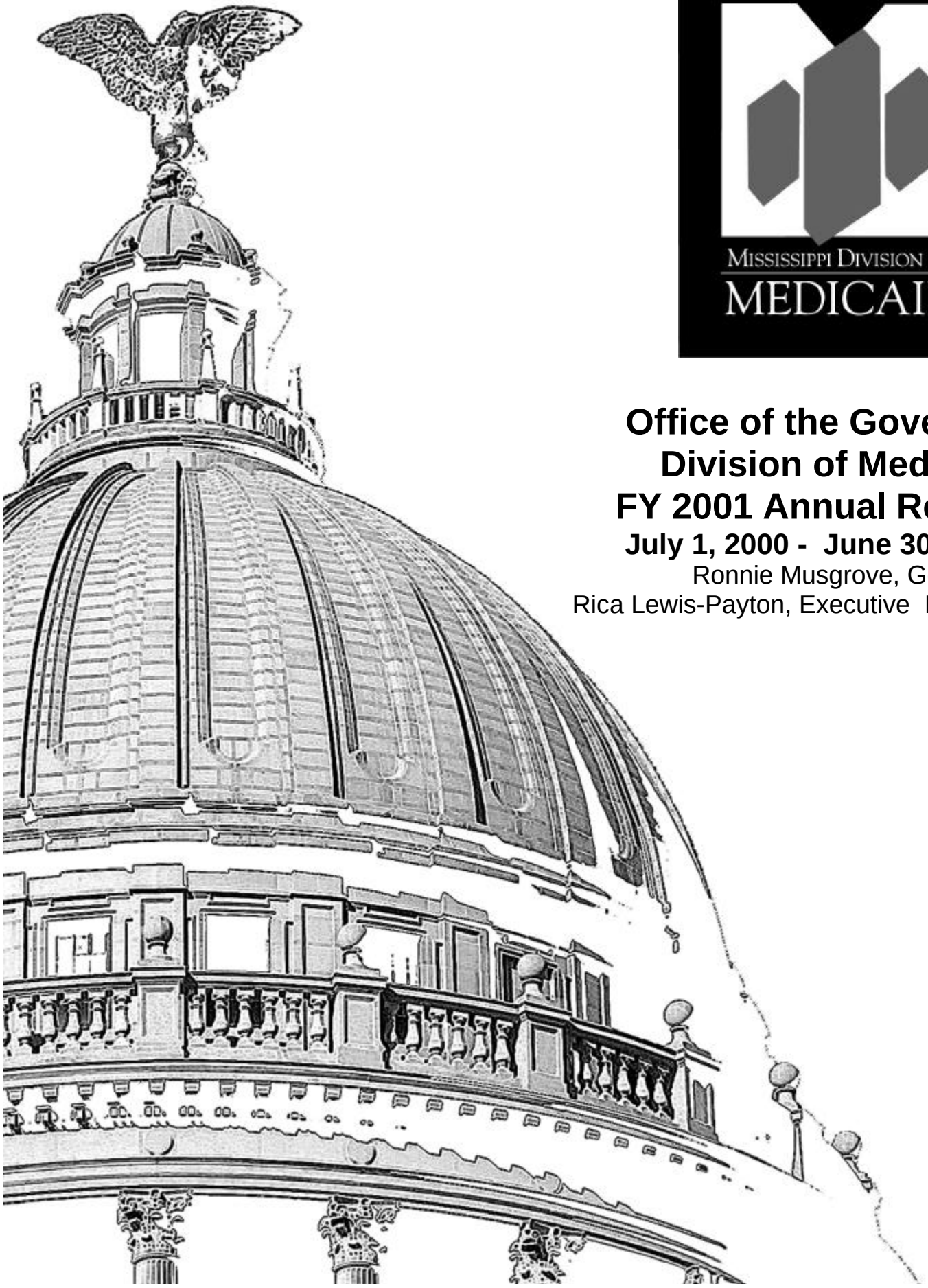

MISSISSIPPI DIVISION OF
MEDICAID

Office of the Governor
Division of Medicaid
FY 2001 Annual Report

July 1, 2000 - June 30, 2001

Ronnie Musgrove, Governor
Rica Lewis-Payton, Executive Director

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

RICA LEWIS-PAYTON
EXECUTIVE DIRECTOR

May 6, 2002

Honorable Ronnie Musgrove
Governor of the State of Mississippi
and
Members of the Mississippi State Legislature

Governor Musgrove and Members of the Legislature:

It is my pleasure to submit to you the Annual Report of the Office of the Governor Division of Medicaid for FY 2001. It is being submitted in accordance with the requirements of Section 43-13-127 of the Mississippi Code of 1972 as amended.

The Division gratefully acknowledges the vital contributions made by the Department of Human Services, the Department of Health, the Department of Mental Health and the Department of Rehabilitation Services to the ongoing administration of Mississippi's Medicaid program. In addition, we acknowledge the continued commitment of our providers. Together we are moving towards our goal of providing every citizen in the State of Mississippi equal opportunity to quality healthcare despite their socio-economic status.

I see this as an investment. If we can ensure quality healthcare services to our most vulnerable citizens they will have the opportunity to be more productive. A healthier Mississippi is a more productive Mississippi.

On behalf of the 646,925 Mississippians who were enrolled in the Medicaid program in FY 2001, we wish to thank you for continuing to make these services available.

Respectfully,

Rica Lewis-Payton

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Mission

THE MISSION of the Office of the Governor Division of Medicaid, is to promote a caring organization and to treat our beneficiaries, providers and employees with respect, dignity, honesty and compassion. We strive to provide financial assistance for the provision of quality health services to our beneficiaries with professionalism, integrity, compassion and commitment. We are advocates for, and accountable to the people we serve.

Values

- We value integrity and observe the highest ethical standards and obey all laws and regulations. We pledge to be good stewards of the State's resources entrusted to us.
- We value a positive spirit of service to our recipients and to our providers.
- We understand that to be effective we must be willing to change. Therefore, we value new ideas, innovation, and a positive response to change.
- We value our well-trained staff that is committed to getting better every day in everything we do.
- We value teamwork. We encourage team accomplishments over the goals of any one individual. We encourage open discussion of issues, but once a decision is made, commitment is expected from everyone. We understand that the success of our organization relies upon the building and maintenance of effective teams.

Vision Statements

- We will provide quality cost-effective healthcare services to all qualified beneficiaries.
- We will show respect and dignity to our beneficiaries and our providers.
- We will be healthcare partners with families, individuals and communities.
- We will aggressively reach out to the general public regarding the benefits offered by the Medicaid program.
- We will position Medicaid as a leading healthcare provider.
- We will make referrals for individuals requiring additional services provided by other agencies in an effort to assist them in obtaining a better quality of life.
- We will develop innovative and cost efficient programs to allow for the provision of maximum health benefits to more eligibles.
- We will be the preferred workplace for individuals seeking public healthcare service.
- We will work as a team with legislative officials to provide quality health benefits to eligible individuals within budgetary constraints.

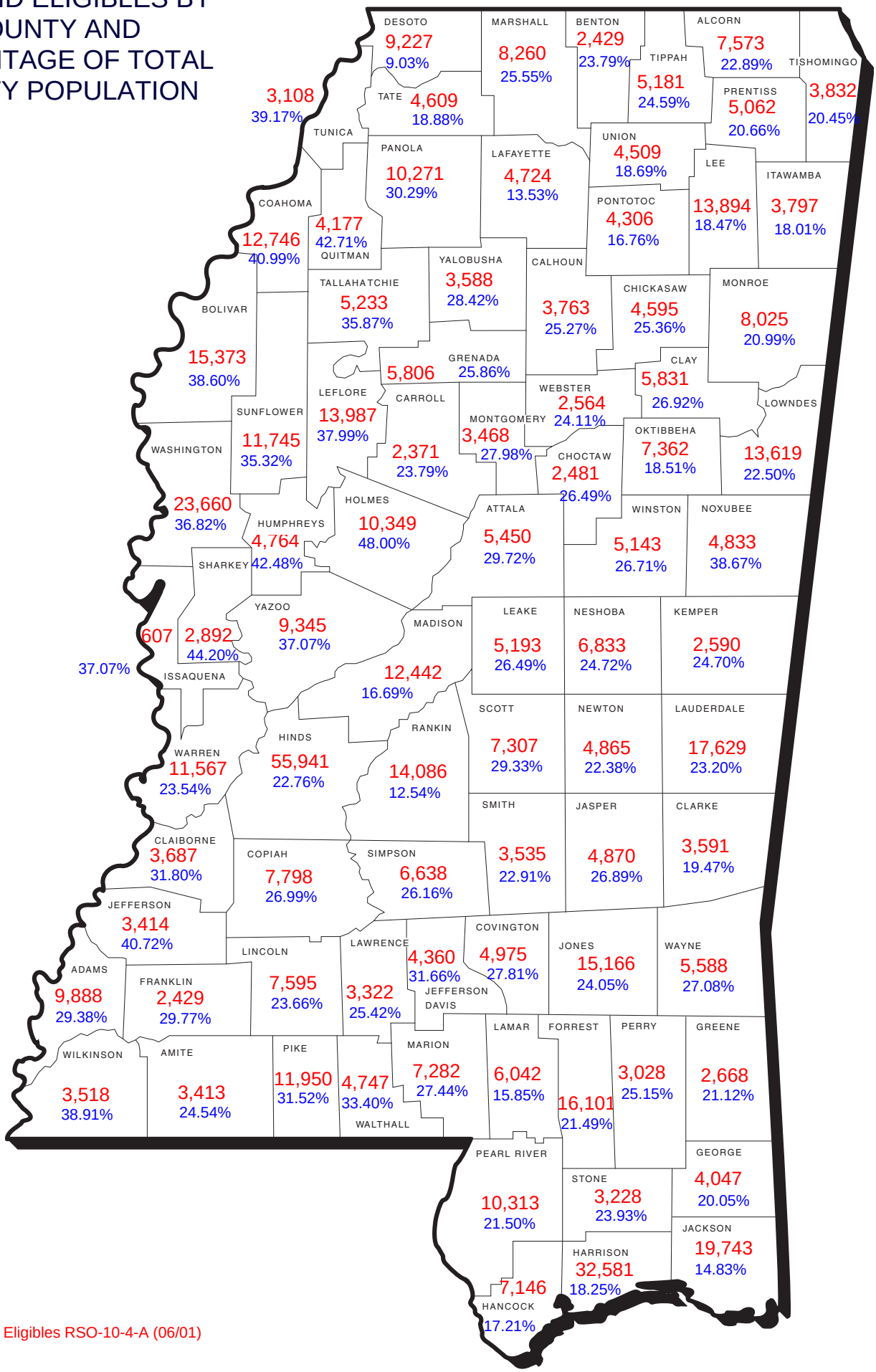
Performance Categories

- Beneficiary and provider satisfaction
- Program oversight to ensure uniformity and consistency of service
- Program oversight to ensure cost-effective service
- Staff competence and retention

Slogan

- *Quality Healthcare Service, Improving Lives*

MEDICAID ELIGIBLES BY COUNTY AND PERCENTAGE OF TOTAL COUNTY POPULATION



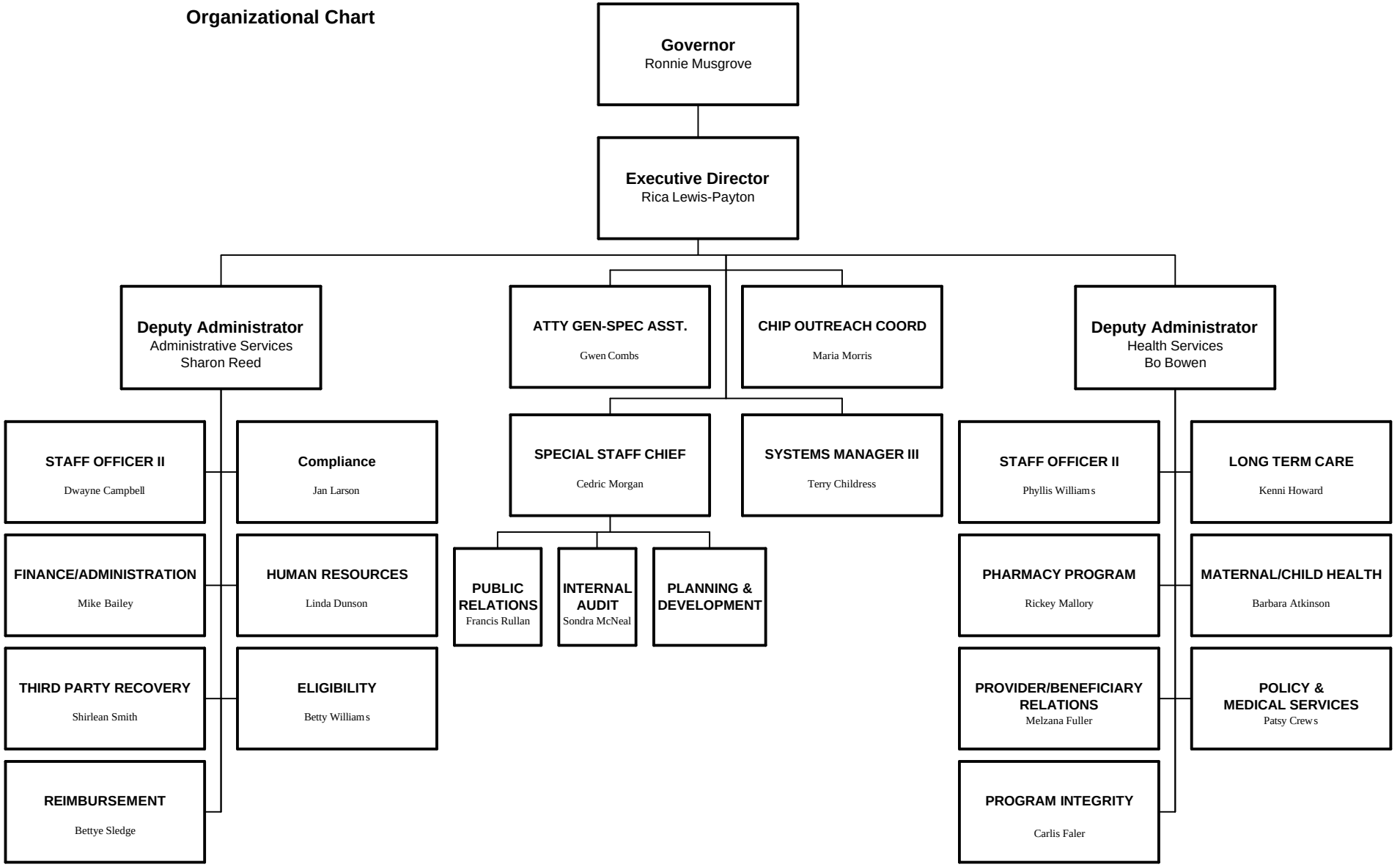
Source: Medicaid Eligibles RSO-10-4-A (06/01)

Source: County Population, U.S. Census Bureau Population Estimate Program Release Date 3/9/2000

Office of the Governor

Division of Medicaid

Organizational Chart



Agency Overview

Executive Director ~ The Executive Director is responsible for the overall administration of the Division of Medicaid which also includes working with staff from the Centers for Medicare and Medicaid Services (CMS) to maintain compliance with federal laws and regulations; monitoring state legislative activity regarding Medicaid; presenting budget information to the Governor and to the Legislature; networking with other agencies and organizations for improved health care; maintaining the State Plan; and processing information requests.

Deputy Director for Administrative Services ~ Administrative Services provides support to the agency and its staff in developing and executing the day-to-day administrative responsibilities mandated by federal and state laws and agency policy. In addition, the Deputy Director for Administrative Services is responsible for oversight of the auditing and financial operations of the bureaus of Accounting, Budget and Finance, Compliance and Financial Review, Reimbursement, and Third Party Recovery, as well as the administration of personnel policies and procedures in the Bureau of Human Resources, and eligibility related matters in the Bureau of Eligibility.

Deputy Administrator for Health Services ~ Responsibilities include executing the day-to-day administrative duties for the Bureau of Health Services which is comprised of the Bureaus of LTC/Medical Services, Maternal and Child Health, Policy and Special Projects, Pharmacy, and Provider and Beneficiary Relations. Health Services is responsible for the overall development, implementation and operation of all Medicaid health care related services and benefits, and for ensuring that Medicaid beneficiaries are provided appropriate, accessible and quality services.

Bureau of Accounting, Budget & Finance ~ Responsible for effective funds management, ensuring timely drawdown and transfer of funds to the fiscal agent for claims payment, deposit of funds received, and payment of vendor invoices for the ongoing business of the Agency; concomitantly, the Bureau is responsible for records maintenance, property and equipment management, purchasing, space management, and Federal and state reporting for the Agency. Responsible for analyzing and trending medical service and administrative expenditures and, using these data sets, formulating annual budget projections for the agency. Bureau staff members are also responsible for preparing state and federal documents and reports necessary to ensure maximization of Mississippi's federal match rate for Medicaid expenditures. Staff members document medical service and administrative service expenditures monthly in order to keep agency managers abreast of the financial impact of their respective programs. The Bureau is also responsible for analyzing new or proposed legislation in order to determine the financial impact on State general fund revenues. The Bureau of Accounting, Budget & Finance is a service arm of the Division of Medicaid and has as its primary role assistance to all other units of the Agency.

(Continued)

Bureau of Compliance and Finance Review ~ The BCFR conducts compliance and/or financial reviews of selected Medicaid providers and contractors. The purpose of these reviews is to 1) ensure Medicaid is properly charged by these vendors and that the agency is receiving services per the terms of the contracts or provider agreements, and 2) ensure the contractors and providers understand the requirements of their contracts or provider agreements. The BCFR includes two units. The Provider Review Unit (PRU) conducts financial reviews of the cost reports of selected nursing facilities, rural health clinics, and federally qualified health centers each year. The Contracts Monitoring Unit (CMU) conducts reviews of the resident trust funds at nursing facilities that manages the personal funds of residents who receive assistance from the Medicaid program. The CMU is also responsible for Non-Emergency Transportation (NET) and compliance and financial reviews of selected Agency contractors.

Bureau of Eligibility ~ The State Office staff manages the following functions: policy and on-line system development; Regional Office administration; State level appeals of eligibility decisions; staff training; the Buy-In of Medicare premiums for all dually eligible beneficiaries and incoming calls from the KIDS NOW hotline. State level staff also have oversight responsibility for the electronic transmission of eligibility for over 150,000 SSI eligibles who automatically receive Medicaid and policy oversight for the Medicaid coverage groups certified by the State Department of Human Services (400,000 eligibles).
The Medicaid Regional Office staff is responsible for eligibility determinations for over 75,000 aged or disabled recipients living in private and long term care settings and for determining the cost of care calculations for each recipient in a nursing facility.

Bureau of Executive Services ~Responsible for responding to public information requests in accordance with Division of Medicaid policy and the Access to Public Records Act. The Bureau also supports the Executive Director by attending key meetings of other state agencies and legislative bodies, and ascertaining from these meetings information needed by participants, and coordinates with appropriate agency personnel the collection of this information. The bureau performs other tasks related to special projects as assigned by the Executive Director. Executive Services includes: Planning and Development, Internal Audit, and Public Relations.

