

Case Study: Mississippi

State Long-Term Services and Supports Scorecard: How One State Improved

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This report presents the findings from a case study of Mississippi. The study was conducted following the release of the 2014 *State Long-Term Services and Supports Scorecard*¹ to understand factors that lead to improved performance on measures of long-term services and supports (LTSS) for older adults and people with physical disabilities. Case studies can provide a deeper context for understanding how some states have improved the performance of their LTSS systems over time. While Mississippi still scores low on the overall *Scorecard*, it shows significant progress.

FINDINGS

Mississippi LTSS system performance improved because:

- Policy makers and elected officials developed a clear vision of what LTSS services should be;
- Legislators, state staff, providers, and advocacy organizations worked together, aided by strong and consistent LTSS leadership; and
- Policy makers took advantage of both state and federal funding opportunities to improve their LTSS system.

National data show Mississippi substantially improved the percentage of funds spent on Home and Community-Based Services (HCBS) programs during the 5-year period 2007–12. For example, in 2007 Mississippi spent 15.6 percent of its LTSS dollars on HCBS. By 2012, that percentage increased to 27.4 percent, an increase of about 75 percent.

This 75 percent increase is the highest rate of increase of any state during this period.

State data reveal that Medicaid-paid days in nursing homes declined between 2007 and 2014 and Medicaid use of HCBS increased substantially as reflected by the number of people receiving HCBS services under Medicaid waiver programs.

In the 2014 *Scorecard*, Mississippi improvements were clustered in two dimensions:

- *Choice of providers and setting of care*, and
- *Quality of life and quality of care*.

Historical Initiatives to Strengthen LTSS

The origins of current efforts to improve Mississippi LTSS date back to 2001 when a plan was developed in response to the Olmstead Supreme Court decision. State legislators saw the need for more HCBS programs and provided funds to reduce waiting lists. During the period 2001–10, there was incremental progress in expanding HCBS programs as additional state funding was provided to reduce HCBS waiting lists.



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In 2010, a 3-year moratorium on increases in Medicaid payment rates to nursing homes was implemented.

In 2011, Mississippi received federal funds to operate a Money Follows the Person (MFP) program, known in Mississippi as Bridge to Independence (B2I). This program offers a choice of living arrangements to people residing in institutions and helps them transition from the institution to a community setting.

Also in 2011, the U.S. Department of Justice issued a “findings of fact” that stated that too large a proportion of people with mental illness and developmental disabilities were in institutions and more community living arrangements needed to be made available.² While this did not directly affect nursing homes or older adults and people with physical disabilities, federal pressure for more community services has been a constant background influence since 2011 and contributed to receiving additional funding to reduce the waiting list for the Elderly and Disabled waiver.

LTSS innovations have been consistently supported by a coalition of partners including state government agencies, academics, associations, and advocacy groups such as the State of Mississippi Department of Rehabilitation Services, LIFE of Mississippi, Inc., the Independent Nursing Home Association, and AARP Mississippi. For example, AARP Mississippi worked on the Mississippi at Home project and was involved in discussions about the moratorium of nursing home rates.

In 2012, Mississippi received federal Medicaid approval to participate in the Balancing Incentive Program (BIP) and received an enhanced 5 percent federal match for funds spent on LTSS. These additional federal funds, approximately \$65 million over the life of the program, were placed in a separate account. With federal approval, funds are spent from this account to strengthen LTSS services and programs.

Balancing Incentive Program

- Approximately one-third of BIP funds are being spent on technology improvements that will create a single system that spans all LTSS

programs operated by Mississippi departments. Regular intradepartmental meetings to develop and implement operating procedures have led to greater cooperation among state staff and understanding of how the new system will technologically link agencies together.

- Using BIP funds, Mississippi staff in Aging and Adult Services opened six Mississippi Access to Care (MAC) Centers in October 2014 throughout the state, which function as Aging and Disability Resource Centers (ADRCs) where people can obtain information and assistance to locate LTSS services.

In addition, the Department of Medicaid launched a free web-based housing locator service as part of the B2I program. MSHousingSearch.org, along with a full-service call center, is designed to give people the ability to search for rental housing regardless of disability or financial status. The locator service was implemented in part to help people transition from institutional care to a home- and community-based setting.

INTRODUCTION

The 2014 *State Long-Term Services and Supports Scorecard* articulates the vision of a high-performing LTSS system and operationalizes that vision with clear measurements of key indicators. The *Scorecard* tracks changes over time and helps people use this information to focus on policies and programs that can improve LTSS.³ The *Scorecard* uses a multidimensional approach to rank states on 26 measures across 5 dimensions of a high-performing LTSS system: (1) Affordability and Access, (2) Choice of Setting and Provider, (3) Quality of Life and Quality of Care, (4) Support for Family Caregivers, and (5) Effective Transitions. The *Scorecard* describes the goals to aim for when considering both public policies and private-sector actions that affect how a state organizes, finances, and delivers services and supports for older adults and people with physical disabilities who need ongoing help with activities of daily living (ADLs), instrumental activities of daily living, health maintenance tasks, service coordination, and supports to family caregivers.

The *Scorecard* found wide variation in state performance. Because the *Scorecard* is designed to help states improve the performance of their LTSS systems, states can look to other states that performed well in specific areas to identify potential paths for improvement. Leading states do well on multiple indicators, but even states with a low ranking scored in the top quartile for at least one indicator. Further, states that rank low can show significant improvement in their performance over time.

AARP published its first *Scorecard* in September 2011 and data from that report allow comparison with 2014 scores on 19 of the 26 indicators.⁴ This case study focuses on Mississippi, which improved on 11 of these 19 indicators and declined on just 1.⁵ Only two states, Massachusetts and Pennsylvania, improved on more indicators than Mississippi. The study addresses the indicators where Mississippi showed improvement and where state policy can make a difference.

