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Gateway Policy Explorer: Long-Term Care Series

Mississippi, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2024

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Mississippi, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Mississippi are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Mississippi, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, Mississippi's Medicaid LTC system has been subject to two major policy reforms: the 2000 expansion of Mississippi's more generous income limits for Medicaid nursing facility care beneficiaries to include individuals seeking home and community-based services (HCBS) through the Elderly & Disabled program in addition to the increase in its federal poverty level (FPL)-based Medicaid income threshold from 100% of the FPL to 135% of the FPL, and the implementation of a new care needs assessment in 2007 aimed at harmonizing assessment criteria between its nursing facility care and HCBS benefits.

Key Dates

First law: 1965

Major changes since 1992: 2000, 2007

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1999

Overview

Long-term care (LTC) benefits in Mississippi are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Mississippi is administered at the state level by the Mississippi Division of Medicaid, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Mississippi are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and institutional respite care. Those applying for the Elderly & Disabled program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Elderly & Disabled program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Policy changes during this period:

- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (US Congress, 1996).
- (1997) The Elderly & Disabled program expanded statewide, having previously only been available in select counties (MS Legis., 1997).
- (1999) Effective July 1, two reforms were implemented to expand access to LTC:
  - Individuals can qualify for Elderly & Disabled program services under eligibility track 2b (Federal Poverty Level, FPL, aged and disabled) (MDM, 2014b).
  - The resource limits to qualify for Medicaid under eligibility tracks 2a (Institutional Rules for People Receiving LTC) and 2b (FPL aged and disabled) were raised from $2,000 for an individual and $3,000 for couples to $3,000 for an individual and $4,000 for couples (MDM, 2010).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024b)

Mississippi Law for Medicaid

- Mississippi Administrative Code: Title 23, Medicaid (MDM, 2024a)
- Mississippi Code of 1972: Title 43, Public Welfare, Chapter 13, Medical Assistance for the Aged; Medicaid (Miss. Code, 2024)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Mississippi Medicaid spending on beneficiaries in fiscal year 1992 was 79.99%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Mississippi Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Mississippi.

Eligibility for Medicaid in Mississippi for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (MDM, 1992).[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a Mississippi resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a U.S. citizen or qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (CMS, 2006). In 1992 this was $1,266 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[5] If an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard.
  - Asset requirements: Resources may not exceed $2,000 for an individual. In 1999, the resource limit was raised to $3,000 for an individual (MDM, 2010, 300.02). Assets for this track are evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[6]

        - Asset transfer: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care.
- 2b. Federal Poverty Level (FPL) aged and disabled
    - Income requirements: Monthly income may not exceed 100% of the FPL (MDM, 2014a). In 1992, this was $568 for an individual and $766 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly & Disabled program and has a spouse residing in the community.[5]
    - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. In 1999, resource limits were raised to $3,000 for an individual and $4,000 for a couple (MDM, 2010, 300.02). Additional asset disregards exist if a person is institutionalized or enrolled in the Elderly & Disabled program and has a spouse residing in the community.[6]
        - Asset transfer: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be at least age 65 or disabled.[4]
        - From July 1, 1999, individuals can qualify for Elderly & Disabled program services under this eligibility track (MDM, 2014b).

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Elderly & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 20-64 and physically disabled (MDM, 2012). Until 1999 applicants must be eligible for Medicaid through eligibility track 1a - SSI recipients, and from 1999 they may also be eligible for Medicaid through eligibility track 2b - FPL aged and disabled. If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Independent Living Program — from 1994

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 60 visits per state fiscal year (MS Legis., 1997). In 2005 the limit was decreased to 25 visits per state fiscal year (MDM, 2005).

Nursing Facility Care

Nursing facility care does not provide home care.

Elderly & Disabled

The Elderly & Disabled program provides the following home care services (MDM, 2003a; MDM, 2001):

- Home health services: As described above, provided if home health services are needed in excess of the state plan home health benefit
- Homemaker services: General household activities and chores essential to the beneficiary's care (e.g., personal laundry, meal preparation, having prescriptions filled)

Community care

Community care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly & Disabled

The Elderly & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (MDM, 2001; MDM, 2003a; MDM, 2023).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Elderly & Disabled

These programs do not provide residential care.

Nursing Facility Care

Mississippi Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs (MDM, 2003c; MDM, 2024b). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Mississippi's largest home and community-based services (HCBS) program.

Mississippi Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly & Disabled

The Elderly & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (MDM, 2001; MDM, 2003a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Institutional respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care, provided at a nursing facility or hospital

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (MDM, 2003b).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30; MDM, 2003c).

Elderly & Disabled

Elderly & Disabled program services are provided by authorized staff of state-approved providers. The type of provider agency or facility varies by authorized service (MDM, 2003a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be essentially homebound, meaning they are unable to travel to an outpatient setting for needed services due to medical hardship (MDM, 2003b; MDM, 2018).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement (MDM, 2002b; MDM 2003c).

Elderly & Disabled

Beneficiaries must meet an NFLOC by having a physician certify that they are unable to perform at least 3 out of 7 activities of daily living (ADLs) without substantial human assistance (MDM, 2003a).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (MDM, 2003b; MDM, 2024d; 42 CFR 484.55).