Bureau of Human Resources - The Bureau of Human Resources is responsible for the administration of personnel policies and procedures originated by the Mississippi State Legislature, Mississippi State Personnel Board, Federal Office of Personnel Management and Division of Medicaid. These policies and procedures may include, but are not limited to the following: Certified Public Manager Program (CPM), Classification and Compensation, Employee Relations, Performance Appraisal Review (PAR), Payroll, Recruitment and Selection, and Training. Additionally, the Human Resources staff is responsible for guiding and assisting the agency's employees in personnel services through division goals and objectives as deemed necessary by the directors for the Division of Medicaid.

(Continued)

Bureau of Long Term Care ~ This multi-branch bureau is composed of Community Long Term Care, Institutional Long Term Care and , Mental Health. Community Long Term Care is composed of three divisions: Home and Community-Based Services (HCBS) Division, which is responsible for the operation of all HCBS waiver programs that provide individuals alternatives to nursing home placement; LTC Alternatives Division, which provides information, education and referral to Medicaid beneficiaries and applicants who are seeking alternatives to nursing home care; and Hospice, which is an optional benefit available for individual's that have a terminal illness with a life expectancy of six (6) months or less. A variety of in-home or institutional services are available that emphasize palliative rather than curative care.

The Institutional LTC Division is responsible for the nursing home program, Case Mix reimbursement audits, and the imposition of civil money penalties on nursing facilities.

The Mental Health Division is responsible for in-patient and community mental health services. Staff is responsible for the certification of psychiatric residential treatment facilities, monitoring of the state's community mental health centers, the pre-admission screening and resident review program (PASRR), and other mental health services covered by Medicaid.

Bureau of Maternal and Child Health ~ The Bureau of Maternal and Child Health (MCH) is a multi-branch bureau responsible for the administration of maternal and child health services. The Early and Periodic Screening, Diagnosis, and treatment (EPSDT) program, a mandatory service under Medicaid, provides preventive and comprehensive health services for children and youth up to age twenty-one (21). The Expanded EPSDT/School-Related Services Program provides any necessary Medicaid reimbursable health care services not routinely covered under the regular Medicaid program. The Vaccine for Children and the Perinatal High Risk Management/Infant Services System (PHRM/ISS) is a voluntary program established to provide health care and enhanced services to eligible women and children at risk during the perinatal period.

Bureau of Policy & Medical Services ~ The Bureau of Policy and Medical Services consists of two divisions, the Policy Division and the Medical Services Division. The primary function of the Policy Division is to research new and existing policy issues through the analysis of state and federal laws, medical standards of care, and related data for the purpose of developing and distributing written policy to all Medicaid providers which can be consistently applied in order to facilitate proper utilization of services and funding for the Medicaid programs and to ensure quality services are delivered to the beneficiaries.

In addition, the Policy Division coordinates the prior authorizations for solid organ and bone marrow transplants and oversees the Peer Review Organization contract which handles certifications of inpatient days for hospitals, swing beds, and psychiatric residential treatment facilities, prior authorization of durable medical equipment, home health agency visits, and private duty nursing services for beneficiaries under age 21 and medical necessity reviews for transplants.

The role of the Medical Services Division is the direction of the following Medicaid Programs: Ambulatory Surgical Centers, Chiropractor, Dental, Dialysis Facilities, Federally Qualified Health Centers, Hospital, Indian Health, Mississippi State Department of Health Clinics, Physician, Nursing Services, Rural Health, and Swing Beds. This includes responding to verbal and written inquiries, the implementation of changes in policy or legislation that impact the programs, coding and reimbursement updates, and systematic enhancements. In addition, the division performs utilization review and trend analysis for the various programs for the purpose of budgeting and forecasting as Medicaid strives to maximize efficient and quality services to its beneficiaries and providers.

(Continued)

Bureau of Program Integrity ~ The Bureau of Program Integrity consists of four units: Investigations, Beneficiary Recoupment, Medical Review, and Medicaid Eligibility Quality Control. Our mission is to identify and prevent fraud and abuse of the Medicaid program, to identify weak areas in policy and the Medicaid Management Information System and make recommendations for changes and improvement, and to determine the accuracy of Medicaid eligibility decisions. The Bureau also conducts investigations of providers and beneficiaries suspected of fraud and/or abuse, and monitors both providers' and beneficiaries' utilization of Medicaid benefits.

Bureau of Provider & Beneficiary Relations ~ Within this Bureau are three Divisions - Managed Care, Provider Relations, and Beneficiary Relations. The Managed Care Division is responsible for the administration and oversight of the primary care case management program, HealthMACS. The Provider Relations Division has responsibility for overseeing enrollment of providers in the Mississippi Medicaid program and any other issues related to providers. The primary responsibilities of the Beneficiary Relations Division are to provide education and conduct outreach activities about the Medicaid program with beneficiaries and those who work with beneficiaries, such as Head Start Centers, local Departments of Human Services, and many other local agencies and organizations.

Bureau of Reimbursement ~ Responsible for calculating Medicaid reimbursement rates paid to hospitals (inpatient and outpatient services), nursing facilities, intermediate care facilities for the mentally retarded, psychiatric residential treatment facilities, rural health clinics, federally qualified health centers, home health agencies, swing beds, hospices and the Mississippi State Department of Health clinics.

Bureau of Systems ~ Supports the Division of Medicaid (DOM) by ensuring the Agency's Fiscal Agent operates the MMIS in compliance with key performance indicators, Federal, State, and Division guidelines; by providing data analysis to support changes in state health policy and health care reform; and by providing state of the art technological support in data processing, communications, and computer training. We support this mission through two major areas of responsibility; the network area which includes the operation and maintenance of all the Agency's Local and Wide area networks and the Agency's telecommunications services; and the MMIS area which includes the oversight of the MMIS and fiscal agent contract management.

Bureau of Third Party Recovery ~ Federal and state laws and regulations require that Medicaid program liability be secondary to any third party benefits to which a Medicaid beneficiary is entitled. Third Party is defined as any individual, institution, corporation, or public or private agency that is liable to pay for all or part of the medical cost of injury, disease, or disability for a Medicaid beneficiary. By law, it is a condition of Medicaid eligibility that the individual cooperate with Medicaid by furnishing required third party information and by assigning all rights to any third party resources to the Division of Medicaid. Federal law also requires that the third party information be integrated with the Medicaid claims payment system in order to avoid payment of claims when a third party is known to be liable; to recover from the third party source when its existence is learned after the fact; and to pay for those services that the states are mandated by federal law to pay and then seek recovery from the known third party sources.

Children's Health Insurance Program (CHIP) ~ The Children's Health Insurance Program is called the Mississippi Health Benefits Program. The CHIP Coordinator is primarily responsible for the identification and enrollment of all eligible uninsured children in the state of Mississippi under 200% of the Federal Poverty Level (FPL).

(Continued)

Legal Division ~ Three Special Assistant Attorneys General provide, by contract, legal representation to the Division of Medicaid. Their responsibilities include the following:

1) Providing legal representation for the agency in third party liability matters.
2) Providing legal representation in estate recovery matters.
3) Handling contracts, administrative hearings, garnishments, levies, liens, bankruptcy matters that impact the agency.
4) Assisting the AG's civil litigation division with defense of the Division of Medicaid.
5) Providing general advice on policy matters, provider agreements, and eligibility questions.
6) Serving as liaison with the Medicaid Fraud Control Unit.
7) Providing analysis of pending legislation, both state and federal, and providing legal research and general legal advice to the agency's bureaus.

Office of Internal Audit ~ This Office is responsible for providing management with an independent appraisal of activities within the Division of Medicaid. The primary purpose is to examine and evaluate the effectiveness, efficiency, and economy of its activities by assessing internal controls, management goals and verifying compliance with Medicaid policies and procedures, state statutes and rules and federal laws and regulations.

Planning and Development ~ The Bureau of Planning and Development was created to provide strategic planning leadership for the Division of Medicaid (DOM). It is responsible for planning and developing initiatives that support the mission of DOM and seeking resources from foundations and governmental entities. Planning and Development is also responsible for pursuing opportunities to assist people in need of services and assistance, and developing programs to gather and analyze information to protect vulnerable people of all ages with limited income.

Public Relations ~ This Division is responsible for formulating, directing, and controlling the Public Relations operations through bureau and division directors. Maintains working relationships with the press, various advertising agencies, other state agencies and the Office of the Governor regarding press releases. Also, works with other professional Medicaid staff in the development of brochures and other information materials for distribution to public officials and the general public.

Program Overview

Mississippi's Medicaid program was created by the Legislature in 1969 (Section 43-13-101, MS Code of 1972) in order to provide medical assistance to low-income people.

There are three main categories of Medicaid services:

Those mandated by federal law:

- Certified nurse practitioners, pediatric and family
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- Family planning services
- Federally qualified health clinic services
- Inpatient hospital services
- Laboratory/X-ray services
- Non-Emergency Transportation
- Nursing facility services
- Nurse midwife services
- Outpatient hospital services
- Physician services
- Rural health clinic services

Waiver programs offering additional enhanced services:

1) Primary care case management services

2) Home and community-based services for the elderly and disabled

3) Home and community-based services for the neurologically or orthopedically impaired

4) Home and community-based services for the mentally retarded/developmentally disabled

5) Home and community-based services for individuals in Assisted Living facilities

(Continued)

Optional services the state elects to provide:

- Intermediate Care Facilities for the Mentally Retarded (ICF/MRs)
- Pediatric skilled nursing services
- Prescription drugs
- Dental services
- Eyeglasses
- Clinic services: ambulatory surgical centers, birthing centers, freestanding dialysis centers
- Mental health services
- Psychiatric residential treatment facilities
- Inpatient psychiatric services
- Non-emergency transportation
- Chiropractic services
- Perinatal risk management services
- Emergency ambulance
- Home health
- Christian science sanatoria services
- Durable medical equipment
- Hospice
- Managed care services
- Targeted case management services for children with special needs
- Ambulatory services: state department of health clinic services
- Podiatry services
- Disease management services

Home and Community Based Services (HCBS)

HCBS program goals:

1) To increase the number of beneficiaries enrolled in all HCBS Waiver programs by 20% this fiscal year.
2) To increase service providers for all HCBS Waiver programs this fiscal year.
3) To conduct provider education, policy revisions and on-site compliance reviews to improve the quality of services provided within HCBS programs.

Waiver for the Elderly and Disabled:

The Elderly and Disabled Home and Community-Based Services Waiver provides services to individuals, who but for the provisions of such services, would require placement in a nursing facility. This Waiver is state-wide and operated directly through the Division of Medicaid and can serve 10,000 unduplicated beneficiaries. Beneficiaries of this Waiver must be Medicaid eligible as SSI recipients, Poverty Level, Aged or Disabled or must meet the requirements for the special income category, which allows income level up to 300% of the SSI federal benefit rate. Services available are Case Management, Institutional Respite, In-Home respite, Homemaker Services, Home Delivered Meals, Adult Day Care, Escorted Transportation and Expanded Home Health Services. Referrals from this program can be made through the Community Long Term Care Unit of Medicaid or through the various Area Agencies on Aging. For FY 2001 there were 6,587 enrolled in this Waiver.

During FY 2001, the Elderly and Disabled Waiver has shown a 66.6% growth in the number of individuals served in this program. There has been the following growth in providers for this Waiver: (40) Case management teams; (18) Homemaker providers; (3) Adult Day Services providers; (7) In-Home Respite providers; (4) Institutional Respite providers; and (3) Escorted Transportation providers.

Waiver for Independent Living:

The Independent Living Waiver was created to assist severely orthopedically and/or neurologically impaired individuals, to live independently through the services of a Personal Care Attendant. The beneficiary must be capable of communicating effectively with care givers, personal care attendants, case managers, and others involved in their care. They must be medically stable. Beneficiaries are also provided Case Management Services. These services enable beneficiaries to remain at home rather than be placed in a nursing facility. This statewide program was limited to a maximum of 550 unduplicated beneficiaries for FY 2001. Beneficiaries of this Waiver must be Medicaid eligible as SSI recipients or must meet the requirements for the disability coverage group, which allows an income level up to 300%

(Continued)

of the SSI federal benefit rate. This Waiver is operated through the Department of Rehabilitation Services. Referrals for this program can be made through the Long Term Care Unit of Medicaid or through the Department of Rehabilitation Services.

During FY 2001, the Independent Living Waiver has shown a 172% growth in the number of individuals served in this program. At the close of FY 2001, there were 354 enrolled in this Waiver.

Waiver for the Mentally Retarded/Developmentally Disabled:

The Mentally Retarded/Developmentally Disabled Waiver provides services to individuals who, but for the provision of such services, would require placement in an intermediate care facility for the mentally retarded (ICF/MR) or persons with related conditions. This statewide program was limited to a maximum of 1900 unduplicated beneficiaries for FY 2001. Beneficiaries of this Waiver must be Medicaid eligible through one of the following eligibility categories: 1) SSI Recipients, 2) TANF Recipients, 3) Disabled Child Living at Home, or 4) income limits up to 300% of the SSI federal benefit rate. This Waiver is operated through the Department of Mental Health, Bureau of Mental Retardation. Currently the services available are In-home Respite; Community Respite; ICF/MR Respite; Residential Habilitation; Attendant Care Services; Day Habilitation; Pre-vocational Services; Supported Employment; Physical Therapy; Occupational Therapy; and Speech, Language, and Hearing Services; specialized medical supplies; behavioral support and intervention. Referrals for this program can be made through the Community Long Term Care Unit of Medicaid, the Bureau of Mental Retardation of the Department of Mental Health, or the Waiver Support Coordinators at each of the Regional ICF/MRs.

During FY 2001, the Mentally Retarded/Developmentally Disabled Waiver has shown a 99% growth in the number of individuals served in this program. At the close of FY 2001, there were 1,462 enrolled in this Waiver. There has been the following growth in providers for this Waiver: (45) In-Home Respite providers, (1) Attendant Care provider, (3) Habilitation providers, and (4) Multiple services providers.

Waiver for Assisted Living:

Assisted Living Waiver provides services in a home-like environment in a licensed (Level 1) community care facility. These services are supportive services provided or accomplished while a client resides in such a facility, by trained staff that involves one or more of the following primary duties: personal care services, homemaker, chore, attendant care, medication oversight, therapeutic, social and recreational programming, 24 hour on-site response staff to meet scheduled or unpredictable needs in a way to promote maximum dignity and independence, as well as to provide supervision, safety and security. Additionally, other services which may be provided include: medication administration, intermittent skilled nursing services, transportation specified in the plan of care and attendant call systems. No payment will be made for 24-hour skilled care or supervision.

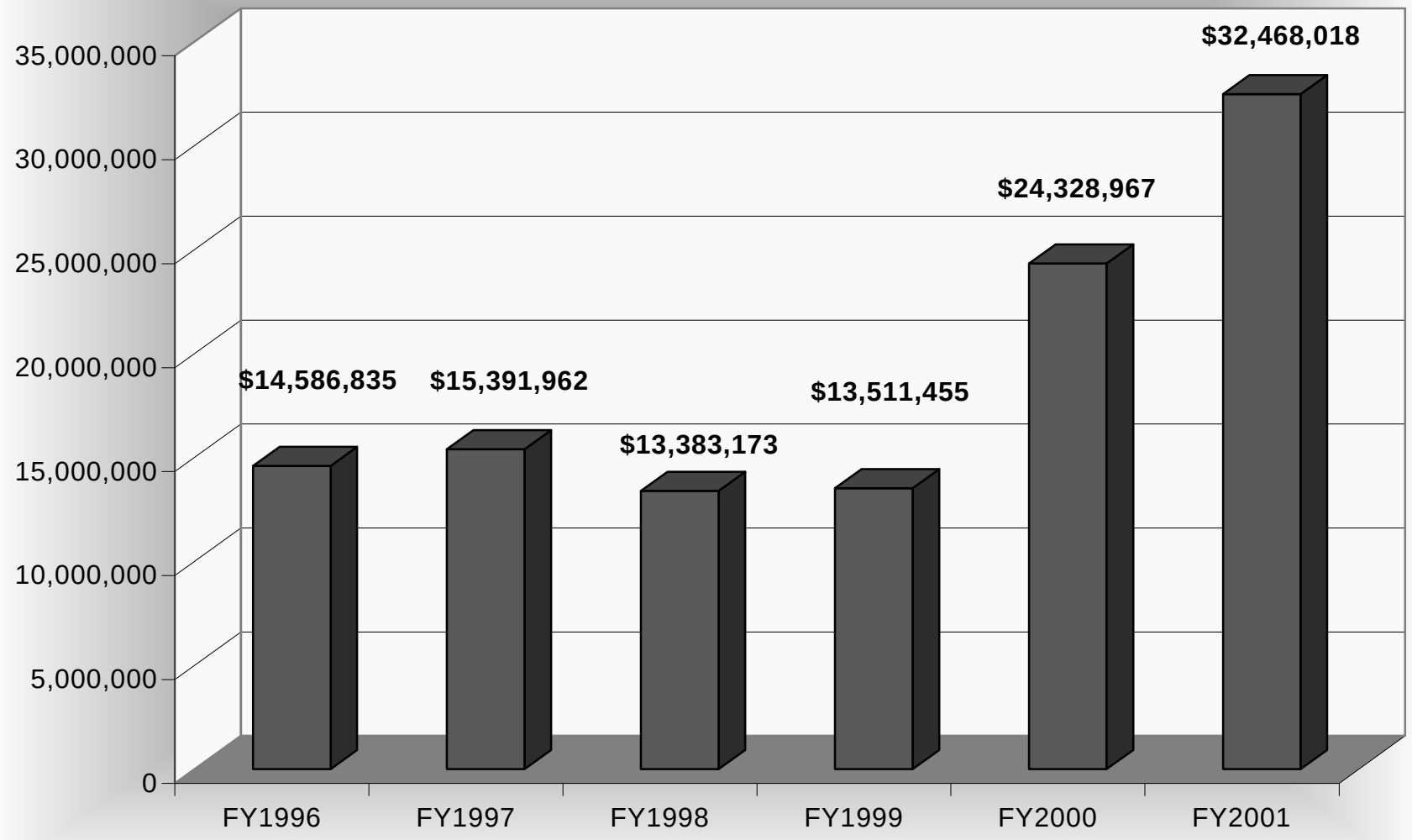
This program was implemented October 1, 2000, as a pilot program in the following counties: Bolivar, Forrest, Harrison, Hinds, Lee, Newton, and Sunflower. At the close of FY 2001, Medicaid had only one provider for this waiver, with (5) beneficiaries enrolled.