Like many other southern states, Mississippi ranked in the lowest quartile of state LTSS performance in the 2014 *Scorecard*. As shown in table A-3 in the appendix, Mississippi ranked 49th, meaning that all but one state scored higher than Mississippi on the overall ranking. Table A-3 provides a complete summary of Mississippi's overall ranking, along with the state's ranking on each of the 26 indicators the *Scorecard*'s 5 dimensions comprise.

Background

As a state, Mississippi is both rural and impoverished. It has a population of approximately 3 million with a population density of 63 people per square mile, as compared to the national average of 87 people per square mile. In 2010, approximately half the population lived in rural areas.⁶ In 2013, Mississippi had the fourth-lowest median household income in the country, approximately 80 percent of the national average.⁷ The median income is accompanied by a high percentage of people living in poverty. In 2011, Mississippi had 22.6 percent of its population living in poverty, the highest percentage in the country.⁸

Reported disability rates are also very high. U.S. Census data show that 16.7 percent of the people in Mississippi reported having a disability, the fourth-highest rate in the country after West Virginia, Arkansas, and Kentucky.⁹

The Mississippi Division of Medicaid, in the Office of the Governor, is designated by state statute as the single state agency responsible for administering Medicaid in Mississippi.¹⁰ Table 1 below shows that administrative responsibilities for specific LTSS programs are spread across the Division of Medicaid and the departments of Human Services, Mental Health, and Rehabilitative Services.

TABLE 1
Mississippi LTSS Programs and the Responsible Administrative Unit, 2014

LTSS Program	Mississippi Administrative Unit
Mississippi Access Centers	Department of Human Services
Elderly and Disabled Waiver	Division of Medicaid
Assisted Living Waiver	Division of Medicaid
Transition to Community Referral	Division of Medicaid
Bridge to Independence (B2I)	Division of Medicaid
1915(i) State Plan HCBS Waiver*	Department of Mental Health
Intellectual Disabilities (ID)/ Developmental Disabilities (DD) Waiver*	Department of Mental Health
Independent Living Waiver*	Department of Rehabilitative Services
Traumatic Brain Injury (TBI)/Spinal Cord Injury Waiver*	Department of Rehabilitative Services

Source: LTSS program and administrative unit information based upon October 2014 discussions with various Mississippi state office staff.

* The population served under the 1915(i), ID/DD, IL, and TBI/SCI waivers is outside the scope of the *Scorecard* and this case study. Information and data on these LTSS waiver programs are available in the appendix of this study.

In October 2014, using BIP funding, the Department of Human Services (MDHS), Office of Aging and Adult Services, opened six LTSS information and referral centers called Mississippi Access to Care (MAC) Centers.

The Division of Medicaid operates 30 regional offices¹¹ and has direct operating responsibility for the state's largest waiver program, referred to as the Elderly and Disabled Waiver, as well as the Assisted Living Waiver, and two other programs that facilitate relocating people from institutions to the community.

- The *Transition to Community Referral* is a program that identifies people who express a desire to be transferred to a community setting, and
- *Bridge to Independence (B2I)* is a program that helps people transition out of institutions. People in this program also receive priority status on the waiting list for HCBS.

The Department of Health does not operate LTSS programs but is responsible for licensing nursing homes; personal care homes, which include assisted living facilities; and home health agencies. Adult day care is not licensed in Mississippi, in part because it is considered more of a social model than a medical model.

In July 2014, Mississippi had 210 nursing homes with an average size of 90 beds.¹² Mississippi's nursing homes are smaller than homes nationally and are distributed throughout the state.¹³ Eighteen of the nursing homes had a dementia care unit. In 2014, the state had 188 personal care homes, of which 92 were licensed as assisted living facilities and 12 were designated as dementia care units. An analysis of state licensing records revealed that the average size of an assisted living facility in Mississippi was 39 beds, and the average size of all other personal care homes was 15 beds.¹⁴

Methodology

To better understand Mississippi's improvement in specific *Scorecard* indicators, the authors reviewed relevant documents, and conducted on-site meetings and phone interviews in October and November 2014.

Interviews with multiple stakeholders included the following:

- State officials in the Division of Medicaid, departments of Human Services and Mental Health, the Mississippi Board of Nursing, and Ombudsman staff;
- LTSS providers; and
- Consumer advocates.

We focused on the *Scorecard* indicators where Mississippi had improved and sought to understand the history and factors that accounted for this improvement.¹⁵ See table A-3 in the appendix for a list of the *Scorecard* indicators with Mississippi's scores.

MISSISSIPPI PERFORMANCE ON SCORECARD INDICATORS

Affordability and Access

The *Affordability and Access* dimension measures the extent to which individuals and their families can easily navigate their state's LTSS system and find readily available, timely, and clear information to help them make decisions about LTSS. In a high-performing system, services are affordable for those with moderate and higher incomes, and a safety net is available for those who cannot afford services. Eligibility is determined easily and quickly, and the costs of LTSS do not impoverish the spouse of the person needing services and supports.

Mississippi improved on two *Affordability and Access* dimension indicators:

- Percentage of low-income people with disabilities receiving Medicaid, and
- The reach of Medicaid HCBS services.

Increases in these measures are consistent with the state's greater emphasis on HCBS as discussed in the following sections of this report.