Nursing Facility Care

Nursing facility level of care (NFLOC) must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities. After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Elderly & Disabled

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (MDM, 2013; MDM, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly & Disabled

The individual must be at least age 65, or 21-64 and disabled (MDM, 2012; MDM, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be essentially homebound, meaning they are unable to travel to an outpatient setting for needed services due to medical hardship (MDM, 2003b; MDM, 2018).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement using form DOM 260-NF (MDM, 2002b; MDM 2003c).

Elderly & Disabled

Beneficiaries must meet an NFLOC by having a physician certify that they are unable to perform at least 3 activities of daily living (ADLs) without substantial human assistance or supervision (MDM, 2003a). NFLOC is certified using form DOM 260-HCBS. See Table 3 for more information on how the form assesses ADL impairment as well as other information collected to inform NFLOC certification and the plan of care.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (MDM, 2003b).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care using screening form DOM 260-NF (MDM, 2002b; MDM 2003c). The form consists of a Preadmission Screening and Resident Review (PASRR), which is required by federal law and which screens for mental illness or intellectual disability that would require specialized services in addition to nursing facility care. If the PASRR does not indicate that the beneficiary requires further screening for mental illness or intellectual disability, the physician can certify that the resident is appropriate for nursing facility placement and submit form DOM-260NF to the nursing facility.

To certify the beneficiary's need for nursing facility care, the physician must also conduct a preliminary evaluation that considers the following in assessing the beneficiary's impairments and care needs (MDM 2003c, p. 267):

- Functional developmental status
- Mobility

- Learning
- Self-care
- Communication
- Self-direction
- Capacity for independent living
- Social skills
- Health, nutritional, and behavioral status

See MDM (2003c, p. 271) to view form DOM 260-NF, and see Box 1 for more information on the PASRR. Nursing facilities are also required by federal law to conduct periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the MDS.

Elderly & Disabled

A licensed physician must certify that the beneficiary meets an NFLOC using physician certification form DOM 260-HCBS before services can be rendered. The form collects information on the following (MDM, 2003a):

- Medical diagnoses
- Behavioral issues (e.g., anxious, disoriented, wanders)
- Sensory issues (e.g., paralysis, hearing/vision impairment, cannot communicate)
- Elimination (i.e., bladder and bowel incontinence)
- Medications and treatments
- Rehabilitative services (i.e., physical, respiratory, occupational, or speech therapies)
- Activities of daily living (ADLs): Eating, toileting, bathing, personal hygiene, ambulation, transferring, dressing

NFLOC is determined using the ADLs section of the form. An NFLOC is met if an individual requires substantial assistance with at least 3 ADLs. See Table 3 for more information on how the ADLs are evaluated to determine the level of assistance needed.

Once the physician certification is completed, the beneficiary is assessed for eligibility for case management services using HCBS-305, and a plan of care is established using HCBS-301. The three completed forms are submitted to the Division of Medicaid for final approval and certification (MDM, 2003a). See Table 3 for more information on form DOM 260-HCBS, and see MDM (2003a) to view forms DOM 260-HCBS and HCBS-301.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services, develop a written plan of care, and periodically review the plan of care (MDM, 2003b).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care using screening form DOM 260-NF. Periodic assessments using the Minimum Data Set (MDS) are conducted or coordinated by a registered nurse (MDM, 2002b; MDM 2003c).

Elderly & Disabled

A licensed physician must certify that the beneficiary meets an NFLOC, and must order services by developing a plan of care. Case management services are authorized and provided by a social worker or registered nurse employed by a state-certified case management agency. NFLOC, plan of care, and case management forms are submitted to the Division of Medicaid for final approval (MDM, 2003a).

Benefit limitations

Can you mix LTC benefits?

All Mississippi Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the three largest programs.

Medicaid

In 1994, Mississippi implemented an estate recovery program as required by federal law (Miss. Code 43-13-317). The acceptance of Medicaid in Mississippi creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care or HCBS program services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Home health services are subject to a $2 copayment per visit (MDM, 2003b).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 1992, the federal minimum PNA was $30 per month. In 1998, the PNA was increased to $44 per month (CMS, 2003).

Author's Note: Authors have not identified the PNAs between 1992-1998, but they are subject to the federal minimum of $30 per month. The PNA policy is is pending requested materials.

Elderly & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2000-2006

Policy change in 2000
In 2000, Mississippi increased the income limit for eligibility track 2b (Federal Poverty Level, FPL, aged and disabled) from 100% of the FPL to 135% of the FPL (MS Legis., 2000). Additionally, Mississippi extended eligibility for eligibility track 2a (Institutional Rules for People Receiving LTC) to individuals receiving home and community-based services (HCBS) through the Elderly & Disabled program. Previously, this track was limited to individuals receiving Medicaid nursing facility care.

Other policy changes during this period:

