

Recent Changes in Health Policy for Low-Income People in Mississippi

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Overview

State health policy in Mississippi evolves slowly, as funding constraints generally limit opportunities for new initiatives. In recent years, when new funding has been made available, the state has acted. The availability of federal funding under the State Children's Health Insurance Program (SCHIP) in the late 1990s resulted in swift response as attention focused on the design and implementation of Mississippi's SCHIP program. The program has been implemented in phases beginning with a small Medicaid expansion and followed by the development of a private insurance option for low-income children. A third phase of subsidized insurance for higher income groups is under consideration but not imminent. Much of the state share of SCHIP funding has come from the tobacco settlement funds, which have been dedicated broadly to health.

Other current health policy issues include maximizing federal dollars for the state's health programs in an era of emerging fiscal constraints; implementing coverage expansions for children and the aged, blind, and disabled; and expanding long-term care options for people with mental retardation or developmental disabilities. Some initiatives from the late 1990s—the implementation of capitated managed care for Medicaid recipients and increased regulation of HMOs—have become moot as Medicaid has ended its capitated program and all but two managed care organiza-

tions have ceased operating or have exited the state.

In 2000, the governorship changed hands with Democrat Ronnie Musgrove replacing Republican Kirk Fordice. Although Musgrove ran on a platform emphasizing education, crime reduction, and economic development, he has clearly stated his support for the SCHIP program and for improvements in the state employees' health insurance program. In addition, he announced his intention to increase support for rural providers, an important initiative in a state that is nearly two-thirds rural.¹

The state has been under severe budget pressure in fiscal year (FY) 2001. In response to a revenue shortfall, two rounds of budget cuts were announced, in November 2000 and again in February 2001. Medicaid was spared these cuts, which fell primarily on non-health programs and on health programs not receiving federal matching funds, such as public health and mental health. Mississippi's Medicaid match rate is the most favorable in the nation, and Medicaid is viewed as a revenue generator for the state. Although expanding the Medicaid program would bring in additional federal funds, the state has difficulty generating the state share for the program and has been slow to take full advantage of this opportunity.

The budget problems are expected to worsen in the coming year. The events of September 11, 2001, have accelerated the downturn in the national economy. This

Mississippi suffers from the problem of having a large poor population with significant health care needs and a small state budget with which to meet those needs.

deterioration in the overall economy will likely create fiscal problems in Mississippi and may increase the general budgetary pressure. Whether Medicaid will continue to be protected is an important question. On the other hand, all of Mississippi's tobacco settlement funds are targeted for health, and the use of those funds has mitigated the budget crunch for health-related programs. Two-thirds of the tobacco settlement funds have been allocated to Medicaid. Funding, nonetheless, remains a dominant concern.

Given Medicaid's protected budgetary status and the fact that eligibility standards are, with a few notable exceptions, already near federal minimums in most areas, there has been no serious discussion of cutting enrollment. The tobacco settlement funds have been used to fund the state's SCHIP program and eligibility expansions for the aged and individuals with disabilities. Many state officials would like to expand coverage further by expanding eligibility to parents of eligible children through SCHIP or by using Medicaid Section 1931 provisions, but budget pressures make any action in this area difficult in the near future. Similarly, there is no talk of cutting benefits. Indeed, tobacco settlement funds have allowed small expansions of benefits and increases in some provider payment rates.

The rate of increase in Medicaid expenditures has been rising, driven by expansions for children under SCHIP and, more significantly, for high-cost groups such as those with disabilities or HIV. Increased expenditures on pharmaceuticals are another important contributor to rising program costs. Medicaid officials hope to contain costs by eliminating waste in the program, targeting the big-ticket items first—nursing homes, pharmaceuticals, and inpatient care. The state's brief experiment with capitated managed care as a cost containment strategy ended in 2000, leaving primary care case management as the dominant form of managed care in the state.

Expenditures on nursing homes represent about 20 percent of total Medicaid expenditures. The tightly controlled supply of nursing home beds acts to keep utilization low, and Medicaid officials are seeking to expand home and community-based alternatives to nursing homes for both the elderly and people with disabilities. Mississippi has five Section 1915(c) Medicaid waiver programs providing targeted home and community-based services.

Motivation: This study of Mississippi is part of a series of reports on 13 states that examines state priority setting, program operations, and health policy affecting the low-income population.² The past five years have given states new opportunities in health policy for low-income people but have also put new pressures on policy formulation. Many developments increased state flexibility, including welfare reform and the delinking of Medicaid from cash assistance, new funding for children's health insurance coverage under SCHIP, the repeal of federal minimum standards for nursing home and hospital reimbursement that had constrained states' control over Medicaid payments, and increased federal willingness to grant waivers under Medicaid (and now under SCHIP as well). Fiscal capacity also rose from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support, which was believed to have been abused by some states; political pressure for state tax cuts; and, starting in 2001, an economic slowdown and fears of recession. New pressures also arose from the Supreme Court's *Olmstead* decision that detailed a right to home and community-based services under the Americans with Disabilities Act, rapid growth in pharmaceutical spending, and the difficulties many states faced with Medicaid managed care. Political demands for public action arose from developments such as the rise in uninsurance, growth in private and public managed care, rising pharmaceutical costs, hospital fiscal woes, and events specific to each state.

Five major sets of issues are addressed in this set of reports examining how states have responded to both federal constraints and state flexibility during the last half decade. First, how have the political and fiscal circumstances of the state changed over the last several years? Second, has the state expanded public or private health insurance coverage through

Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has access been affected by managed care plan withdrawals from Medicaid or backlash against plans by providers or beneficiaries? How are states coping with federal Disproportionate Share Hospital (DSH) program cuts? Fourth, how are states responding to pressures to expand home and community-based services for disabled persons, their new freedom to set reimbursement rates, and the labor shortage? Fifth, what other issues are prominent?

This report on Mississippi assesses changes and continuities in the last five years, building on an earlier study.³ Information came from in-person interviews on site in May 2001, supplemented by telephone and written responses. Interviewees included state officials, consumer and provider associations, and other knowledgeable observers. Secondary sources included publicly available documents, newspapers, and Web sites; written sources are cited in the endnotes. Interviewees were given the opportunity to comment on a draft, and changes were tracked through the end of June 2001.

Background

Demographics and Insurance Coverage

Mississippi is a predominantly rural state with 65.2 percent of its population residing in nonmetropolitan areas (see table 1). In 1999, whites constituted the majority (60.0 percent)

TABLE 1. Selected Mississippi Characteristics, 2002

	Mississippi	United States
Population Characteristics		
Population (2000) (in thousands) ^a	2,845	281,422
Percent under age 18 (1999) ^a	27.3%	25.7%
Percent Hispanic (1999) ^b	0.6%	12.5%
Percent black (1999) ^b	38.7%	12.8%
Percent Asian (1999) ^b	0.7%	4.1%
Percent nonmetropolitan (1999) ^c	65.2%	20.3%
State Economic Characteristics		
Per capita income (2000) ^d	\$20,993	\$29,676
Percent change per capita income (1995–1999) ^d	10.1%	10.8%
Unemployment rate (2001) ^e	5.0%	4.5%
Family Profile		
Percent children in poverty (1998) ^f	27.9%	17.5%
Percent change children in poverty (1996–1998) ^f	–17.7%	–15.0%
Percent adults in poverty (1998) ^f	15.9%	11.2%
Percent change adults in poverty (1996–1998) ^f	–22.8%	–10.4%
Political		
Governor's affiliation (2001) ^g	Democrat	NA
Party composition of senate (2001) ^h	33D-18R-11	NA
Party composition of house (2001) ^h	86D-33R-31	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC) ⁱ	36.5%	59.3%
1998 (TANF) ⁱ	21.1%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996 ^{j,k}	96%	124%
1998 ^{j,l}	113%	178%
2000 ^{j,m}	200%	205%

Table 1 notes begin on page 23.

of the population. Mississippi's minority population is made up almost entirely of blacks, although in some areas immigrant populations are beginning to change the mix. Blacks represented 38.7 percent of the population in 1999 in comparison with the national average of 12.8 percent. Hispanics of any race and Asians each represented less than 1 percent of the population. The national averages for these groups are 12.5 and 4.1 percent, respectively. A larger share of the population lives in poverty in Mississippi than in the nation at large, but that share dropped more between 1996 and 1998 in Mississippi than elsewhere.