Mississippi did not score well on an indicator in the *Affordability and Access* dimension that measured the function of information and referral centers. Mississippi ranked 51st (last) in the functions performed by Aging and Disability Resource Centers (ADRCs). ADRCs establish information and

referral centers where individuals can obtain objective data about LTSS programs, regardless of age, income, or type of disability. Stakeholders interviewed indicated that Mississippi’s scores on this indicator should improve in future *Scorecards*. The office of Aging and Adult Services in MDHS began a new program called Mississippi Access to Care (MAC), which opened six centers in October 2014. Through these MAC Centers, people can obtain information and assistance to locate LTSS or apply for benefits to receive services.¹⁶

The six MAC Centers currently have about 18 staff and are funded from the state BIP funds. MAC Center operations are folded into the new LTSS technology platform that Mississippi is using to integrate and improve the efficiency of its HCBS programs. The most significant issue facing future operations of the MAC Centers is the sustainability of their operations after the BIP ends in 2015–16.¹⁷

Choice of Setting and Provider

The dimension where Mississippi showed marked improvement was *Choice of Setting and Provider*. A high-performing LTSS system contains substantial HCBS alternatives providing individuals a choice of care, and places high value on helping individuals exercise choice and control over where they receive services and who provides them.

Data permitting an analysis of change over time were available for four of the five indicators in

this dimension. Mississippi improved on all four of these indicators. Two of the indicators were:

- Percentage of Medicaid and state LTSS spending going to HCBS for older people and adults with physical disabilities, and
- Percentage of new Medicaid aged/disabled LTSS users first receiving services in the community.

These two indicators are highly correlated, and it is not surprising that states that do well on one also do well on the other.

Evidence of a Shift in Spending from Nursing Homes to HCBS

A comparison of Mississippi data for nursing homes and HCBS expenditures documents the shift from nursing homes to HCBS. State data reveal that Medicaid-paid days in nursing homes declined between 2007 and 2014 and Medicaid use of HCBS increased substantially, as reflected by the number of people receiving HCBS under Medicaid waiver programs.

Excluding some yearly fluctuations, table 2 illustrates that Medicaid paid days in nursing homes have declined since 2007 by over 4 percent. Expenditures increased by more than 13 percent, while the number of people served declined by almost 5 percent.

While the number of nursing home paid days has been declining since 2007, enrollment in Medicaid HCBS programs has increased

TABLE 2
Mississippi Medicaid Nursing Home Data: Number of People Served, Paid Days, and Total Reimbursement, 2007-14

State Fiscal Year	Beneficiary Count	Paid Days	Reimbursement
2007	18,847	4,532,003	\$635,411,066
2008	18,755	4,541,464	\$681,421,870
2009	18,771	4,491,927	\$693,897,928
2010	18,507	4,496,461	\$715,759,527
2011	18,386	4,461,754	\$724,117,343
2012	18,223	4,469,087	\$734,847,131
2013	18,145	4,385,418	\$720,969,946
2014	17,935	4,334,587	\$719,197,900

Source: Mississippi Division of Medicaid. Counts include claims with a date of service that occurred during SFY 2007–14. All claims accounted for are of type “N” Long-Term Care, Category of Service 04 Nursing Facility Services, Revenue Codes 0181 – All inclusive rate room and BO, 0183 – Leave of absence – Reserved, 0101 – Leave of absence – Therapeutic. Encounter claims data were excluded.

substantially during the same period. Table 3 shows data for the Medicaid Assisted Living waiver program and the Elderly and Disabled HCBS waiver program. Between 2007 and 2014, there was a 277 percent increase in the number of people receiving services in the Assisted Living waiver program and an 81 percent increase in those receiving HCBS services in the Elderly and Disabled waiver program.

Growth in Mississippi HCBS programs has depended upon periodic legislative appropriations to reduce waiting lists. The *Your Dignity Your Future Your Choice* grassroots campaign launched by AARP Mississippi in early 2011 increased awareness of the need to expand HCBS and increase funding for services in the state. The campaign contributed to the success of state legislators allocating \$16 million for HCBS waiver slots, the largest amount ever allocated for these services in the state's history. Despite ongoing efforts to reduce waiting lists, Mississippi continues to experience long waiting lists, especially in the Elderly and Disabled HCBS waiver program (see table 4).

National data from federal records indicate that, in 2007, Mississippi spent 15.6 percent of its LTSS funds on HCBS. By 2012, LTSS spending for HCBS increased by approximately 75 percent to 27.4 percent.¹⁸ This increase is the most dramatic change of any state across the period 2007–12.

TABLE 3

Mississippi Medicaid Assisted Living and Elderly and Disabled HCBS Waiver Programs: Number of People Served and Total Expenditures, 2007–14

	Assisted Living		Elderly and Disabled	
	Number of Unduplicated Persons	Total Expenditures	Number of Unduplicated Persons	Total Expenditures
2007	191	\$1,652,879	10,300	\$61,730,390
2008	236	\$2,014,344	10,352	\$66,494,417
2009	311	\$2,091,057	10,910	\$72,860,344
2010	350	\$2,846,764	10,944	\$80,976,239
2011	464	\$5,586,048	13,293	\$94,462,415
2012	552	\$6,751,527	16,060	\$129,046,509
2013	683	\$8,183,654	17,584	\$143,889,003
2014	720	\$10,340,379	18,671	\$157,554,136

Source: Mississippi Division of Medicaid.

TABLE 4

Waiting Lists for Mississippi Medicaid HCBS Waiver Programs, 2011–14

	Number of People on Waiting List	
	Assisted Living	Elderly and Disabled
2011	129	3,966
2012	107	3,523
2013	202	3,525
2014	179	4,661

Source: Mississippi Division of Medicaid.

The two other indicators in the *Choice of Setting and Provider* dimension where Mississippi improved are:

- Home health and personal care aides per 1,000 population age 65+, and
- Assisted living and residential care units per 1,000 population age 65+.