- (2000) The resource limits for individuals qualifying for Medicaid under eligibility tracks 2a (Institutional Rules for People Receiving LTC) and 2b (FPL aged and disabled) were raised from $3,000 for an individual and $4,000 for a couple to $4,000 for an individual and $6,000 for a couple (MDM, 2010, 300.02).
- (2000) The Elderly & Disabled program respite benefit was expanded to include in-home respite services in addition to institutional respite provided in nursing facilities and hospitals (MDM, 2001; MDM, 2002a).
- (2005) Mississippi decreased the maximum number of home health service visits that can be authorized from 60 visits to 25 per state fiscal year (MDM, 2005).
- (2006) The Deficit Reduction Act of 2005 implemented the following changes to Mississippi's Medicaid program (MDM, 2010, 302.04):
  - A home equity limit of $500,00 was imposed on Medicaid applicants applying on or after January 1, 2006. Prior to this, in determining an applicant's assets, the value of an individual's home was usually exempt. Under the new law, a person with more than $500,000 in home equity is ineligible for nursing facility care under Medicaid. Homes occupied by a spouse or disabled or minor child are exempt.
  - The look back period for transfers of assets was extended from 36 months to 60 months for all transfers.
- (2006) Effective January 1, Mississippi made two additional changes related to Medicaid eligibility:
  - Eliminated eligibility track 2b (FPL aged and disabled) (MS Legis., 2005).
  - Implemented the Healthier Mississippi program to provide Medicaid to individuals who may have lost coverage due to the elimination of eligibility track 2b (FPL aged and disbaled). The program provides a limited package of benefits to up to 6,000 aged or disabled individuals who make up to 135% of the FPL (CMS, 2015). The only long-term care services offered to program recipients are home health services, which are capped at 25 visits per year.

Overview

Long-term care (LTC) benefits in Mississippi are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Mississippi is administered at the state level by the Mississippi Division of Medicaid, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Mississippi are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Those applying for the Elderly & Disabled program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Elderly & DIsabled program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024b)

Mississippi Law for Medicaid

- Mississippi Administrative Code: Title 23, Medicaid (MDM, 2024a)

- Mississippi Code of 1972: Title 43, Public Welfare, Chapter 13, Medical Assistance for the Aged; Medicaid (Miss. Code, 2024)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Mississippi Medicaid spending on beneficiaries in fiscal year 2000 was 76.80%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Mississippi Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Mississippi.

Eligibility for Medicaid in Mississippi for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (MS Legis., 2000).[1] In 2000, the monthly federal benefit amount was $513 for an individual and $769 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[7]
    - Home equity limit: From 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (MDM, 2010).[8]
  - Citizenship/immigration requirements: The applicant must be a Mississippi resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.

- ◇ Other requirements
  - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (CMS, 2006). In 2000 this was $1,539 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[9] If an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard.
  - ◇ Asset requirements: Resources may not exceed $4,000 for an individual (MDM, 2010, 300.02). Assets for this track are evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., Elderly & Disabled).
- 2b. Federal Poverty Level (FPL) aged and disabled — until 2006
  - ◇ Income requirements: Monthly income may not exceed 135% of the FPL (MDM, 2014a). In 2000, this was $939 for an individual and $1,266 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly & Disabled program and has a spouse residing in the community.[9]
  - ◇ Asset requirements: Resources may not exceed $4,000 for an individual and $6,000 for a couple (MS Legis., 2000; MDM, 2010, 300.02). Additional asset disregards exist if a person is institutionalized or enrolled in the Elderly & Disabled program and has a spouse residing in the community.[10]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be at least age 65 or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Mississippi Breast and Cervical Cancer Program (MS-BCCP): From 2001, provides Medicaid coverage, including long-term care, for women who are under age 65 with income up to 250% of the FPL who have been found to have breast or cervical cancer including a precancerous condition.
- Healthier Mississippi Program: From 2006, extends Medicaid coverage to up to 6,000 aged or disabled individuals who make up to 135% of the FPL, offering a limited benefit package that excludes long-term care services such as nursing facility care and home and community-based services.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Elderly & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 20-64 and physically disabled (MDM, 2012). If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Independent Living Program
- Assisted Living Program — from 2000

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 60 visits per state fiscal year (MS Legis., 1997). In 2005 the limit was decreased to 25 visits per state fiscal year (MDM, 2005).

Nursing Facility Care

Nursing facility care does not provide home care.

Elderly & Disabled

The Elderly & Disabled program provides the following home care services (MDM, 2003a; MDM, 2001):

- Home health services: As described above, provided if home health services are needed in excess of the state plan home health benefit
- Homemaker services: General household activities and chores essential to the beneficiary's care (e.g., personal laundry, meal preparation, having prescriptions filled)

Community care

Community care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly & Disabled

The Elderly & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (MDM, 2001; MDM, 2003a; MDM, 2023).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Elderly & Disabled

These programs do not provide residential care.

Nursing Facility Care

Mississippi Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs (MDM, 2003c; MDM, 2024b). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Mississippi's largest home and community-based services (HCBS) program.

Mississippi Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly & Disabled

The Elderly & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (MDM, 2001; MDM, 2003a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day
- Respite (in-home & institutional): Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care, provided either in the beneficiary's home, or at a nursing facility or hospital

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (MDM, 2003b).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30; MDM, 2003c).

Elderly & Disabled

Elderly & Disabled program services are provided by authorized staff of state-approved providers. The type of provider agency or facility varies by authorized service (MDM, 2003a).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be essentially homebound, meaning they are unable to travel to an outpatient setting for needed services due to medical hardship (MDM, 2003b; MDM, 2018).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement (MDM, 2002b; MDM 2003c).

Elderly & Disabled

Beneficiaries must meet an NFLOC by having a physician certify that they are unable to perform at least 3 out of 7 activities of daily living (ADLs) without substantial human assistance (MDM, 2003a).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (MDM, 2003b; MDM, 2024d; 42 CFR 484.55).

Nursing Facility Care

Nursing facility level of care (NFLOC) must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities. After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Elderly & Disabled

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (MDM, 2013; MDM, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly & Disabled

The individual must be at least age 65, or 21-64 and disabled (MDM, 2012; MDM, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be essentially homebound, meaning they are unable to travel to an outpatient setting for needed services due to medical hardship (MDM, 2003b; MDM, 2018).