Mississippi residents are less likely than average to have employer-sponsored health insurance coverage (see table 2). Reflecting the higher rate of poverty, they are more likely than average to have Medicaid coverage. Nonetheless, public coverage, before the recent expansions, covered a lower percentage of poor children and poor adults in Mississippi than nationally. The higher Medicaid coverage does not make up for the low level of employer-sponsored insurance so that, overall, a larger proportion of Mississippi's population is uninsured than the national average.

Political Developments

Mississippi's U.S. congressional delegation is majority Republican, including both senators. In contrast, Democrats control both the state legislature and the governor's office. Governor Musgrove, formerly the state's lieutenant governor, replaced the two-term Republican Fordice, who could not succeed himself. The 1999 election was close, with Musgrove winning a plurality, 49.6 percent, of the vote, to his opponent's 48.5 percent. Since neither candidate gained a majority, the election was decided in the state's house of

TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, Mississippi and the United States, 1999

	Children (Ages 0–18) ^a (%)		Adults (Ages 19–64) ^b (%)	
	Mississippi	United States	Mississippi	United States
Below 200% FPL				
Employer-sponsored	35.4	38.7	40.0	41.7
Medicaid/SCHIP/state	34.3	35.2	12.4	14.7
Other coverage	4.3	3.8	9.4	8.8
Uninsured	26.1	22.4	38.2	34.9
Above 200% FPL				
Employer-sponsored	81.9	85.3	81.3	83.7
Medicaid/SCHIP/state	3.7	3.8	1.4	1.1
Other coverage	5.6	4.9	8.2	5.8
Uninsured	8.8	6.0	9.2	9.4
All Incomes				
Employer-sponsored	57.3	66.7	65.9	72.3
Medicaid/SCHIP/state	19.9	16.4	5.5	4.8
Other coverage	4.9	4.5	8.6	6.6
Uninsured	18.0	12.5	20.0	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

FPL = federal poverty level

SCHIP = State Children's Health Insurance Program

Note: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or better.

representatives, where Musgrove prevailed easily on a largely party-line vote. Despite this initial show of support, Musgrove's relations with the legislature have reportedly been strained during his tenure as governor. He vetoed all of the appropriations bills in the latest budget negotiations, and all of these vetoes were subsequently overridden.

Although health care has not been a high priority in Musgrove's administration, the governor has been supportive of many health initiatives, particularly increasing enrollment in Mississippi's SCHIP program. Health care issues may be rising as a priority, however, as evidenced by a series of health care summits scheduled for 2001. The first summit, held in June 2001, focused on the uninsured.⁵ The strength of political support for state health spending appears to be strong, driven by the generous federal matching rates for both Medicaid and SCHIP, currently 76.8 and 83.8 percent, respectively.

Institutionally, the governor's office is weak, so the legislature plays a major role in health policy. Given the short legislative session, however, much of the day-to-day responsibility for policy direction rests with the heads of the various governmental agencies. Some agency heads are appointed by the governor, others by commissions, and others are elected. The governor appoints the Medicaid director, whereas the directors of the Departments of Health and of Mental Health are appointed by commissions. The state attorney general and the insurance director, both of whom have important roles in health policy, are elected.

In FY 2001, the Legislative Budget Committee's priorities were education, crime reduction, and economic development.⁶ The Committee's stated priorities for FY 2002 are education, health care, and crime reduction.⁷

Market Developments

There have been few developments in the insurance and hospital markets in the past three years. Blue Cross, the state's largest health insurer, controls about 40 to 50 percent of the health insurance market, and the plan is financially sound. Mergers and failures among other plans have drawn some attention, but all of the plans involved were small. Three small health maintenance organizations (HMOs) became insolvent and were taken over by state regulators. The failures were all among HMOs set up to participate in the state's capitated Medicaid managed care program (discussed below). One other insolvency involved an indemnity carrier, requiring the use of the state's guaranty fund.

In the hospital market, mergers or other affiliations were common in the 1990s, but this activity has abated. The early 1990s also witnessed several hospital closures, and although the pace of closures has slowed somewhat, six hospitals closed between 1997 and 1999.⁸ Hospital occupancy rates remain low (only about 52 percent on average for acute care hospitals statewide),⁹ suggesting that there may still be overcapacity in the sector. Indeed, the number of hospital beds per 100,000 population (473) is well above the national figure of 311.¹⁰ The hospital association in the state is said to be well organized and powerful. Evidence of the competitive nature of the hospital sector in Mississippi is seen in suits that hospitals have brought against one another regarding state certificate-of-need (CON) applications that regulate their ability to change size, location, or services.

Fiscal Circumstances of the State

Although Mississippi's economy performed well throughout the latter half of the 1990s, the state still ranks last in per capita income—\$20,993 in 2000, about \$9,000 below the national average (see table 1). In recent years, growth in per capita income has been slightly below national growth rates. When former Governor Fordice took office in 1992 in the aftermath of a recession, the state's rainy day fund was nearly depleted. As he left in January 2000, the state's rainy day fund was about 7.5 percent of appropriations.¹¹ Improvement in the operating budget came from strong growth in revenues, due in part to the growing gaming industry. Between 1995 and 2000, annual budgetary growth was 9 percent, higher than the national average of 6 percent (see table 3). The gaming industry

TABLE 3. Mississippi Spending by Category, 1995 and 2000 (\$ in Millions)

Program	State General-Fund Expenditures ^a				Total Expenditures ^b			
	Actual 1995	Estimated 2000	Annual Growth (%)		Actual 1995	Estimated 2000	Annual Growth (%)	
			MS	U.S.			MS	U.S.
Total	\$2,517	\$3,461	7	5	\$6,477	\$10,132	9	6
Medicaid^{c,d}	\$144	\$195	6	5	\$1,443	\$2,209	9	4
% of Total	6%	6%			22%	22%		
K-12 Education	\$1,054	\$1,357	5	7	\$1,613	\$2,075	5	7
% of Total	42%	39%			25%	20%		
Higher Education	\$458	\$634	7	5	\$1,084	\$1,448	6	5
% of Total	18%	18%			17%	14%		
Public Assistance	\$17	\$13	-5	-6	\$80	\$28	-19	-5
% of Total	1%	0%			1%	0%		
<i>AFDC/TANF</i>	\$17	\$13	-5	-9	\$79	\$26	-20	-7
% of Total	1%	0%			1%	0%		
Corrections	\$192	\$240	5	6	\$199	\$249	5	6
% of Total	8%	7%			3%	2%		
Transportation	\$-	\$10	—	5	\$563	\$1,299	18	6
% of Total	0%	0%			9%	13%		
All Other^e	\$652	\$1,011	9	5	\$1,495	\$2,821	14	8
% of Total	26%	29%			23%	28%		

Source: National Association of State Budget Officers 1997. 1996 State Expenditure Report and 2000. 1999 State Expenditure Report.

a. State general-fund expenditures exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

revenue increases seen in the past have leveled off, leading budget officials to expect more moderate overall growth. The state's level of debt—about 5.5 percent of expenditures or \$196 million in FY 2002—is currently seen as manageable and predictable.

