long Term Care Alternatives Program<sup>9</sup>

The Long Term Care Alternatives program was authorized by the State legislature in 1999 and implemented statewide on November 1, 1999. DOM contracts on an annual basis with the local AAAs through the PDDs. The PDDs contact Medicaid beneficiaries and applicants who apply for admission to nursing facilities to discuss community-based alternatives. If home and community-based services are available, the individual can choose a home and community-based alternative to nursing facility placement. The individual is also advised if appropriate home or community-based services are not available.

Within 24 hours of completing the physician's certification for nursing facility care for someone who does not require an evaluation by the Department of Mental Health, the physician must fax a copy to the DOM State Office. Upon receipt of the certification, DOM faxes a copy to the PDD licensed social worker (LSW). The LSW is required by contract to contact or attempt to contact the person and/or family member the day of receipt of the certification from DOM. If requested by the family/person, the LSW conducts home visits to discuss the LTCA program; otherwise, the LSW will mail information. According to DOM data, in state fiscal year 2006, the PDDs contacted 1,172 individuals.

In addition to following-up on every nursing facility certification, the LSW conducts various outreach activities. For example, the current contract requires the LSW to: (1) visit an in-service staff at each hospital, nursing facility, personal care home/assisted living facility, adult day care center, and home health agency in the PDD catchment area no less than twice per year; (2) provide literature about the LTCA program to families, beneficiaries, providers, and community contacts; and (3) visit regional Medicaid offices in the PDD area quarterly to share information.

### **Aging and Disability Resource Center Grant Program**

In 2005 Mississippi Department of Human Services Division of Aging and Adult Services (DAAS) was awarded a grant through the federal Administration on Aging's (AoA's) Aging and Disability Resource Center Grant Program to create a single coordinated system of information and access for all persons seeking long term support to minimize confusion, enhance individual choice, and support informed decision-making. The Mississippi program, *Mississippi GetHelp*, is

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<sup>8</sup> Billy A., 2003, p. V-7

<sup>9</sup> Information on the Long Term Care Alternatives program is available at:  
[http://www.dom.state.ms.us/LTC\\_Alternative/ltc\\_alternative.html](http://www.dom.state.ms.us/LTC_Alternative/ltc_alternative.html)

being developed and will be piloted at the Central Mississippi AAA.

Mississippi *GetHelp* is targeting individuals age 60+ during its first year and will expand in years 2 and 3 to include adults with disabilities, family caregivers and others planning for future long-term care needs.

Under Mississippi *GetHelp*, the scope of services provided by the Central Mississippi AAA will be expanded, the number of users will be increased, staff will be cross-trained to provide culturally competent, up-to-date information, web-based information and assistance packages will be available to supplement paper copies, a toll-free telephone number will be available to consumers, and the DAAS Management Information Systems (MIS) will be redesigned and enhanced to provide information on products or assistance, track client information and program planning and provide evaluation information.

Evaluation of Mississippi *GetHelp* will be performed by the University of Southern Mississippi, Institute for Disability Studies. The evaluation will examine the program's purpose and objectives, impact on the long-term support system, and consumer outcomes.

#### **D. Overview of Current Utilization Figures**

Mississippi's nursing facility residents were 4.3% of its elderly population in 2005, which was higher than the U.S. average of 3.6%.<sup>10</sup> Nursing facility beds per 1,000 population was slightly higher in Mississippi than the U.S. average. Mississippi's Medicaid program relies more on nursing facilities than most other states. The historical design of the federal Medicaid program as well as ongoing design features resulted in state Medicaid programs being built around institutional services.

As mentioned above, a waiver of federal Medicaid regulations is required to provide long-term care services in the community.

It is only in the past decade that these waiver programs have covered more than a small number of people and in most states nursing facilities are still the primary sources of Medicaid long-term care services to the elderly. Although CMS has offered states more opportunities to expand community-based long term care services in recent years, states have found that it is a long, multi-year process to rebalance their long-term care delivery system. There are several underlying factors. Some of these factors stem from the design of Medicaid regulations, which do not place community-based long term care services on equal footing with institutional long-term care services. While state plan nursing home services for individuals in the Medicaid program who are 21 years of age or older are an entitlement, this is not true of community long-term care services offered through waivers. As a result, many states find it difficult to shift funds from institutional long-term care settings to community long-term care settings. Limited Medicaid funds are often directed toward those services which are entitlements and waiver services experience waiting lists due to lack of available funding.

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<sup>10</sup> Annual Estimates of the Population for the United States and States, and for Puerto Rico: April 1, 2000 to July 1, 2005, Population Division, U.S. Census Bureau, Release Date: December 22, 2005; Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 through 2004, by Charlene Harrington, PhD, et al. August 2005, p. 11

In addition, reimbursement for institutional services may favor institutional providers in some states. For example, Mississippi’s case mix adjusted cost-based nursing home reimbursement system may also affect the ability to shift limited funds toward community-based long-term care services. Transferring a nursing home patient to home and community-based services would not reduce the number of Medicaid nursing home beds. Either the beds would be filled by other patients or unfilled beds would be accounted for on the cost report so there would not be a reduction in nursing home expenditures. { {Mississippi does not have line item budgeting by program and the agency budget requests have been under-funded} }

In 2005 Mississippi HCBS waiver expenditures were 10.5% of total Medicaid expenditures, less than half of the U.S. average of 24.0%. Mississippi currently has approved waiver “slots” that would have shifted the delivery of long-term care services more toward the national average. However, in order to shift expenditures and underlying utilization toward the national average, the state would need to consider the allocation of additional funds toward these community waiver programs. The information below serves as a backdrop for such discussions.

The number of nursing facility beds per 1,000 population in Mississippi has remained fairly steady during recent years, decreasing from 5.71 per 1,000 in 2002 to 5.55 per 1,000 in 2004.

**Nursing Facility Beds per 1,000 Population, 2002-2004<sup>11</sup>**

	<b>Beds per 1,000 Population, 2002</b>	<b>Beds per 1,000 Population, 2003</b>	<b>Beds per 1,000 Population, 2004</b>
<i>Mississippi</i>	5.71	5.20	5.55

Mississippi Waiver Population

In recent years Mississippi has increased the number of individuals participating in HCBS waivers by nearly 400%, as shown in the table on the following page. However, as will be shown later in the comparison with the other states, Mississippi’s expenditures for individuals enrolled in HCBS waivers as a percentage of total Medicaid expenditures is only 10.5%, well below the national average of 24.0%. (See the table below). The total number of participants can exceed the total number of slots because of turnover.

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<sup>11</sup> Annual Estimates of the Population for the United States and States, and for Puerto Rico: April 1, 2000 to July 1, 2005, Population Division, U.S. Census Bureau, Release Date: December 22, 2005; Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1998 through 2004, by Charlene Harrington, PhD, et al. August 2005, p. 15

**Mississippi Waiver Participants, 1999 - 2006<sup>12</sup>**

	1999	2000	2001	2002	2003	2004	2005	2006	% Change 1999-2006
<b>Independent Living</b>	127	170	330	463	627	932	923	1118	
<i>% Change</i>		33.9%	94.1%	40.3%	35.4%	48.6%	-1.0%	11.6%	780.3%
<b>TBI/SCI</b>	0	0	0	138	326	452	557	608	
<i>% Change</i>		N/A	N/A	N/A	136.2%	38.7%	23.2%	6.8%	340.6%
<b>Elderly and Disabled</b>	2,540	3,954	6,951	10,078	10,181	10,691	10,804	10,732	
<i>% Change</i>		55.7%	75.8%	45.0%	1.0%	5.0%	1.1%	-3.3%	322.5%
<b>Assisted Living</b>	0	0	0	56	87	127	178	294	
<i>% Change</i>		N/A	N/A	N/A	55.4%	46.0%	40.2%	65.2%	425.0%
<b>MR/DD</b>	348	475	516	1,826	2,048	2,215	2,099	2,002	
<i>% Change</i>		36%	9%	254%	12.2%	8.2%	-5.2%	-5.5%	475.3%
<b>Total</b>	3,015	4,599	7,797	12,561	13,269	14,417	14,561	14,754	% Change 1999-2006
<i>% Change</i>		52.5%	69.5%	61.1%	5.6%	8.7%	1.0%	1.3%	389.3%

**Note:** CMS-372 data is based on state fiscal year data, except Assisted Living Waiver numbers, which are based on Federal fiscal year data **Note:** % Change 1999-2006 is shown for all waivers except TBI/SCI (%change shown is 2002-2006) and Assisted Living (% change shown is 2002-2006)

<sup>12</sup> M Kitchener et al., "Medicaid Home and Community-Based Services: Program Data, 1992-2001", Table 1A, June 2003 (for 1998-2001 data); Mississippi CMS-372 Reports (for 2002 data)

## SECTION II: COMPARISON TO OTHER STATES

In order to assess any “gaps” in Mississippi’s Medicaid program it is necessary to determine not only how the Mississippi program currently works (Section I), but also how the program compares to the nation and other comparative states in key programmatic areas.

For comparative purposes, six Southern states were chosen for a more detailed analysis of Mississippi’s Medicaid program. The states chosen include:

- ❑ Arkansas
- ❑ Florida
- ❑ Georgia
- ❑ Louisiana
- ❑ South Carolina
- ❑ Tennessee

These states were chosen because of their similar sizes and demographics.