Nursing Facility Care

Beneficiaries must meet a nursing facility level of care (NFLOC) by having a physician certify the medical necessity of their nursing home placement using form DOM 260-NF (MDM, 2002b; MDM 2003c).

Elderly & Disabled

Beneficiaries must meet an NFLOC by having a physician certify that they are unable to perform at least 3 activities of daily living (ADLs) without substantial human assistance or supervision (MDM, 2003a). NFLOC is certified using form DOM 260-HCBS. See Table 3 for more information on how the form assesses ADL impairment as well as other information collected to inform NFLOC certification and the plan of care.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (MDM, 2003b).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care using screening form DOM 260-NF (MDM, 2002b; MDM 2003c). The form consists of a Preadmission Screening and Resident Review (PASRR), which is required by federal law and which screens for mental illness or intellectual disability that would require specialized services in addition to nursing facility care. If the PASRR does not indicate that the beneficiary requires further screening for mental illness or intellectual disability, the physician can certify that the resident is appropriate for nursing facility placement and submit form DOM-260NF to the nursing facility.

To certify the beneficiary's need for nursing facility care, the physician must also conduct a preliminary evaluation that considers the following in assessing the beneficiary's impairments and care needs (MDM 2003c, p. 267):

- Functional developmental status
- Mobility
- Learning
- Self-care
- Communication
- Self-direction
- Capacity for independent living
- Social skills
- Health, nutritional, and behavioral status

See MDM (2003c, p. 271) to view form DOM 260-NF, and see Box 1 for more information on the PASRR. Nursing facilities are also required by federal law to conduct periodic assessments using the Minimum Data Set (MDS). See Box 2 for more information on the MDS.

Elderly & Disabled

A licensed physician must certify that the beneficiary meets an NFLOC using physician certification form DOM 260-HCBS before services can be rendered. The form collects information on the following (MDM, 2003a):

- Medical diagnoses
- Behavioral issues (e.g., anxious, disoriented, wanders)
- Sensory issues (e.g., paralysis, hearing/vision impairment, cannot communicate)
- Elimination (i.e., bladder and bowel incontinence)
- Medications and treatments
- Rehabilitative services (i.e., physical, respiratory, occupational, or speech therapies)
- Activities of daily living (ADLs): Eating, toileting, bathing, personal hygiene, ambulation, transferring, dressing

NFLOC is determined using the ADLs section of the form. An NFLOC is met if an individual requires substantial assistance with at least 3 ADLs. See Table 3 for more information on how the ADLs are evaluated to determine the level of assistance needed.

Once the physician certification is completed, the beneficiary is assessed for eligibility for case management services using HCBS-305, and a plan of care is established using HCBS-301. The three completed forms are submitted to the Division of Medicaid for final approval and certification (MDM, 2003a). See Table 3 for more information on form DOM 260-HCBS, and see MDM (2003a) to view forms DOM 260-HCBS and HCBS-301.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services, develop a written plan of care, and periodically review the plan of care (MDM, 2003b).

Nursing Facility Care

A licensed physician must certify the beneficiary's need for nursing facility care using screening form DOM 260-NF. Periodic assessments using the Minimum Data Set (MDS) are conducted or coordinated by a registered nurse (MDM, 2002b; MDM 2003c).

Elderly & Disabled

A licensed physician must certify that the beneficiary meets an NFLOC, and must order services by developing a plan of care. Case management services are authorized and provided by a social worker or registered nurse employed by a state-certified case management agency. NFLOC, plan of care, and case management forms are submitted to the Division of Medicaid for final approval (MDM, 2003a).

Benefit limitations

Can you mix LTC benefits?

All Mississippi Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the three largest programs.

Medicaid

As required by federal law, Mississippi enforces Estate Recovery. The acceptance of Medicaid in Mississippi creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care or HCBS program services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Home health services are subject to a $2 copayment per visit (MDM, 2003b).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2000, the PNA was $44 per month (MDM, 2000).

Elderly & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2007-2024

Policy change in 2007
In 2007, the Mississippi Division of Medicaid implemented the Pre Admission Screening, a new care needs assessment to certify eligibility for beneficiaries seeking access to both nursing facility and home and community-based services (HCBS). The PAS includes new assessment items including home environment, social supports, and additional activities of daily living (ADLs) to certify that an individual requires a nursing facility level of care (NFLOC).

Other policy changes during this period:

- (2011) From January 1, the home equity limit for Medicaid nursing facility residents increases annually with inflation (MDM, 2010, 302.04).
- (2012) Effective July 1, the Elderly & Disabled program removed the homemaker services benefit, and replaced it with a personal care services benefit. Personal care services include assistance with ADLs and instrumental activities of daily living (IADLs). (MDM, 2012).
- (2015) The Elderly & Disabled program added community transition services as a benefit to support nursing facility residents in transitioning to a home or community-based setting (MDM, 2015).
- (2019) Effective July 1, the maximum number of home health service visits that can be authorized increased from 25 to 36 visits per state fiscal year (CMS, 2019).
- (2023) Effective May 1, the Division of Medicaid eliminated all copayments for pharmacy and health care services, including the $2 copayment for home health service visits (CMS, 2023).
- (2024) The Elderly & Disabled program added medication management and environmental safety services to the benefit package (MDM, 2023).