Mississippi ranks 31st in the nation in total state tax revenues per capita. However, given its low per capita income, it ranks 11th in state tax revenues as a percent of personal income.¹² Families with incomes below the federal poverty level currently pay no income taxes.¹³

The economic slowdown that has recently affected many states is also being felt in Mississippi. The events of September 11, 2001, have accelerated this downturn. The deterioration in the national economy will likely create fiscal problems in Mississippi and may increase the already serious budgetary pressure in the state. In fiscal years 2000 and 2001, state revenues fell short of projections, and expenditures had to be curtailed. The state originally projected an FY 2000 growth of 5.3 percent, subsequently lowered to 4.7 percent. Similarly, growth projections for FY 2001 were lowered from 5.8 percent to 3.9 percent.¹⁴ The FY 2002 budget projects that revenues will increase by 3.7 percent, \$129 million, over the revised estimates for FY 2001.¹⁵ Individual agency budgets have historically been set

using inflation-based formulas. However, new guidelines were adopted for the FY 2001 budget to allow greater discretion in setting agency budgets.¹⁶

In Mississippi, if revenues fall below 98 percent of projections, the governor is required by statute to cut expenditures. He has the authority to make selective, nonuniform cuts in agency budgets by up to 5 percent, but no agency's budget can be cut by more than 5 percent until all agency budgets have been cut. Budget cuts over 5 percent must be of a uniform percentage reduction. A few agencies are, by law, exempt from these cuts. In November 2000, in response to lower-than-expected income and sales tax collections, Governor Musgrove ordered about \$50 million in cuts; further cuts were ordered in February 2001. Budget revisions and cuts for FY 2001 totaled \$119 million.¹⁷ The Division of Medicaid was spared but not the state's other health care agencies, including the Department of Health and the Department of Mental Health.

Budget stringency is expected to continue. Spending on corrections and social welfare is scheduled to increase, with nearly all other spending expected to decline. Portions of the Medicaid budget are protected. The budget explicitly makes \$30 million in "built-in" funds available for "mandated expansion, normal growth of the programs, medical cost inflation, and reductions in Intergovernmental Transfers (related to the Disproportionate Share Hospital Program) mandated by the federal government"¹⁸ so that adequate funds are available to meet the obligations of the program. All funds generated by intergovernmental transfers remain in the Medicaid budget. A deficit is expected in the FY 2002 Medicaid budget as well as a sizeable increase in the requested budget for FY 2003.

The Medicaid program's share of state general-fund spending remained constant at 6 percent between 1995 and 2000. Transportation expenditures, driven by non-general-fund revenues, have increased at a rate three times the national average—18 percent versus 6 percent—while the rate of increase in funding for primary and secondary education (K–12)—5 percent—was below the national average of 7 percent (see table 3). Higher education spending grew slightly faster than the national average, 6 percent versus 5 percent, and it is expected to increase further with the settlement of the long-standing discrimination suit that claimed that the state's historically black colleges were underfunded relative to other state colleges. Total cash assistance (AFDC/TANF¹⁹) decreased markedly faster than the national average over the period, at an average of 20 percent per year versus 7 percent nationally.

State finances have benefited from the tobacco settlement in which Mississippi had a prominent role through the leadership of its attorney general, Mike Moore. Moore was a key player in both state and national efforts to recover smoking-related costs from tobacco companies. In 1993, he brought suit against 13 national tobacco companies and numerous tobacco wholesalers and marketers in what became the first antismoking court victory. Encouraged by his success, Attorney General Moore persuaded other attorneys general to file suits. These suits resulted in three other state settlements (Florida, Minnesota, and Texas) and eventually in a national settlement between the tobacco companies and states' attorneys general.

Under the settlement, the state expects to receive payments over at least a 25-year period. The first payment, \$170 million, was placed in an interest-bearing, court-ordered trust fund. During the 1998 legislative session, the legislature agreed to spend 94 percent of the interest and to focus those expenditures on health care. The principal and 6 percent of the annual interest will remain untouched. In 1999, the state created the Health Care Trust Fund, which holds and invests the tobacco settlement proceeds, and the Health Care Expendable Fund, to which monies are to be transferred from the trust fund over time for appropriation.²⁰ Between FY 2000 and FY 2003, \$165.5 million will be transferred; thereafter, annual transfers will be equal to the average annual amount of investment income from the Health Care Trust Fund since July 1, 1999.²¹

Unlike in most states, all of the funds generated from the tobacco settlement in Mississippi are to be put toward health-related programs, broadly defined. Advocates fear, however, that budgetary pressure may lead the state to back away from this commitment.

Specifically, there are concerns that tobacco funds may be used to supplant current state health spending. Some funds are allocated specifically for smoking cessation programs. Other portions are earmarked for hospitals to pay for uncompensated trauma care and for state grants to community health centers. Sixty-nine percent of the FY 2001 allocation (\$48 million) is allocated to Medicaid, 16 percent to the Department of Health, 11 percent to the Department of Mental Health, and the remainder to other state agencies.

Medicaid Trends

Overview

The Medicaid program budget for FY 2000 was \$2.1 billion, of which the federal share is 76.8 percent. A combination of state general funds, tobacco funds, and intergovernmental transfers funds the state share. In FY 2000, intergovernmental transfers contributed over 40 percent of the state share.²² At all levels of government, officials are aware that Medicaid not only provides health insurance for a vulnerable population but also brings substantial federal funds into the state. The general attitude is “we can’t afford not to take advantage of it.” For this reason, the Medicaid program is nearly sacrosanct within the budget.

The current governor, in contrast to his predecessor, strongly supports the Medicaid program. Under Musgrove, the perception of the program has changed from one of a welfare program whose costs are to be minimized to that of an opportunity to bring federal funds into the state to meet persistent health care needs. Musgrove’s approach to the program is to get people enrolled and keep them enrolled, which is viewed locally as a real change in attitude from his predecessor. More critically, given the distribution of authority in Mississippi government, the legislature is protective of the program. In the recent round of budget cuts to meet the shortfall, all programs were cut except Medicaid and K–12 education, the latter a particular priority for the current governor. Nonetheless, while there is support for the current program, Medicaid proponents have had little success in getting eligibility expanded for families and children, nor has there been talk of instituting a medically needy program. Eligibility has been expanded, however, for poverty-level aged and disabled.

Under Musgrove the state is actively pursuing various opportunities to increase federal participation in its Medicaid program, given the highly favorable federal matching rate and constrained local resources. In particular, the state has identified services that it is providing to Medicaid-eligible residents through other state agencies and brought these services into the Medicaid program. For example, immunizations provided by the Mississippi State Department of Health (MSDH) to Medicaid recipients are now claimed for Medicaid reimbursement. In addition, the state has submitted a waiver to the Centers for Medicare and Medicaid Services (CMS) for the provision of family planning services. Currently, 20 percent of MSDH’s family planning clients are Medicaid-eligible. Under the waiver, the income eligibility for family planning services would be raised to 185 percent of the federal poverty level (FPL), which would make an estimated 90 percent of current services eligible for Medicaid reimbursement.

Beyond the change in governor, the next most important influence on the Medicaid program in recent years has been the allocation of tobacco settlement funds. This infusion of funds has allowed the governor’s new approach to Medicaid to bear fruit. The limit on prescriptions has been raised from 5 to 10 per month. Reimbursement levels have been raised for physicians and dentists in an effort to improve provider participation. The eligibility level for the aged and disabled has been raised to 135 percent of FPL (the highest in the nation) using income disregards under Section 1902(r)(2) provisions. Since 1998, the working disabled have been allowed to buy into Medicaid. Finally, Medicaid now covers eyeglasses for adult enrollees. The tobacco settlement has also funded the state share of the SCHIP program.

Enrollment in Medicaid fell with the delinking of welfare and Medicaid under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), although much of the loss has since been made up. Eligibility was expanded for children

under SCHIP in 1998 and for the aged, blind, and disabled in 2000. Between 1995 and 1998 (the latest year for which consistent data are available), Mississippi's Medicaid expenditures kept pace with national Medicaid expenditures in spite of the fact that Mississippi's enrollment declined more sharply. The distribution of the expenditure growth, however, is quite different from the national pattern. Mississippi's expenditure growth is above the national average for long-term care and administration but below average for acute care services.

Medicaid managed care has been only moderately successful in Mississippi. Primary care case management for AFDC/TANF-related beneficiaries began in 1993 under HealthMACS. Capitated managed care was implemented under Medicaid in FY 1997 as a pilot program with voluntary enrollment in a limited geographic area. It was largely unsuccessful and was discontinued in early FY 2000.