### A. Total Medicaid Spending Facts and Figures

Mississippi has a higher percentage of its Medicaid population enrolled as children, elderly, blind and disabled than the U.S. overall but only half the percentage of adults. Both growth in Medicaid spending and Medicaid expenditures per capita ranks above the national average, however, in 2003, Medicaid expenditures represented only 7.9% of the State’s general fund, which was 48<sup>th</sup> across the states. As mentioned earlier, Medicaid is a jointly funded state-federal program. In FY 2007, Mississippi had the highest Federal Medical Assistance Percentage matching (FMAP) of 75.89%, resulting in Mississippi’s state’s share percentage for Medicaid services being the lowest across the states.

#### General Medicaid Enrollment

In 2006, Mississippi Medicaid had 605,000 individuals enrolled in its Medicaid program.<sup>13</sup> Data collected for Medicaid population figures classifies enrolled individuals into the following categories:

- ❑ Children: Generally individuals 17 and younger, however, some individuals under age 18 may be classified as adults and some individuals 18 and older may be classified as children based on each state’s practices
- ❑ Adults: Generally individuals aged 18 to 64
- ❑ Elderly: Includes all people age 65 and older
- ❑ Blind and Disabled: Includes younger persons (age 64 and under) who are reported as eligible due to a disability

In 2003 Medicaid enrollment across population groups showed that Mississippi ranked very high for elderly, blind, and disabled, but remained low for adults among states. As seen in the following table, in 2003 Mississippi enrollment included a higher percentage of elderly, blind

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<sup>13</sup> Mississippi Division of Medicaid SY2006 Annual Report Summary

and disabled enrollees than the rest of the country. 13.3% of Mississippi Medicaid enrollees were elderly while 19.8% were categorized as Blind and Disabled. Conversely, enrollees classified as adults accounted for only 12.5% of Mississippi Medicaid enrollees, placing the State near the bottom of this category, compared to the national average of 25.6%.

**Distribution of Medicaid Enrollees by Group, 2003<sup>14</sup>**

State	Children		Adults		Elderly		Blind and Disabled	
	% of Medicaid Population	Rank	% of Medicaid Population	Rank	% of Medicaid Population	Rank	% of Medicaid Population	Rank
United States	49.6%		25.6%		10.5%		14.2%	
Mississippi	54.4%	19	12.5%	50	13.3%	8	19.8%	5
Arkansas	50.9%	30	23.6%	16	10.5%	32	16.0%	17
Florida	51.5%	29	20.4%	28	12.6%	12	15.6%	21
Georgia	57.5%	12	17.3%	37	10.0%	29	15.2%	22
Louisiana	60.5%	10	11.6%	51	10.3%	26	17.5%	9
South Carolina	49.9%	33	23.0%	19	13.9%	6	13.2%	32
Tennessee	43.8%	45	28.8%	9	10.1%	27	17.2%	12

### General Medicaid Spending

In general, the amount Mississippi spends on Medicaid, in terms of per capita expenditures and the rate of growth in Medicaid spending, is fairly consistent with the nation as well as the comparative states.

The ways in which Mississippi diverges from the national averages are as follows:

- ❑ Medicaid Spending as a Percentage of the State General Fund
- ❑ Medicaid Enrollment and Spending per Category is Disproportionately Lower for Adults

As shown in the table below, the State ranks near the bottom (48<sup>th</sup>) in terms of its spending on Medicaid as a proportion of its general fund. In 2003 the Mississippi general fund was \$3,113,000,000. Of this, \$237,000,000, or 7.6% was spent on the Medicaid program<sup>15</sup>. This falls short of the national average of 16.5%. When compared to the states in this study, Mississippi ranks last for the same category. Mississippi's 7.6% is approximately 1.5 percentage points below the next lowest state (South Carolina, 9.1%) and is approximately 17.6 percentage points lower than the highest comparative state (Tennessee, 25.2%).

<sup>14</sup> Kaiser Family Foundation located at [www.statehealthfactors.org](http://www.statehealthfactors.org)

<sup>15</sup> Mississippi Division of Medicaid SFY2003 Annual Report Summary

**Medicaid Spending as a Percentage of the State General Fund, 2003<sup>16</sup>**

<b>State</b>	<b>SFY 2003 Total State General Fund Expenditures (In Millions)</b>	<b>Data (In Millions)</b>	<b>% of General Fund</b>	<b>Rank</b>
United States	499,425	82,322	16.5%	
Mississippi	3,113	237	7.6%	48
Arkansas	3,238	368	11.4%	37
Florida	20,249	3,598	17.8%	15
Georgia	14,589	1,609	11.0%	39
Louisiana	6,462	789	12.2%	34
South Carolina	5,009	455	9.1%	44
Tennessee	8,150	2,057	25.2%	2

Since 1991 Mississippi has been increasing its Medicaid spending. From 1991 to 2001 Mississippi Medicaid spending increased by 13%, the 9<sup>th</sup> highest increase among all of the states for this time period. Mississippi's 13% growth in Medicaid spending during this period is above the average national growth of 11%. Mississippi and Tennessee have the largest growth in Medicaid spending among the comparative states.

**Growth in Medicaid Spending, FY 1991-2001<sup>17</sup>**

<b>State</b>	<b>Growth in Medicaid Spending</b>	<b>Rank</b>
United States	11%	
Mississippi	13%	9
Arkansas	10%	34
Florida	12%	19
Georgia	11%	25
Louisiana	11%	25
South Carolina	12%	19
Tennessee	13%	9

Mississippi spent approximately \$1,156 Medicaid dollars per Mississippi resident in 2005. This per capita Medicaid spending ranks it as 14<sup>th</sup> highest in total Medicaid per capita expenditures. Mississippi spends \$142 more on Medicaid, per capita, than the national average. Of the comparative states, only Tennessee spends more per capita on Medicaid than Mississippi. With the exception of Florida, which only spends \$751.74 per capita on Medicaid and Georgia, which only spends \$852.70, Mississippi spends roughly the same amount on Medicaid per capita as the comparative states.

<sup>16</sup> The Kaiser Family Foundation, [www.statehealthfacts.org](http://www.statehealthfacts.org) Data Sources: Tables 1 and 28

<sup>17</sup>The Kaiser Family Foundation, [statehealthfacts.org](http://statehealthfacts.org). Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from the HCFA-64 report.

### Total Medicaid Expenditures Per Capita<sup>18</sup>

	2004	Rank	2005	Rank
United States	\$973.90		\$1,013.13	
Mississippi	\$1,178.54	9	\$1,155.87	14
Arkansas	\$943.75	22	\$1,033.71	18
Florida	\$730.67	41	\$751.74	44
Georgia	\$1,033.87	19	\$852.70	32
Louisiana	\$1,125.18	13	\$1,211.39	12
South Carolina	\$939.41	23	\$986.46	22
Tennessee	\$1,191.14	8	\$1,250.92	9

However, Mississippi, as well as the other comparative states, does not fare so well in payments made per enrollee. In 2003 Mississippi had Medicaid payments of \$3,784 per enrollee, ranking it 36<sup>th</sup> among the states. However, this still placed Mississippi as the highest ranking of the comparative states. No single category (children, adults, elderly, and blind and disabled) stood out as using a disproportionate share compared to the other states.

### Medicaid Payments per Enrollee, FY2003<sup>19</sup>

	Children	Adults	Elderly	Blind and Disabled	All Enrollees	Total Rank
United States	\$1,467	1,872	\$10,799	\$12,265	\$4,072	
Mississippi	\$1,225	\$2,664	\$8,142	\$7,132	\$3,784	36
Arkansas	\$1,396	\$879	\$9,919	\$8,420	\$3,215	44
Florida	\$1,160	\$1,696	\$8,986	\$9,938	\$3,621	34
Georgia	\$1,302	\$2,606	\$7,336	\$7,241	\$3,061	47
Louisiana	\$912	\$2,572	\$7,671	\$9,100	\$3,236	43
South Carolina	\$1,421	\$1,538	\$4,901	\$9,352	\$2,974	48
Tennessee	\$1,163	\$2,658	\$7,307	\$7,361	\$3,283	41

Mississippi Medicaid does not spend a greater proportion of its dollars on one category of individuals, when compared to the other states, which can be seen in the table below. Mississippi does have a higher percentage of children, elderly and blind and disabled in its Medicaid program when compared to the nation. As a result, Mississippi Medicaid payments are proportionately higher for these categories than the rest of the comparative states. The percentage of the Mississippi Medicaid population comprised of adults is substantially less than the rest of the country, but the percentage of Medicaid payments for adults is only slightly less than the national average.