Overview

Long-term care (LTC) benefits in Mississippi are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Mississippi is administered at the state level by the Mississippi Division of Medicaid, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Mississippi are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly & Disabled).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly & Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC) and respite care. Those applying for the Elderly & Disabled program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list administered on a first-come, first-serve basis.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Elderly & DIsabled program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024b)

Mississippi Law for Medicaid

- Mississippi Administrative Code: Title 23, Medicaid (MDM, 2024a)
- Mississippi Code of 1972: Title 43, Public Welfare, Chapter 13, Medical Assistance for the Aged; Medicaid (Miss. Code, 2024)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Mississippi Medicaid spending on beneficiaries in fiscal year 2007 was 75.89%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

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This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for Mississippi Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Mississippi.

Eligibility for Medicaid in Mississippi for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (MDM, 2014a).[1] In 2007, the monthly federal benefit amount was $623 for an individual and $934 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[11]
    - Home equity limit: The equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. From 2011, this figure increases annually with inflation (MDM, 2010).[8]
  - Citizenship/immigration requirements: The applicant must be a Mississippi resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (MDM, 2014a). In 2007 this was $1,869 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[12] If an individual has monthly income above this threshold, they can set up a Qualified Income Trust to meet this standard.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Assets for this track are evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[13]
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a federally approved HCBS program (e.g., Elderly & Disabled).

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Mississippi Breast and Cervical Cancer Program (MS-BCCP): Provides Medicaid coverage, including long-term care, for women who are under age 65 with income up to 250% of the FPL who have been found to have breast or cervical cancer including a precancerous condition.
- Healthier Mississippi Program: Extends Medicaid coverage to up to 6,000 aged or disabled individuals who make up to 135% of the FPL, offering a limited benefit package that excludes long-term care services such as nursing facility care and home and community-based services.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Elderly & Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 20-64 and physically disabled (MDM, 2023). If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Independent Living Program
- Assisted Living Program

Benefit

Home care benefit

Home care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

Home Health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 25 visits per state fiscal year. Effective July 1, 2019, the limit was increased to 36 visits per state fiscal year (CMS, 2019; MDM, 2024d).

Nursing Facility Care

Nursing facility care does not provide home care.

Elderly & Disabled

The Elderly & Disabled program provides the following home care services (MDM, 2023):

- Home health services: As described above, provided as an extension of the state plan home health services benefit
- Homemaker services (until 2012): General household activities and chores essential to the beneficiary's care (e.g., personal laundry, meal preparation, having prescriptions filled)
- Personal care services (from 2012):
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Community care

Community care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly & Disabled

The Elderly & Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (MDM, 2001; MDM, 2003a; MDM, 2023).

Residential care

Residential care benefits vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services, Elderly & Disabled

These programs do not provide residential care.

Nursing Facility Care

Mississippi Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs (MDM, 2003c; MDM, 2024b). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by LTC health benefit program. Below we detail other benefits provided by the Medicaid state plan, followed by Mississippi's largest home and community-based services (HCBS) program.

Mississippi Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly & Disabled

The Elderly & Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (MDM, 2023):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Meal preparation and delivery to the beneficiary of one nutritional meal per day

- Respite (in-home & institutional): Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care, provided either in the beneficiary's home, or at a nursing facility or hospital
- Community transition services (from 2015): Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)
- Environmental safety services (from 2024): Services provided to maintain a healthy and safe living environment that are beyond the beneficiary's capability (e.g., minor home repairs, pest control, non-routine yard maintenance)
- Medication management (from 2024): Consultations and visits by a licensed pharmacist to periodically review prescription regimens and support adherence for beneficiaries with one or more chronic health conditions

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services beneficiaries must receive a supervisory visit made by a registered nurse every 60 days (MDM, 2024d).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (42 CFR 483.30; MDM, 2024b).

Elderly & Disabled

Elderly & Disabled program services are provided by authorized staff or volunteers of state-approved providers. The type of provider agency or facility varies by authorized service (MDM, 2024c).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be essentially homebound, meaning they are unable to travel to an outpatient setting for needed services due to medical hardship. The homebound requirement was lifted in 2018, while the requirement that the beneficiary be unable to travel to an outpatient setting for needed services remained in place (MDM, 2018; MDM, 2024d, p. 3).

Nursing Facility Care, Elderly & Disabled

The beneficiary must meet a nursing facility level of care (NFLOC) by scoring at least 50 points on the Pre-Admission Screening (PAS).

To qualify for institutional care in a nursing facility, the beneficiary must have signed physician's orders upon admission (MDM, 2023; MDM, 2024b). To qualify for the Elderly & Disabled program, beneficiaries must also require at least 2 program services per month (MDM, 2023).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (MDM, 2003b; MDM, 2024d; 42 CFR 484.55).

Nursing Facility Care

Nursing facility level of care (NFLOC) must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities. After admission, Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Elderly & Disabled

NFLOC must be recertified on an annual basis, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (MDM, 2013; MDM, 2023).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Elderly & Disabled

The individual must be at least age 65, or 21-64 and disabled (MDM, 2012; MDM, 2023).

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be essentially homebound, meaning they are unable to travel to an outpatient setting for needed services due to medical hardship. The homebound requirement was lifted in 2018, while the requirement that the beneficiary be unable to travel to an outpatient setting for needed services remained in place (MDM, 2018; MDM, 2024d, p. 3).