Enrollment

Between 1995 and 1998, average monthly enrollment in Medicaid fell by 3.8 percent, as compared with a decline of 1.0 percent nationally (see table 4). Much of this decrease appears to be attributable to the delinking of eligibility for welfare and Medicaid, as the greatest enrollment losses are seen among children and adults on cash assistance. More recent numbers from the state suggest that some of the problems have been corrected. The Division of Medicaid reports that nearly 560,000 people were enrolled in Medicaid at some time during FY 2000.²³ This number mirrors the FY 1996 enrollment of nearly 557,000, suggesting that there was little change in enrollment over the period. In reality, enrollment dipped sharply between 1996 and 2000, reaching a low of about 518,000 in 1999, before rebounding in 2000.²⁴ Medicaid officials report that TANF-related beneficiaries were down by nearly one half during this period; many were later restored to the rolls with some shifted to noncash assistance categories. Poverty-level pregnant women and children represented only 36.7 percent of enrollees in 1999 but 45.1 percent in 2000.²⁵ Enrollment of SSI beneficiaries was reported as steady.

The eligibility expansion for poverty-level aged and disabled in July 2000 added some 17,000 people to the rolls. Eligibility for three waiver programs—elderly and disabled, independent living for the neurologically or orthopedically impaired, and mentally retarded/developmentally disabled—was raised to 300 percent of the federal SSI benefit level beginning in 2000. In addition, Mississippi was the first in the nation to take advantage of the provision in the 1997 Balanced Budget Act (BBA) allowing coverage of the working disabled and recently received approval for a demonstration to cover HIV/AIDS patients as potentially disabled. A proposal to expand eligibility to families of eligible children using Section 1931 provisions failed in the legislature in 2000 but is expected to be reintroduced in the next session. While eligibility expansions are supported by the governor and some legislators, others in the legislature would like to see the currently eligible population in both Medicaid and SCHIP better served before expanding eligibility.

Mississippi is working to improve enrollment and retention in Medicaid. It will use the welfare reform delinking funds available to it with a 90 percent federal match to hire and train 47 new outstationed eligibility workers, adding to the 22 already in place. These workers will be placed in community health centers and hospitals that have agreed to put up the 10 percent local share. In addition, it has instituted presumptive eligibility and is seeking CMS approval to drop income verification.

Expenditures

Total Medicaid expenditures grew at an average annual rate of 3.9 percent between 1995 and 1998, matching the national rate (see table 4). Expenditures on medical services, however, grew more slowly than nationally (3.9 percent versus 5.1 percent), while expenditures on administration grew more rapidly (20.2 percent versus 8.5 percent). Despite this growth, administrative expenditures as a percent of total expenditures remain below the national average. Expenditure growth was above average for long-term care services (8.5

TABLE 4. Medicaid Enrollment and Expenditures in Mississippi, 1998

	Mississippi, 1998			Average Annual Growth (%), 1995-1998				
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures	Avg. Monthly Enrollment	Expenditures per Enrollee		
	Mississippi	United States	Mississippi	United States	Mississippi	United States	Mississippi	United States
Total Expenditures	\$1,749	-	-	3.9	-	-	-	-
Medical Services								
By Eligible Group	\$1,505	401	\$3,754	3.9	-3.8	-1.0	8.0	6.1
Elderly	\$511	58	\$8,801	8.5	-1.8	0.1	10.4	4.2
Blind and disabled	\$692	129	\$5,344	7.5	1.9	3.6	5.5	4.7
Adults	\$97	33	\$2,926	-11.3	-1.4	-4.4	5.0	3.1
Cash assistance	\$34	16	\$2,119	-27.9	-10.4	-14.9	-0.9	5.3
Other enrollees	\$63	17	\$3,696	10.0	7.8	9.3	0.2	-1.4
Children	\$206	180	\$1,141	-5.8	2.7	-5.2	-0.6	4.3
Cash assistance	\$46	45	\$1,014	-21.3	-8.8	-25.3	5.4	3.9
Other enrollees	\$160	135	\$1,183	1.8	12.4	9.5	-7.0	2.4
By Type of Service	\$1,505	-	-	3.9	5.1	-	-	-
Acute care	\$991	-	-	1.8	4.0	-	-	-
Long-term care	\$515	-	-	8.5	6.5	-	-	-
DSH	\$184	-	-	0.2	-7.3	-	-	-
Administration	\$60	-	-	20.2	8.5	-	-	-

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Notes: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. "Cash assistance" refers to enrollees who receive AFDC/TANF or SSI or who are eligible under Section 1931 provisions. "Other enrollees" include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. "Acute care" services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners' care, payments to managed care organizations (MCOs), and payments to Medicare. "Long-term care" services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. "DSH" stands for disproportionate share hospital payments. Figures may not add to totals shown due to rounding.

percent in Mississippi versus 6.5 percent nationally) but below average for acute care services (1.8 percent versus 4.0 percent). Long-term care services accounted for 34.2 percent of medical services expenditures in 1998. The Mississippi state budget reports expenditures of \$1,894 million in 1999 and a budget of \$2,132 million for 2002, for an expected average annual growth rate of 6.9 percent between 1999 and 2002.²⁶

Medicaid officials report that in FY 2001, for the first time, prescription drugs replaced nursing homes as the largest category of expenditures under Medicaid, with each representing about 20 percent of the total budget. Between 1999 and 2000 expenditures on prescription drugs grew by 30 percent, and they are predicted to rise by 25 percent in FY 2001.²⁷ This growth is driven by the increasing cost of pharmaceuticals nationally but also by the relaxation of the restriction on the number of prescriptions available without prior approval from 5 per month to 10 per month. The effect of this change will likely increase as more HIV patients are enrolled in Medicaid under the newly approved demonstration program. The Division of Medicaid has issued a Request for Proposals (RFP) for a pharmacy benefits manager in order to address this rapidly growing component of expenditures, although officials expressed concern about the effect this might have on the many small pharmacies that provide the bulk of the services to program beneficiaries. Furthermore, Mississippi participates in the federal pharmaceutical rebate program and is thus limited in its ability to restrict its formulary. It has, however, instituted a prior approval requirement for selected costly brand-name drugs.

In long-term care services, home care is growing most rapidly (19.2 percent average annual growth between 1995 and 1998), but this category represents only a small percentage of total expenditures. Medicaid officials report that home health expenditures rose by 60 percent in the most recent fiscal year as new services were added. Mississippi is one of six pilot states for case-mix reimbursement for nursing homes. Since payments are based on the level of service needed, strict criteria are not imposed for entry into a nursing home. Officials estimate that about 20 percent of residents of nursing homes could live at home if adequate home and community-based services were available.

State officials had expected to see a decrease in DSH expenditures over the period as mandated under the BBA.²⁸ Under the revisions in the later Benefits Improvement and Protection Act (BIPA), these have remained constant at about \$184 million. The structure of Mississippi's DSH program has not changed since 1997. The state share is funded through intergovernmental transfers and participating hospitals keep a fixed percentage of the revenues thus generated. The rules for participation in the program were modified in October 1997 to allow fewer hospitals to participate, with the result that four hospitals were dropped from the program.

The state began a new Upper Payment Limit (UPL) program for hospital reimbursement, effective October 2000, which is expected to bring in an additional \$200 million.²⁹ The program will cover state-owned hospitals and will be administered through the Mississippi Hospital Association. A waiver to extend the program to all hospitals was submitted in March 2001. Hospitals are currently reimbursed on a per diem basis.

Expenditures per Enrollee

Like its sister states in the South, Mississippi's spending per enrollee is below the national average for all categories of enrollees, with the exception of nonelderly, nondisabled adults. Growth in expenditures per enrollee for the 1995–1998 period, however, is higher in Mississippi than in the country as a whole (8.0 percent versus 6.1 percent). As was the case for expenditures as a whole, the pattern of growth is different for different enrollees. For the elderly, the blind and disabled, cash assistance children, and noncash assistance adults, expenditures per enrollee are growing more rapidly while for noncash assistance children and cash assistance adults they actually declined over the period.