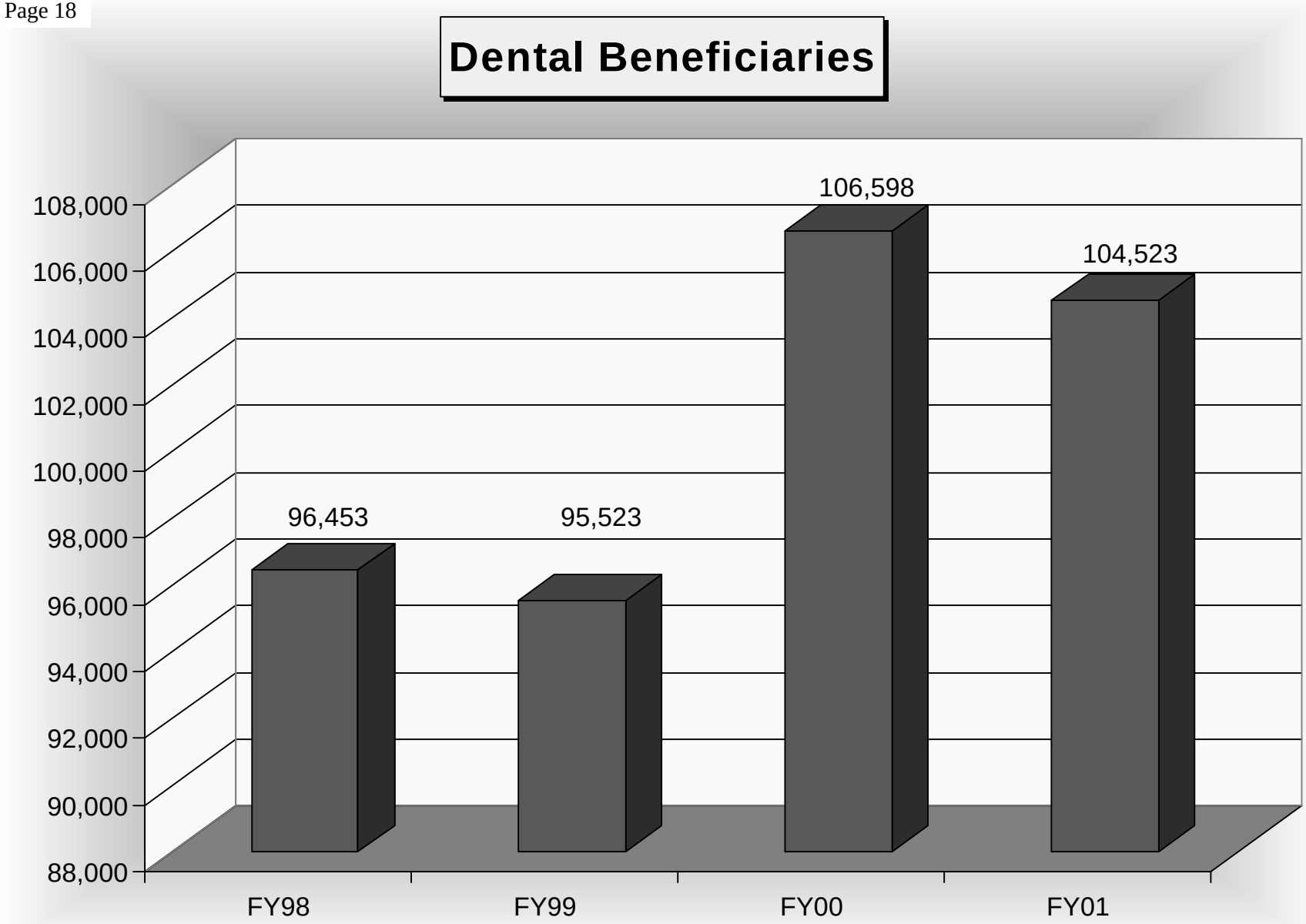
Dental Services
(EPSDT Dental Services Included)

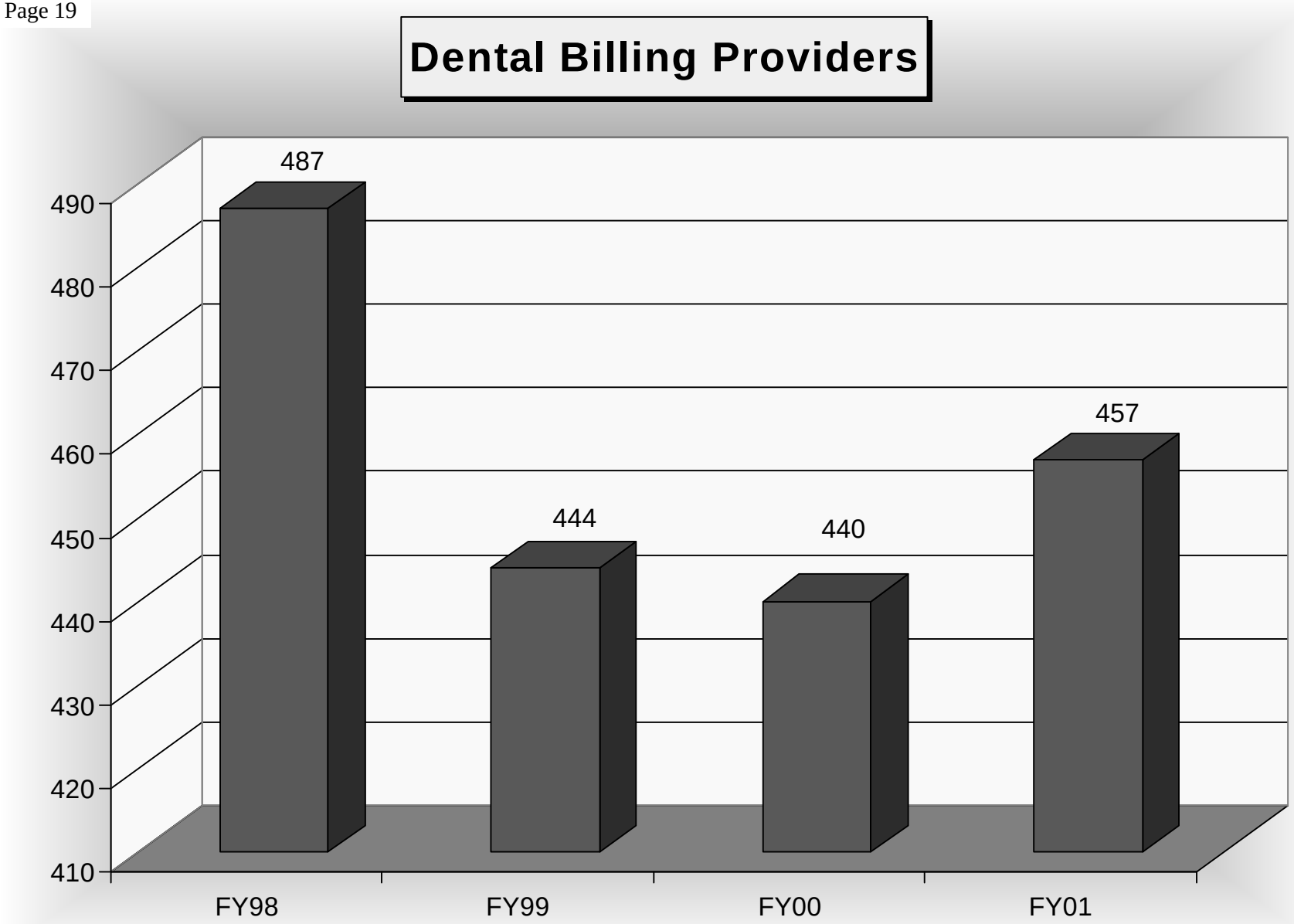
In Fiscal Year 2001, dental services were rendered to a total of 104,523 Medicaid beneficiaries at a cost of $32,468,017. This includes services for 73,956 children with expenditures totaling $26,675,648. A total of 30,567 adults were treated with costs reaching $5,792,369. Providers rendering services totaled 457.

In comparison, during Fiscal Year 2000, there were 106,598 beneficiaries provided dental services for a total of $24,328,968 in expenditures made to 440 providers. Therefore, approximately the same number of beneficiaries were served, however, each received a greater number of treatments.

Dental Expenditures (Adult/Children)




Dental Beneficiaries
108,000
106,000
104,000
102,000
100,000
98,000
96,000
94,000
92,000
90,000
88,000
96,453
95,523
106,598
104,523
FY98
FY99
FY00
FY01


Dental Billing Providers
487
444
440
457
490
480
470
460
450
440
430
420
410
FY98
FY99
FY00
FY01

Hospital Services

Inpatient Hospital Services

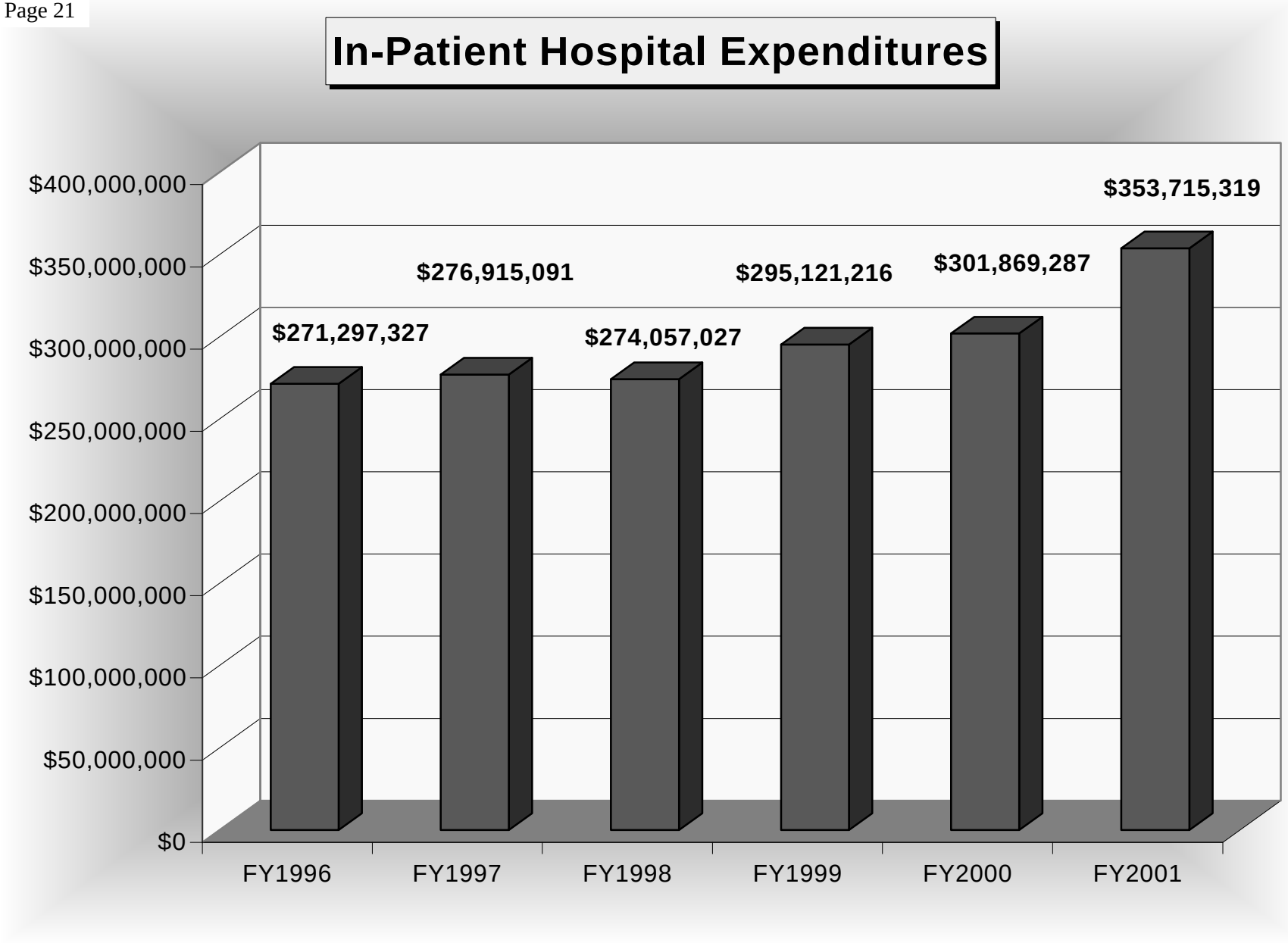
During Fiscal Year 2001, Medicaid provided for 414,905 days of inpatient hospital care, with total discharges equaling 375,365. In contrast, during Fiscal Year 2000, a total of 377,139 days of inpatient care were provided. In Fiscal Year 2001, inpatient hospital services expenditures were $353,715,319 for services rendered to 70,266 beneficiaries.

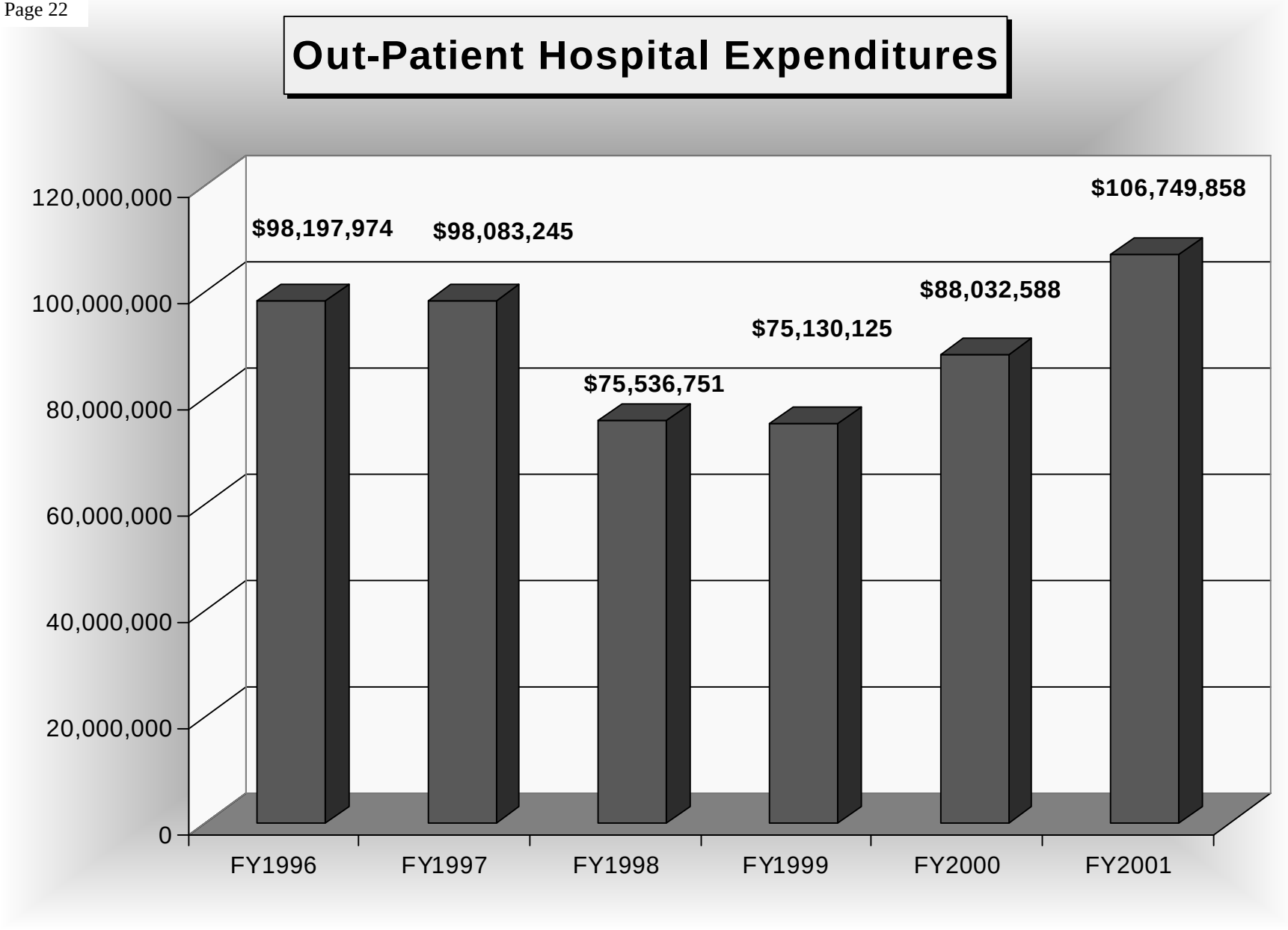
Outpatient Hospital Services

Outpatient Hospital Services were provided to 277,407 beneficiaries during Fiscal Year 2001. There was a total of 688,223 outpatient visits, an increase from the previous Fiscal Year where there were 583,417 visits. For Fiscal Year 2001, the average number of visits per beneficiary was 2.48, decreasing slightly from the year before when the average was 2.60. Expenditures for outpatient services were $106,749,858 during Fiscal Year 2001.