Nursing Facility Care, Elderly & Disabled

Beneficiaries must meet a nursing facility level of care (NFLOC) by scoring at least 50 points on the Pre-Admission Screening (PAS). The PAS screens potential beneficiaries for functional limitations and care needs across 6 domains (MDM, 2013). See Box 3 and Box 4 for PAS assessment items and scoring criteria. In order to qualify for the Elderly & Disabled program, the beneficiary must also have their need for at least two program services per month authorized by a physician prior to receiving services (MDM, 2023).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and an in-person or

telehealth visit must be conducted up to 90 days before or 30 days after the start of home health services to confirm medical need for and the appropriateness of the plan of care (MDM, 2024d).

Nursing Facility Care, Elderly & Disabled

The Pre-Admission Screening (PAS) is completed during an in-person interview with the applicant and with any caregivers or designated representatives as applicable. Once the PAS is completed the screener must obtain a physician's certification before the completed assessment can be submitted electronically to the Division of Medicaid for approval. Individuals must score at least 50 points to qualify as requiring a nursing facility level of care (NFLOC), and individuals who score between 44-49 points are flagged for a secondary review to be performed by a Division of Medicaid clinician (MDM, 2013). The 10 sections of the PAS assessment include:

1. Background information
2. Functional Screen: ADLs/IADLs, communication/sensory
3. Cognitive screen
4. Mood/psychosocial, behaviors
5. Medical screen: Medical conditions, health-related services, medications, medical stability
6. Social Supports: Primary caregiver, formal support (not asked to applicants seeking care in a nursing facility)
7. Home environment (not asked to applicants seeking care in a nursing facility)
8. Informed choice (applicant's informed consent in choice between nursing facility or home and community-based care)
9. Level II Determination (PASRR)
10. Physician certification

See Box 3 and Box 4 for PAS assessment items and scoring criteria. See MDM (2007a) to view the PAS assessment form, and MDM (2007b) for the full scoring matrix.

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services, develop a written plan of care, and periodically review the plan of care (MDM, 2024d).

Nursing Facility Care, Elderly & Disabled

The Pre-Admission Screening (PAS) is completed by a qualified individual, which can be a physician, nurse, social worker, rehabilitation counselor, or a facility designee (MDM, 2013).

Benefit limitations

Can you mix LTC benefits?

All Mississippi Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the three largest programs.

Medicaid

As required by federal law, Mississippi enforces Estate Recovery. The acceptance of Medicaid in Mississippi creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for nursing facility care or HCBS program services after the recipient reached 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Home health services are subject to a $2 copayment per visit until May 1, 2023 when the Division of Medicaid eliminated Medicaid copayments for pharmacy and health care services (CMS, 2023).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. In 2007, the PNA was $44 per month (MDM, 2000).

Elderly & Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Mississippi Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2024)

Fiscal Year	FMAP
1992	79.99%
1993	79.01
1994	78.85
1995	78.58
1996	78.07
1997	77.22
1998	77.09
1999	76.78
2000	76.80
2001	76.82
2002	76.09
2003	78.10
2004	79.29
2005	77.08
2006	76.00
2007	75.89
2008	76.29
2009	83.93
2010	84.86
2011	80.68
2012	74.18
2013	73.43
2014	73.05
2015	73.58
2016	74.17
2017	74.63
2018	75.65
2019	76.39
2020	81.63
2021	83.96
2022	84.51
2023[1]	82.84
2024	77.65

Source: U.S. DHHS (2024)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201).

[1]The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Mississippi Medicaid Income Limits (1992-2024)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	FPL Aged and Disabled (Individual)	FPL Aged and Disabled (Couple)
1992	$422	$633	$1,266	$1,899	$568	$766
1993	434	652	1,302	1,956	581	786
1994	446	669	1,338	2,007	613	820
1995	458	687	1,374	2,061	623	836
1996	470	705	1,410	2,115	645	863
1997	484	726	1,452	2,178	658	884
1998	494	741	1,482	2,223	671	904
1999	500	751	1,500	2,253	687	922
2000	513	769	1,539	2,307	939	1,266
2001	531	796	1,593	2,388	966	1,306
2002	545	817	1,635	2,451	997	1,343
2003	552	829	1,656	2,487	1,010	1,364
2004	564	846	1,692	2,538	1,047	1,405
2005	579	869	1,737	2,607	1,077	1,443
2006	603	904	1,809	2,712	1,103	1,485
2007	623	934	1,869	2,802		
2008	637	956	1,911	2,868		
2009	674	1,011	2,022	3,033		
2010	674	1,011	2,022	3,033		
2011	674	1,011	2,022	3,033		
2012	698	1,048	2,094	3,144		
2013	710	1,066	2,130	3,198		
2014	721	1,082	2,163	3,246		
2015	733	1,100	2,199	3,300		
2016	733	1,100	2,199	3,300		
2017	735	1,103	2,205	3,309		
2018	750	1,125	2,250	3,375		
2019	771	1,157	2,313	3,471		
2020	783	1,175	2,349	3,525		
2021	794	1,191	2,382	3,573		
2022	841	1,261	2,523	3,783		
2023	914	1,371	2,742	4,113		
2024	943	1,415	2,829	4,245		

Source: SSA (2024), HHS (2024)

Notes: Income limits for individuals and couples are monthly. The FPL Aged and Disabled income limit was set at 100% of the FPL until 2000, when this track increased to 135% of the FPL.