For the elderly and the blind and disabled, the difference in expenditures per enrollee comes from Medicaid's much lower expenditures on long-term care, particularly for the elderly. Acute care expenditures for elderly enrollees are higher than the national average,

while long-term care expenditures are just over half the national average. For the blind and disabled, acute care expenditures are 60.4 percent of the national average, but long-term care expenditures are only 37.8 percent.³⁰

Budgetary Perspective and Expectations for the Future

The Medicaid program has come to the end of each recent fiscal year with a cash balance it has been allowed to carry forward to the next year. The current fiscal year is the first in recent years in which a cash balance is not predicted. Furthermore, the legislature has restricted the program's authority to carry funds over to the next year (intergovernmental transfers excepted). As a result, Medicaid officials report that the accuracy of budget projections is becoming more important.

Because of the federal dollars it brings into the state, the Medicaid program is likely to continue to be funded at least at current levels as Mississippi moves into the economic downturn. The state share is funded through a combination of state general funds, tobacco funds, and intergovernmental transfers; the tobacco settlement has provided funding for new initiatives. The SCHIP program is largely separate from the Medicaid program and will not affect funding. DSH dollars have not declined, and the expanded UPL program promises to bring in new funding.

On the other hand, Medicaid eligibility standards are already at or near federal minimums in many eligibility categories (the aged and disabled program is a notable exception) and provide little room for maneuvering should enrollment rise with the darkening economic outlook. The expected savings from reduced emergency room use under managed care have not materialized, in part because of restrictions on limiting such care under prudent layperson guidelines. Officials note that there is room to reduce expenditures through improved efficiency and reduced waste and fraud but, beyond that, their ability to control the budget is limited.

Health Insurance Coverage

While Mississippi's expansion for poverty-level aged and disabled adults is noteworthy as the most generous in the nation, the bulk of policymakers' attention has been focused on children. Prior to federal enactment of SCHIP in 1997, the state provided Medicaid coverage for children, except infants, at federally mandated levels. For infants, the state was more generous, providing coverage to infants in families with incomes up to 185 percent of the FPL. Federal law mandates that children up to age 6 with family incomes up to 133 percent of the FPL and older children born after September 30, 1983, with family incomes up to 100 percent of the FPL are eligible for coverage. The first phase of the state's SCHIP program effectively accelerated the mandated phase-in of this older population into Medicaid in October 1998. The state appointed an SCHIP commission to decide how to structure a further SCHIP initiative, specifically whether to expand Medicaid or to implement a private coverage program.

Former Governor Fordice was not interested in expanding Medicaid because of its entitlement nature. Consequently, state Medicaid officials testified that they did not want a new program to be run by Medicaid, an agency controlled by the governor's office. Although advocates had often complained about access to providers and low payments under Medicaid, they testified in favor of a Medicaid expansion because of Medicaid's rich benefit package and entitlement status. Problems with access under Medicaid provided further arguments for the commission to choose the private route. In the end, the governor prevailed and a private insurance model was adopted for the second phase of the state's SCHIP program. In February 1999, Mississippi received federal approval to offer private, non-Medicaid coverage to children in families with incomes up to 133 percent of FPL (subsequently increased to 200 percent). This non-Medicaid phase of Mississippi's SCHIP program was implemented on December 20, 2000. The two phases of the program, along with

Medicaid coverage for pregnant women and children, are known jointly as the Mississippi Health Benefits Program.

Three state agencies—the Division of Medicaid, the Division of Human Services, and the Department of Finance and Administration—were directed to play roles in the SCHIP initiatives. The Division of Medicaid has responsibility for policy development and outreach and serves as the fiscal agent. The Department of Human Services makes eligibility determinations. The Department of Finance and Administration is responsible for administering the program via the State and School Employees' Health Insurance Management Board and for contracting with the health plan for service delivery. Medicaid pays the Department a fee for administering the program. While this division of responsibility appears to work well, lack of compatible information systems in Medicaid and the Department of Human Services has hampered enrollment efforts.

As the state began developing an RFP for coverage under phase II, its initial consultations with various health plans suggested that few, if any, would be interested in bidding under the proposed terms. Specifically, the plans wanted a reduction in the level of risk to be borne by the plans. The plans feared that pent-up demand would lead to unpredictable utilization by new enrollees, and plan actuaries could not estimate how much SCHIP children would cost. The RFP was restructured and enticed Blue Cross/Blue Shield (BCBS) into bidding by allowing it some influence in the program's structure. The RFP was designed to follow as much as possible existing BCBS procedures and to impose as little risk as possible on BCBS. Premiums were to be renegotiated in six months and quarterly thereafter. If claims were significantly lower than anticipated, BCBS would refund money to the state, but the state agreed to assume the risk if claims were significantly higher. BCBS was the only health plan to bid on the program.

It appears that some of BCBS's fears were justified. At the beginning of the program, claims were submitted at very high rates, leading to a high medical loss ratio for the first month. The state, eager to see the program succeed, responded by increasing its first month payment to BCBS.

The state continues to fund the program generously. During the first year, as utilization fluctuated, rates were renegotiated regularly to cover the medical loss ratio plus a fixed administrative fee. Rates have now stabilized below \$150 per member per month with the state bearing all of the risk. The state has in effect simply purchased BCBS's network, using BCBS's claims forms and rate structure. The standard BCBS utilization review procedures are in place. Though direct comparisons are hard to make, it is generally believed that the state's payments to BCBS, and BCBS's payments to providers, are higher than Medicaid payments.

At the outset of the program, BCBS viewed SCHIP as a high risk for minimal gain and hoped for low enrollment in order to minimize its losses. Its trepidation about participating in the SCHIP program appears to have abated, and some respondents indicated that BCBS is now actively seeking SCHIP enrollees. Nonetheless, insurance agents who contract with BCBS do not promote the SCHIP program, primarily because there is no financial incentive to do so. Instead, agents promote BCBS's recently launched child-only policy.

All non-Medicaid SCHIP enrollees receive coverage through BCBS's statewide service delivery network, the same network used by BCBS for its private plans, with additional dental and vision care providers. The BCBS network includes 80 to 85 percent of practicing physicians in the state and 100 percent of acute care hospitals. The benefit package was designed to mirror the state employee health benefits plan. Benefits, though less extensive than those under Medicaid, are generous, exceeding the federal minimums for SCHIP. Policymakers believed they could reduce possible crowd-out by making the program's benefits similar to private coverage. Benefits have been expanded since implementation, primarily to provide a more comprehensive dental benefit, which is not available under the standard BCBS package. While Medicaid benefits are more generous, SCHIP, with its network of BCBS providers, is thought to provide better access.

Mississippi has not equalized eligibility thresholds for SCHIP and Medicaid across age groups within families, and some fault the Mississippi Health Benefits Program because eligibility may differ across age groups within a given family. Within a low-income family, some children may be eligible for Medicaid while others are eligible for subsidized SCHIP coverage provided by BCBS. A joint application covers all components of the program which simplifies the application process for families. A family can apply for Mississippi Health Benefits and the Department of Human Services will determine for which program each family member is eligible.

Both phases of the SCHIP program started slowly. Consequently, enrollment and total expenditures were initially lower than anticipated. Enrollment has grown over time. In December 1998, enrollment was 5,968; by June 2000 enrollment had reached 21,217.³¹ Of these, about half were enrolled in the Medicaid SCHIP expansion and half in the non-Medicaid component. According to state figures, 41,542 children were enrolled in May 2001. Mississippi officials believe that the Mississippi Health Benefits Program enrollment has had a large spillover effect on Medicaid, as the number of children eligible for Medicaid who are not receiving cash assistance has increased markedly since the program's inception.