Improved Performance in Home Health Staffing and Residential Care Supply

The *Scorecard* shows that Mississippi increased the number of home health and personal care workers from 19 per 1,000 people during the 3-year period 2007–09 to 28 workers per 1,000 people during the period 2010–12. Although Mississippi is still below the all-state median rate of 33 workers per 1,000 people, the state's 47 percent rate of improvement on this indicator is quite notable. The reasons for the increase are not well specified. The state has had a moratorium on home health agencies since 1983 so increases in the number of home health agencies is not a factor. There has been an expansion in the number of people receiving Medicaid waiver services, and home health and personal care services are a component of waiver services so this may have brought more workers into the home health field. An increase in the number of people receiving home health services has a multiplier effect on labor demand. In 2010, the average home health patient in Mississippi received 44 visits.¹⁹ In addition to an increase in home health funding, the economic recession in recent years may have made this work more attractive. In 2013 Mississippi had 6,310 home health aides with a median hourly wage of \$10.25.

Mississippi increased the number of assisted living and residential care units per 1,000 population age 65+ from the 2011 LTSS *Scorecard* to the 2014 *Scorecard*. In 2010, Mississippi had 176 assisted living/personal care facilities with 5,079 beds.²⁰ In 2014, Mississippi had 188 assisted living/personal care facilities with 5,718 beds, a growth of 13 percent from 2010 to 2014.

Reasons for the increase in the supply of assisted living and residential care are also not well specified. Costs of assisted living in Mississippi are in line with regional costs. Mississippi's median annual cost of assisted living is \$34,800, a figure that is similar to neighboring states. Comparable assisted living services in Arkansas cost \$34,200, in Louisiana \$37,875, and in Alabama \$34,728.²¹

The importance of assisted living and personal care homes to LTSS is that they are alternatives to living in institutions. It is well known that sometimes

the only reason a person cannot live outside of an institution is the lack of alternative living accommodations. State LTSS programs that seek to expand noninstitutional living inevitably encounter shortages of accessible and affordable housing alternatives. This is an ongoing problem not only in Mississippi, but across the country.

In August 2014, a partnership of Mississippi agencies implemented MSHousingSearch.org, a free housing listing and locator service. MSHousingSearch.org currently lists approximately 30,000 rental housing units. The initiative was funded by a \$300,000 federal Real Choice Systems Change Grant for Community Living, in part to help people transition from institutional care to a home- and community-based setting. The website is available in both English and Spanish and also has a resource link with websites of housing organizations and housing information sources.²²

Quality of Life and Quality of Care

The *Quality of Life and Quality of Care* dimension includes indicators for level of support, life satisfaction, and employment of working-age people with disabilities living in the community, and three indicators of quality in nursing homes. A high-performing LTSS system promotes the quality of life that individuals have as well as the quality of care that they receive.

Mississippi showed improvement on indicators measuring quality of life and quality of care and improved on all four of the indicators for which change could be compared. Indicators where Mississippi showed improvement include:

- Percentage of adults age 18+ with disabilities in the community usually or always getting needed support;
- Percentage of adults age 18+ with disabilities in the community satisfied or very satisfied with life;
- Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64; and
- Nursing home staffing turnover: ratio of employee terminations to the average number of active employees.

Data on the percentage of adults age 18+ in the community are based on population surveys. While Mississippi improved on these indicators, it is not clear how state policies have a direct effect on attitudes within the general population. However, states can influence the rate of employment for people with disabilities.

Mississippi Employment Program Initiatives for People with Disabilities

In 2007, advocates in Mississippi established a state chapter of the Association of People Supporting Employment First (APSE).²³ This was an important development because it provided an organizational structure for efforts to promote the employment of people with disabilities. An examination of its membership shows that there are overlaps between the people associated with APSE and the people who later worked on the MFP initiative. Mississippi APSE conducts biannual training sessions and cooperates with other partners to sponsor joint events such as the 2011 training conducted with the disabilities and employment Technical Assistance Center.

In 2012, APSE sponsored a conference on “Employment First,” attended by 80 people. Work on Employment First continued into 2013 and 2014. In 2013, the Mississippi Senate passed Senate Concurrent Resolution (SCR) No. 563 stating that Mississippi would commit to becoming an Employment First state relative to people with disabilities.²⁴ While SCR 563 was not adopted by the House, nonetheless in January 2014, the governor of Mississippi issued Executive Order No. 1335, which directed state agencies to coordinate their disability employment efforts and share data and resources.²⁵ The Mississippi Disability Resource Commission was assigned the tasks of monitoring the activities of state agencies and preparing an annual report addressing agency achievements and barriers that may have been encountered.²⁶

Under the 2014 State Plan for Vocational Rehabilitation, the Mississippi Department of Rehabilitation Services (MDRS) estimated that it would serve about 19,000 people.²⁷ A comparison of Mississippi state vocational rehabilitation performance with federal standards indicates that

Mississippi exceeds federal standards.²⁸ Mississippi has achieved this despite the state’s low economic environment and high unemployment rate, which have negatively impacted the number of vocational rehabilitation applications received by MDRS. Staff reported that due to the high unemployment rate, many people with disabilities chose to pursue Social Security disability benefits instead of competing for the limited number of jobs available in the state. For example, the Disability Determination Services in Mississippi saw an increase of almost 1,200 claimants in federal fiscal year (FFY) 2014 over the number of claimants in FFY 2013.

MDRS staff report that they work closely with Mississippi Medicaid, which has operated a Medicaid “Buy-In” program since 1999. By 2000, only 12 states had initiated a Medicaid Buy-In program.²⁹ Mississippi was one of these early adopters. Through a Medicaid Buy-In program, workers who earn over a certain amount of wages can receive Medicaid health care services if they pay a monthly premium to purchase their Medicaid benefits.³⁰

The Workforce Innovation and Opportunity Act, signed into national law on July 22, 2014, will bring substantial changes to the U.S. Department of Labor and state vocational rehabilitation and economic security programs. These changes could potentially help even more people with disabilities find employment in the future.