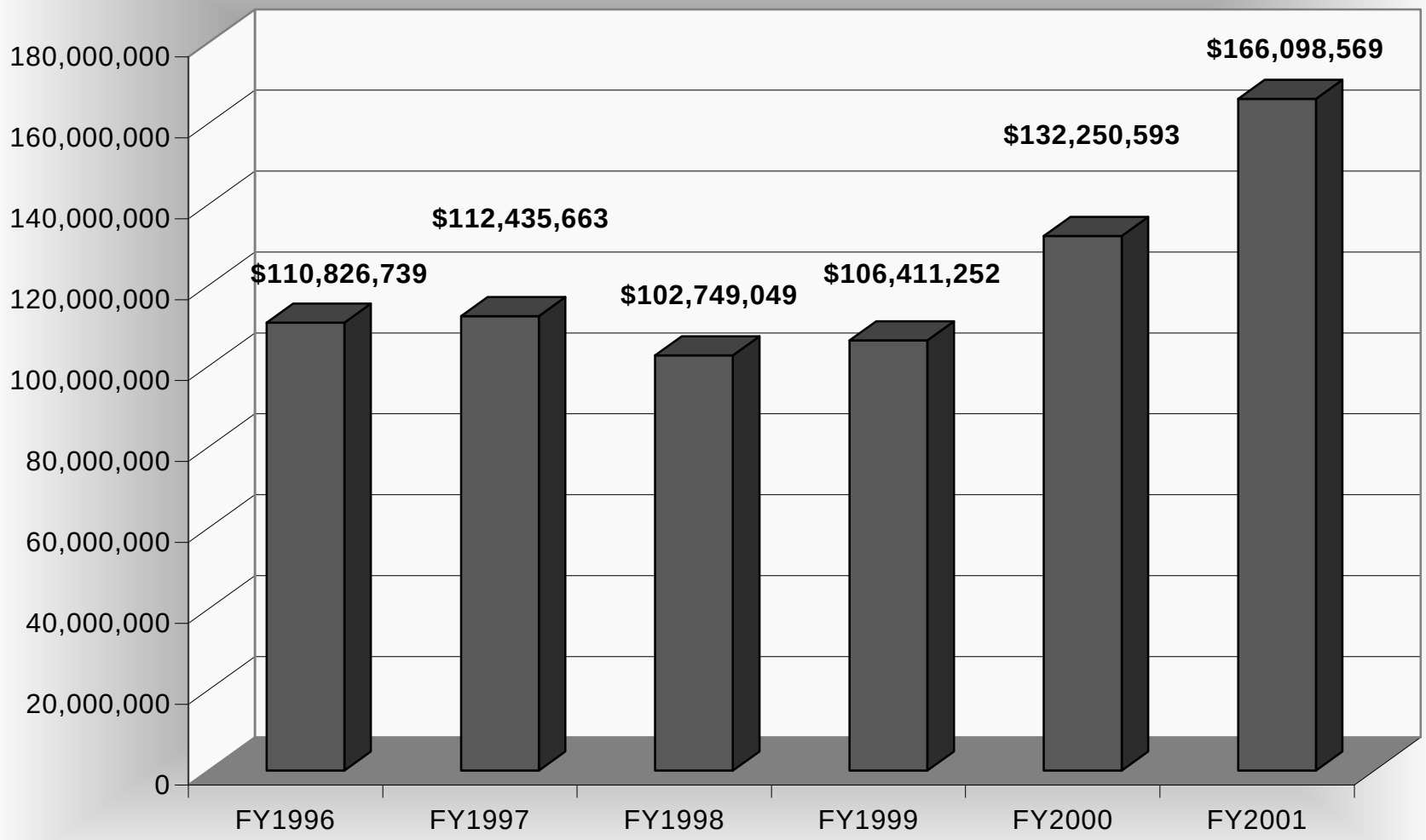
Physician Services

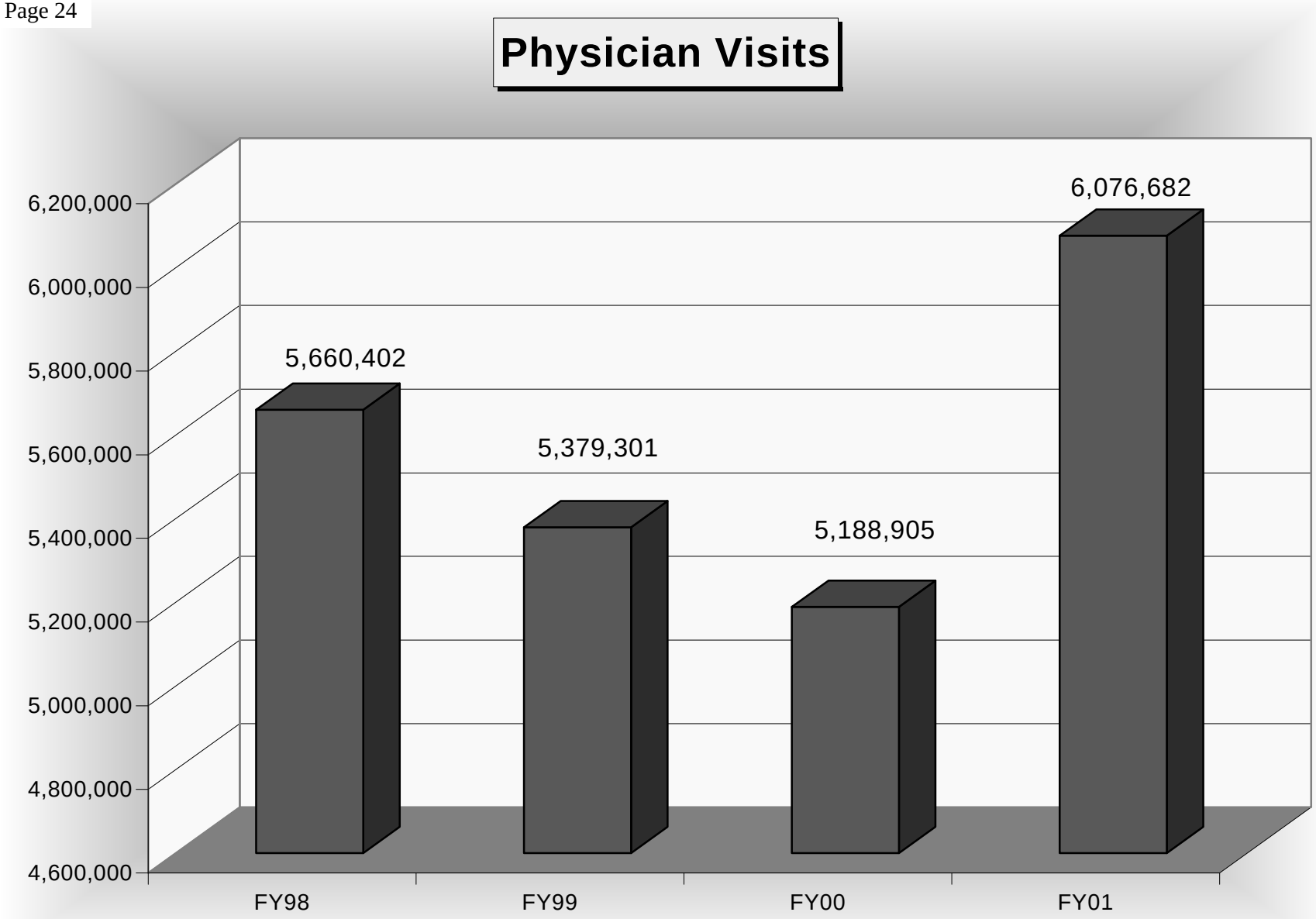
In Fiscal Year 2001, there was a 19% increase in the number of beneficiaries receiving physician services. 403,977 beneficiaries were rendered services compared to only 340,748 the previous year. In addition, there was an increase in physician visits from 5,188,905 in Fiscal Year 2000 to 6,076,682 in Fiscal Year 2001. The number of billing physician providers decreased 3.2%, from Fiscal Year 2000 to 2001. There were a total of 3802 billing providers in year 2000, while 3,684 billed for services in 2001. Physician Service Expenditures increased from $132,250,593 in Fiscal Year 2000 to $166,098,569 in Fiscal Year 2001. This represents over a 25% increase.

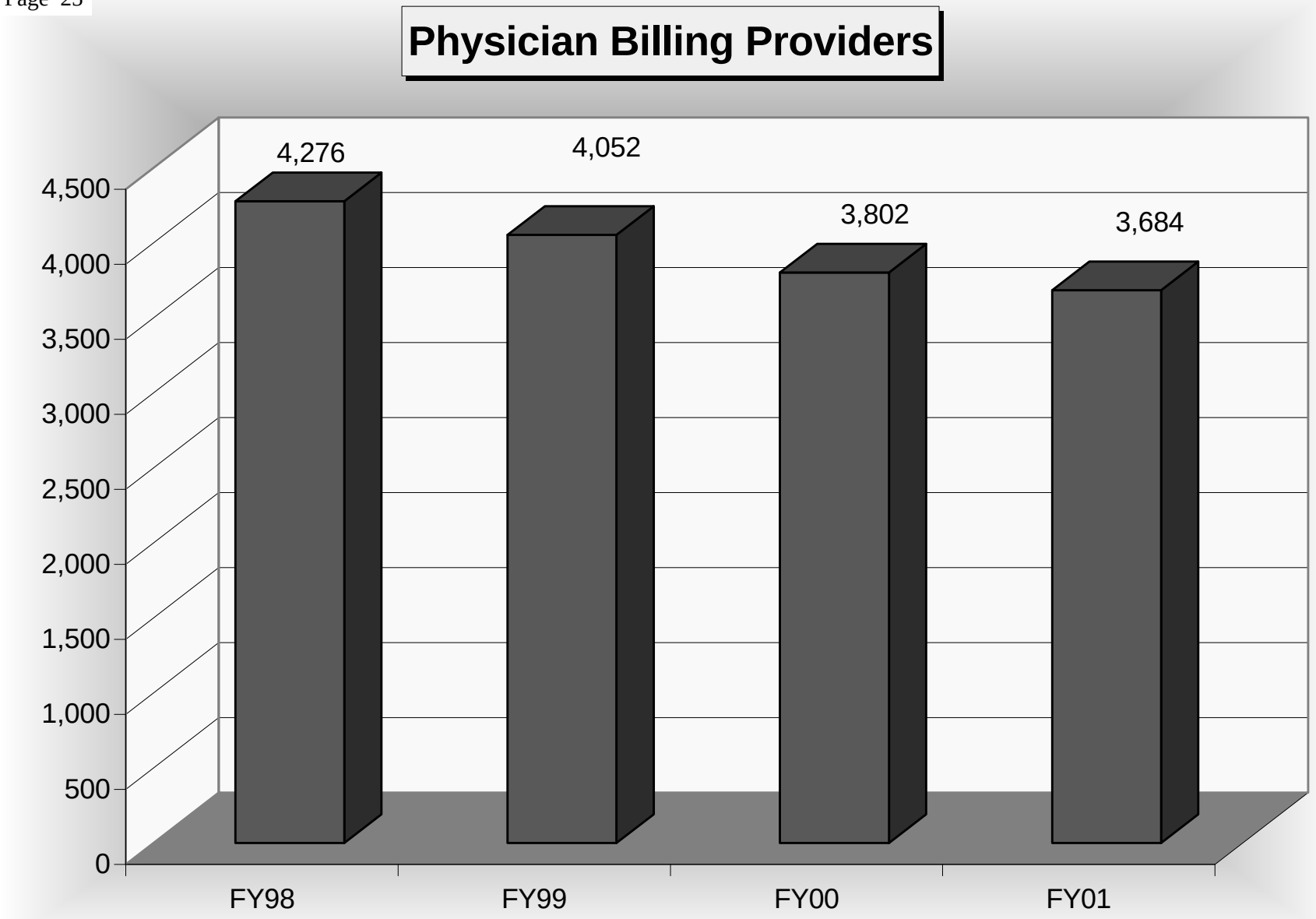

In-Patient Hospital Expenditures
$400,000,000
$350,000,000
$300,000,000
$250,000,000
$200,000,000
$150,000,000
$100,000,000
$50,000,000
$0
$271,297,327
$276,915,091
$274,057,027
$295,121,216
$301,869,287
$353,715,319
FY1996
FY1997
FY1998
FY1999
FY2000
FY2001


Out-Patient Hospital Expenditures
120,000,000
100,000,000
80,000,000
60,000,000
40,000,000
20,000,000
0
$98,197,974
$98,083,245
$75,536,751
$75,130,125
$88,032,588
$106,749,858
FY1996
FY1997
FY1998
FY1999
FY2000
FY2001

Physician Expenditures




Physician Visits
6,200,000
6,000,000
5,800,000
5,600,000
5,400,000
5,200,000
5,000,000
4,800,000
4,600,000
5,660,402
5,379,301
5,188,905
6,076,682
FY98
FY99
FY00
FY01


Physician Billing Providers
4,276
4,052
3,802
3,684
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
FY98
FY99
FY00
FY01

Pharmacy

In FY 2001, Pharmacy Program expenditures were approximately $465 million dollars, representing 22% of the overall budget, and a 37% increase over FY 2000 expenditures of almost $340 million dollars.

The number of Medicaid recipients receiving prescription drugs increased from 463,492 in FY 2000 to 545,816 in FY 2001, an increase of 23%, which contributed to a total increase in prescriptions of 26%, from 7,102,196 in FY 2000 to 8,920,159 in FY 2001.

Increases in drug expenditures during FY 2002 are expected to continue at a rate equal to or exceeding the rate of the continued increase in the number of Medicaid recipients.

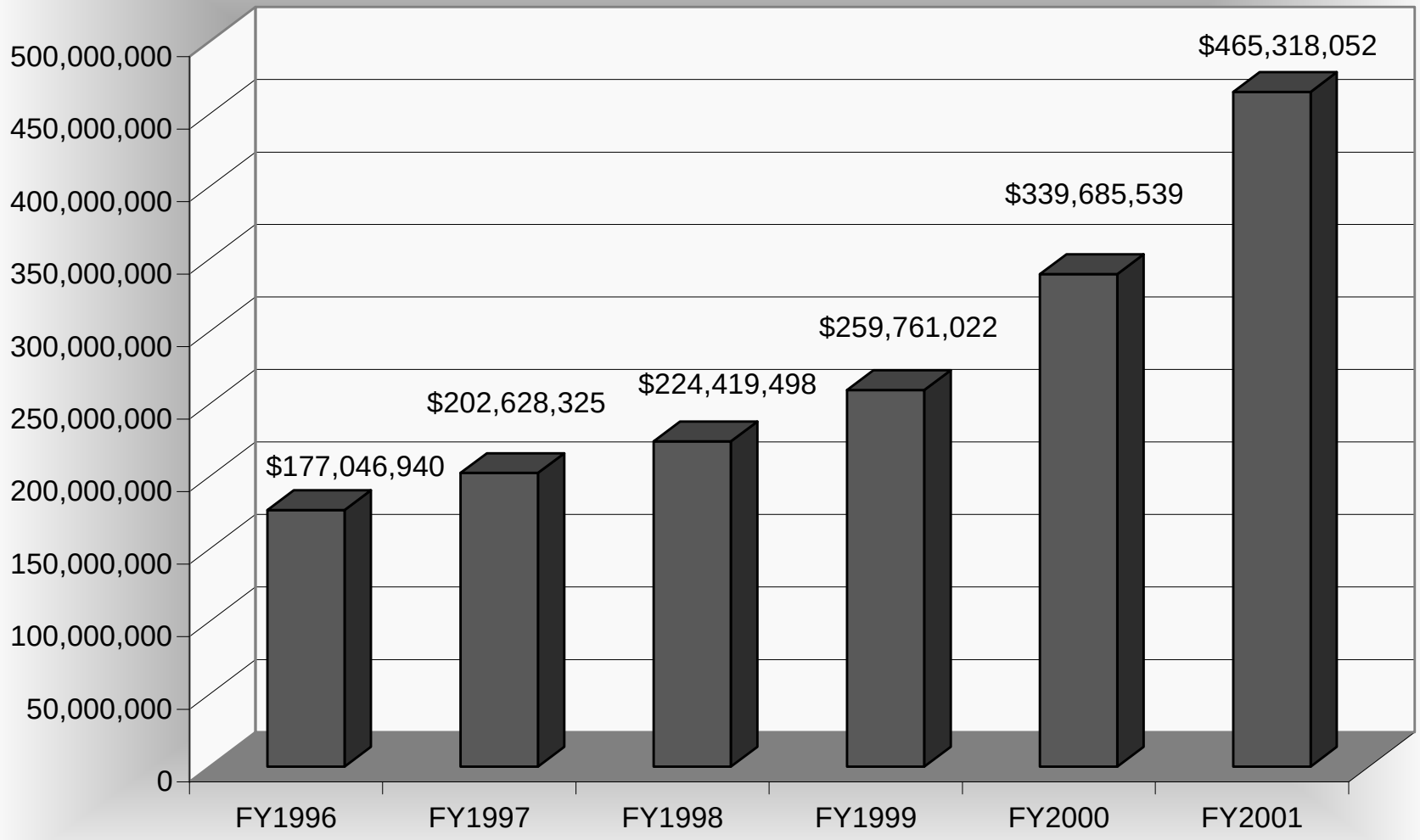
Approximately $78 million in rebates were received from drug manufacturers in FY 2001.

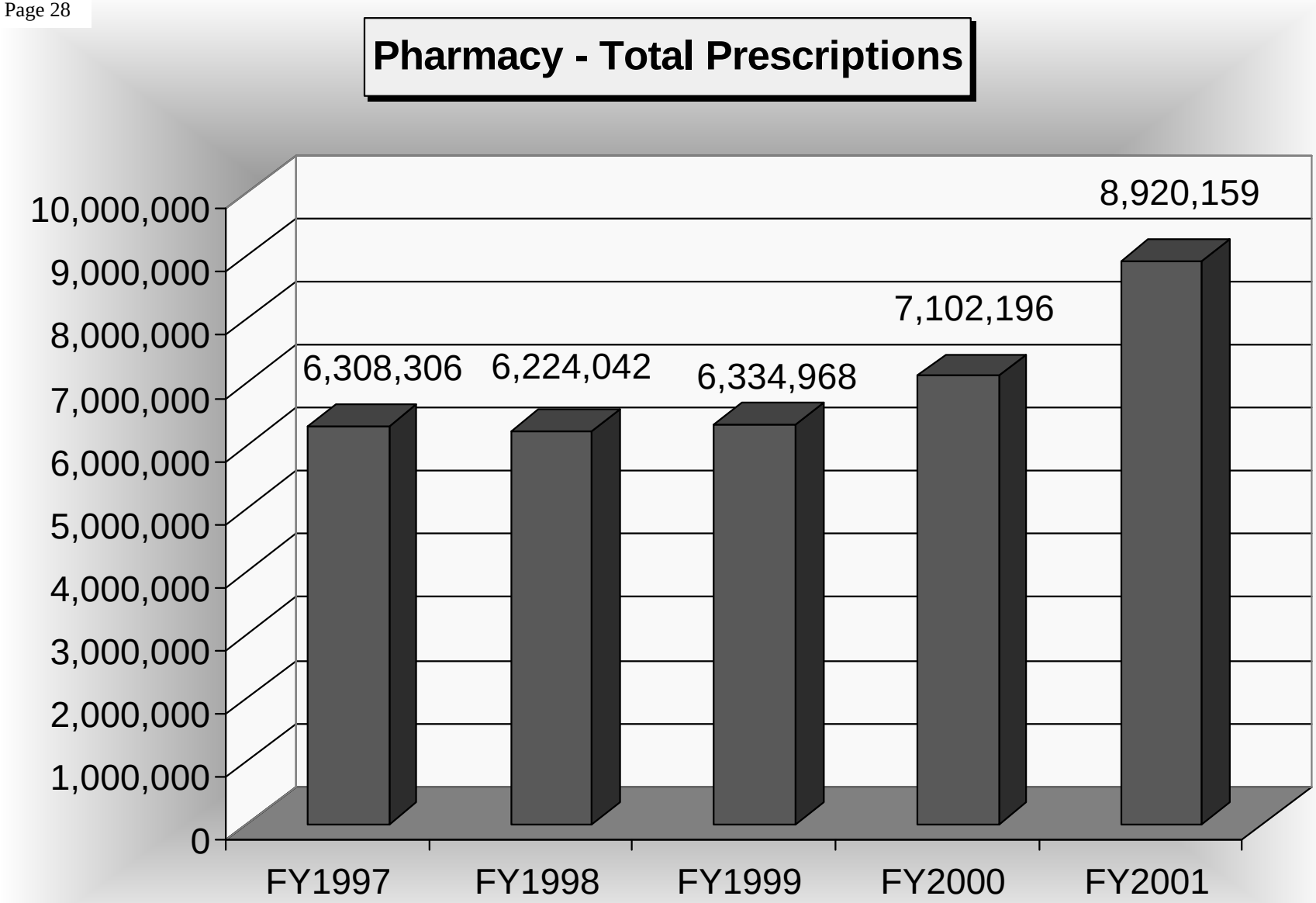
Cost containment measures presently in place include prior approval requirements for selected costly brand name drugs and edits in the payment system to prevent early refills and duplicate prescriptions.