Expenditures have followed enrollment, rising to over \$30 million in federal FY 1999 and FY 2000 (federal and state funds combined).³² Nonetheless, Mississippi had spent only 50 percent of the state's 1998 federal allotment by the end of 2000, \$29 million out of \$56 million.³³ Nationally, states spent 68 percent of their 1998 allotment. To boost enrollment and draw down the allotment, the state eased eligibility rules and administration and eliminated the required six-month waiting period with no insurance before eligibility. Recertification has been a problem, so the state stopped disenrolling children who had failed to recertify until the recertification process could be streamlined. The state also plans to increase the number of eligibility workers out-stationed at hospitals and other community-based sites. The program does not require premium contributions, but does require \$5 copayments for physician services for families with incomes above 150 percent of the federal poverty level, excluding well-child care and other preventive measures, and \$15 copayments for emergency room services.

Mississippi was one of the first states to receive federal approval to use SCHIP dollars to subsidize employer-based coverage under a planned third phase of the program. However, federal rules related to the employer subsidy component are viewed as unworkable and implementation has been delayed indefinitely. To subsidize employer-based coverage, federal rules require that coverage be cheaper than providing direct coverage through the SCHIP program and that employers cover at least 50 percent of the costs. A BCBS actuary determined that less than 10 percent of the current subscriber base would qualify to participate in SCHIP under these rules. State officials have concluded that implementation of an employer-subsidy component would be expensive and labor intensive and would impose huge administrative costs. The state's plans are on hold until federal regulations are revised to make employer-subsidies easier to implement.

Mississippi is one of only two states, the other being North Carolina, that can enroll children of state employees into the state's SCHIP program. (These were the only two states where coverage for dependents of state employees was not subsidized.) Mississippi has a large number of state employees who could potentially take advantage of the program. The Mississippi Department of Health has encouraged its lower-income employees without dependent coverage to apply. The Department of Finance and Administration has not pushed this idea fearing a scarcity of SCHIP funds. Nonetheless, in the past year, about 2,000 children of state employees have dropped state coverage. It is not clear whether they have picked up SCHIP coverage or BCBS's child-only plan.

Many interviewees expressed optimism that coverage for children would be expanded further once the state has surmounted its current budget problems. Many also believe that policymakers' focus will shift to adults, and that the next group offered coverage will be parents of children eligible for either the Medicaid or the SCHIP component of Mississippi

Health Benefits. The availability of funding to cover the state share of funding for any expansion will remain a constraint. General funding for the Department of Finance and Administration comes from premiums on private insurance policies and is secure.

Acute Care Issues

Medicaid Managed Care

In its 1995 session, the legislature created a program of capitated managed care for Medicaid as a way to control rising expenditures. The Health Care Financing Administration (HCFA, now CMS) approved a model HMO contract and capitation rates in January 1996. The program had the support of then-Governor Fordice both as a cost-cutting measure and as a means to providing better services. Medicaid managed care was originally envisioned as a statewide program, but negative publicity surrounding managed care in neighboring Tennessee and the lack of a base of commercial managed care on which to build quickly led to reduced support for the program. The legislature decided to scale it back from statewide to a pilot program in 11 counties and to make enrollment voluntary rather than mandatory. In addition, it required that the program come up for reauthorization each year.

A number of factors contributed to the failure of capitated managed care. First, Medicaid officials had hoped to use managed care as a way around the limitations on services in fee-for-service Medicaid by assigning HMOs responsibility for patient care. Under fee-for-service Medicaid, beneficiaries are limited to 30 days of inpatient care and 12 physician visits annually and, at that time, five prescriptions per month. As hoped, all of the participating HMOs removed these restrictions. Since the program was based on voluntary enrollment, the removal of service restrictions introduced the potential for adverse selection into the program. Second, there is very little commercial managed care in Mississippi, so neither providers nor beneficiaries has had much experience with managed care. Finally, Mississippi is a predominantly rural state, making the development of provider networks difficult and hindering the spread of managed care. By 2000, all of the participating HMOs had either withdrawn or been placed in receivership.

While some out-of-state plans did enter the Medicaid market hoping to buy a share of the potential managed care market, insurance market observers suggested that they underestimated the difficulties. The capitation rates were based on category of eligibility, age, sex, and geographic region and were approved by HCFA. The plans came into the market knowing the rates but still complained that they were inadequate. Some of the HMOs that were licensed in Mississippi in anticipation of the program decided not to participate when the legislature limited the geographic range of the program and made it voluntary. Of those that did proceed, most eventually failed to meet the state's solvency requirement or faced other financial problems, and all eventually left the program. On the other hand, Medicaid officials report that participating beneficiaries were generally pleased with the program.

As the program folded, Medicaid HMO enrollees were easily shifted back to fee-for-service Medicaid and then, if they were eligible, to the state's primary care case management program, HealthMACS. HealthMACS was implemented in October 1993 and by FY 2000 covered almost 65 percent of the eligible population.³⁴ Beneficiaries are assigned to a primary care provider (PCP) who acts as a gatekeeper for other services in exchange for a monthly case management fee. While Medicaid officials have not achieved cost savings commensurate with their original expectations, they see the program as worthwhile in its establishment of medical homes for beneficiaries.

Currently, only TANF-related beneficiaries are eligible for HealthMACS, but officials are considering expanding the program to the elderly and disabled once remaining issues with the TANF population are resolved. Medicaid officials would like to look into the use of the emergency room for nonurgent conditions and quality and continuity of care issues. They would also like to determine what case management functions the PCPs are provid-

ing and what other steps can be taken to improve beneficiaries' access to and rational utilization of the health care system.

Provider Participation in Medicaid

In FY 1999, in an effort to increase provider participation, particularly for dentists and physicians, Medicaid raised provider reimbursement rates. Fees for physician services had been set at 80 percent of Medicare fees in 1986 and had not been raised since then. Now they are set at 90 percent of Medicare rates for all services, well above the national average of 64 percent.³⁵ Rates are updated annually. Medicaid officials have been disappointed that raising dental reimbursement has not brought about the expected increase in dental participation. Dentists that were already participating in Medicaid have been seeing more patients and providing more services, but the number of new dentists in the program is very small. The state has formed a Dental Advisory Group, which includes dentists on its panel, to identify issues other than reimbursement that inhibit participation. Other such task forces have been convened for home health providers and providers of durable medical equipment to improve their participation rates as well.

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

Nursing Homes and Community-Based Care

Mississippi has around 180 nursing facilities with approximately 15,800 beds. About two-thirds of the state's nursing homes are privately owned, accounting for 70 percent of all licensed beds. Nearly one-fifth of the state's nursing homes are publicly owned or leased. Not-for-profit nursing homes account for slightly over a tenth of all nursing homes and beds.³⁶ About four-fifths of the state's nursing home care is funded by the state's Medicaid program, higher than the national average of 68 percent.³⁷ The state's Medicaid program pays lower-than-average Medicaid rates to nursing homes.³⁸ Rates are facility-specific and set prospectively based on facility cost reports.³⁹ The federal repeal of Boren Amendment requirements has not been a factor in state policymaking.

Although the state's projected growth in the elderly population is lower than the national average, Mississippi has experienced increases in both the number and the proportion of elderly people.⁴⁰ Demand for nursing home care has been increasing. In the late 1990s, the state had high occupancy rates and, according to some sources, relatively long waiting lists for nursing home care. The American Association of Retired Persons estimated the occupancy rate to be 93.7 percent in 1999, the second highest in the nation.⁴¹ Prior to 1997 there had been a proliferation of hospital "distinct part" skilled nursing facilities but this growth stopped with passage of the Balanced Budget Act, which eliminated the preferential reimbursement for these units. In late 1998, the state health department estimated that over 2,000 additional beds would be needed to satisfy demand by 2000.⁴² There are pockets in the state with low occupancy and it has been argued that, historically, beds have been allocated unevenly in the state, in ways that favor areas with political influence.⁴³ Although some nursing home officials dispute the need for more nursing home beds, there appears to be a consensus that more beds are needed for Alzheimer's patients.