Nursing Home Staffing Turnover

High staffing turnover has been a significant problem among nursing homes in the United States. Mississippi scores on this indicator showed improvement from 2008 to 2010. Mississippi ranked 11th in the country on this measure indicating that its staffing turnover was less than turnover in 40 other states. Considerable evidence exists that staffing levels and staff turnover have demonstrable impacts on the quality of care people experience in nursing homes.³¹

- Mississippi state officials and advocates provided the following reasons why staffing turnover may have declined almost 18 percent during this 2-year period: **The recent economic recession may have lowered staff turnover in all industries, not**

just nursing homes. Although the most recent data reported in the *Scorecard* is for 2010, this explanation is not consistent with observations that staff vacancy rates increased nationally in nursing homes over the period 2010–12. In 2012, there were 70,000 staff vacancies in nursing homes nationally, an increase of about 17 percent from 2010.³²

- Mississippi is a rural state with many small towns. **Nursing homes are widely distributed throughout the state. Mississippi nursing home staff tends to live close to where they work and close to their families and do not readily relocate to work in a different nursing home.** This observation seems reasonable in explaining why Mississippi has lower rates of staff turnover generally.
- In the last 5 years a number of hospitals took on a magnet status and stopped hiring licensed practical nurses (LPNs). This change left job openings for LPNs largely in nursing homes and clinics.³³ For example, there are no hospitals in Jackson that will currently hire LPNs. As a result, nursing home staff primarily comprise LPNs and nursing assistants, with few registered nurses (RNs) employed in nursing homes. **The lack of position opportunities in hospitals could have an impact on increased LPN staff retention rates in nursing homes.**
- Culture change transformations of nursing home operations have been widely discussed for more than a decade.³⁴ **One component of culture change with Mississippi nursing home staff is an emphasis on activities that reduce staff turnover and improve the continuity of staff care within nursing homes.** Mississippi has a long history of culture change. For example, the first Green House Projects in the nation began in Tupelo in 2003.³⁵

Mississippi also has an active culture change association called GROW Mississippi, a coalition that promotes the Eden Alternative and other sound principles of elder care transformation. GROW Mississippi puts on two conferences a year.³⁶ Fourteen homes in Mississippi are certified as Eden Alternative homes.³⁷ Ombudsman staff who

A Green House home is a small, “purpose-built” community for a group of older adults and staff. A Green House is designed to be a home for 6 to 10 people who need skilled nursing or assisted living care. The purpose of the Green House is to be a place where older adults can receive assistance and support with ADLs and clinical care, without the assistance and care becoming the focus of their existence.³⁸

were interviewed reported it was their perception that staff in nursing homes were remaining on the job longer. While salary levels have not increased, homes are placing more emphasis on hiring the most suitable candidate for the position. In addition, emphasis on staff retention and continuity has influenced nursing homes that are not officially Eden Alternative–certified to pursue initiatives to change the culture of care. **Observations about the impact of culture change, especially the stepped-up efforts since 2009, also help to explain why Mississippi lowered its staff turnover recently.**

The Eden Alternative is a philosophy of culture change built around a set of 10 principles that focus on eliminating the 3 plagues of loneliness, helplessness, and boredom for older adults. The Eden Alternative has grown to become the most practiced approach to culture change.³⁹

Innovative Approach Aimed at Reducing Antipsychotic Medication Use in Nursing Homes

The 2014 *Scorecard* includes a new indicator in the *Quality of Life and Quality of Care* dimension that measures the percent of long-stay nursing home residents who are receiving an antipsychotic medication. Although Mississippi scored below the 2013 nationwide prevalence rate of 20.2 percent (see table A-3 in the appendix), the state has since

adopted an innovative strategy of using civil money penalties paid by nursing homes to fund activities aimed at reducing inappropriate use of antipsychotic medication.

The Centers for Medicare & Medicaid Services awarded a Civil Money Penalty Grant to the GROW Mississippi Culture Change Coalition in March 2014. The purpose of this grant was to provide education, training, and resources to providers, advocates, the state Long-Term Care Ombudsman, Quality Improvement Organization staff, and state agency surveyors on the National Partnership to Improve Dementia Care, a public-private coalition. The goal of the National Partnership is to improve the quality of life of long-stay nursing home residents with dementia by reducing the use of antipsychotic medications.⁴⁰ State survey and certification staff who attended training sessions indicated that they are better informed and will be able to more closely observe alternative strategies used by nursing homes to help residents with dementia in lieu of using antipsychotic medications.

Support for Family Caregivers

Family caregivers are an important component in the care of older adults and people with disabilities.⁴¹ A high-performing LTSS system supports family caregiving. Three indicators were used to measure state support for family caregivers. On two of the indicators, there was no change; however, change may be forthcoming for supports for family caregivers. In a move urged by AARP Mississippi, the legislature passed a bipartisan bill in March 2014 that established a 13-member ad hoc committee to study family caregiver needs and identify ways to assist them in caring for aging relatives at home. Mississippi did improve on the third measure. This improvement was based on questions from a national public opinion survey asking if caregivers experienced worry and stress, had enough time, or were well rested. It is hard to see the direct impact of state policy on how random samples of state residents answer these questions so the indicator is not a focus in this study.

Nurse Delegation

Registered nurses are authorized under the Mississippi Board of Nursing (BoN) Administrative Code to delegate to qualified unlicensed direct care LTSS workers specific nursing duties and patient treatments that do not involve medication administration. In line with the governor's focus on health care as an economic-development driver, the BoN joined the Mississippi Economic Council and is working with the Board of Supervisors to address nursing regulations. The new mission of the fully staffed BoN Board of Directors is to "inform and educate." The board of directors recognizes the need to move forward and be proactive in delegating all nonmedication-related health maintenance tasks to qualified LTSS workers.