The Division of Medicaid determined that to effectively manage the drug utilization review functions and provide for increased management, both clinical and financial, that the expertise of a pharmacy benefits management services organization would be necessary. The Division of Medicaid issued a Request for Proposal from experienced, responsible and financially sound pharmacy benefits management/ drug utilization review organizations that have the capability to ensure that quality, appropriate, and accessible pharmaceutical products are provided the Medicaid beneficiaries in the outpatient setting and long-term care setting.

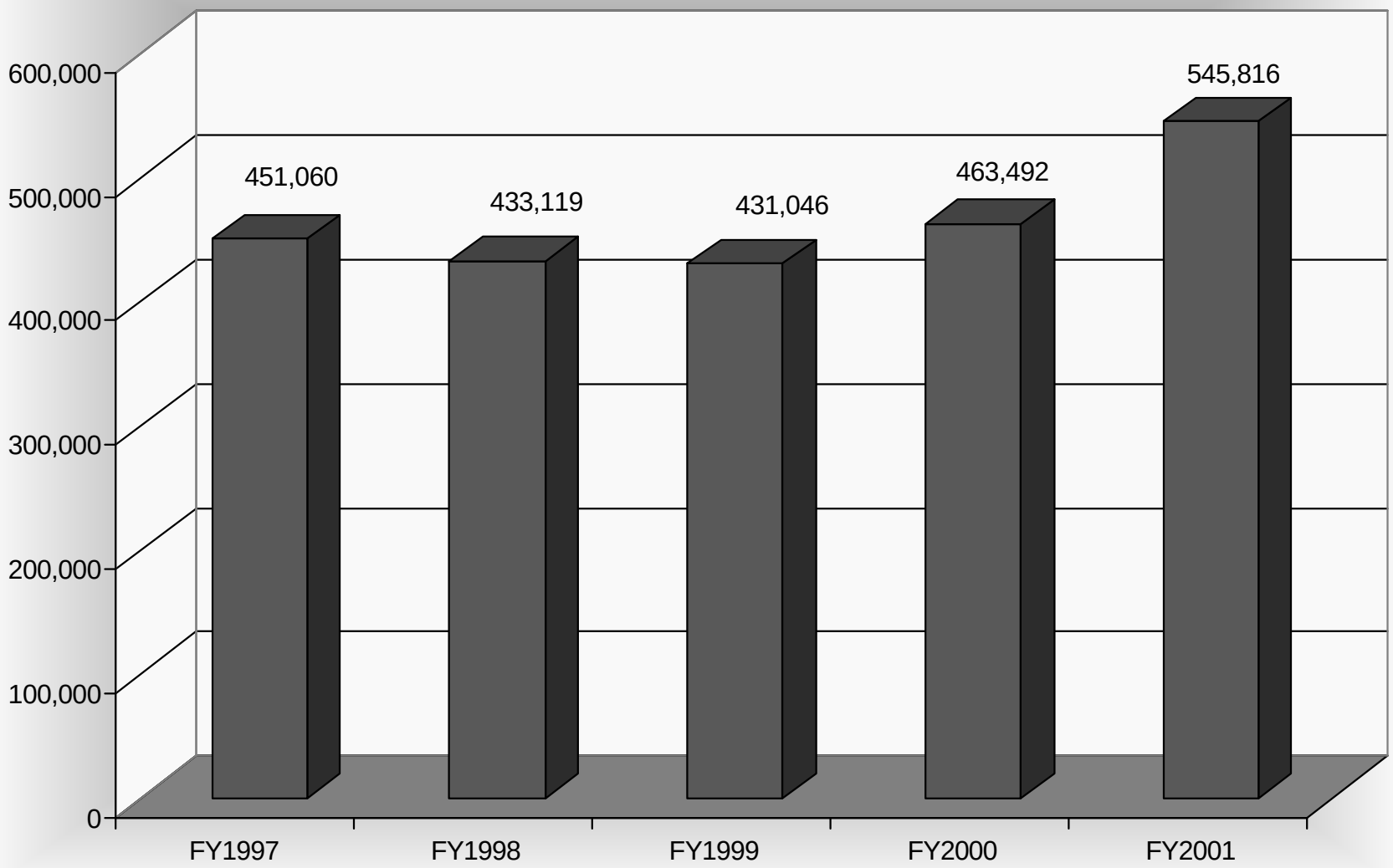
The Division of Medicaid is expecting the contractor to evaluate our Pharmacy Program, and make recommendations for changes to the program that will significantly reduce the yearly increase in Medicaid drug expenditures without any restriction or reduction in needed health care for our beneficiaries.

Pharmacy - Total Expenditures




Pharmacy - Total Prescriptions
10,000,000
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0
6,308,306
6,224,042
6,334,968
7,102,196
8,920,159
FY1997
FY1998
FY1999
FY2000
FY2001

Pharmacy - Total Recipients



Maternal and Child Health

The Bureau of Maternal and Child Health (MCH) is a multi-branch bureau responsible for the administration of maternal and child health services. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, a mandatory service under Medicaid, provides preventive and comprehensive health services for children and youth up to age twenty-one (21). The Expanded EPSDT/School-Related Services Program provides any necessary Medicaid reimbursable health care services not routinely covered under the regular Medicaid program. Vaccine for Children, Disabled Child Living at Home and the Perinatal High Risk Management/Infant Services System (PHRM/ISS) are three other programs in the Bureau.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis, and Treatment preventive health program requires the screening of Medicaid-eligible children 21 years of age and under for physical, mental and developmental defects and provides for the necessary health care to correct or ameliorate those defects. The screening ratio FY 2001 is 38%. That is a 3% increase from the previous FY 2000.

Through the EPSDT program abnormal conditions such as hypertension, heart conditions, bronchitis, diabetes, skin disorders, dental, vision and hearing disorders have been detected and treated.

Currently there are 537 providers of EPSDT services. These include health departments, federally qualified health centers, rural health clinics, private physicians, nurse practitioners and some approved nurse run clinics. The Division of Medicaid is actively recruiting new providers for the EPSDT program.

Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis, and Treatment Program was amended in 1989 to require that all medically necessary expanded services identified through periodic screening be provided to Medicaid-eligible children. The EPSDT Unit processed and approved approximately 650 Prior Authorization (PA's) requests per month for Medicaid-eligible children 0 - 21 years of age during Fiscal year 2001. These expanded services included enteral feedings, office visits, prescriptions, enteral and IV durable medical supplies, eyeglasses, hearing aids, contact lens and therapies (speech, occupational, and physical).

(Continued)

EPSDT program goals:

1) To increase the frequency of screening examinations to identify and treat preventable health problems.
2) To facilitate entry into the health care delivery system.
3) To improve provider participation in the program.
4) To expand the package of diagnostic and treatment services to which children are entitled under the program.

Program Goal Accomplishments

1.) FY 2001 the number of EPSDT eligibles to receive EPSDT screening increased from the previous FY by 19%**.** The screening ratio also increased by 3%.

2 & 3) FY 2001 the EPSDT Program increased provider participation by one hundred and eight (108) new providers. Of the one hundred-eight providers ninety three (93) were individual and facilities on-site and fifteen (15) were off-site providers, which offers an alternate entry to access the system.

4.) FY 2001 the Division of Medicaid increased service limits for children under 21 for the following services: office visit from twelve (12) to twenty-four (24), prescriptions limit from five (5) to ten (10), and the number of outpatient visits from six (6) to twelve (12).

Expanded School-Related Services Program

The Expanded School-Related Services Program provides services for children with disabilities or special needs as defined in IDEA (Individuals with Disabilities Education Act) and identified through the IEP (Individualized Education Plan) or the IFSP (Individualized Family Services Plan).

This health-related service provides services to Medicaid - eligible children with disabilities ages 3 to 21 and early intervention services for infants and toddlers from birth to age three.

During FY 2001 there were 27 school districts participating as Medicaid providers. Despite the fact that not all of the districts are Medicaid providers, 559 students received services, and school districts were reimbursed $246,456. Medicaid reimbursed approximately $441 per student.

Disabled Child Living at Home (DCLH)

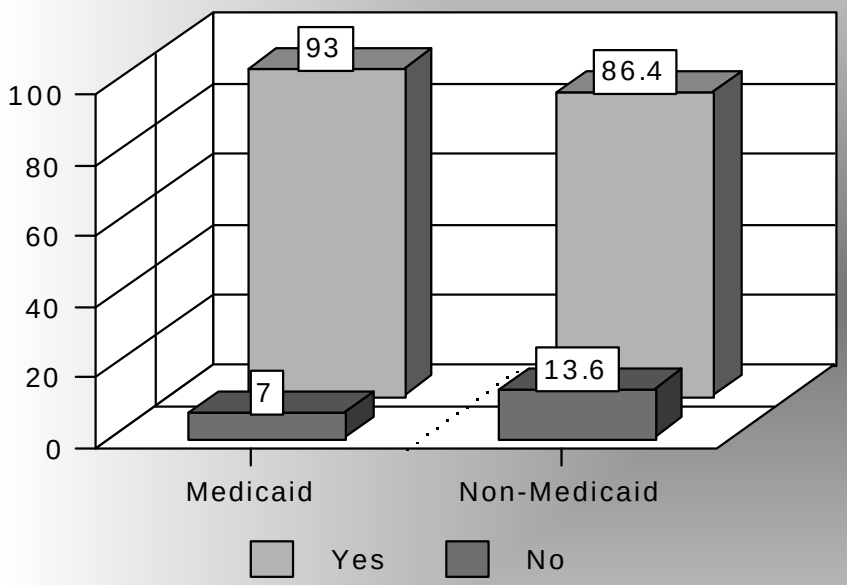
The Disabled Child Living at Home Program (DCLH) is a program that began in 1989 to make benefits available to children ages 18 and under who live at home and have qualified as disabled. The DCLH program provides necessary services to children who would not otherwise be eligible for Medicaid. This program enables services for the physically handicapped, severely emotionally disturbed as well as many conditions that may otherwise cause a family to become financially devastated. According to current expenditure reports Medicaid spends an average of $5200 per child for services rendered under this program. During fiscal year 2001 MCH processed over 600 DCLH applications for children 18 and under who met the criteria.

Vaccine for Children Program (VFC)

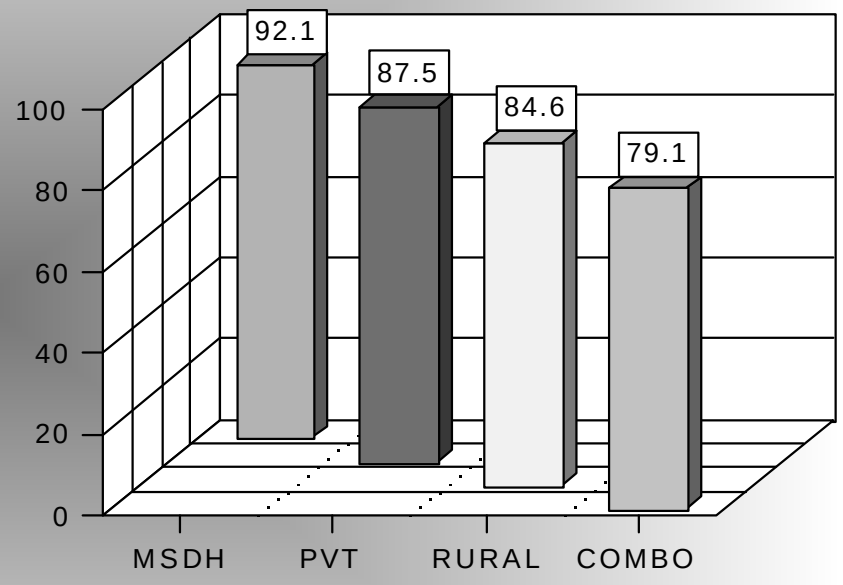
This federally funded immunization program has provided vaccines for Medicaid eligible, under insured, and uninsured children since October 1994. The Mississippi State Department of Health Fiscal Year 2001 survey showed a completion rate of 92.1% for Medicaid - eligible beneficiaries between 0 - 27 months. The same survey showed a 93 % Medicaid completion rate compared to 86.4% for Non-Medicaid using the same age population.

(Continued)

Immunization Rate For Up to 27 Months of Age



4:3:1 Completion by 27 Months by Medicaid vs. Non-Medicaid



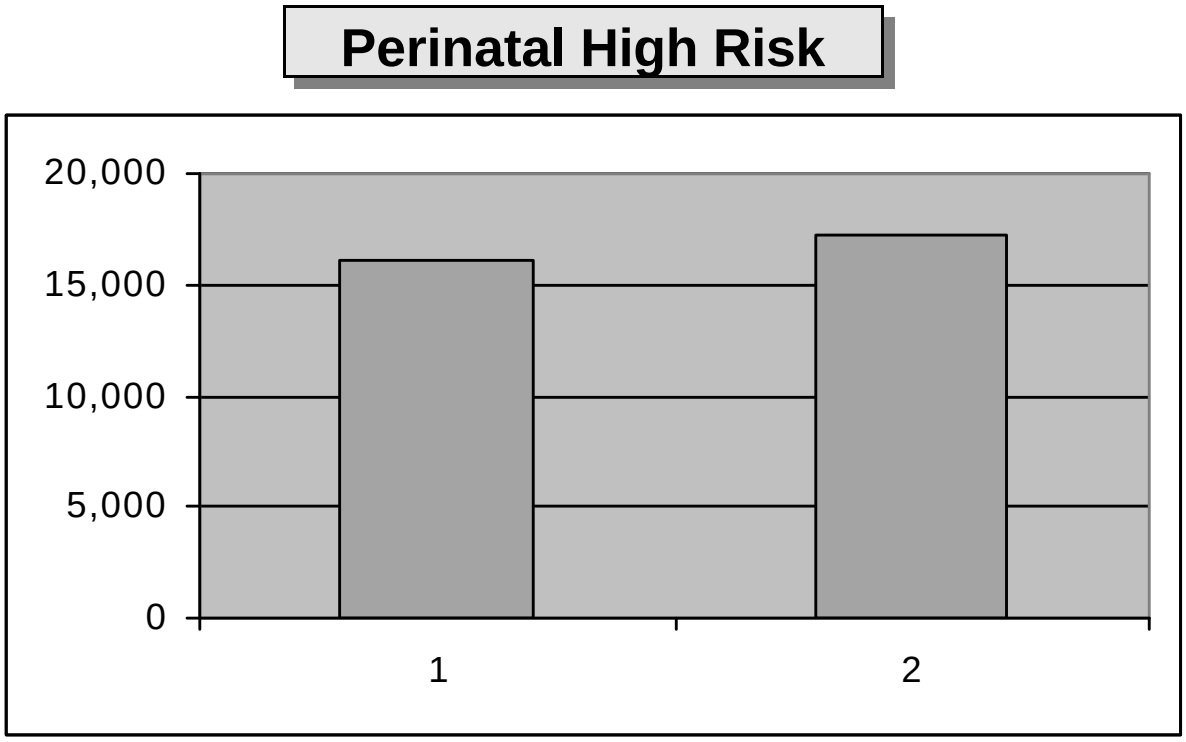
4:3:1 Completion by 27 Months Medicaid Eligible by Provider

Perinatal High Risk Management/Infant Services System (PHRM/ISS)

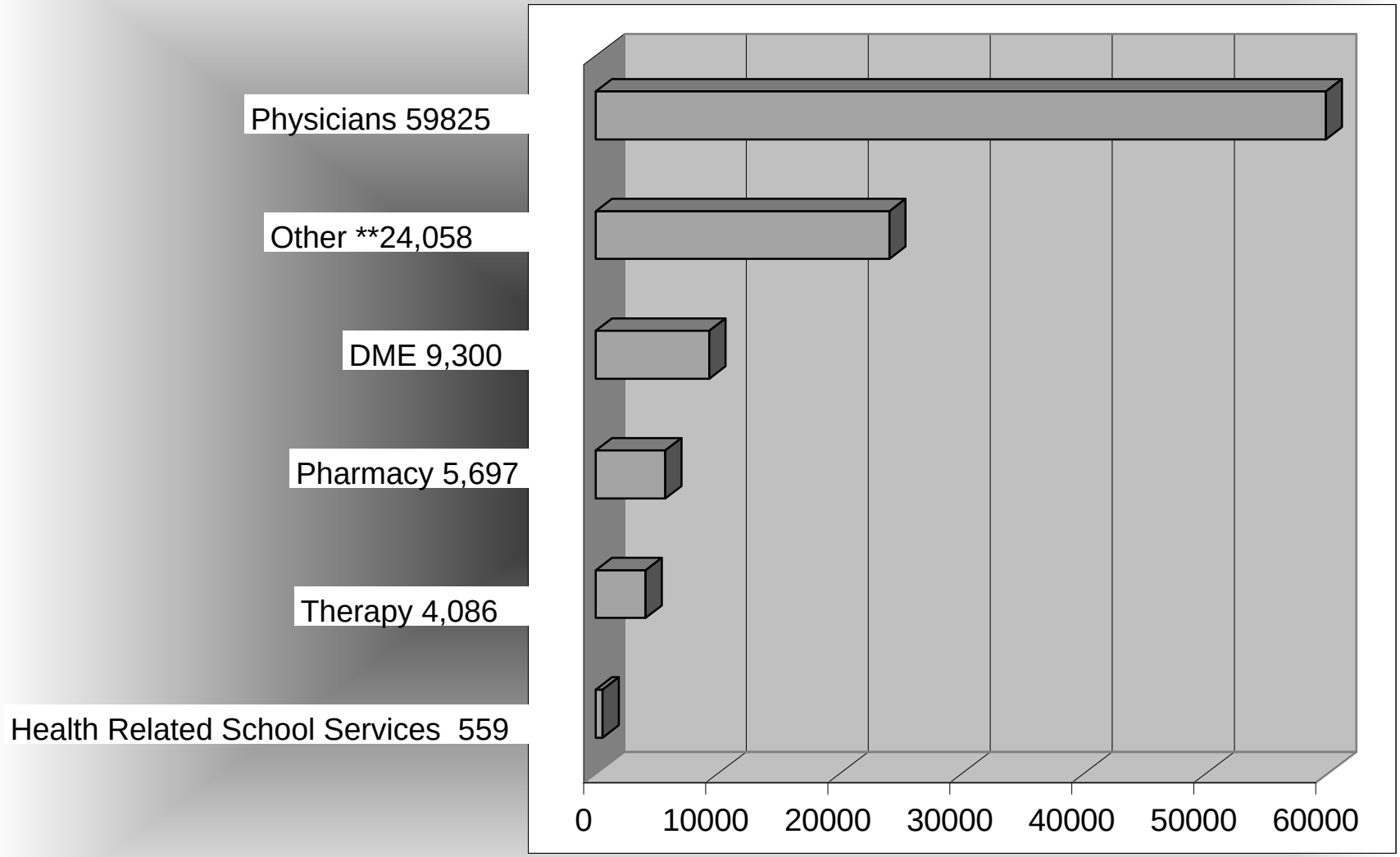
The Perinatal High Risk Management/Infant Services System (PHRM/ISS) Program is a multidisciplinary enhanced case management program established to improve access to health care and to provide enhanced services to certain Medicaid-eligible pregnant/postpartum women and infants. The interdisciplinary team of physicians, nurse practitioners, certified nurse-midwives, registered nurses, licensed nutritionists/dietitians, and licensed social workers provide enhanced services for this target population. These services include case management, nutritional assessment/counseling, psychosocial assessment/ counseling, home visits, and health education.