Box 1: Preadmission Screening and Resident Review (PASARR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASARR). The purpose of the PASARR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASARR evaluation.

Source: 42 CFR 483.100-138

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2024)

Table 3: Mississippi Division of Medicaid Physician Certification Form 260-HCBS Sections (1993-2007)

Section	Assessment Items
Admitting Diagnosis	• Primary • Secondary • Significant problem(s)
Behavior: check all that apply	• Anxious • Agitated • Confused • Depressed • Wanders • Disoriented (person, time, place) • Hostile • Lethargic • Hallucinates
Sensory: check all that apply	• Hearing impaired • Vision impaired • Cannot communicate • Comatose • Semi-comatose • Paralysis
Diet: indicate type, and if tube fed	
Elimination: check all that apply	• Incontinent (bladder) • Foley (bladder) • Incontinent (bowel) • Colostomy (bowel)
Activities of Daily Living (ADLs): for each ADL check whether the beneficiary is capable of self care, or if assisted care or total care is needed	• Eating • Toileting • Bathing • Personal Hygiene • Ambulation • Transferring • Dressing
Rehabilitative Services: check all that apply	• Physical therapy • Respiratory therapy • Occupational therapy • Speech therapy • Other
Medications: list dose and frequency	
Treatments: list frequency	

Source: MDM (2003a)

Notes: Form 260-HCBS is used to certify eligibility for Elderly & Disabled program services. NFLOC is determined using the ADLs section of the form. Authors are not able to identify a copy of the form from 1992, and can only confirm its use from 1993-2007.A1

Box 3: Mississippi Division of Medicaid Pre-Admission Screening (2007-2024) Part 1

Section I. Intake: Collects personal information and living arrangement

Section II. Functional Screen, A: Activities of daily living and instrumental activities of daily living (IADL). The following ADLs and IADLs are scored based on whether they are independent (0 pts), supervision needed (1 pt), physical assistance needed (2 pts), or totally dependent (3 pts):

- Mobility/Ambulation
- Community mobility
- Transferring
- Eating
- Meal preparation
- Toileting
- Bathing
- Dressing
- Personal hygiene
- Medication management

If the individual uses insulin, they are asked the following 3 questions (yes, no, N/A):

- Can person administer finger sticks and understand glucose testing results?
- If on a fixed dose, can person self-inject insulin with a pre-filled syringe?
- If on a sliding scale, can person draw up the correct amount and inject insulin?

The following continence ADLs are scored based on whether the beneficiary has complete voluntary control (0 pts), incontinent episodes less than weekly (1 pt), Incontinent episodes once per week (2 pts), or incontinent episodes 2 or more times per week (3 pts):

- Bladder continence
- Bowel continence

Underlying causes of ADL/IADL limitations: Physical impairments (e.g., balance problems, sensory impairment, limited range of motion) as well as supervision need (e.g., behavior issues, history of falls, memory impairment). The form lists 31 physical impairments related to each of the above ADLs. Each is given a binary score of 0 or 1, with a 10-point maximum for this category.

Section II. Functional Screen, B: Communication and sensory impairments are scored as follows:

- Expressive communication
    0. Person can fully communicate with no or only mild impairment (e.g., slow speech)
    1. Person can fully communicate with use of assistive device
    2. Person can communicate only basic needs to others
    3. Person has no effective communication
- Ability to understand others
    0. Person understands
    1. Person usually understands, may miss some part/intent of message
    2. Person sometimes understands, responds adequately to simple direct communication
    3. Person rarely/never understands
- Vision
    0. Adequate
    1. Mildly impaired
    2. Moderately impaired
    3. Highly impaired
    4. Severely impaired
- Hearing
    0. Hears adequately
    1. Mildly impaired
    2. Moderately impaired
    3. Highly impaired

Source: MDM (2013)

Notes: 50 points scored on the PAS are needed to qualify as requiring a nursing facility level of care (NFLOC). See MDM (2007a) for the Pre-Admission Screening (PAS) Application, MDM (2013) for the PAS Instruction Manual, and MDM (2007b) for the PAS Scoring Matrix.

Box 4: Mississippi Division of Medicaid Pre-Admission Screening (2007-2024) Part 2

Section III. Cognitive Screen, Orientation: Assesses the person's level of awareness to person, place, and time. Individuals are scored based on whether they know (0 pts) or do not know (1 pt) the following items, with a maximum 33 points possible in this section:

1. Person
    - ◇ First name, last name, caregiver's name
2. Place
    - ◇ Immediate environment, place of residence, city, state
3. Time
    - ◇ Day, month, year, time of day
4. Overall rating of orientation/situational awareness
    0. No problem
    1. Mildly or moderately disoriented/confused
    2. Severely disoriented/confused

Section IV. Mood/psychosocial behaviors, A. Current mood/psychosocial: lists 25 psychosocial issues that can be checked as relevant. This section does not contribute to the total score used to determine NFLOC.