Although the *Scorecard* did not show change in performance on the nurse delegation measure, Mississippi staff clarified that two additional health maintenance tasks not previously reported are permitted to be delegated by RNs under the Mississippi BoN Administrative Code. These additional health maintenance tasks include gastrostomy tube feeding and ostomy care.⁴² Other health maintenance tasks may also be delegated to direct care workers if they do not include medication. These tasks include (1) administering eye/ear drops and (2) inserting a suppository. Delegation of respiratory therapy-related health maintenance tasks falls under the authority of the Respiratory Therapist Licensure Board, rather than the BoN Administrative Code.

TECHNOLOGICAL INNOVATIONS

The adoption of technological innovations to support LTSS operations is not a *Scorecard* indicator. However, technological innovations can make LTSS systems more efficient. Top-ranked states are noted for having integrated delivery systems permitting the sharing of case management and health information among multiple agencies.⁴³ Minnesota, for example, the top-ranked LTSS program in the country, uses an integrative communications strategy linking all LTSS users. Approximately 1,700 Minnesota users from different agencies are on the shared system.⁴⁴

In 2013, Mississippi issued a request for proposal for an LTSS Information and Tracking System. The first application under the contract, the information and referral support for the MAC, was rolled out in September 2014. Between January and July 2015, Mississippi's six waivers and its quality improvement program will be incorporated into the new system. Electronic visit and verification capabilities will be added to the system in September 2015.

When complete, all LTSS staff, regardless of program or agency, will have access to a single case management system. This is a "role-based" management system in which access to client information is limited by the agency and worker's responsibilities.⁴⁵ For example, a financial eligibility worker would have access to an individual's financial information but not their health services information.

The new LTSS system cost approximately \$19 million and was paid for out of BIP funding. The implementation strategy was to pay for the entire system up front out of BIP funding rather than incur downstream state costs for the initial system development. This "up-front" structuring means the state will have only small maintenance costs going forward.⁴⁶

Interviews with state and nonprofit agency staff that participated in designing the system specifications indicated that discussions had an integrative effect on state HCBS operations. People from multiple state and nonprofit agencies met regularly during 2013 and 2014 to analyze data collection forms and collection procedures, data that had been collected, and data utilization. While staff said they generally knew what other agencies did, frequent meetings provided significant insight into what other agencies actually did and how information and administrative activities could be better coordinated.

CONCLUSION

Mississippi is an interesting case study because it is an example of how substantial program change can occur in states that do not historically score well in national rankings. AARP's analysis of change over time identified Mississippi as a state that has made consistent progress in rebalancing its LTSS programs despite the handicaps of being a small rural state with significant economic challenges. A review of state data and interviews with people in Mississippi indicate this progress was achieved for three main reasons:

First, policy makers and elected officials developed a vision. Discussions around the meaning of the Olmstead lawsuit and the development of a state plan paved the way to creating a vision for what LTSS should be.

Second, legislators, state agency staff, providers, and advocates—aided by strong, consistent leadership—worked together to improve LTSS. This group was persistent and made steady incremental progress over a multiyear period despite a long-standing institutional bias in state service delivery systems and lack of funding. For example, the group was able to obtain periodic funding to reduce HCBS waiting lists.

Third, the politics of patience are evident here, since significant progress became possible when new federal funding opportunities arose. The state used these additional federal funds to promote changes including reinvigorating information and referral programs, expanding HCBS, and committing to major technological innovations that will integrate LTSS programs over the next decade.

Mississippi has taken significant steps toward rebalancing its LTSS with the aim of strengthening HCBS services and programs and reducing institutionalization. Enrollment in Medicaid HCBS programs has increased substantially, while the number of people receiving care in nursing homes has declined.

APPENDIX

Mississippi LTSS Waiver Programs Administered by the Departments of Mental Health and Rehabilitative Services

The Department of Mental Health (MDMH) has responsibility for services to people with intellectual disabilities (ID) and developmental disabilities (DD) as well as behavioral health services. In December 2013, the Centers for Medicare & Medicaid Services approved the state’s §1915(i) HCBS State Plan Amendment, which authorizes HCBS services to people with ID/DD who do not meet Mississippi’s institutional level of need. MDMH operates the ID/DD waiver. MDMH operates 6 state mental health hospitals, 5 regional ID/DD centers, 14 community mental health centers, and 9 crisis stabilization units.

The Department of Rehabilitative Services administers two waivers: Independent Living and Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI).

The Independent Living and TBI/SCI waiver programs show growth in the number of people served and expenditures from 2007 to 2014. Table A-1 shows that there was a 68 percent increase in people being served under the independent living waiver program and a 48 percent increase in the TBI/SCI program.

Like Mississippi’s Assisted Living and Elderly and Disabled HCBS

waiver programs, growth in the Independent Living and TBI/SCI waivers has also depended upon periodic legislative appropriations to reduce waiting lists. Despite ongoing efforts to reduce waiting lists, the state continues to experience a lengthy waiting list in the Independent Living HCBS waiver program (see table A-2 below).

TABLE A-1
Mississippi Medicaid Independent Living and Traumatic Brain Injury/Spinal Cord Injury HCBS Waiver Programs: Number of People Served and Expenditures, 2007-14

	Independent Living		Traumatic Brain Injury/Spinal Cord Injury	
	Number of Unduplicated People	Total Expenditures	Number of Unduplicated People	Total Expenditures
2007	1,506	\$16,918,974	603	\$10,748,144
2008	1,773	\$25,094,489	666	\$13,478,125
2009	2,313	\$33,804,354	756	\$16,490,997
2010	2,493	\$42,977,971	817	\$18,052,101
2011	2,532	\$41,528,783	814	\$17,923,080
2012	2,557	\$45,997,820	821	\$18,273,845
2013	2,522	\$47,096,138	833	\$18,784,794
2014	2,534	\$46,957,229	892	\$20,435,591

Source: Mississippi Division of Medicaid.