22,587 Medicaid-eligible beneficiaries were enrolled in the PHRM/ISS Program during Fiscal Year 2001. The majority of the enrollees receiving enhanced services (71%) were pregnant/postpartum women (16,106). 17,242 pregnant women were identified as at risk and met the requirements to receive enhanced services for this voluntary participation program. 16,106 (93%) of the 17, 242 women received enhanced services even though participation in this program is voluntary. 6,481 (29%) of the 22,587 enrollees were infants. The infant mortality rate for the PHRM/ISS case management population was 2.7 % based on data collected by the Division of Medicaid. (See graph below)

Currently, the Division of Medicaid has seven community health centers and 84 county health department providers participating in the PHRM/ISS Program. The Division of Medicaid is actively recruiting new providers for the program.



Expanded Services



** Includes: Lab, Home and Community Based, Eyeglasses, Hearing, Nurse, Periodic Screening and Ambulatory Surgical Services

Non-Emergency Transportation

The Division of Medicaid assures that beneficiaries have access to medical services available to them through the Medicaid program by providing non-emergency transportation (NET) assistance. Eligible beneficiaries are those individuals who have no means of transportation of their own or who cannot access alternative transportation because it is too costly for them or it is unavailable in their communities. NET assistance is available to beneficiaries in all 82 counties of the state who need transportation services on an occasional basis or on a repetitive basis. Beneficiaries who use the service repetitively may be transported three times a week or more to receive such services as dialysis treatments, therapies, or cancer treatments.

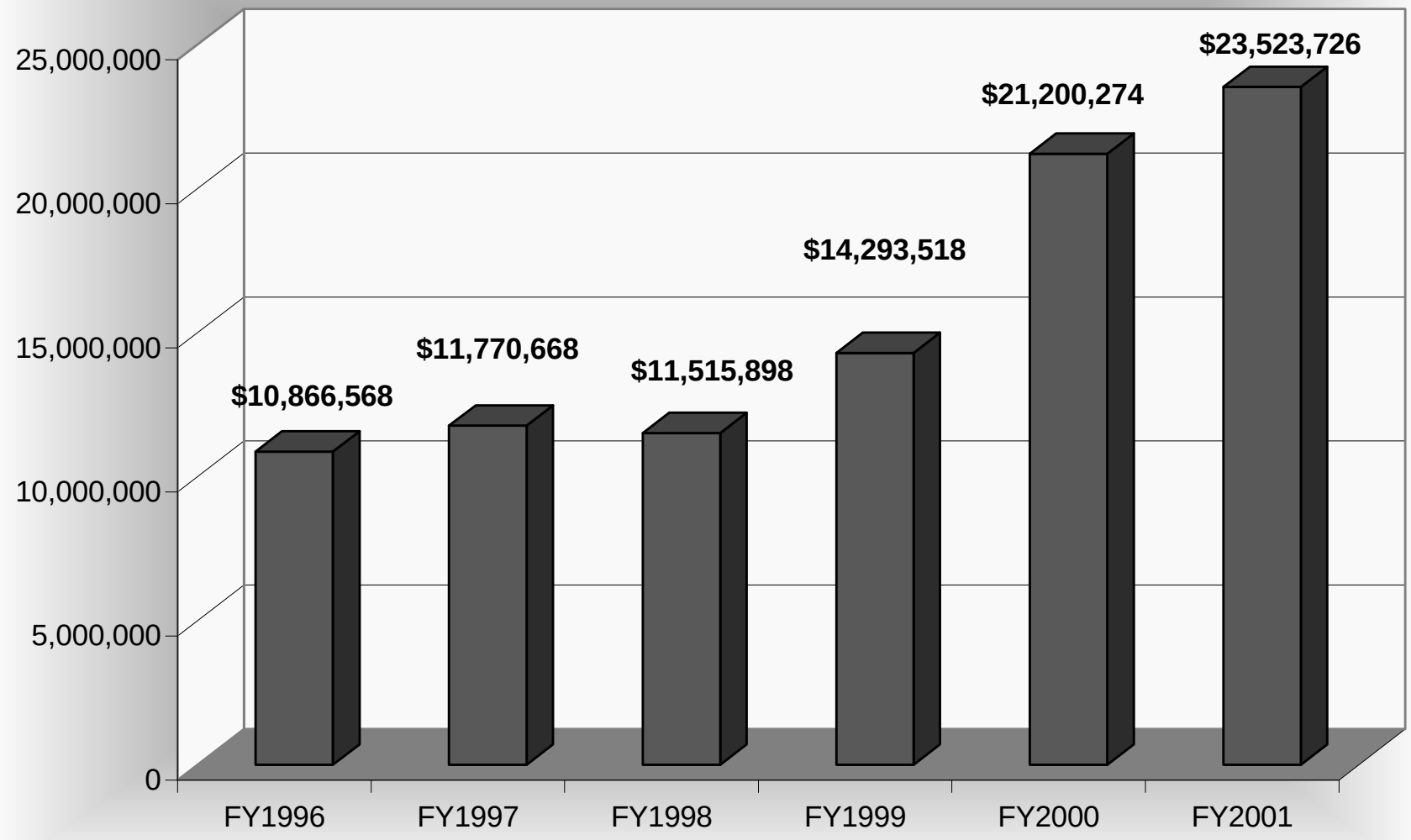
Transportation assistance is made available through agreements between the Division of Medicaid and individual providers or group providers which offer transportation services. The individual and group providers offer demand-response, door-to-door transportation assistance to Medicaid beneficiaries. Individual providers are volunteers who are reimbursed for the expenses they incur to transport Medicaid beneficiaries. Group providers include companies or agencies which offer transportation assistance and are paid on a negotiated rate basis. In addition to providing ambulatory services, the group providers have specialized vehicles to assist mobility-impaired beneficiaries with their transportation needs. The Division of Medicaid also provides special NET assistance to beneficiaries who must travel by ambulance or who must be transported by commercial providers such as public air carriers.

Transports for Medicaid beneficiaries are prior approved by NET coordinators who are located in twenty- four (24) Medicaid regional offices. The coordinators handle all requests from Medicaid beneficiaries for NET assistance and are responsible for the assignment of transports to area transportation providers. Beneficiaries who require NET assistance must contact their local NET coordinators at least seventy-two (72) hours or three (3) working days before their scheduled appointments. Special transports, such as ambulance transports and transports by commercial transporters such as airlines and bus lines, are arranged by NET staff at DOM's state office.

The utilization of NET services by Medicaid beneficiaries continues to grow. During FY 2001, over 395,000 one- way transports were provided by individual and group providers.

The Division of Medicaid will continue to monitor the NET program for opportunities to improve the quality of service available to the beneficiaries while managing the cost of these services. The agency will also work toward ensuring that Medicaid beneficiaries who need NET assistance are informed about its availability.

Transportation Expenditures



Third Party Liability (TPL)

In accordance with Title XIX of the Social Security Act as well as state law, Medicaid is the payer of last resort which means that Medicaid reimbursement is available only when other third party benefits have been exhausted. Third party sources are any entities, individuals, or programs who are legally responsible for paying the medical expenses of Medicaid beneficiaries. The Bureau of Third Party Recovery is responsible for identifying any third party sources and for incorporating this information into the Medicaid Management Information System (MMIS) so that when a claim is filed, payment is avoided. This third party information is also directed to the medical provider.

The Bureau of Third Party Recovery operates a successful program which has saved Mississippi taxpayers millions of dollars through cost avoidance and post-payment recovery of private health and casualty insurance resources. Medicaid also pays Medicare premiums for qualified Medicare eligibles, enabling avoided costs of Medicare covered services. Further, as a result of the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), the state enacted legislation requiring the pursuit of medical support in the form of cash or insurance from absent parents. This new law eliminates many of the barriers which have restricted the coverage of children of non-custodial parents by employer-related health insurance. Through this enforcement of medical support orders, Medicaid expects increased savings to the program due to an increase in the number of children who will be enrolled in group health insurance plans.

In Fiscal Year 2001, third party savings in the form of cost avoided or recovered payments from both public and private sources totaled over $581 million. As an example of the effectiveness of the Bureau of Third Party Recovery, almost $18 was recovered for every one dollar invested in salaries of the Medicaid investigators involved in the in-house recoveries.

Medicare Buy-In

Because some Medicaid eligibles are also eligible for Medicare, it is necessary to have some means by which this group may be identified. The MMIS includes edits for Medicare coverage to ensure that claims which are submitted to Medicaid as the primary payer are returned to providers to file with Medicare. The MMIS also contains segments that allow for the monitoring of payment of Medicare premiums for qualified individuals. In Fiscal Year 2001, 21% of the Mississippi population also had Medicare coverage. Claims payment edits and the buy-in program yielded $550 million in Medicaid cost avoidance.

(Continued)

Private Health Insurance Resources

Slightly more than three (3) percent of the state Medicaid population was covered by some form of private health insurance in Fiscal Year 2001. Through cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment), the Medicaid agency saved approximately $25.7 million. Through post-payment recovery (the Medicaid agency bills the third party for reimbursement), the Bureau of Third Party Recovery collected $2.1 million.

Casualty/Tort Resources

A significant number of Medicaid beneficiaries receive medical care each month as the result of injuries or accident. Medicaid is responsible for identifying those beneficiaries whose medical care for these injuries may be the liability of another party and pursue recovery. These resources are identified through the MMIS edits and referrals from outside entities such as insurance companies, providers, and attorneys. In Fiscal Year 2001, the Bureau of Third Party Recovery collected slightly less than $2.8 million from casualty/tort resources.

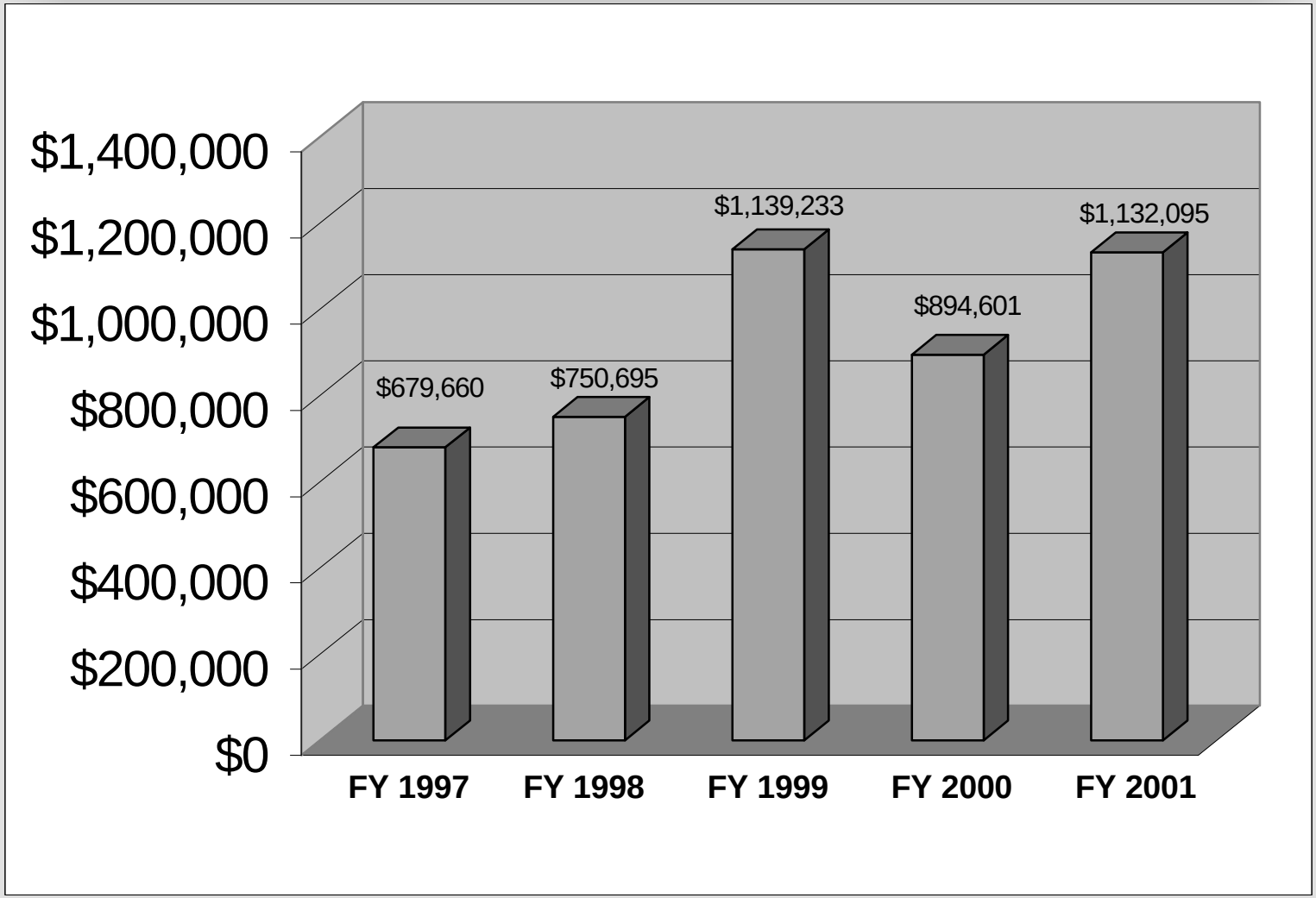
Prescribed Drug Recovery Program

The Division of Medicaid has obtained a federal waiver which allows Medicaid to reimburse pharmacists participating in the program, even if the MMIS contains a record of third party liability. Medicaid then pursues recovery from the third party sources. The Bureau of Third Party Recovery reported a recoupment of slightly less than $1 million in the drug program in Fiscal Year 2001.

Estate Recovery

As a result of OBRA 1993, the state enacted legislation allowing recovery of medical payments from the estates of certain beneficiaries who were residents of nursing facilities at the time of death. In Fiscal Year 2001, the Estate Recovery program returned slightly more than $1 million.

TPL Recovery Program Returns



Funding

Source of Funds and Percentage of Distribution for FY 2001

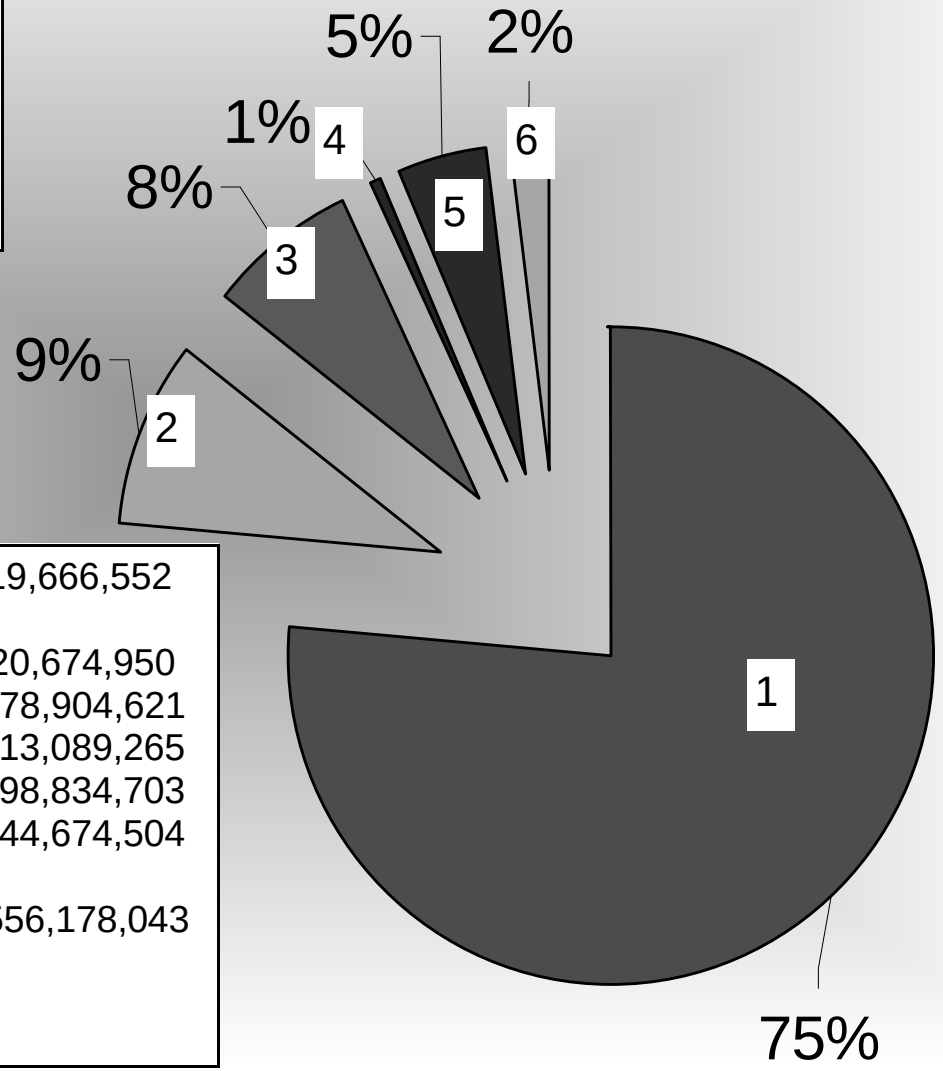
Throughout the nation, Medicaid is funded with federal dollars matched by individual state contributions. In FY 2001, Mississippi's overall matching rate, which is determined by the state's per capita income, increased slightly from 76.80% in FY 2000 to 76.82%. With this matching rate, a single state dollar invested brought into the state an additional $3.31 through federal matching funds.

For FY 2001, federal contributions amounted to $1,819,666,552 which, when combined with state dollars, provided for total expenditures of $2,375,844,595. Over 97% of this total was paid to Mississippi providers for medical services to Medicaid beneficiaries and thereby recycled into local economies throughout the state.

Within the Medicaid program, individual matching rates may vary depending upon the specific funding area. During FY 2001, total administrative expenses were $69,175,470 with federal contributions $41,187,075 or 59.54%. Administrative expenses for FY 2001, which continue to be among the lowest in the Southeastern region, amounted to only 2.8% of the total budget.