<sup>18</sup> Medstat CMS-64 data

<sup>19</sup> The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2006

### Medicaid Population and Percent of Total Payments, 2003<sup>20</sup>

State	% of Medicaid Population				% of Total Payments			
	Children	Adults	Elderly	Blind and Disabled	Children	Adults	Elderly	Blind and Disabled
United States	49.7%	24.5%	10.9%	14.9%	16.3%	10.6%	28.9%	39.5%
Mississippi	54.7%	11.0%	13.8%	20.5%	17.2%	8.6%	31.8%	41.7%
Arkansas	49.6%	21.9%	11.7%	16.7%	20.9%	6.2%	28.9%	42.7%
Florida	50.0%	20.4%	13.0%	16.5%	14.9%	8.7%	29.1%	40.5%
Georgia	55.4%	19.1%	10.2%	15.3%	20.6%	12.8%	26.1%	35.1%
Louisiana	57.5%	11.6%	11.4%	19.6%	15.1%	8.1%	26.1%	47.1%
South Carolina	51.9%	25.3%	9.1%	13.7%	18.5%	8.1%	20.6%	33.2%
Tennessee	43.3%	29.4%	9.6%	17.7%	19.1%	27.4%	19.5%	33.9%

#### B. Long-Term Care Spending Facts and Figures

Mississippi ranks 35<sup>th</sup> nationally in terms of its long-term care spending as a percentage of its total Medicaid expenditures. Within these expenditures, Mississippi devotes a majority of its long-term care spending on nursing homes and larger ICF/MR. Only 10.5% of its total Medicaid long-term care spending is devoted to HCBS. Nationally, the states are devoting 24% of their long-term care spending to HCBS.

Total U.S. Medicaid spending in 2003 was \$259.565 billion. Mississippi's total Medicaid spending was \$2.896 billion, the lowest of the comparison states. South Carolina and Louisiana were the highest of the comparison states, with total Medicaid spending at \$38.480 billion for each state. Medicaid long-term care spending as a percent of total Medicaid spending for Mississippi in 2003 was 27.2%. Of the comparative states, only Arkansas and Florida had higher relative percentages of Medicaid long-term care spending than Mississippi.

#### Total Long-Term Care as a Percentage of Total Medicaid Expenditures<sup>21</sup>

	2000	2001	2002	2003	2004	2005	2005 Rank
United States	35.3%	35.6%	34.5%	32.4%	31.8%	31.5%	
Mississippi	28.7%	25.8%	24.7%	27.2%	24.9%	27.9%	35
Arkansas	37.4%	35.2%	31.3%	31.4%	31.7%	31.1%	24
Florida	30.9%	30.5%	29.5%	29.8%	27.2%	25.9%	40
Georgia	25.3%	21.2%	19.9%	17.8%	22.5%	25.8%	42
Louisiana	28.0%	38.3%	38.1%	26.2%	25.7%	26.3%	39
South Carolina	27.1%	25.5%	25.5%	24.4%	23.3%	23.1%	48
Tennessee	29.8%	22.0%	25.1%	20.4%	21.2%	21.3%	50

*Note: Community-based care includes: HCBS waivers, personal care, and home health*

<sup>20</sup> The Kaiser Family Foundation, statehealthfacts.org. Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Centers for Medicare and Medicaid Services-64 reports, September 2005.

<sup>21</sup> Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long-Term Care Expenditures in FY 2005, Medstat, July 5, 2005*

While Mississippi ranks 35<sup>th</sup> in long-term care spending as a percentage of its overall Medicaid expenditures, Mississippi ranked last among states for community-based care as a percentage of long-term care. The percentage of Mississippi's spending on community-based services (12.7%) was approximately one-third of the national average of 36.9%. The comparison states were also relatively low compared to the US average. However the comparison states had a higher percentage of Medicaid long-term care spending devoted to HCBS.

### Community-Based Care as a Percentage of Long-Term Care Expenditures<sup>22</sup>

	2000	2001	2002	2003	2004	2005	2005 Rank
United States	27.5%	30.3%	30.9%	33.8%	36.1%	36.9%	
Mississippi	5.4%	9.3%	12.6%	12.8%	12.2%	12.7%	51
Arkansas	28.0%	28.0%	25.3%	25.4%	25.8%	29.2%	37
Florida	20.2%	24.7%	25.7%	25.9%	26.0%	27.1%	41
Georgia	19.2%	20.6%	25.4%	23.6%	24.3%	22.7%	49
Louisiana	13.5%	9.7%	9.8%	18.8%	22.2%	25.3%	43
South Carolina	28.2%	31.2%	34.6%	32.8%	30.6%	31.0%	34
Tennessee	13.8%	15.2%	18.4%	13.3%	17.3%	24.6%	44

*Note: Community-based care includes: HCBS waivers, personal care, and home health*

In terms of total long-term care per capita spending, Mississippi ranked 22<sup>nd</sup> in the nation. Mississippi also ranked higher than any of the comparison states in this category. Again, the bulk of this per capita spending is comprised of spending for services in institutional settings as opposed to community settings.

### Total LTC Spending Per Capita<sup>23</sup>

	2004	Rank	2005	Rank
United States	\$310.00		\$318.81	
Mississippi	\$293.78	24	\$322.21	22
Arkansas	\$299.54	22	\$321.43	23
Florida	\$198.69	45	\$195.00	45
Georgia	\$242.90	41	\$219.65	43
Louisiana	\$288.90	25	\$318.69	24
South Carolina	\$218.53	44	\$227.53	41
Tennessee	\$252.94	34	\$266.13	34

Between 2000 and 2005, Mississippi's Medicaid nursing home expenditures as a percent of total Medicaid long-term care spending decreased from 67.0% to 65.1%, while the State's Medicaid ICF/MR expenditures as a percentage of its total Medicaid long term care spending also decreased from 27.6% to 22.2%. While nursing home and ICF/MR expenditures did decrease,

<sup>22</sup> The Kaiser Family Foundation, statehealthfacts.org. Data Sources: University of California at San Francisco (UCSF) estimates based on the Centers for Medicare & Medicaid Services (CMS) Form 372 for the Kaiser Commission on Medicaid and the Uninsured, July 2005. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at <http://www.kff.org/medicaid/upload/7345%20rev081105.pdf>.

Mississippi still ranked in the top 11 among the states for both categories.

**Medicaid Nursing Home Expenditures as a % of  
Total Medicaid Long-Term Care Spending<sup>22</sup>**

	2000	2001	2002	2003	2004	2005	FY2005 rankings in Home Health Expend.
Total US	3.4%	3.4%	3.3%	3.4%	3.8%	3.8%	
Mississippi	1.6%	1.7%	2.0%	1.8%	3.5%	1.9%	28
Arkansas	3.8%	3.6%	3.5%	3.3%	4.5%	4.9%	9
Florida	3.2%	3.2%	3.4%	3.6%	3.8%	4.2%	23
Georgia	4.5%	4.4%	4.9%	5.0%	5.1%	4.7%	17
Louisiana	2.3%	1.4%	1.4%	2.4%	2.1%	2.0%	27
South Carolina	2.1%	2.6%	1.5%	1.4%	1.4%	1.4%	38

**Medicaid ICF/MR Expenditures as a %  
of Total Medicaid Long-Term Care Spending<sup>23</sup>**

	2000	2001	2002	2003	2004	2005	FY2005 rankings in ICF-MR Expenditures
Total US	14.5%	13.6%	13.5%	13.6%	13.2%	12.8%	
Mississippi	27.6%	26.4%	24.8%	23.3%	21.8%	22.2%	7
Arkansas	20.5%	14.9%	4.1%	2.4%	8.7%	15.8%	13
Florida	12.0%	11.0%	10.6%	9.6%	8.9%	8.7%	36
Georgia	10.3%	10.2%	8.7%	8.8%	7.3%	5.0%	40
Louisiana	34.8%	21.2%	19.3%	31.0%	31.9%	29.5%	4
South Carolina	23.3%	21.4%	20.2%	19.2%	19.1%	16.7%	19
Tennessee	16.0%	19.4%	17.3%	19.2%	15.2%	18.2%	14

**Medicaid HCBS Expenditures as a %  
of Total Medicaid Long-Term Care Spending<sup>24</sup>**

	2000	FY2005 rankings in Total HCBS Expenditures	2001	2002	2003	2004	2005
Total US	18.6%	19.4%	20.4%	22.1%	23.6%	24.0%	
Mississippi	3.8%	7.5%	10.7%	11.0%	8.2%	10.5%	47
Arkansas	13.9%	14.9%	13.6%	14.4%	14.0%	16.8%	40
Florida	16.4%	20.8%	21.6%	21.7%	21.5%	22.2%	44
Georgia	14.7%	16.3%	20.5%	18.4%	21.3%	17.9%	45
Louisiana	11.2%	8.3%	8.5%	16.4%	20.0%	20.0%	38
South Carolina	25.9%	28.4%	32.9%	31.3%	29.1%	29.1%	31
Tennessee	13.8%	15.2%	18.4%	13.3%	17.3%	24.6%	34

<sup>23</sup> Ibid.

<sup>24</sup> Ibid

Between 2000 and 2005, Mississippi's Medicaid personal care expenditures as a percent of total Medicaid long-term care spending increased from 0.0% to 0.3%. Louisiana's, Georgia's, and South Carolina's Medicaid personal care expenditures also increased, while Arkansas' decreased from 10.3% in 2000 to 7.5% in 2005. Florida's expenditures declined from 0.7% to 0.6%.