Section IV. Mood/psychosocial behaviors, B. Behaviors: Each of the following behaviors is given two scores, one based on frequency of behavior (0 = has not occurred, 1 = occasional/no more than once per week, 2 = frequent/more than weekly but less than daily, 3 = constant behavior requiring daily intervention) and intensity of behavior (0 = behavior is easily altered, 1 = behavior is not easily altered)

1. Verbally aggressive
2. Physically aggressive
3. Resistive
4. Wandering/elopement
5. Inappropriate/unsafe
6. Self-injurious
7. Other (delusions, hallucinations, manic symptoms, mood swings)

Section V. Medical conditions: Medical diagnoses related to ADL impairments or cognitive/behavioral status are checked if present. The following diagnoses, if checked, contribute to the point total used to determine NFLOC:

- Alzheimer's/dementia
- Paralysis
- Traumatic brain injury
- Severe orthopedic/neurological impairment

Section VI. Health-related services: Services needed as well as service frequency are indicated. The following services, if received, contribute to the point total used to determine NFLOC

- Catheter care
- Occupational therapy
- Ostomy care
- Oxygen
- Physical therapy
- Pressure/other ulcer care
- Tube feeding
- Turning and positioning

Any items that do not contribute toward the point total are available for consideration by the Division of Medicaid as part of a secondary review, if necessary.

Source: MDM (2013)

Notes: 50 points scored on the PAS are needed to qualify as requiring a nursing facility level of care (NFLOC). See MDM (2007a) for the Pre-Admission Screening (PAS) Application, MDM (2013) for the PAS Instruction Manual, and MDM (2007b) for the PAS Scoring Matrix.

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Department of Health and Human Services (2024). Prior HHS Guidelines and Federal Register References. As of November 5, 2024 [Link]

Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): ADHC is a community-based long term care benefit that provides nursing care, personal care, social, nutritional, and therapeutic services, typically furnished in a community center for four or more hours per day at least once per week.

Elderly & Disabled: Program providing home and community-based services to a limited number of Medicaid recipients under federal 1915(c) waiver authority.

Alternate Living Services (ALS): ALS homes provide 24-hour supervision with access to medically related personal care, nursing services, physical/occupational/speech therapies, dietitians, and meal services to individuals unable to continue living independently at home. Residents are responsible for covering room and board.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Division of Health Facilities Licensure and Certification: Division within the Mississippi Department of Health responsible for licensing and overseeing Medicaid health providers.

Division of Medicaid: Mississippi state agency, organized under the Office of the Governor, responsible for administering the state's Medicaid program.

DOM 260-NF: Form used to certify medical necessity of care and residence in a nursing facility. This form was used until 2007 when it was replaced by the Pre Admission Screening (PAS).

DOM 260-HCBS: Form used to certify that a beneficiary qualifies for home and community-based services (HCBS) by requiring a nursing facility level of care (NFLOC). This form was used to authorize access to Medicaid HCBS until 2007 when it was replaced by the Pre Admission Screening (PAS).

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules for People Receiving LTC: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends

to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). In the relatively rare instance where this track applies to HCBS recipients only, eligibility is granted based on whether an individual would be eligible if institutionalized and institutional rules still apply. It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits up to 100 percent of the federal poverty level for individuals that are at least age 65, blind, or disabled.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

HCBS-301: Form used to detail and certify a beneficiary's plan of care for home and community-based services under the Elderly and Disabled (E&D) Program.

HCBS-305: Form used by case managers to determine eligibility for the case management benefit under the Elderly and Disabled (E&D) Program.

Healthier Mississippi Program: Program implemented under section 1115 demonstration authority to provide a modified benefits package to aged and disabled individuals who make up to 135 percent of the federal poverty limit (FPL) and who are not covered by Medicaid or Medicare. The program offers a modified benefits package that does not include LTC (nursing facility care, home and community-based program services).

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Homemaker Services: Supportive services provided primarily in the home by a trained homemaker to assist functionally impaired persons to remain in their home by providing assistance in the activities of daily living, housekeeping, laundry, meal planning, marketing, food preparation, and other types of home management tasks to prevent the risk of institutionalization.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate care facility: A long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility (SNF), but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid state plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Permanently Residing Under Color of Law (PRUCOL): An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Pre-Admission Screening: A screening and care needs assessment instrument implemented by the Mississippi Division of Medicaid in 2007, used to determine clinical eligibility for Medicaid long-term care across both institutional and home and community-based settings.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Private Duty Nursing: Skilled nursing interventions on an individual and continuous basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

Qualified Income Trust (QIT): A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits under eligibility track 2a (Institutional rules). Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

Section 1915(c) Waiver: Section 1915(c) of the Social Security Act gives the Secretary of HHS the authority to approve programs allowing states to offer home- and community-based services to Medicaid beneficiaries who need long-term care and who would otherwise be institutionalized. The program waives Medicaid comparability requirements, meaning that states can tailor the services to specific groups of enrollees and their needs.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Disability Insurance (SSDI) : Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

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1. SSI recipients in some states receive a State Supplementary Payment (SSP). Mississippi is one of six states that do not pay State Supplementary Payments. See SSA (2011) for more information.
2. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period was 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of a nd permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024c) for more information on these requirements.
5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance

(MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in Mississippi was $1,718 per month.

6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $68,715 in 1992. Countable assets/property are real and personal property that are counted to determine eligibility.

7. The look back period is 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. In 2006 the Deficit Reduction Act extended the look back period to 60 months for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).

8. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.

9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2000, the MMNA in Mississippi was $2,103 per month.

10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $84,120 in 2000. Countable assets/property are real and personal property that are counted to determine eligibility.

11. The look back period is 60 months prior to the date of application for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult.

12. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2007, the MMNA in Mississippi was $2,541 per month.

13. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $101,640 in 2007. Countable assets/property are real and personal property that are counted to determine eligibility.

Version information

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Version History

- 1.0 (December 2024): First version.