TABLE A-2
Waiting Lists for Mississippi Medicaid HCBS Waiver Programs, 2011-14

	Number of People on Waiting List	
	Independent Living	Traumatic Brain Injury/Spinal Cord Injury
2011	1,275	90
2012	1,891	160
2013	2,816	77
2014	1,259	9

Source: Mississippi Division of Medicaid.

TABLE A-3

Mississippi: 2014 State Long-Term Services and Supports Scorecard Dimensions and Data

Dimension and Indicator (Current Data Year)	Baseline Rate	Current Rate	Rank	Change	All States Median	Top State Rate
OVERALL RANK			49			
Affordability and Access			49			
Median annual nursing home private pay cost as a percentage of median household income age 65+ (2013)	267%	250%	34	↔	234%	168%
Median annual home care private pay cost as a percentage of median household income age 65+ (2013)	96%	89%	36	↔	84%	47%
Private long-term care insurance policies in effect per 1,000 population age 40+ (2011)	31	31	46	↔	44	130
Percentage of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance (2011-12)	54.6%	58.5%	9	✓	51.4%	78.1%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community (2009)	24.8	31.9	34	✓	42.3	85.2
ADRC functions (composite indicator, scale 0-70) (2012)	**	14	51	✗	54	67
Choice of Setting and Provider			48			
Percentage of Medicaid and state LTSS spending going to HCBS for older people and adults with physical disabilities (2011)	15.8%	19.1%	45	✓	31.4%	65.4%
Percentage of new Medicaid aged/disabled LTSS users first receiving services in the community (2009)	32.5%	48.1%	24	✓	50.7%	81.9%
Number of people participant-directing services per 1,000 adults age 18+ with disabilities (2013)	*	1.4	44	*	8.8	127.3
Home health and personal care aides per 1,000 population age 65+ (2010-12)	19	28	36	✓	33	76
Assisted living and residential care units per 1,000 population age 65+ (2012-13)	13	15	45	✓	27	125
Quality of Life and Quality of Care			42			
Percentage of adults age 18+ with disabilities in the community usually or always getting needed support (2010)	61.3%	66.6%	51	✓	71.8%	79.1%
Percentage of adults age 18+ with disabilities in the community satisfied or very satisfied with life (2010)	84.4%	87.6%	16	✓	86.7%	92.1%
Rate of employment for adults with ADL disability ages 18-64 relative to rate of employment for adults without ADL disability ages 18-64 (2011-12)	16.7%	19.2%	46	✓	23.4%	37.2%
Percentage of high-risk nursing home residents with pressure sores (2013)	*	7.6%	46	*	5.9%	3.0%
Nursing home staffing turnover: ratio of employee terminations to the average number of active employees (2010)	36.5%	30.0%	11	✓	38.1%	15.4%
Percentage of long-stay nursing home residents who are receiving an antipsychotic medication (2013)	*	24.7%	46	*	20.2%	11.9%

(continued)

TABLE A-3 (continued)

Dimension and Indicator (Current Data Year)	Baseline Rate	Current Rate	Rank	Change	All States Median	Top State Rate
Support for Family Caregivers				28		
Legal and system supports for family caregivers (composite indicator, scale 0–14.5) (2012–13)	**	3.00	26	↔	3.00	8.00
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks) (2013)	3	3	36	↔	9.5	16
Family caregivers without much worry or stress, with enough time, well rested (2011–12)	60.4%	63.0%	10	✓	61.6%	72.8%
Effective Transitions				50		
Percentage of nursing home residents with low care needs (2010)	17.5%	16.3%	39	↔	11.7%	1.1%
Percentage of home health patients with a hospital admission (2012)	*	30.3%	48	*	25.5%	18.9%
Percentage of long-stay nursing home residents hospitalized within a 6-month period (2010)	32.5%	31.1%	48	↔	18.9%	7.3%
Percentage of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life (2009)	*	37.4%	50	*	20.3%	7.1%
Percentage of new nursing home stays lasting 100 days or more (2009)	*	24.6%	47	*	19.8%	10.3%
Percentage of people with 90+ day nursing home stays successfully transitioning back to the community (2009)	*	7.0%	35	*	7.9%	15.8%

Source: Mississippi Fact Sheet. See <http://www.longtermscorecard.org>.

*Comparable data not available for baseline and/or current year. Change in performance cannot be calculated without baseline and current data.

**Composite measure. Baseline rate is not shown as some components of the measure are available only for the current year. Change in performance is based on only those components with comparable prior data. See page 73 and page 83 in Raising Expectations 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers for more detail. Notes: ADL = activities of daily living; ADRC = Aging and Disability Resource Center; HCBS = home- and community-based services; LTSS = long-term services and supports.

Please refer to Appendix B2 on page 97 in the LTSS Scorecard report for full indicator descriptions, data sources, and other notes about methodology; for baseline data years, please see exhibit 2 on page 11. The full report is available at www.longtermscorecard.org.

Key for Change:	
Performance improvement	✓
Little or no change in performance	↔
Performance decline	✗