**Medicaid Personal Care Expenditures as a %  
of Total Medicaid Long-Term Care Spending<sup>25</sup>**

	FY2005 rankings in Personal Care Expenditures	2000	2001	2002	2003	2004	2005
Total US	5.6%	7.5%	7.3%	8.2%	8.6%	9.1%	
Mississippi	0.0%	0.0%	0.0%	0.0%	0.4%	0.3%	34
Arkansas	10.3%	9.6%	8.2%	7.6%	7.3%	7.5%	14
Florida	0.7%	0.7%	0.6%	0.6%	0.6%	0.6%	32
Georgia	0.0%	0.0%	0.0%	0.1%	-2.1%	0.1%	36
Louisiana	0.0%	0.0%	0.0%	0.0%	0.1%	3.3%	21
South Carolina	0.2%	0.2%	0.2%	0.1%	0.2%	0.5%	33

Home health expenditures as a percent of total Medicaid long-term care spending in Mississippi increased between 2000 and 2004, from 1.6% to 3.5% and then decreased to 1.9%. In this category Mississippi falls below the national average of 3.8%. The State Legislature decreased the number of home health visits from 60 to 25 per year. Physical and speech therapy were no longer provided in home health settings. Georgia, Arkansas, and Florida also showed increases in home health expenditures relative to total Medicaid long-term care spending during this time period. Tennessee did not have personal care expenditures from 2000 to 2005.

**Medicaid Home Health Expenditures as a %  
of Total Medicaid Long-Term Care Spending<sup>26</sup>**

	FY2005 rankings in Home Health Expenditures	2000	2001	2002	2003	2004	2005
Total US	3.4%	3.4%	3.3%	3.4%	3.8%	3.8%	
Mississippi	1.6%	1.7%	2.0%	1.8%	3.5%	1.9%	28
Arkansas	3.8%	3.6%	3.5%	3.3%	4.5%	4.9%	9
Florida	3.2%	3.2%	3.4%	3.6%	3.8%	4.2%	23
Georgia	4.5%	4.4%	4.9%	5.0%	5.1%	4.7%	17
Louisiana	2.3%	1.4%	1.4%	2.4%	2.1%	2.0%	27
South Carolina	2.1%	2.6%	1.5%	1.4%	1.4%	1.4%	38

Mississippi's home health expenditures per participant escalated rapidly between 1999 and 2002. In 1999, Mississippi's expenditures were \$6,188,836. By 2002, these expenditures had increased to \$13,005,819, an increase of 110.1%, the largest change relative to the comparison states.

<sup>25</sup> Ibid

<sup>26</sup> Ibid

During this same time period, Arkansas' home health expenditures per participant decreased by 28.0%, and Georgia's decreased by 3.3%. Tennessee had very small home health expenditures from 2000 to 2005.

**Trends in Total Medicaid Home Health Expenditures from 2000 to 2005<sup>27</sup> (\$1000's)**

State	2000	2001	2002	2003	2004	2005	% Change 2000-2005	2005 Rank
Total US	\$2,301,100	\$2,572,840	\$2,764,850	\$2,894,079	\$3,445,549	\$3,568,642	55%	
Mississippi	\$9,095	\$11,250	\$14,267	\$14,423	\$30,126	\$17,644	94%	17
Arkansas	\$22,551	\$23,078	\$24,485	\$24,894	\$37,063	\$43,484	93%	10
Georgia	\$48,453	\$48,255	\$62,274	\$59,104	\$102,655	\$93,400	93%	14
Florida	\$74,218	\$86,047	\$101,235	\$119,333	\$132,434	\$146,388	97%	23
Louisiana	\$22,860	\$23,402	\$25,856	\$28,069	\$27,855	\$28,468	25%	26
S. Carolina	\$15,338	\$20,279	\$12,868	\$12,191	\$12,427	\$13,557	-12%	38

**Trends in Medicaid Home Health Expenditures per Participant from 1999 to 2002<sup>28</sup>**

State	1999	2000	2001	2002	% Change 1999-2002	2002 Rank	1999-2002 Change Rank
Total US	\$3,652	\$3,827	\$4,220	\$4,091	12.00%		
Mississippi	\$1,184	\$1,262	\$1,397	\$1,401	18.40%	39	21
Arkansas	\$1,398	\$1,380	\$1,401	\$1,404	0.50%	38	33
Florida	\$1,340	\$1,625	\$1,930	\$2,367	76.60%	27	7
Georgia	\$1,586	\$1,503	\$1,453	\$1,622	2.30%	34	31
Louisiana	\$1,729	\$1,446	\$2,040	\$2,203	27.50%	31	17
South Carolina	\$1,399	\$1,404	\$1,374	\$1,622	15.90%	35	22
Tennessee	\$6,826	\$8,639	\$9,130	\$9,275	35.90%	4	15

**Home Health per Capita<sup>29</sup>**

	2004	Rank	2005	Rank
United States	\$11.73		\$12.04	
Mississippi	\$10.38	17	\$6.04	28
Arkansas	\$13.47	10	\$15.65	9
Florida	\$6.17	23	\$8.23	23
Georgia	\$11.63	14	\$10.29	17
Louisiana	\$6.17	26	\$6.29	27
South Carolina	\$2.96	38	\$3.19	38
Tennessee	\$0.00	51	\$0.00	51

<sup>27</sup> Ibid

<sup>28</sup> Ibid

<sup>29</sup> The State of the States in Developmental Disabilities, 2005. David Braddock, et al., Department of Psychiatry and Coleman Institute for Cognitive Disabilities, The University of Colorado, page 18.

## C. Nursing Facilities

In an era when states are moving towards community-based care and smaller institutional settings, Mississippi continues to rely on larger institutional based settings such as nursing facilities. Nearly 80% of nursing facility residents in Mississippi rely on Medicaid as their primary payer; the third highest percentage in the country. Nationally, the number of nursing facility residents with Medicaid as the primary payer has dropped to 63%. Additionally, Mississippi nursing facilities were ranked 14th highest in utilization by individuals with MR/DD in the nation.

### Residential and Nursing Facility Placements

Between 2002 and 2004, utilization rates per 100,000 of the state general population in community residences for 1 to 15 persons increased 5%, while institutional utilization rates declined 8%. Nationwide, there were 168 residential placements per 100,000 (state general population) in 2004. Utilization rates declined in 15 states from 2002 to 2004. All but two of these states, Idaho and Mississippi, also posted declines in total residents during 2002-2004.<sup>30</sup> Mississippi has the highest percentage of total persons with MR/DD in out-of-home settings who are residing in 1-6 person settings of all states. Mississippi also has the highest percentage (49%) of persons residing in 16+ settings.<sup>24</sup>

### **Out-of-Home Residential Placements by Size of Setting: FY 2004<sup>31</sup>**

	Number	%	Rank <sup>2</sup>	Number	%	Number	%	Total	Rate <sup>4</sup>
United States	355,107	68%		54,586	11%	102,692	21%	492,385	168
Mississippi	1,833	37%	51	705	14%	2,432	49%	4,970	172
Arkansas	2,664	43%	50	896	15%	2,616	42%	6,176	225
Florida	10,342	64%	33	2,736	17%	3,120	19%	16,198	94
Georgia	4,634	58%	38	0	0%	3,320	42%	7,954	91
Louisiana	3,991	49%	45	1,001	12%	3,178	39%	8,170	181
South Carolina	2,558	53%	44	1,077	23%	1,150	24%	4,785	115
Tennessee	4,198	61%	34	925	13%	1,739	25%	6,862	117

The table reports average daily residents for FY 2004.

<sup>1</sup> Settings for 1-6 persons included 155,047 supported living/personal assistance participants.

<sup>2</sup> States' ranking, highest to lowest, on percentage of total persons with MR/DD in out-of-home settings who are residing in 1-6 person settings.

<sup>3</sup> 16+ settings include state-operated institutions, private ICF-MR, and non-ICF-MR, and nursing facilities.

<sup>4</sup> Utilization rate, per 100,000 citizens of the general population, for all MR/DD out-of-home placements in the state.

During 2002-2004, the number of people with MR/DD reported to be residing in nursing facilities in the U.S. declined by 4%, from 31,403 to 30,062.<sup>25</sup> There was marked state variation

<sup>30</sup> Ibid

<sup>31</sup> Ibid

in the utilization of nursing facilities. Reductions in populations were reported by 27 states and no change was reported by 10 additional states, including Mississippi and Louisiana.

**Nursing Facility Residents with MR/DD<sup>32</sup>**

State	2004	2002	% Change 2002-2004	Utilization Rate, 2004 <sub>1</sub>
Mississippi	408	408	0%	14
Arkansas	959	974	-1%	35
Florida	278	248	12%	2
Georgia	1,808	1,636	11%	21
Louisiana	580	579	0%	13
South Carolina	162	168	-4%	4
Tennessee	895	895	0%	15

Rate: Nursing Facility placements in 2004 per 100,000 of the state's general population.

Nursing Home Expenditures

Mississippi's nursing home, per capita, spending in 2005 ranked it at number 11 in the nation with \$209.63, well above the US average of \$159.37. Additionally, Mississippi's per capita nursing home spending was well above the comparative states.

**Nursing Home per Capita<sup>33</sup>**

State	2004	Rank	2005	Rank
United States	\$156.10		\$159.37	
Mississippi	\$194.06	13	\$209.63	11
Arkansas	\$196.29	12	\$176.95	18
Florida	\$129.36	36	\$125.27	36
Georgia	\$166.05	25	\$158.79	35
Louisiana	\$131.39	33	\$144.06	31
South Carolina	\$110.02	40	\$119.07	39
Tennessee	\$170.59	18	\$152.20	29

In 2003, Mississippi had 16,057 nursing home facility residents, and a national ranking of 31. Nursing home residents were five percent of the population over age 65. Arkansas, Florida, Georgia, Louisiana, South Carolina, and Tennessee all ranked lower than Louisiana. Arkansas had 17,997 residents (28 national rank) with nursing home residents as 5% of those over age 65, while Florida had 71,987 (7 national rank), with nursing home residents as 3% of the population over age 65.