Medicaid FY 2001 Funding

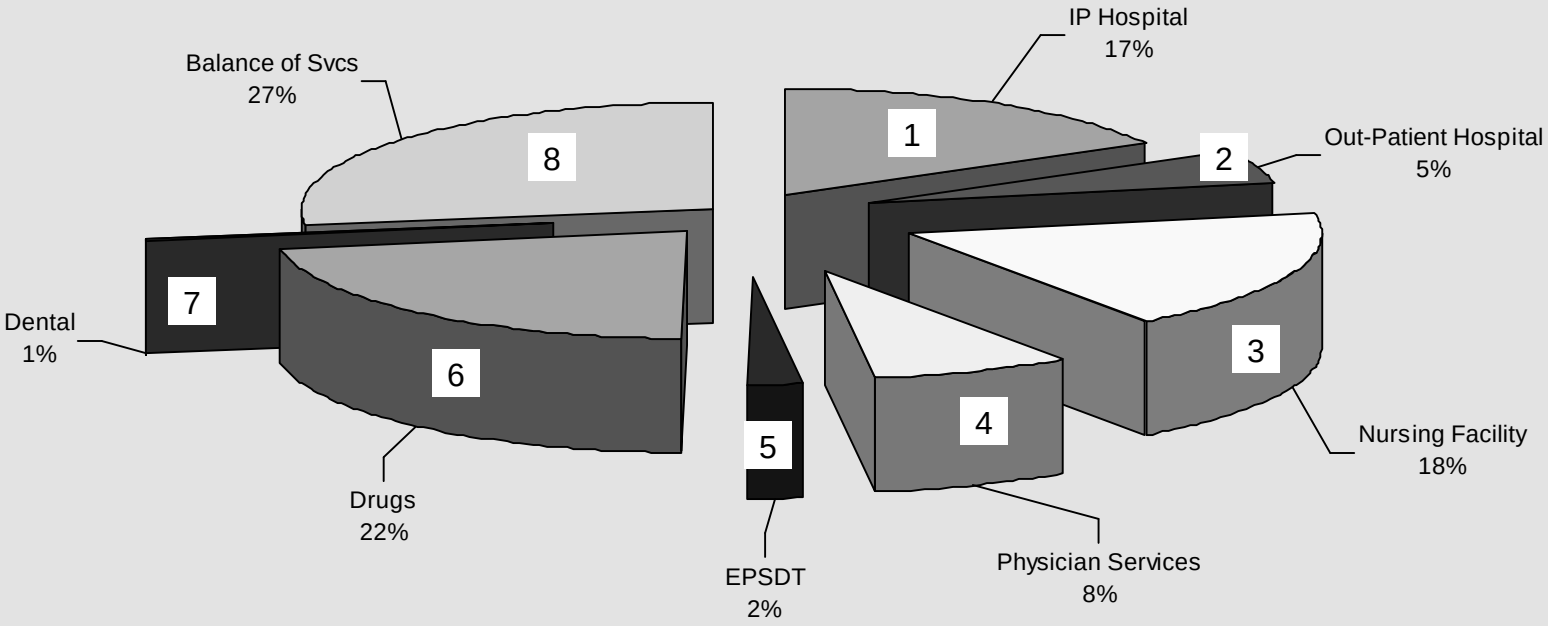
1 - Federal Funds
2 - General Funds
3 - Intergovernmental Transfers
4 - Assessments
5 - Funds from Other State Agencies
6 - H.C.E.F. Fund



Federal Funds	$ 1,819,666,552
General Funds	220,674,950
Intergovernmental Transfers	178,904,621
Assessments	13,089,265
Funds from Other Agencies	98,834,703
H.C.E.F. Funds	44,674,504
Sub Total of State Match	$ 556,178,043

Total $2,375,844,595

Expenditures for Medical Services - FY 2001



1 - In-Patient Hospital	5 - EPSDT
2 - Out-Patient Hospital	6 - Drugs
3 - Nursing Facility	7 - Dental
4 - Physician Services	8 - Balance of Services

Eligibility

Eligibility for the following groups is determined by the Division of Medicaid:

- Persons in medical facilities who would qualify for SSI except for their institutional status.
- Persons in institutions who are eligible under a special income level who remain institutionalized for 30 consecutive days or longer.
- Persons who are age 65 or over or disabled whose income does not exceed 100% of the federal poverty level and whose resources do not exceed $3,000 for an individual and $4,000 for a couple.
- Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income is below 100% of the federal poverty level. There is no resource test for this group. (This group is eligible for Medicare cost-sharing only.)
- Certain former SSI eligibles who are "deemed" Medicaid eligible because of specified circumstances.
- Certain qualified working disabled persons who are only eligible for Medicaid to pay their Part A Medicare premiums.
- Certain disabled children under age 18 who live at home but who would be eligible if they lived in a medical institution as certified by DOM.
- Specified Low-Income Medicare Beneficiaries (SLMBs) who are entitled to Medicare Part A whose income does not exceed 120% of the federal poverty level. There is no resource test for this group. The only benefit paid by Medicaid for this group is the Medicare Part B premium. (These individuals must be entitled to Part A Medicare benefits under their own coverage, as Medicaid does not pay the Part A premium for them.)
- Individuals receiving hospice services who would be eligible for Medicaid if they were living in a Medicaid-certified institution.

(Continued)

- Individuals who meet the qualifications for participation in the Home and Community-Based Waiver Programs whose income and resources do not exceed prescribed limits for participation.

- Working disabled individuals whose earnings do not exceed 250% of the federal poverty level and whose unearned income does not exceed the SSI limit. Disabled workers qualify for full Medicaid benefits but may have to pay a premium to buy-in to Medicaid if earnings exceed 150% of the poverty level.

- Qualifying Individuals (QI's) qualify for payment or partial payment of their Medicare Part B premium, provided the individual has Medicare Part A.QI-1's can have income between 120% to 135% of the federal poverty level for payment of their Medicare Part B premium. QI-2's can have income from 135% to 175% of the federal poverty level for partial payment of Medicare Part B premiums. There is no resource test for this group.

Eligibility for the following categories is determined by the Department of Human Services:

- Low-income families with children who receive Medicaid-only or TANF Temporary Assistance for Needy Families).

- Children in licensed foster homes or private child-care institutions for whom public agencies in Mississippi are assuming financial responsibility.

- Children receiving subsidized adoption payments.

- Children under age six whose family income does not exceed 133% of the federal poverty level.

- Pregnant women and children under age one whose family income does not exceed 185% of the federal poverty level. Infants born to Medicaid-eligible mothers are eligible for the first year of the infant's life, provided the child lives with the mother. Eligible pregnant women remain eligible for 60 days after pregnancy ends.

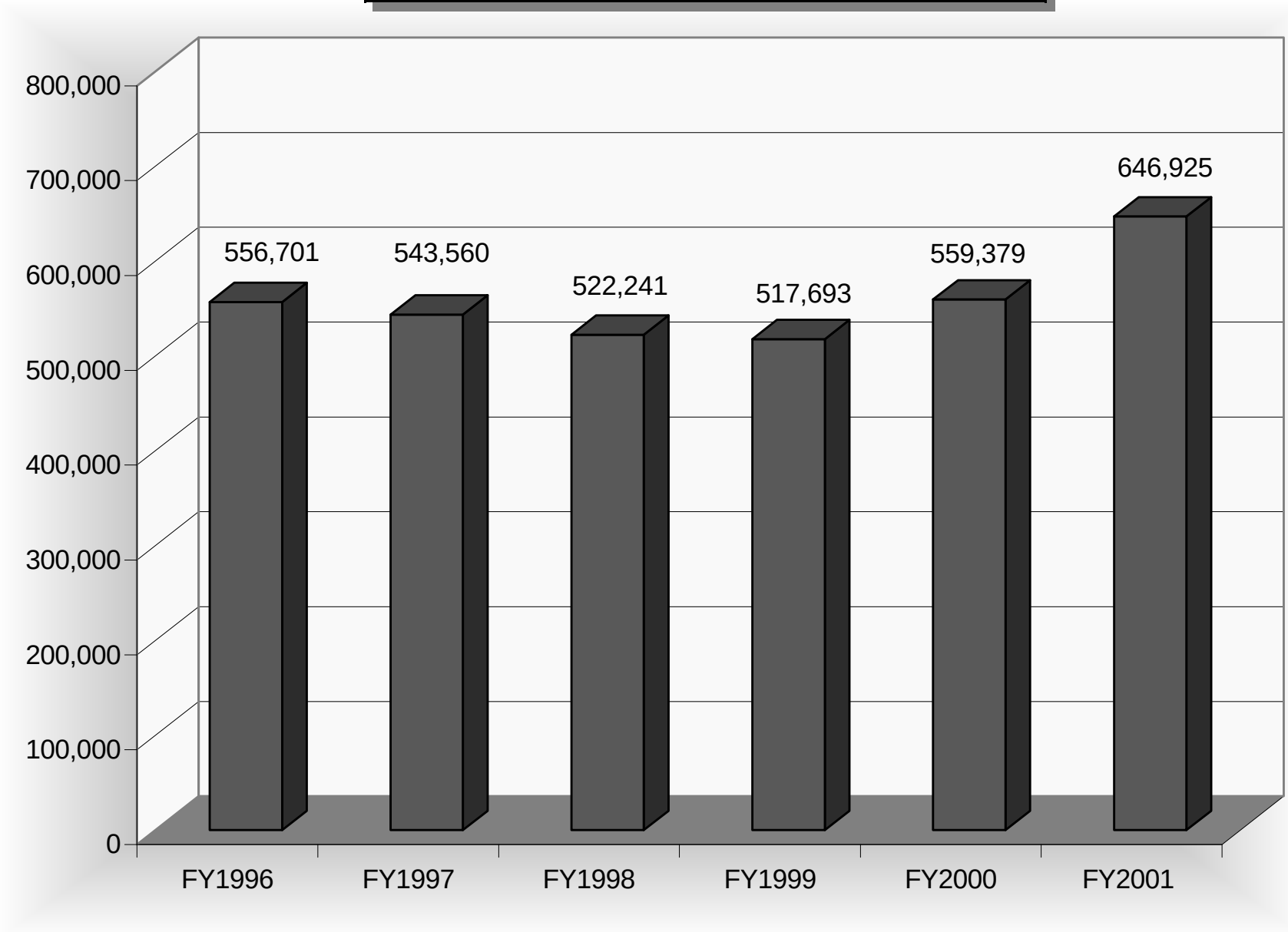
- Children under age 19 whose family income does not exceed 100% of the federal poverty level. Children born prior to 10/01/83 who are under age 19 are eligible under the Children's Health Insurance Program (CHIP) Medicaid expansion.

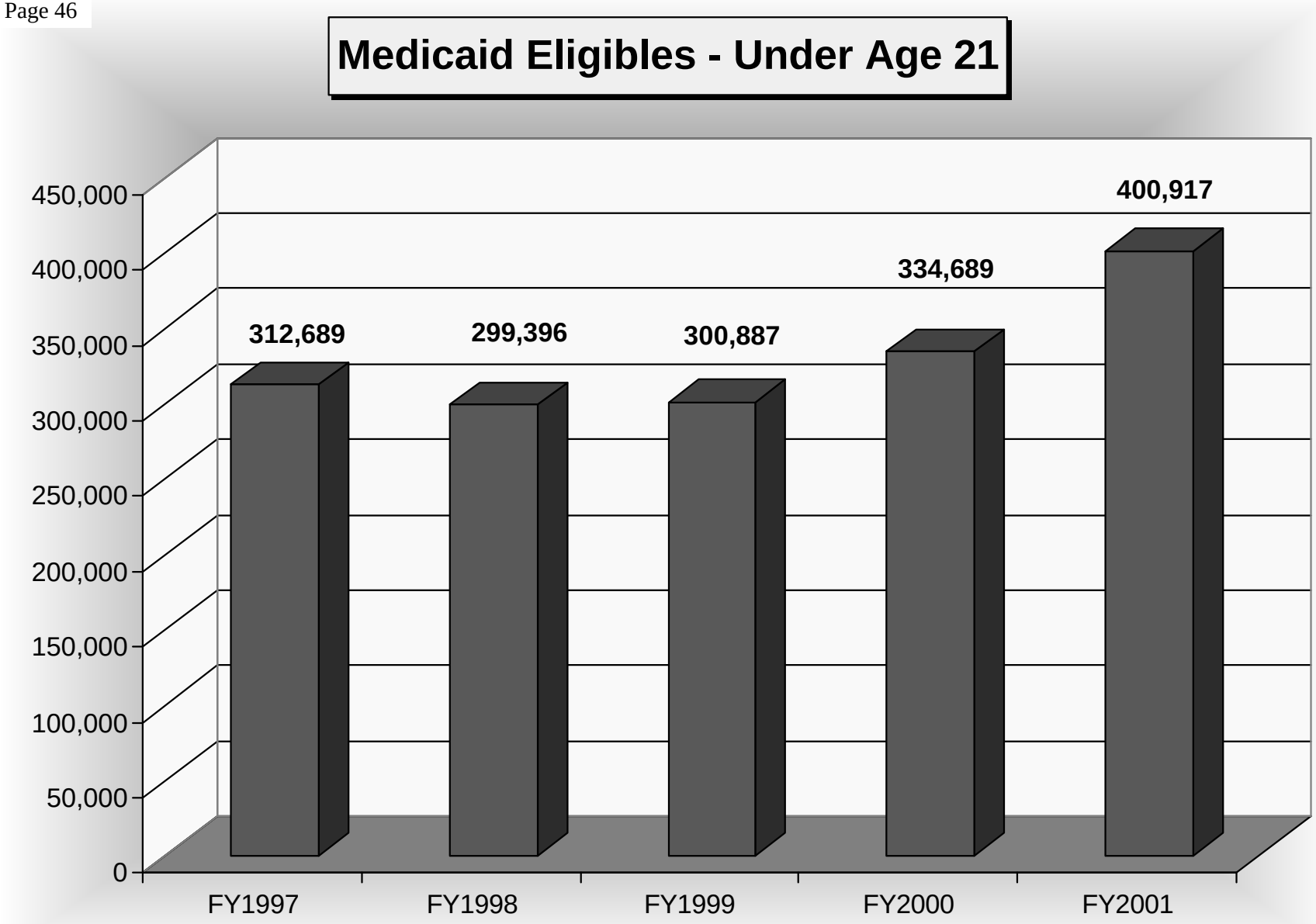
- Uninsured children under age 19 whose family income does not exceed 200% of the federal poverty level. Children who meet this criteria are eligible for health insurance coverage under the Children's Health Insurance Program (CHIP).

Offices of the Social Security Administration determine eligibility for:

- Persons who are age 65 or over, blind, or disabled who receive Supplemental Security Income (SSI) cash assistance.

Total Certified Medicaid Eligibles




Medicaid Eligibles - Under Age 21
450,000
400,000
350,000
300,000
250,000
200,000
150,000
100,000
50,000
0
312,689
299,396
300,887
334,689
400,917
FY1997
FY1998
FY1999
FY2000
FY2001

Regional Offices

The Division of Medicaid operates 25 regional Offices throughout the state to offer local accessibility for eligibility determinations. Listed below are the address and telephone number for each office.

Brandon
1647 Government Street
Brandon, MS 39042-2410
(601) 825-0477

Brookhaven
128 South First Street
Brookhaven, MS 39601-3317
(601) 835-2020

Clarksdale
325 Lee Drive
Clarksdale, MS 38614-1912
(662) 627-1493

Cleveland
201 E. Sunflower, Suite 5
Cleveland, MS 38932-2715
(662) 843-7753

Columbia
1111 Hwy 98 Bypass, Suite B
Columbia, MS 39429-3701
(601) 731-2271

Columbus
2207 5th Street North
Columbus, MS 39701-2211
(662) 329-2190

Corinth
2619 South Harper Road
Corinth, MS 38834-9399
(662) 286-8091

Greenville
585 Tennessee Gas Road
Greenville, MS 38701-8160
(662) 332-9370

Greenwood
805 West Park Avenue, Suite 6
Greenwood, MS 38930-2832
(662) 455-1053

Grenada
1321 C Sunset Plaza
Highway 8 West
Grenada, MS 38901-4005
(662) 226-4406

Gulfport
101 Hardy Court Shopping Center
Gulfport, MS 39507-2528
(228) 863-3328

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Hattiesburg
132 Mayfair Boulevard
Hattiesburg, MS 39402-1463
(601) 264-5386

Holly Springs
695 Highway 4 East
Holly Springs, MS 38635-2109
(662) 252-3439

Jackson
5202 Keele Street, Suite I
Jackson, MS 39206-4398
(601) 961-4361

Kosciusko
405 West Adams Street
Kosciusko, MS 39090
(662) 289-4477

Laurel
1100 Hillcrest Drive
Laurel, MS 39440
(601) 425-3175

McComb
301 Apache Drive
McComb, MS 39648-6309
(601) 249-2071

Meridian
3848 Old Hwy 45 North
Meridian, MS 39301
(601) 483-9944

Natchez
116 South Canal Street
Natchez, MS 39120-3456
(601) 445-4971

Newton
105 School Street Extension
Newton, MS 39345 - 2622
(601) 683-2581

Pascagoula
2035 Old Mobile Avenue
Pascagoula, MS 39567-4413
(228) 762-9591

Philadelphia
1120 East Main St., Eastgate Plaza, Suite 12
Philadelphia, MS 3950-2300
(601) 656-3131

Starkville
LaGalerie Shopping Center
500 Russell Street, Suite 28
Starkville, MS 39759-5405
(662)323-3688

Tupelo
1830 North Gloster Street
Tupelo. MS 38804-1218
(662) 844-5304

Vicksburg
2734 Washington Street
Vicksburg, MS 39180-4656
(601) 638-6137

Mississippi Health Benefits (CHIP)

During FY 2001, Mississippi Health Benefits Program, the State's Children's Health Insurance Program (CHIP), aggressively advanced the accomplishment of its mission: To ensure that every child in the state of Mississippi has access to quality health care. On January 01, 2000 Phase II of Mississippi Health Benefits Program (MHB) was implemented which expanded health coverage to children. Children under age 19 years of age in families with income under 200% of the Federal Poverty Level could now be covered under a separate health insurance plan administered by Blue Cross Blue Shield of Mississippi.

Mississippi Health Benefits Program (CHIP) Program Goals:

1) To enroll all eligible children in Mississippi Health Benefits Program.

Objective 1: To increase public awareness of Mississippi Health Benefits Program (MHB).
Progress: In October 2000, the Division of Medicaid increased the CHIP staff to four persons: the CHIP Administrator and three CHIP Coordinators. This staff primary function is to provide on-going trainings, presentations and updates to the public upon demand. It is estimated that the CHIP staff has conducted at least 125 sessions during FY 2001. A second wave of the media campaign was started in the spring of 2001 at the end of the first media buy. This also included a focus on securing advisement in specialty print i.e., Jackson Advocate, Parents and Kids Magazine, faith-based publications..

Objective 2: To increase community-based MBH program activities focused on increased outreach and enrollment.
Progress: The MS Health Benefits application underwent another revision in April 2001 to incorporate more changes to further simply the enrollment process. With the new application all critical information can be self-declared for most applicant. This meant that copying of **any** documents was no longer required except for the self-employed or those family members counted in the family unit who choose not to provide their social security numbers. With the support of the Mississippi State Department of Health, a network was established to make applications and information readily available at the local level. Community organizations or groups can now go to their local county health departments and pick up applications, posters or available MHB materials. If the materials requested are not available the day requested, they can be shipped from their Jackson Central Supply and delivered to that location the next day.