Since 1980, the state has had a moratorium on construction of Medicaid-funded nursing home beds and on increasing the number of home health agencies under its Certificate of Need (CON) rules. Under the moratorium, nursing homes are allowed to increase their beds by no more than 10 percent or 10 beds, whichever is less, over a three-year period without applying for a CON. In the late 1990s, numerous bills were introduced in the legislature to that end, but passage proved difficult. Toward the close of the 1998 legislative session, a bill finally passed that would have partially lifted the moratorium. Governor Fordice vetoed the legislation citing the increased financial burden on the state and lack of alternatives to nursing home care. The house overrode the governor's veto but it was upheld in the senate. To address the governor's concerns, the senate devised alternative legislation that included authorization for both nursing homes and expanding home and

community-based care.⁴⁴ The legislation would add 1,560 nursing home beds and an additional 240 beds specifically for Alzheimer's patients.

Demand for alternatives to institutional care is growing. Medicaid officials envision a system in which people needing long-term care would be screened to determine both eligibility and if their needs could be met through home or community-based services or whether nursing facility care was required. They are hopeful that such a system will come out of the task force that has been set up to draft the state's responses to the *Olmstead* decision. In November 2000, Governor Musgrove ordered the Division of Medicaid to take the lead on *Olmstead*. In response, the Division formalized a working group of several state agencies that had been discussing services for persons with disabilities and their families, Mississippi Access to Care, and opened membership in the group to all in the community. The working group is to develop a plan to provide (1) an estimate on the number of disabled residents who need or will need services, (2) an estimate of the cost to implement the plan, and (3) a proposal for funding. The long-range goal is to make community services available to all persons with disabilities by June 30, 2011. The working group is split into eight subgroups to study issues such as the transition from institutions to the community, the transition from child/adolescent services to adult services, and transportation. Six of the eight subgroups are chaired by community advocates. Over a dozen meetings have been held across the state. The final plan is due to the legislature by 2002.

Several options already exist for Medicaid-funded community-based care. In 1986, Mississippi began to implement the elderly and disabled waiver program, designed to provide home and community-based services for Medicaid recipients eligible for nursing home care. The program was originally limited to a maximum number of 2,600 participants but has been expanded to allow up to 8,000 participants with a built-in option for further expansion. Under this waiver, eligible individuals can choose to receive supportive services in their homes rather than enter a nursing home. Medicaid also operates three other home and community-based programs under federal program waivers. The independent living program for people with neurological impairment is authorized to serve up to 550 participants. An assisted living program waiver serves up to 500 clients. The number of clients served under the program waiver for community-based services for people with mental retardation or developmental disabilities was just increased to 1,900. The estimated cost per person of each program is 20 percent to 50 percent of the cost of nursing home care.

Community-based care is often provided by home health care agencies. Home health care is particularly important in rural areas, where transportation can be a major barrier to care. In 1999, there were 69 home health agencies in Mississippi.⁴⁵ Slightly more than two-thirds were free-standing or hospital-based agencies and the rest were based in local health departments. Nearly two-thirds of home health agencies reported nonprofit status; more than half of the agencies were private. About 95 percent of home health visits were paid for by Medicare, with the rest paid for by Medicaid or privately. Medicaid spending on home and community-based services has grown rapidly in recent years, rising from \$4.9 million in FY 1998 to \$19.0 million in FY 2000.⁴⁶ In contrast, in 2000, Mississippi Medicaid spent \$508.6 million for nursing home care.⁴⁷

People with Mental Illness, Mental Retardation, or Developmental Disabilities

The provision of publicly funded mental health services is the responsibility of the Mississippi Department of Mental Health, which also manages the state's programs for individuals with mental retardation or developmental disabilities. The Department's Bureau of Mental Health provides services to persons with mental illness, alcohol or drug abuse problems, and persons with Alzheimer's disease or other dementia. Mental health services are provided through state-operated facilities, regional community mental health services, and other nonprofit service organizations. Increasing the provision of mental health services in community-based settings is a primary departmental goal. Toward that

end, the Department has reduced the size of its large institutional facilities, increased the number of smaller regional facilities, and expanded community-based service options.⁴⁸

Overall, in FY 2000, the public community mental health system served about 37,000 adults and 21,000 children with serious mental illness, excluding those in psychiatric institutions. The state runs two comprehensive regional psychiatric hospitals—Mississippi State Hospital and East Mississippi State Hospital—which together provide the majority of inpatient psychiatric care. Average daily census at these two institutions declined by about 5 percent between mid-1999 and mid-2000. Mississippi also has over a dozen hospital-based clinics and several freestanding adult psychiatric facilities distributed throughout the state. In the past two years, the state opened two regional acute care psychiatric hospitals for adults—one in northern Mississippi at Tupelo and the other in the south at Purvis—each with about 50 beds. During that time, Mississippi also opened several small crisis centers for adults and satellite facilities affiliated with the regional hospitals. In 2002, the state will begin providing home and community-based services for adults on a former college campus. The site will eventually have 12 group homes, each with 12 beds.

The state has been expanding residential facilities for children, including a new acute psychiatric inpatient facility for adolescents to replace an existing facility, and two facilities for youths who are deemed to have mental illness or mental retardation and are involved with the state's criminal justice system. The new facility to serve emotionally disturbed juvenile offenders is projected to open in 2001. Outpatient mental health services for children are provided through 15 community mental health centers and a number of private not-for-profit mental health organizations funded by the Department.

Historically, the state has experienced problems with access to mental health care. In response, the legislature and governor approved funding, beginning in 1995, to significantly expand inpatient or specialized residential mental health care services for both adults and children. The overall Department budget has grown steadily in the last half of the past decade, about 14 percent per year between 1994 and 1997 and about 12 percent per year between 1997 and 2000. In FY 2000, the Department spent \$428 million, excluding the federal share of Medicaid funds drawn by community mental health centers. Overall, one-half of the Department of Mental Health's revenue comes from general revenue, approximately 6 percent from federal grants and 43 percent from Medicaid, patient/client fees, Medicare, or self-generating funds. The state's 2001 budgetary woes are expected to constrain the Department's budget for the near future.

Within the Department of Mental Health, the Bureau of Mental Retardation focuses on the needs of individuals with mental retardation or developmental disabilities (MR/DD). Five state-operated comprehensive regional centers for individuals with MR/DD and a juvenile rehabilitation facility for youth with mental retardation provide residential services. At the end of 1999, there were 1,415 institutional beds. The 15 regional community health centers and other Department-funded community-based organizations that serve people with mental illness also serve those with mental retardation. In FY 2000, 913 individuals received community living/respice services and 850 individuals received services through the state's home and community-based services—MR/DD waiver, which began in 1995. State officials believe that approximately 37,000 individuals in Mississippi have developmental disabilities, all but a few thousand of whom reside outside of institutional facilities.

Other Issues

Insurance Market Developments and State Regulation

Mississippi's insurance market has been stable in recent years. There have been few insurer insolvencies, with the exception of the HMOs in the state's Medicaid program, and little market consolidation. Indemnity or preferred provider organization insurance dominates with little penetration by HMOs. The insurance commissioner has considered ways to help the market for HMOs but thinks they are unlikely to become a major player in the

Mississippi health care market, except possibly in the state's most populated areas.⁴⁹ Mississippi has one of the lowest penetrations of managed care in the country. In 2001, of the 14 HMOs licensed in the state, United HealthCare of Mississippi was the largest, and only two were enrolling members. Many HMOs were licensed in the Mississippi market in anticipation of Medicaid managed care but these have largely remained inactive. United HealthCare never entered the Medicaid market. Respondents stated that Mississippi is generally anti-managed care, noting that the state employees' health benefits plan is legally prohibited from having an HMO option.

The individual insurance market has several players. The largest, BCBS, recently issued a new product for children only that offers good coverage at a substantially lower price than the state employees' plan. The state plan offers coverage for dependents of state employees but does not help workers cover this cost.