<sup>32</sup> Ibid, at Table 15

<sup>33</sup> Ibid at page 18

### Total Number of Nursing Facility Residents and Percentage Over age 65 in 2003<sup>34</sup>

State	Total Nursing Facility Residents, 2003		Nursing Facility Residents (% of Age 65+), 2003	
	Data	National Rank	Data	National Rank
Total U.S.	1,451,762		4%	
Mississippi	16,057	31	5%	18
Arkansas	17,997	28	5%	16
Florida	71,987	7	3%	46
Georgia	36,372	15	4%	24
Louisiana	29,151	18	6%	9
South Carolina	16,220	30	3%	40
Tennessee	33,503	17	5%	18

Mississippi has one of the highest percentages of nursing facility residents with Medicaid as the primary payer. At 79.4%, Mississippi has a national ranking of 3. Georgia follows close behind at 77.6%, with Louisiana at 75.5% (national rankings of 4 and 5, respectively). Florida has a much higher national rank (40), with 61.4%. Mississippi's percentage of nursing facility residents with Medicare as the primary payer is 9.6% (national rank of 36), significantly lower than its Medicaid primary payer population. The national average is 11.3%.

### Percentage of Nursing Facility Residents with Medicaid, Medicare, And "Other" as Primary Payer, 2003<sup>35</sup>

State	Nursing Facility Residents with Medicaid as Primary Payer, 2003		Nursing Facility Residents with Medicare as Primary Payer, 2003		Nursing Facility Residents with "Other" as Primary Payer, 2003	
	Data	National Rank	Data	National Rank	Data	National Rank
Total U.S.	66.3%		11.3%		22.4%	
Mississippi	79.4%	3	9.6%	36	11.0%	49
Arkansas	72.8%	7	8.2%	42	19.0%	37
Florida	61.4%	40	16.6%	1	22.0%	27
Georgia	77.6%	4	8.8%	39	13.6%	48
Louisiana	75.5%	5	8.1%	43	16.4%	40
South Carolina	71.5%	12	13.3%	10	15.1%	45
Tennessee	71.3%	13	12.6%	14	16.1%	41

In 2003, there were 204 nursing facilities in Mississippi, and 16,323 in the United States. Mississippi was ranked 31 in its number of nursing facilities. All other comparison states, except South Carolina, had a greater number of nursing facilities in 2003. Florida had 693, with a national rank of 6, while Arkansas was closer to Mississippi, with 242 nursing facilities and a

<sup>34</sup> AARP Public Policy Institute, Across the States Profiles of Long-Term Care 2004, pages 234-235

<sup>35</sup> Ibid at page 238

national rank of 27. South Carolina had 178 nursing facilities, with a ranking of 32. Mississippi and South Carolina had nursing facility occupancy rates of 88.5% and 88.6%, respectively, the highest occupancy rates of the comparison states, with Tennessee following close behind at 88.3%. The total U.S. nursing facility occupancy rate percentage in 2003 was 82.6%.

**Total Nursing Facilities, Beds, and Occupancy Rates, 2003<sup>36</sup>**

State	Total Nursing Facilities, 2003		Nursing Facility Beds per 1,000 Age 65+, 2003		Nursing Facility Occupancy Rate, 2003	
	Data	National Rank	Data	National Rank	Data	National Rank
Total U.S.	16,323		49		82.6%	
Mississippi	204	31	52	20	88.5%	19
Arkansas	242	27	66	12	72.6%	46
Florida	693	6	28	46	87.2%	24
Georgia	360	18	48	26	90.9%	12
Louisiana	314	21	73	3	75.9%	42
South Carolina	178	32	36	42	88.6%	18
Tennessee	337	20	52	20	88.3%	20

#### **D. Medicaid HCBS Spending Facts and Figures**

In terms of the number of HCBS waivers, Mississippi ranks on par with the nation and the comparative states, with the exception of Florida which has nearly three times as many waivers as Mississippi and the other five comparative states. However, because Mississippi directs a large share of its total Medicaid long-term care spending to institutional settings, it ranks near the bottom for HCBS waiver spending per capita nationally.

Mississippi enrolls, and spends, a disproportionately higher share of its HCBS expenditures on its aged and disabled individuals, and a lower share on individuals with MR/DD.

#### Overview of 1915(c) Waivers in Six States

##### *Arkansas*

Arkansas has five 1915(c) waivers:<sup>37</sup>

- Alternative Community Service – To provide case management, supported employment, adaptive equipment, integrated supports, medical supplies, consult services, companion, activities therapy, child care supports and crisis abatement and crisis intervention to individuals with Developmental Disabilities.
- Elder Health Choices Program – To provide homemaker/chore, home-delivered meals, Personalized Emergency Response Services, adult day health and care,

<sup>36</sup> Ibid

<sup>37</sup> Source: CMS Waivers and Demonstration list (CMS Website).

adult foster care and respite to A/D.

- Family Friends Respite Waiver 1 - To provide respite care to children who are physically disabled from birth to age 19. This waiver was set to expire on September 30, 2006.
- Family Friends Respite Waiver 2 - To provide respite care for MR or DD children birth to age 19. This waiver was set to expire on October 31, 2006.
- Assisted Living - To provide adult residential care, assisted living, prescribed drugs and pharmacist consultant services to individuals aged and disabled age 21 to death.

### *Florida*

Florida has two 1915(b) (c) waivers and 12 1915(c) waivers:<sup>38</sup>

#### 1915(b) (c)

- Alzheimer's Medicaid Home and Community Based Waiver Program – This waiver provides mental health services to the elderly in specific geographic areas within the State through a restricted provider network.
- Comprehensive Adult Day Health Care Program – Selective contracting waiver that limits the number of adult day health providers that provide adult day health care services to Medicaid beneficiaries aged 75 and over. This waiver was set to expire on March 31, 2006.

#### 1915(c)

- Elderly and Disabled Adults – Provide case management, homemaker, personal care, respite, adult day health, environmental access adaptations, skilled nursing, special medical equipment and supplies, chore, PERS, companion services, family training, attendant care, physical therapy, occupational therapy, SHL, home delivered meals, financial risk reduction, counseling, case aide, escort, consumable medical supplies, pest control, rehab engineering evaluation and respiratory therapy to elderly and disabled adults.
- Developmental Services – To provide case management, homemaker, personal care, respite, habilitation (residential and supported employment), environmental accessibility adaptations, skilled nursing, transportation, specialized medical equipment and supplies, chore services, PERS, companion services, private duty nursing, extended state plan physical therapy, occupational therapy, and SHL services, adult dental services, behavior analysis, behavior assistant services, specialized mental health services, adult day training, dietician services, in-home support, medication review, psychological assessment, therapeutic massage and assessment, residential nursing services, and respiratory therapy.

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<sup>38</sup> Ibid

- ❑ Channeling Services for Frail Elders – Provide case management, home health aide, personal care, respite, adult day health, environmental access adaptations, skilled nursing, chore, PERS, companion services, family training, financial education and protective services, in-home counseling, special drug and nutritional assessment, special home delivered meals, special medical equipment, special medical supplies, physical therapy, occupational therapy, and speech therapy to elderly individuals residing in Broward and Dade counties.
- ❑ Project AIDS Care - To provide case management, homemaker, personal care, environmental access adaptations, skilled nursing, specialized medical equipment & supplies, chore, day health, education & support, specialized personal care for foster care children, home delivered meals, therapeutic management, adult dental and nutritional risk reduction for individuals diagnosed with AIDS.
- ❑ Assisted Living for the Frail Elderly -To provide case management, assisted living and incontinence supplies to frail/elderly and disabled individuals aged 60 and over.
- ❑ Supported Living – To correct technical error in targeting restrictions by deleting “children living in the family home” from groups covered under the Family and Supported Living Waiver.
- ❑ Nursing Home Diversion – To provide case management, homemaker, personal care, respite, adult day health, environmental modifications, special medical equipment and supplies, chore, PERS, companion services, private duty nursing, family training, adult residential care, assisted living, consumable medical supplies, escort, financial assessment risk reduction, home delivered meals, nutrition assessment risk reduction, occupational therapy, physical therapy, speech therapy, and respiratory therapy for aged 65 and older. This waiver was set to expire on June 30, 2006.
- ❑ TBI and Spinal Cord – To provide personal care, environmental access adaptations, companion services, attendant care, assistive technologies, behavioral programming, community support coordination, life skills training, personal adjustment counseling and rehabilitative engineering evaluation, adaptive health and wellness services and consumable medical supplies to individuals 18 and older with TBI or spinal cord injuries.
- ❑ Adult Cystic Fibrosis – To provide case management, homemaker, personal care, respite, adult day health, skilled nursing, transportation, specialized medical equipment and supplies, chore, PERS, companion services, durable medical equipment, in-home care services, in-home care supplies, vitamins and nutritional supplements, acupuncture, massage therapy, exercise therapy, individual and family counseling and respiratory therapy for adults disabled with cystic fibrosis.
- ❑ Comprehensive Adult Day Health Care Program – To provide adult day health to individuals age 75 and older in Lee and Palm Beach counties.