- 1 S. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2014). Available at <http://www.longtermscorecard.org>.
- 2 See http://www.ada.gov/olmstead/olmstead_cases_by_issue.htm.
- 3 S. Reinhard, E. Kassner, A. Houser, K. Ujvari, R. Mollica, and L. Hendrickson, *Raising Expectations, 2014: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2014). Available at <http://www.longtermscorecard.org>.
- 4 Appendix B4 of the 2014 *Scorecard* has a complete discussion of changes to the indicators from the 2011 *Scorecard* and which indicators could be compared over time. See <http://www.longtermscorecard.org/>, p. 102.
- 5 See Exhibit A4 (p. 67) of the 2014 *Scorecard* for a view of how states improved, and Appendix B5 (p. 105) and p. 22 of the report for how changes are quantified as improvements. See <http://www.longtermscorecard.org/>.
- 6 <https://www.census.gov/geo/reference/ua/urban-rural-2010.html>. Only three other states had a higher percentage of residents living in rural areas: Maine, Vermont, and West Virginia.
- 7 <http://www.census.gov/hhes/www/income/data/statemedian/>.
- 8 <http://www.census.gov/prod/2012pubs/acsbr11-01.pdf>.
- 9 U.S. Census Bureau, American Community Survey 2013, Table R1810, "Percent of People with a Disability for the Civilian Noninstitutionalized Population." Available at <http://factfinder.census.gov>.
- 10 The Mississippi Division of Medicaid has more than 900 employees located throughout one central office, 30 regional offices, and more than 90 outstations. See <http://www.medicaid.ms.gov/about/>.
- 11 <http://www.medicaid.ms.gov/about/office-locations/>.
- 12 http://www.msdh.state.ms.us/msdhsite/_static/resources/5235.pdf and American Health Care Association, *Nursing Facility Operational Characteristics Report* (June 2014), Table 4. Available at http://alt.ahcancal.org/research_data/oscar_data/Nursing%20Facility%20Operational%20Characteristics/LTC%20STATS_PVNF_OPERATIONS_2014Q2_FINAL.pdf.
- 13 Ibid. The report shows that the average nursing home in the United States has 106 beds.
- 14 States vary in how they define "assisted living." National comparisons are not possible due to definitional variations.
- 15 Appendix B5 of the 2014 *Scorecard* contains an explanation of when an improvement was deemed to occur. See <http://www.longtermscorecard.org/>, p. 109.
- 16 For example, see <http://www.trpdd.com/mac/>.
- 17 See <http://www.balancingincentiveprogram.org/resources/when-do-payments-balancing-incentive-program-end>.
- 18 Steve Eiken, Kate Sredl, Lisa Gold, Jessica Kasten, Brian Burwell, and Paul Saucier, "Medicaid Expenditures for Long-Term Services and Supports in FFY 2012," Truven Health Analytics (April 2014), Table AK. Available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/LTSS-Expenditures-2012.pdf>.
- 19 See <http://www.msdh.state.ms.us/msdhsite/index.cfm/19,5137,184,pdf/FY2013StateHealthPlan.pdf>, p. 18.
- 20 See AARP, *Across the States 2012*. Available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf, p. 190.
- 21 Genworth Financial, *Genworth 2014 Cost of Care Study* (Richmond, VA: Genworth Financial, April 2014).
- 22 See <http://www.medicaid.ms.gov/medicaid-announces-free-housing-locator-service/>.
- 23 See Mississippi chapter website at <http://www.apse.org/chapter/mississippi/>.
- 24 See <http://legiscan.com/MS/bill/SC563/2013>.
- 25 See <http://www.governorbryant.com/wp-content/uploads/2012/07/EO-1335.pdf>.
- 26 The Resource Commission has no website and is not listed in the Mississippi state agency directory. It appears to produce no reports or agendas that can be found on the Internet.
- 27 See Mississippi Vocational Rehabilitation State Plan at <http://www.mdrs.ms.gov/About/StatePlanDocs/4-11b.pdf>.
- 28 See Mississippi Vocational Rehabilitation State Plan at <http://www.mdrs.ms.gov/About/StatePlanDocs/4-11e2.pdf>.
- 29 For general information on the Medicaid Buy-In programs, see http://www.uiowa.edu/~lhpdc/work/III_framework.html; for information on the Mississippi Medicaid Buy-In program, see <http://www.medicaid.ms.gov/wp-content/uploads/2014/03/Working-Disabled.pdf>.

- 30 Only a few states, including Colorado, Massachusetts, and Minnesota, have higher limits. See http://www.mathematica-mpr.com/~media/publications/pdfs/disability/medicaidbuy-in_high earners.pdf.
- 31 For a review of this literature, see http://www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf.
- 32 Ibid. p. 4.
- 33 See <http://medical-dictionary.thefreedictionary.com/magnet+hospital>.
- 34 See <https://www.pioneernetwork.net/>.
- 35 See <http://www.mss.org/index.php/locations/traceway/>. Green House homes are now located in 32 states.
- 36 See <http://www.growms.org/>.
- 37 See <http://www.edenalt.org/resources/find-a-registry-member/registry-member-map/>.
- 38 See <https://www.pioneernetwork.net/>.
- 39 See <https://www.pioneernetwork.net/>.
- 40 By the end of 2014, the Partnership had a national goal of reducing the use of antipsychotic medications in long-stay nursing home residents by 15 percent from the 2011 fourth quarter baseline rate. The National Partnership is now working with nursing homes to reduce that rate even further with a new national goal of reducing rates by 25 percent and 30 percent by the end of 2015 and 2016, respectively. See <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-09-19.html>.
- 41 For example, in 2011 AARP estimated the economic value of family caregiving was \$450 billion per year. See <http://www.aarp.org/relationships/caregiving/info-07-2011/caregivers-save-us-health-care-system-money.html>.
- 42 As of this writing, RNs in Mississippi are authorized to delegate at least 5 of the 16 health maintenance tasks included in the *Scorecard*.
- 43 The importance of technology in integrating delivery systems is seen in state efforts to reform delivery systems such as the Texas and New York Delivery System Reform Incentive Programs (DSRIPs). Texas and New York DSRIPs are noteworthy in their emphasis on integrating case management and electronic health records across hospitals, ambulatory care, behavioral health, and community-based organizations.
- 44 The particular tool used is called LinkLive. See <http://www.revation.com/>.
- 45 Maryland implemented a similar system in 2014.
- 46 In other words, the cost of the system was not “amortized” or paid for in installments. Rather it was “expensed” in the development period so that only maintenance costs will be paid for on an ongoing basis.

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