Mississippi also has a high-risk pool for uninsurable people that serves about 1,500 individuals. Premiums are high but the pool is subsidized by assessments on insurance companies and HMOs. The high-risk pool includes a \$500,000 cap on lifetime benefits.⁵⁰

The chief area of concern in insurance currently is the small group market. Regulators are confident that they have addressed the issues of quality and availability but are concerned about affordability. Many firms who find themselves priced out of the small group market were said to have resorted to catastrophic coverage or stop-loss policies for their employees.

Health Care Market Developments and State Response

Mississippi has a higher-than-average concentration of hospital beds, with 473 beds per 100,000 people in 2000, well above the national average of 311.⁵¹ Mississippi has 97 general acute care hospitals and 8 specialty hospitals, including psychiatric, rehabilitation, and long-term care acute hospitals.⁵² Hospitals are concentrated in the capital, Jackson; nine counties in the state have no hospitals. The majority of hospitals in Mississippi are publicly controlled. Public entities, chiefly counties, own about 58 percent of the state's hospitals, although many county hospitals receive no county financing. Not-for-profits represent about 22 percent of the state's hospitals, and for-profit facilities about 20 percent.⁵³ In 1999, the statewide occupancy rate for acute care hospitals was 51.7 percent with an average length of stay of 5.28 days.⁵⁴ Not surprisingly, given the rural character of the state, most hospitals are small, with 61.7 percent having fewer than 100 beds.⁵⁵

Sixteen hospitals in Mississippi closed in the 1990s,⁵⁶ and state hospital officials fear additional closures in the future. Mississippi hospitals, especially those located in rural areas, are struggling under the pressures of a rapidly changing health care environment. To adapt, Mississippi's hospitals are providing increasing amounts of outpatient services and expanding into such areas as home health and long-term care. In the late 1990s, many hospitals facing financial difficulty converted hospital beds to long-term care beds. The combination of the state's shortage of nursing home beds and the favorable Medicare reimbursement for hospital-based skilled nursing facilities encouraged this trend. The conversion of existing hospital beds to long-term care beds was expected to help small, financially troubled rural hospitals remain economically viable. The withdrawal of the preferential reimbursement in 1997 under the BBA was a serious setback for many of these facilities.

The state has also witnessed recent mergers and affiliations, some politically contentious, such as the late-1990s merger of the two main hospitals in Vicksburg—Parkview and Vicksburg Medical Center. Originally, local officials supported the merger, but enthusiasm waned when layoffs were announced.⁵⁷ Some requests to the state for CONs were also contested. One such battle, in north Jackson, is noteworthy. In 1993, Methodist Hospital was granted a CON for a new hospital. Baptist Medical Center and St. Dominic/Jackson appealed the decision, but in the interim, Methodist opened the hospital. The state supreme court ruled in 1998 that Methodist made a mistake in building the facil-

ity while the court appeal was pending and ordered Methodist to shut it down. An appeal to the legislature to save the \$30 million hospital was not successful.⁵⁸

Rural Health Care

Eighty percent of the state's hospitals representing two-thirds of total beds are located in rural areas. The risk of hospital closure is highest for hospitals that operate fewer than 100 beds, have occupancy rates of 40 percent or less, or have a large percentage of Medicaid days (11 percent or more). Sixty-one percent of Mississippi's hospitals have fewer than 100 beds, and in 1999, over half of Mississippi's rural hospitals reported occupancy rates below 40 percent.⁵⁹ Rural hospitals have diversified their activities to offset dwindling inpatient revenues, often tailoring their service offerings not only to need but also to the availability of preferential reimbursement. In addition to skilled nursing facilities, many rural hospitals opened geriatric psychiatry units during the 1990s.

Rural hospitals have also formed limited alliances to achieve better economies of scale in such areas as purchasing or acquisition of new resources while maintaining individual autonomy. Some have entered into more formal multi-hospital arrangements where the hospital is owned, leased, or managed by another, larger hospital or parent corporation, which facilitates access to capital. The number of multi-hospital arrangements in Mississippi has grown in the past several years, especially in rural areas. Access to capital is critical as many of the state's rural hospitals were built following World War II with funding under the Hill-Burton Act. These facilities are now sorely in need of renovation as the financial stresses of recent years have left few dollars for capital programs.

To assist rural hospitals, the state enacted the Mississippi Rural Hospital Flexibility Act of 1998. The law is designed to strengthen rural hospital systems by designating certain rural hospitals as "critical access hospitals" in accordance with the federal Medicare Rural Hospital Flexibility Program.⁶⁰ This federal program allows small rural hospitals to operate as less than full-service institutions and still receive cost-based Medicare reimbursement. Critical access hospitals can have no more than 15 staffed beds (excluding swing beds), and the maximum allowable stay is 96 hours. Within the 96-hour period, patients must be discharged or transferred to a more comprehensive, full-service hospital. The State Department of Health is charged with approving nonprofit and public rural hospitals as critical access hospitals.

Only one hospital currently operates under critical access status, although two others have received approval. The program is not as attractive to rural hospitals as its designers had hoped. Many hospitals had already restructured their facilities to take advantage of other preferential reimbursement schemes and would have to close these units in order to qualify for critical access status. Geriatric psychiatry units have proved to be popular in rural communities, and many hospitals question whether the loss of this revenue would be balanced by the potential revenue gains under the critical access program. At two rural Mississippi hospitals, new chemical dependency units present the same dilemma. As there is as yet no mechanism in place to reconvert once critical access status is achieved, state officials are advising hospitals to consider the decision very carefully.

Labor issues continue to plague rural areas. In addition to the wider nursing shortage, rural areas face major challenges in the recruitment and retention of physicians. In an attempt to address the fragmentation that has characterized physician recruitment in the state, a clearinghouse for physician recruitment was established in the state's Office of Primary Care. Under this program, the state will track graduates of its medical school to see where they practice. It will also build on the rural training that is given in the state's osteopathic medicine school and encourage these graduates to locate in rural areas.

The state recently established a medical scholarship program for students agreeing to practice in designated areas in the state but failed to fill all of the 20 authorized program slots. Recognizing the lag time involved in medical training and that the need for physicians was immediate, the state redirected the scholarship funding to a loan repayment pro-

gram for medical graduates. Loan repayment should get program physicians into rural practice more quickly than the scholarship program, but, with a required eight-year commitment, the state has had trouble finding enough participants.

In May 2000, Governor Musgrove signed a bill allowing physician assistants to practice throughout the state, not just in urban areas as permitted under the previous legislation. Removing this restriction may help ease the health professional shortage in rural areas.

Conclusion

Mississippi suffers from the problem of having a large poor population with significant health care needs and a small state budget with which to meet those needs. The recent change in governor in Mississippi has brought a new approach to addressing the problem, looking to Medicaid as a way to bring federal dollars into the state to help meet the needs of Mississippi's poorer citizens, but the state has yet to fully implement this strategy. In addition, the tobacco settlement funds, which the state has chosen to devote almost entirely to health, and the SCHIP program have provided new opportunities for the state to expand its public programs.

Mississippi is currently engaged in restructuring its program to take greater advantage of the federal support that is available without additional outlays of state funds. It has come late to this activity, and many of the avenues it is going down, such as the upper payment limit program, are being closed in response to alleged abuses in these programs in other states. So, while Mississippi will benefit from its new approach in many areas, it will not reap the same benefits that other states have in their much longer pursuit of federal dollars. The coming economic downturn may serve to exacerbate Mississippi's woes with potentially rising Medicaid rolls coupled with stagnating state revenues. Cost-cutting measures that have helped other states, such as capitated managed care, have met with less success in Mississippi.

The rural character of the state offers additional challenges to policymakers. Both federal and state programs have been implemented to help address the peculiar problems of rural health systems, particularly the financial position of rural hospitals and the long-standing difficulties of recruitment and retention of health care professionals. Unfortunately, the federal initiatives for hospitals have not proved as helpful as hoped, and the state programs to assist with personnel shortages will take time to achieve their goals.

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Table 1 Notes

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l. In 1998, some states' thresholds represent Medicaid eligibility, and others are either Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are eligible only through Medicaid.

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