- ❑ Alzheimer’s Disease Program – To provide case management, personal care, respite, adult day health, environmental access adaptations, family training, incontinence supplies, wanderer alarm system, wanderer identification and location program, behavioral assessment and intervention and pharmacy review to individuals aged/disabled, age 60 and above with Alzheimer’s disease.
- ❑ Model Waiver – All services in the renewed waiver are the same as those described in the original waiver – respite care, environmental access adaptations and assistive technology, rehabilitation engineering evaluation for individuals aged 21 and under with degenerative spinocerebellar diseases.

*Georgia*

Georgia has four 1915(c) waivers:<sup>39</sup>

- ❑ Elderly and Disabled Individuals- To provide respite, adult day health, personal care, chore, PERS, companion services, home health aide, physical therapy, occupational therapy, speech hearing and language, nursing, home delivered meals, medical social services and alternative living to A/D.
- ❑ Mental Retardation Waiver Program – To provide case management, respite, day habilitation, supported employment, residential training and supervision, environmental modifications, spec. medical equipment and supplies, PERS, extended HH and personal support and vehicle adaptations to MR/DD. Also provides a consumer directed service delivery option.
- ❑ MR/DD – To provide community habilitation and support services, support monitoring and evaluation services, environmental access adaptations and specialized medical equipment and supplies to MR/DD.
- ❑ Home & Community-Based Waiver for Disabled Children – To provide private duty nursing, day care and transportation to respiratory or oxygen dependent individuals up to 21.

*Louisiana*

Louisiana has four 1915(c) waivers:<sup>40</sup>

- ❑ Adult Day Health Care Waiver – To provide adult day health care and transitional services to elderly and disabled adults.
- ❑ Elderly and Disabled Adult Waiver – To provide case management, personal care, environmental modifications, PERS, homemaker and companion services to the elderly and disabled adults.
- ❑ Children’s Choice – To provide case management, respite care (center-based), environmental access adaptations, family training, family support, crisis support

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<sup>39</sup> Ibid

<sup>40</sup> Ibid.

and diapers to individuals MR/DD ages 0 to 18.

- ❑ Independence Plus Waiver – New Opportunities Waiver – To provide respite, habilitation (residential, day, supported employment and employment related training, environmental access, skilled nursing, specialized medical equipment and supplies, PERS, adult residential care (adult foster care), individualized and family support, community integration development, professional services, professional consultation, one-time transitional expenses, and transitional professional support services.

### *South Carolina*

South Carolina has six 1915(c) waivers:<sup>41</sup>

- ❑ Waiver for Elderly and Disabled Individuals – To provide case management, personal care, respite, adult day health, environmental access adaptations, special medical equipment & supplies, PERS, companion services, attendant care, home delivered meals, adult day health care nursing and nursing home transition services to individuals who are elderly and disabled.
- ❑ HIV/AIDS Waiver – To provide case management, personal care aide, private duty nursing, home delivered meals, foster care, counseling services, and modified hospice care, to HIV/AIDS persons. This waiver was set to expire on September 30, 2006.
- ❑ Mental Retardation/Related Disabilities - To provide personal care, respite, adult day health, habilitation (residential, day, prevocational and supported employment), environmental modifications, special medical equipment & supplies, assistive technology, adult companion, psychological services, nursing services, private vehicle modifications., behavior supports, PT, OT, prescribed drugs, SHL, audiology, adult dental and adult vision services to individuals with mental retardation.
- ❑ Waiver for Individuals with Head and Spinal Cord Injuries - To provide respite, habilitation (residential, day, prevocational and supported employment), environmental access, nursing, medical supplies & equipment, assistive technology, PERS, attendant care/personal assistance, psychological services, behavioral support, private vehicle modifications, PT, OT, SHL, health education for consumer-directed care and peer guidance for consumer-directed care and prescribed drugs to individuals with health and spinal cord injuries
- ❑ Choice - To provide personal care, personal assistance services, adult day health services, respite, care advice, environmental access adaptations and appliances, specialized medical equipment and supplies, PERS, adult day health care nursing, home delivered meals, to individuals elderly/disabled. This waiver was set to expire on June 30, 2006.
- ❑ Vent Waiver - To provide personal care, respite care, environmental access, specialized med equip and supplies, PERS, private duty nursing, attendant care and prescribed drugs.

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<sup>41</sup> Ibid.

## *Tennessee*

Tennessee has five 1915(c) waivers:<sup>42</sup>

- ❑ HCBS Shelby Co. - To provide case management, homemaker, personal care, minor home modifications, PERS and home delivered meals to individuals aged and or disabled and residing in Shelby County.
- ❑ ADAPT - To provide case management, personal care, PERS, home delivered meals, and minor home modifications to elderly and disabled individuals in Davidson, Hamilton, and Knox counties.
- ❑ HCBS MR (Arlington) - To provide case management (support coordination), respite, residential habilitation, environ access adaptations, transportation, special medical equipment & supplies, PERS, PT, OT, SHL, nursing services, dental services vision services, behavior, day services, family model residential support, medical residential services, nutrition services, orientation and mobility training, personal assistance, self-determination training and consumer education, supported living and vehicle access modifications to individuals with mental retardation.
- ❑ Elderly and Disabled Individuals - To provide case management, homemaker, respite, minor home modifications, PERS, home delivered meals and personal care to individuals over 21 who are disabled. This waiver was set to expire on September 30, 2006.
- ❑ Self Determination Waiver - To provide respite, supports brokerage, financial administration, personal assistance day services, transportation, designated goods and services, OT, PT, SHL, special medical equipment & supplies, behavior services, vehicle access modifications, environmental access modifications, PERS, orientation and mobility training, adult dental and emergency assistance to individuals with DD (age 0-4) and MR (age 0-Over 65).

## Mississippi Comparison in HCBS<sup>43</sup>

Mississippi, Georgia, Arkansas and Tennessee have the same total number of Home and Community-Based (HCBS) waivers (5). South Carolina has 6 HCBS waivers, and Florida has 15.

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<sup>42</sup> Ibid.

<sup>43</sup> CMS Form 372 data on waiver participation and expenditures only available through 2003; CMS-64 data on expenditures available through 2005

**Total Number of HCBS Waivers<sup>44</sup>**

State	Total HCBS Waivers
United States	251
Mississippi	5
Arkansas	5
Florida	14
Georgia	4
Louisiana	4
South Carolina	6
Tennessee	5

In 2002, 82.2% of Mississippi’s HCBS waiver participants were in the aged and disabled category. This number is significantly higher than for the comparison states (Tennessee has 10.8%, and Florida has 40.8%). In contrast, 13.1% of waiver participants in Mississippi utilize the MR/DD waiver, while 89.2% of waiver participants in Tennessee do the same.

**HCBS Waiver Participants<sup>45</sup>**

	2001	2002	2003
<b>Mississippi Total Beneficiaries</b>	707,911	712,457	717,435
Mississippi HCB Waiver Services for Disabled/Elderly	8,488	9,760	10,116
Mississippi HCB Waiver Services - Other	1,780	2,005	2,610
<b>Arkansas Total Beneficiaries</b>	531,533	579,278	702,064
Arkansas HCB Waiver Services for Disabled/Elderly	0	0	0
Arkansas HCB Waiver Services - Other	10,813	10,510	10,188
<b>Florida Total Beneficiaries</b>	2,471,771	2,676,235	2,743,368
Florida HCB Waiver Services for Disabled/Elderly	17,381	21,011	20,219
Florida HCB Waiver Services - Other	31,707	33,284	32,484
<b>Georgia Total Beneficiaries</b>	1,514,398	1,637,329	1,732,120
Georgia HCB Waiver Services for Disabled/Elderly	0	0	0
Georgia HCB Waiver Services – Other	20,736	23,672	22,061
<b>Louisiana Total Beneficiaries</b>	804,996	898,824	995,362
Louisiana HCB Waiver Services for Disabled/Elderly	6,402	6,930	8,150
Louisiana HCB Waiver Services – Other	5,401	5,852	7,388
<b>South Carolina Total Beneficiaries</b>	760,805	809,136	861,216
South Carolina HCB Waiver Services for Disabled/Elderly	0	0	0
South Carolina HCB Waiver Services – Other	19,020	19,095	19,899
<b>Tennessee Total Beneficiaries</b>	1,602,027	1,732,381	1,729,589
Tennessee HCB Waiver Services for Disabled/Elderly	4,402	4,350	4,416
Tennessee HCB Waiver Services - Other	0	0	0

<sup>44</sup> CMS Waivers and Demonstration list <http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>

<sup>45</sup> Fiscal Years 2001-2003 National MSIS Tables, CMS, Center for Medicaid and State Operations

### HCBS Waiver Participants for 2002<sup>46</sup>

State	% of Total HCBS Waiver Participants for 2002			
	Aged and Disabled	MR/DD	Aged	All Other Waivers
United States	40.9%	38.8%	12.1%	8.2%
Mississippi	82.2%	13.1%	0.0%	4.6%
Arkansas	0.0%	21.9%	70.0%	8.1%
Florida	40.8%	46.8%	0.0%	12.4%
Georgia	62.5%	34.3%	0.0%	3.2%
Louisiana	19.5%	73.8%	0.0%	6.8%
South Carolina	69.1%	22.9%	0.0%	8.0%
Tennessee	10.8%	89.2%	0.0%	0.0%

All Other Waivers includes physically disabled, children, HIV/AIDS, mental health and TBI/SCI

In Mississippi and nationally, 1.8% of the total Medicaid population is HCBS waiver participants. While in Tennessee, only 0.3% of the total Medicaid population is HCBS waiver participants.

### Total HCBS Waiver Participants as a % of Total Medicaid Population, 2003<sup>47</sup>

State	Total Medicaid Population	Total HCBS Waiver Participants	HCBS Participants as a % of Medicaid Population
United States	51,971,173	919,033	1.8%
Mississippi	717,435	12,726	1.8%
Arkansas	702,064	10,188	1.5%
Florida	2,743,368	52,703	1.9%
Georgia	1,732,120	22,061	1.3%
Louisiana	995,362	15,538	1.6%
South Carolina	861,216	19,899	2.3%
Tennessee	1,729,589	4,416	0.3%

As noted above, Mississippi's HCBS expenditures as a percentage of total Medicaid long-term care spending have increased from 3.8% in 2000 to 10.5% in 2005. (See table "Medicaid HCBS Expenditures as a % of Total Medicaid Long-Term Care Spending, page II-5.) However, this still falls below the national average of 24.0%. Additionally, Mississippi's expenditures are still below those of the other comparison states. Arkansas' Medicaid HCBS expenditures are the closest to Mississippi's of the six comparison states, with a percentage of total Medicaid long-term care spending of 16.8% in 2005.

<sup>46</sup> The Kaiser Family Foundation, statehealthfacts.org. Data Sources: University of California at San Francisco (UCSF) estimates based on the Centers for Medicare & Medicaid Services (CMS) Form 372 for the Kaiser Commission on Medicaid and the Uninsured, July 2005. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at <http://www.kff.org/medicaid/upload/7345%20rev081105.pdf>.

<sup>47</sup> Estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Center for Medicare and Medicaid Services, 2006

### Total HCBS Waiver Expenditures in Millions<sup>48</sup>

State	2000	2001	2002	2003	2004	2005	ACRG <sup>1</sup>
Mississippi	\$21.9	\$48.6	\$76.5	\$86.9	\$70.4	\$98.8	35.2%
Arkansas	\$82.0	\$96.4	\$95.7	\$107.9	\$115.5	\$149.7	12.8%
Florida	\$3,842.2	\$551.3	\$635.7	\$716.2	\$744.3	\$770.4	14.9%
Georgia	\$158.2	\$178.7	\$26.1	\$217.4	\$427.3	\$355.8	17.6%
Louisiana	\$111.7	\$140.0	\$158.4	\$195.6	\$262.7	\$288.0	20.9%
South Carolina	\$190.8	\$224.0	\$284.3	\$273.7	\$266.7	\$281.8	8.1%
Tennessee	\$201.7	\$182.4	\$267.7	\$176.4	\$258.4	\$390.0	14.1%

<sup>1</sup> ACRG = Annual Compound Rate of Growth since FY2000

### HCBS Waiver per Capita<sup>49</sup>

	2004	Rank	2005	Rank
United States	\$73.32		\$76.58	
Mississippi	\$24.23	48	\$33.84	47
Arkansas	\$41.96	45	\$53.87	40
Florida	\$42.78	44	\$43.30	44
Georgia	\$48.39	40	\$39.22	45
Louisiana	\$58.17	36	\$63.66	38
South Carolina	\$63.52	31	\$66.23	31
Tennessee	\$43.79	43	\$65.41	34

While Mississippi's HCBS expenditures as a percentage of total Medicaid long-term care spending are lower than the six comparison states, at 35.2%, Mississippi's annual compound rate of growth in waiver expenditures since FY2000 is higher than the six comparison states. South Carolina's is the lowest at 8.1%.

### Annual Percentage Change in HCBS Waiver Expenditures<sup>50</sup>

State	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005	ACRG <sup>1</sup>
Mississippi	122.1%	57.2%	13.7%	-19.0%	40.4%	35.2%
Arkansas	17.6%	-0.8%	12.8%	7.0%	29.7%	12.8%
Florida	43.5%	15.3%	12.7%	3.9%	3.5%	14.9%
Georgia	13.0%	46.2%	-16.8%	96.5%	-16.7%	17.6%
Louisiana	25.3%	13.2%	23.4%	34.3%	9.7%	20.9%
South Carolina	17.4%	26.9%	-3.8%	-2.6%	5.7%	8.1%
Tennessee	-9.6%	46.8%	-34.1%	46.4%	51.0%	14.1%
Total U.S.	16.1%	15.4%	10.6%	13.9%	5.4%	12.2%

<sup>48</sup> Brian Burwell, Kate Sredl, and Steve Eiken, Medicaid Long-Term Care Expenditures in FY 2005, Medstat, July 5, 2006.

<sup>49</sup> Ibid.

<sup>50</sup> The Kaiser Family Foundation, statehealthfacts.org. Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Center for Medicare and Medicaid Services, 2005; and University of California at San Francisco (UCSF) estimates based on the Centers for Medicare & Medicaid Services (CMS) Form 372 for the Kaiser Commission on Medicaid and the Uninsured, July 2005. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at <http://www.kff.org/medicaid/upload/7345%20rev081105.pdf>.

According to 2002 data, Mississippi spends 71.4% of its total HCBS waiver expenditures on the aged and disabled waiver while it spends 22.7% in the MR/DD category. In contrast to Mississippi, Tennessee spends only 2.2% of its total HCBS waiver expenditures on the aged and disabled, while it spends 97.8% in the MR/DD category. Also in contrast to Mississippi, total HCBS waiver expenditures in the United States are 16.8% on the aged and disabled, and 73.3% on individuals with MR/DD.

**Percent of Total HCBS Waiver Expenditures, 2002<sup>51</sup>**

<b>State</b>	<b>Aged and Disabled</b>	<b>MR/DD</b>	<b>Aged</b>	<b>All Other Waivers</b>
United States	16.8%	73.3%	4.1%	5.9%
Mississippi	71.4%	22.7%	0.0%	5.9%
Arkansas	0.0%	54.2%	33.7%	12.1%
Florida	19.2%	78.0%	0.0%	2.7%
Georgia	29.1%	61.5%	0.0%	9.4%
Louisiana	5.4%	92.9%	0.0%	1.7%
South Carolina	32.4%	62.0%	0.0%	5.6%
Tennessee	2.2%	97.8%	0.0%	0.0%

All Other Waivers includes physically disabled, children, HIV/AIDS, mental health and TBI/SCI

Mississippi spends more on each of its Aged and Disabled HCBS waiver participants than any of the comparison states, except Tennessee, and slightly more than the national average.

Mississippi spends \$7,928 on each waiver participant, while the spending per participant in the United States is \$7,210. Tennessee spends \$8,561 per Aged and Disabled HCBS waiver participant.

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<sup>51</sup> The Kaiser Family Foundation, statehealthfacts.org. Data Sources: University of California at San Francisco (UCSF) estimates based on the Centers for Medicare & Medicaid Services (CMS) Form 372 for the Kaiser Commission on Medicaid and the Uninsured, July 2005. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at <http://www.kff.org/medicaid/upload/7345%20rev081105.pdf>.

**Medicaid Aged/Disabled Medicaid 1915 (c) HCBS Waiver Participants  
and Spending for 2002 by State<sup>52</sup>**

State	Total Spending (In Thousands)			Total Participants			Spending per Participant	
	Data	Rank	% of Total	Data	Rank	% of Total	Data	Rank
United States	\$3,517,683			487,877			\$7,210	
Mississippi	\$74,185	17	2.1%	9,357	22	1.9%	\$7,928	23
Arkansas	\$33,247	28	0.9%	7,950	24	1.6%	\$4,182	42
Florida	\$126,043	8	3.6%	22,328	7	4.6%	\$5,645	34
Georgia	\$87,386	10	2.5%	15,418	11	3.2%	\$5,668	33
Louisiana	\$7,162	44	0.2%	1,058	45	0.2%	\$6,769	29
South Carolina	\$77,544	16	2.2%	14,131	14	2.9%	\$5,488	36
Tennessee	\$4,529	47	0.1%	529	48	0.1%	\$8,561	19

**E. Medicaid Mental Health Waivers**

Nationally the Medicaid program represented approximately half of all public health care spending for mental health services in 2003. However, this base of mental health expenditures by the Medicaid program occurred under a somewhat fragmented set of mandated and optional Medicaid service benefits. One of the key gaps in Medicaid coverage historically has been the exclusion of Medicaid coverage for services provided to people age 21 – 64 by Institutions for Mental Disease (IMDs). This exclusion resulted in many state psychiatric hospitals and other residential settings being ineligible for Medicaid reimbursement. In addition, this coverage exclusion made it very difficult to show budget neutrality when requesting CMS approval of mental health community waiver programs because state-only expenditures for services provided in IMDs to individuals 21 – 64 years of age could not be counted in the “without waiver” expenditures. (The 2006 Deficit Reduction Act eliminated this IMD budget neutrality exclusion.) The need for the provision of community-based mental health services is currently being addressed by CMS through a demonstration program authorized under section 6063 of the

Deficit Reduction Act of 2005. The initial announcement was published by CMS in July, 2006. According to CMS, over the last decade, Psychiatric Residential Treatment Facilities (PRTFs) have become the primary provider for youth with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities or ICF/MR, many States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to care, which would keep the youth in their homes and with their families. Section 6063 of the DRA addresses this issue by providing up to \$218 million to up to 10 States to develop demonstration programs that provide home and community-based services to youth as alternatives to PRTFs. Mississippi was selected as one of the 10 states in December 2006 and submitted a Community Alternatives 1915(c) waiver in May 2007.

<sup>52</sup> The Kaiser Family Foundation, [statehealthfacts.org](http://statehealthfacts.org). Data Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Center for Medicare and Medicaid Services, 2005; and University of California at San Francisco (UCSF) estimates based on the Centers for Medicare & Medicaid Services (CMS) Form 372 for the Kaiser Commission on Medicaid and the Uninsured, July 2005. "Medicaid 1915(c) Home and Community-Based Service Programs: Data Update" available at <http://www.kff.org/medicaid/upload/7345%20rev081105.pdf>.

Additionally, several states have Medicaid waiver programs in place that address the mental health needs of waiver participants. For example, in Colorado, the Community Mental Health Services program, a 1915(b) waiver program, is a Medicaid managed care program that provides specialty mental health services to Medicaid recipients. Additionally, Colorado's 1915(c) waiver for Persons with Mental Illness provides homemaker, personal care, respite, adult day health, environmental modifications, transportation, PERS, and alternative care facilities to chronically mentally ill individuals 18 and over needing nursing facility level of care. Kansas has a 1915(c) waiver for individuals with Severe Emotional Disturbances. This waiver provides respite, parent support and training, independent living/skill building and community support facilitation (wraparound) services and psychological testing to chronically mentally ill individuals under age 22 with severe emotional disturbances. Wisconsin has a 1915(c) Children's Mental Health Waiver that provides case management, personal care, and other services, including intensive in-home autism treatment, to chronically mentally ill children age birth to 21.<sup>43</sup>

## **F. Consumer-Directed Programs**

In the past few years a number of states have implemented Medicaid waiver programs utilizing consumer self-direction. The populations targeted by these waivers cover a broad spectrum, including:

- ❑ Individuals with mental retardation or developmental disabilities eligible for ICF/MR level of care (both children and adults)
- ❑ Elderly
- ❑ Individuals with physical disabilities
- ❑ Combination of these categories

States can either allow consumer-direction for every service provided under the waiver or limit self-direction to a few specific services. Just as the populations covered by the self-direction waivers are varied, so too, are the types of services the waivers provide. These services include:

- ❑ Individual and family support services
- ❑ Supported employment
- ❑ Respite
- ❑ Transportation
- ❑ Personal emergency services
- ❑ Interpreter services
- ❑ Personal assistant services
- ❑ Case management
- ❑ Attendant support
- ❑ Homemaker
- ❑ Chore services
- ❑ Adult companion services

States have developed a number of oversight measures for self-direction programs including the use of a budget cap for the consumer. The budget cap is usually defined monthly or annually. States also have various methods for quality oversight and reporting requirements. These include:

- ❑ Criminal background checks
- ❑ Development of back-up plans
- ❑ Feedback from participants
- ❑ Training requirements for budget management
- ❑ Available counselors
- ❑ Complain monitoring
- ❑ Grievance system

All of the comparison states have consumer-directed long-term care program. Arkansas and Florida were among the original cash and counseling demonstration states. Louisiana and Tennessee only have consumer-directed programs for MR/DD beneficiaries. South Carolina enrolls elderly and disabled HCBS waiver participants.

### **Arkansas**

Arkansas Independent Choices is an 1115 waiver demonstration through 2006 that began in December 1998.

#### *Eligibility Requirements*

- ❑ 18 years of age or older
- ❑ Receive Arkansas Medicaid
- ❑ Be in need of personal care assistance
- ❑ Capable of directing own assistance or have someone who will help them direct their own personal assistance

#### *Payment*

- ❑ Counseling Fiscal Agent
- ❑ Cash allowance based on a formula considering number of hours prescribed each month and number of hours actually delivered
- ❑ Assistance with required payroll and bookkeeping tasks is available
- ❑ Participant must report and pay Social Security, Medicare and Unemployment Insurance and report wages to state and federal Internal Revenue Service

#### *Support*

- ❑ Agencies teach about consumer-direction and self-management
- ❑ Counselors available to guide and support in managing the cash allowance.

### **Florida**

Florida's Consumer Directed Care Plus is an 1115 waiver program that began in 2000.

#### *Eligibility Requirements*

- ❑ 18 years of age or older
- ❑ Receive Florida Medicaid
- ❑ Part of a waiver program (developmentally disabled, physically disabled, traumatic

brain and/or spinal cord injury, or aged/disabled waiver)

*Payment*

- ❑ Cash allowance based on beneficiary's care plan multiplied by a discount factor for budget neutrality

*Support*

- ❑ The consultant will train, coach, and provide technical assistance to consumers, as needed on budgeting
- ❑ The fiscal/employer agent assists consumers with paying employer taxes, retaining funds, processing employment information, paying providers, and paying employees according to federal and state laws

**Georgia**

Georgia Community Care Services Program has applied to CMS for approval for an amendment to add participant direction to its Elderly and Disabled Adults HCBS Waiver and has already received approval for amendments to their Physically Disabled and MR waivers. Participants will receive an individual budget to purchase personal care services only and can hire their own workers, use a case manager and a fiscal agent.

**Louisiana**

New Opportunities Waiver (NOW) Program started in 2003 and serves MR/DD children.

*Eligibility*

- ❑ 3 years of age or older
- ❑ Meet ICF/MR level of care
- ❑ MR/DD prior to the age of 22

*Payments*

- ❑ Individual budget
- ❑ Fiscal agent

*Services*

- ❑ Supervised independent living
- ❑ Skilled nursing services
- ❑ Environmental accessibility modification
- ❑ Residential habilitation
- ❑ Emergency Response
- ❑ Specialized medical equipment and supplies

**South Carolina**

SC Choice is an Independence Plus Waiver (HCBS Waiver) started in 2002 which allows participants to employ direct care workers and purchase supplies and equipment with an individual budget. The SC Nursing Home Transition Grant provides community transition services and other supports to help a person's move to the community.

### *Eligibility*

- 21 years of age or older
- Elderly and Disabled HCBS waiver participant
- Unable to perform own activities of daily living

### *Payment*

- Individual decides on services and providers. Individuals receive a budget.
- A care advisor assists in selecting services and provider.

### *Services*

- Personal Care I (general household activities)
- Personal Care II (activities of daily living)
- Companion
- Environmental Modification (minor physical adaptation and pest control)
- Home Delivered Meals
- Adult Day Health Care
- Adult Day Health Care nursing
- Respite care
- Personal Emergency Response System electronic device
- Limited Incontinence Supplies
- Appliances
- Personal Care Supplies

## **Tennessee**

The Tennessee Self-Determination Waiver Program provides community-based services to individuals who would otherwise require ICF/MR started in 2005.

### *Eligibility*

- Have a mental retardation before age 18 OR have a developmental disability and be age 4 or younger
- Financially eligible for Medicaid
- Meet TennCare criteria for payment of institutional ICF/MR care
- Be on the DMRS Waiting List and be classified in one of the crisis, urgent, or active waiting list categories prioritized by urgency of need
- Have an adequate support system to assure health and safety while receiving services in HCBS setting
- Not need staff-supported residential services

### *Services*

- Case Management Services
- Day Services
- Behavioral Services
- Physical, Occupational and Speech Therapy Services
- Respite and Behavioral Respite Services
- Personal Assistance
- Transportation

## **Overview of State Programs with Fiscal Intermediary Services**

Since 2002 more than 15 states have implemented programs utilizing fiscal intermediaries to help support their consumer-directed programs. The role of the fiscal intermediary varies from program to program. However, a couple of basic models have been established. One model used by states provides for disbursement of monies to the consumer, whether directly from the state, or through the fiscal intermediary. The consumer is responsible for payment to the providers and payment of other required items such as payroll taxes. In this model the fiscal intermediary generally assumes a supportive role, including assisting with submission of expenses to the state. Under another model the fiscal intermediary acts more as a payroll agent, disbursing the payment directly to the provider, deducting for payroll and other expenses and performing other functions at the direction of the consumer.

Despite the use of a fiscal intermediary, whether another state entity or a private corporation, the state's Medicaid agency retains final authority over the program and must still maintain sufficient staff for program eligibility reviews, program oversight and other administrative duties. For instance, states develop and review service plans for consumers, make monthly allocations of funds to the fiscal intermediary for disbursement to the consumer or the provider, and reviewing monthly expenditure reports submitted by the fiscal intermediary.

The initial wave of states using fiscal intermediary services has resulted in a number of innovative ideas. For example, South Carolina's contractor collects information about in-home services through an electronic monitoring system it operates for the state. The monitoring system is telephone-based and requires the provider to telephone a dedicated number indicating his arrival at the customer's location. In the event that the provider does not arrive at the consumer's location, the consumer telephones a different number which indicates that the provider has not arrived. The monitoring system helps track provider absenteeism rates and allows the fiscal intermediary to assist the consumer in locating and procuring replacement services.