The contract with Catholic Charities Children's Health Matters that was established in April 2000 and approved by the Governor was renewed in FY 2001.

(Continued)

This group continues to function as a hub to provide training and dissemination of information on Medicaid and CHIP enrollment; to coordinate efforts focused on removing barriers from the application to access; to provide technical support to local outreach initiatives; to continue to serve as a catalyst for improving linkages between the private and public sector; and to develop statewide networks in the Medicaid/CHIP application-to-access process. Children's Health Matters coordinated with DOM in April of 2001, to orchestrate a door-to-door outreach blitz-enrollment campaign in each community across the state. Twenty-one regional planning meetings were held to provide directives for each community to take ownership and develop its own outreach plan of action

In August 2000, Governor Ronnie Musgrove held a press conference announcing the School Outreach Incentive Initiative. Under this initiative, public schools are paid $20 per approved child for Medicaid or CHIP that resulted from MHB applications submitted from schools. In April 2001, Head Start programs were included in this initiative to receive the $20 incentive. As of June 30, 2001 a total of $46,860 has been paid to public schools and $5,460 to Head Start programs for overall total of $52,320.

Objective 3: By June 30, 2001, to increase enrollment in MHB to 80,000.
Progress: Total MHB enrollment:

	June 30, 2001
Medicaid expansion -	8,342
CHIP	35,462
Total	**43,804**

It is important to note that during FY 2001, there was an increase of over 60,000 children in the Medicaid program.

Objective 4: To identify and resolve identified barriers to enrollment in MHB.
Progress:. In October 2000, the major barrier expressed (the six month waiting period) was eliminated. Child support related activities was also identified as a barrier to enrollment. Consequently, the revised MHB application as of April 2001 no longer asked for information regarding the absent parent. Approved children for Medicaid or CHIP are referred to the Child Support Division only upon request of the parent. At this time, self-declaration of income became an option as well.

Objective 5: Develop a mechanism for extending time limits on expenditure of CHIP Funds.
Progress:. Of the $26,838,680 unspent allocated dollars from FY 1998, $17,333,229 was returned to Mississippi resulting in a $9,505,451 net loss in federal funds.

2) To ensure that all children enrolled in MHB have access to primary care providers.
Progress: As of July, 2001 at least 85% of children enrolled in mandated Medicaid managed care had access to a primary care provider. Children enrolled in CHIP received their health services through a Blue Cross Blue Shield provider network. Upon enrollment, the beneficiaries are mailed an identification card, benefit and provider books. According the contract with the insurer, health providers must be within a 15 mile radius in urban/suburban areas and 25 mile radius in rural areas. The Department of Finance and Administration monitors all contractual requirements with the insurer. No areas of non-compliance have been reported.

MISSISSIPPI HEALTH BENEFITS
ENROLLMENT BY COUNTY

County Code	County	Number of Children Ages 0-18 Population	Mississippi Health Benefits Enrollment	Percentage Of Children Enrolled
1	ADAMS	9,203	5,752	62.5%
2	ALCORN	8,259	3,616	43.8%
3	AMITE	3,536	1,884	53.3%
4	ATTALA	5,092	2,892	56.8%
5	BENTON	2,159	1,288	59.7%
6	BOLIVAR	12,027	7,555	62.8%
7	CALHOUN	3,797	1,936	51.0%
8	CARROLL	2,638	1,333	50.5%
9	CHICKASAW	5,560	1,065	19.2%
10	CHOCTAW	2,713	1,446	53.3%
11	CLAIBORNE	3,112	2,214	71.2%
12	CLARKE	4,812	1,939	40.3%
13	CLAY	6,330	3,619	57.2%
14	COAHOMA	10,105	8,102	80.2%
15	COPIAH	7,736	4,637	59.9%
16	COVINGTON	5,589	2,967	53.1%
17	DESOTO	30,230	5,686	18.8%
18	FORREST	17,788	9,971	56.1%
19	FRANKLIN	2,306	1,436	62.3%
20	GEORGE	5,590	2,713	48.5%
21	GREENE	2,793	1,585	56.8%
22	GRENADA	6,328	3,216	50.8%
23	HANCOCK	10,785	4,479	41.5%
24	HARRISON	49,296	20,293	41.2%
25	HINDS	69,973	36,175	51.7%
26	HOLMES	6,936	6,316	91.1%
27	HUMPHREYS	3,664	3,015	82.3%
28	ISSAQUENA	630	407	64.6%

(Continued)

MISSISSIPPI HEALTH BENEFITS
ENROLLMENT BY COUNTY

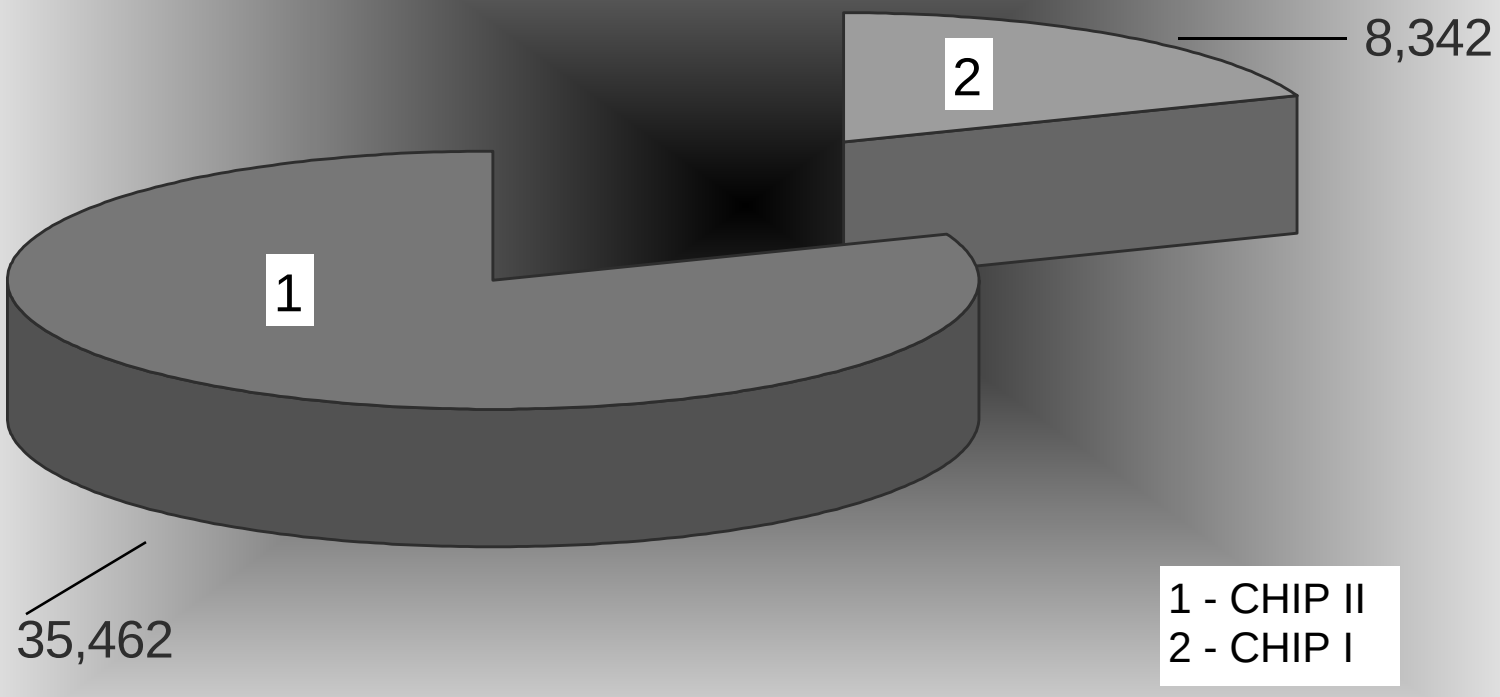
County Code	County	Number of Children Ages 0-18 Population	Mississippi Health Benefits Enrollment	Percentage Of Children Enrolled
29	ITAWAMBA	5510	1,973	35.8%
30	JACKSON	36,403	13,352	36.7%
31	JASPER	5,064	2,683	52.9%
32	JEFFERSON	2,805	2,019	71.9%
33	JEFF. DAVIS	3,965	2,503	63.1%
34	JONES	16,759	8,508	50.8%
35	KEMPER	2,655	1,395	52.6%
36	LAFAYETTE	7,555	2,557	33.9%
37	LAMAR	10,940	3,849	35.2%
38	LAUDERDALE	20,791	10,107	48.6%
39	LAWRENCE	3,619	1,878	51.9%
40	LEAKE	5,633	2,986	53.0%
41	LEE	20,984	7,931	37.8%
42	LEFLORE	11,270	8,494	75.4%
43	LINCOLN	8,855	4,255	48.1%
44	LOWNDES	17,614	8,345	47.4%
45	MADISON	21,357	7,920	37.1%
46	MARION	7,115	4,205	59.1%
47	MARSHALL	9,308	4,566	49.1%
48	MONROE	10,340	4,507	43.6%
49	MONTGOMERY	3,267	1,824	55.8%
50	NESHOBA	8,087	4,004	49.5%
51	NEWTON	5,726	2,633	46.0%
52	NOXUBEE	3,852	2,733	71.0%
53	OKTIBBEHA	9,009	4,252	47.2%
54	PANOLA	10,077	6,219	61.7%
55	PEARL RIVER	13,128	6,372	48.5%
56	PERRY	3,483	1,833	52.6%
57	PIKE	10,786	7,023	65.1%
58	PONTOTOC	7,376	2,319	31.4%

(Continued)

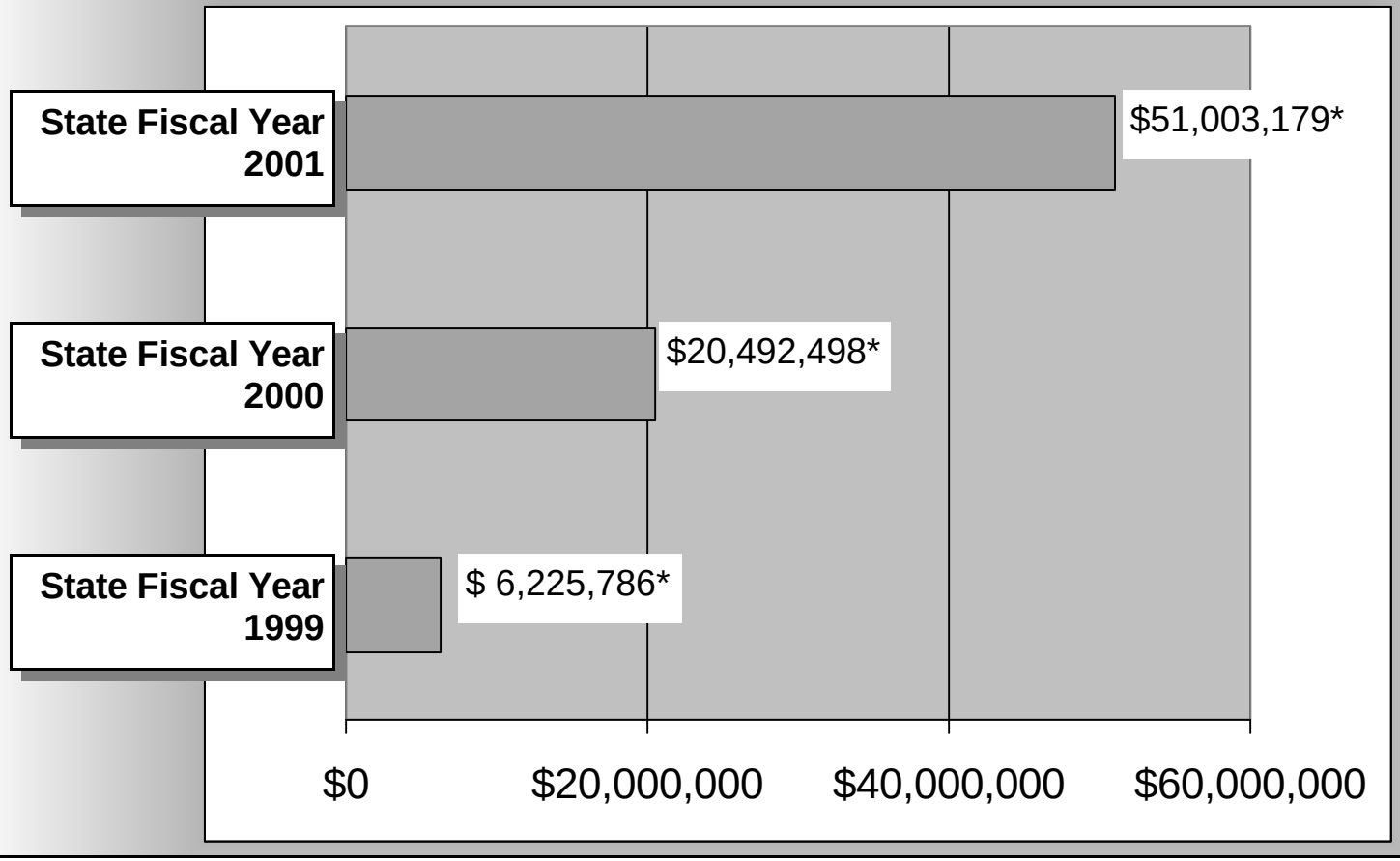
MISSISSIPPI HEALTH BENEFITS
ENROLLMENT BY COUNTY

County Code	County	Number of Children Ages 0-18 Population	Mississippi Health Benefits Enrollment	Percentage Of Children Enrolled
59	PRENTISS	6,389	2,546	39.9%
60	QUITMAN	3,238	2,464	76.1%
61	RANKIN	29,870	8,150	27.3%
62	SCOTT	8,129	4,403	54.2%
63	SHARKEY	2,171	1,802	83.0%
64	SIMPSON	7,711	3,852	49.9%
65	SMITH	4,450	1,954	43.9%
66	STONE	3,651	1,939	53.1%
67	SUNFLOWER	9,589	7,461	77.8%
68	TALLAHATCHIE	4,471	3,078	68.9%
69	TATE	6,875	2,639	38.4%
70	TIPPAH	5,207	2,410	46.3%
71	TISHOMINGO	4,446	1,727	38.9%
72	TUNICA	2,907	1,987	68.4%
73	UNION	6,569	2,407	36.7%
74	WALTHALL	4,304	2,858	66.4%
75	WARREN	14,149	7,276	51.4%
76	WASHINGTON	19,838	15,071	76.0%
77	WAYNE	6,795	3,208	47.2%
78	WEBSTER	2,687	1,354	50.4%
79	WILKINSON	2,661	1,962	73.7%
80	WINSTON	5,403	3,054	56.5%
81	YALOBUSHA	3,341	1,843	55.2%
82	YAZOO	8,023	5,852	72.9%

Mississippi Health Benefits Enrollment as of June 30, 2001



Actual CHIP Expenditures by State Fiscal Year



*These totals include all administrative fees and service related costs directed to our CHIP program.

TABLE 1

Certified Eligibles by Eligibility Category for Fiscal Year 2001

Program Category	Total Number of Eligible Persons	Percent of Total *
Total	646,925	100.00%
Money Payment Eligibles		
Aged	24,188	3.74%
Blind	1,398	0.22%
Disabled	122,992	19.01%
Low Income Families	46,776	7.23%
IV-E Foster Care	2,205	0.34%
CWS Foster Care	1,041	0.16%
Medicaid Only		
Aged	12,400	1.92%
Blind	8	0.00%
Disabled	2,803	0.43%
Disabled Children at home	781	0.12%
Working Disabled	121	0.02%
Low Income Families	4,929	0.76%
Poverty Level Pregnant Women & Children		
At 100% Federal Poverty Level	174,340	26.95%
At 133% Federal Poverty Level	34,846	5.39%
At 185% Federal Poverty Level	51,632	7.98%
Optional & Mandatory Phased-in Children Under Age 18	76,970	11.90%
Qualified Medicare Beneficiary		
Aged	107	0.02%
Blind	24	0.00%
Disabled	20	0.00%
Qualified Individuals		
Aged	1,387	0.21%
Blind	0	0.00%
Disabled	672	0.10%
Poverty Level		
Aged	28,571	4.42%
Disabled	22,840	3.53%
Hospice		
Aged	144	0.02%
Blind	0	0.00%
Disabled	92	0.01%
Other Medical Assitance Only		
Automatic Infants	33,474	5.17%
Specified Low Income Medicare Beneficiaries		
Aged	1,488	0.23%
Blind	14	0.00%
Disabled	440	0.07%
Handicapped		
Aged	54	0.01%
Blind	34	0.01%
Disabled	134	0.02%

Source: RS-O-10-2 (06/01)

* Percentage column may not total 100% due to rounding

TABLE 2

Bureau of Census Population for Mississippi Counties and Number of Medicaid Eligibles by County for Fiscal Year 2001

County	County Population	Number of Medicaid Eligibles	Percent of Population	County	County Population	Number of Medicaid Eligibles	Percent of Population
Adams	33,657	9,888	29.38%	Leflore	36,816	13,987	37.99%
Alcorn	33,080	7,573	22.89%	Lincoln	32,105	7,595	23.66%
Amite	13,906	3,413	24.54%	Lowndes	60,527	13,619	22.50%
Attala	18,338	5,450	29.72%	Madison	74,562	12,442	16.69%
Benton	8,091	2,429	30.02%	Marion	26,538	7,282	27.44%
Bolivar	39,826	15,373	38.60%	Marshall	32,323	8,260	25.55%
Calhoun	14,891	3,763	25.27%	Monroe	38,230	8,025	20.99%
Carroll	9,967	2,371	23.79%	Montgomery	12,394	3,468	27.98%
Chickasaw	18,121	4,595	25.36%	Neshoba	27,639	6,833	24.72%
Choctaw	9,366	2,481	26.49%	Newton	21,741	4,865	22.38%
Claiborne	11,596	3,687	31.80%	Noxubee	12,497	4,833	38.67%
Clarke	18,445	3,591	19.47%	Oktibbeha	39,765	7,362	18.51%
Clay	21,657	5,831	26.92%	Panola	33,913	10,271	30.29%
Coahoma	31,094	12,746	40.99%	Pearl River	47,969	10,313	21.50%
Copiah	28,892	7,798	26.99%	Perry	12,039	3,028	25.15%
Covington	17,889	4,975	27.81%	Pike	37,910	11,950	31.52%
DeSoto	102,131	9,227	9.03%	Pontotoc	25,685	4,306	16.76%
Forrest	74,927	16,101	21.49%	Prentiss	24,497	5,062	20.66%
Franklin	8,160	2,429	29.77%	Quitman	9,780	4,177	42.71%
George	20,185	4,047	20.05%	Rankin	112,348	14,086	12.54%
Greene	12,630	2,668	21.12%	Scott	24,911	7,307	29.33%
Grenada	22,450	5,806	25.86%	Sharkey	6,543	2,892	44.20%
Hancock	41,518	7,146	17.21%	Simpson	25,375	6,638	26.16%
Harrison	178,567	32,581	18.25%	Smith	15,431	3,535	22.91%
Hinds	245,737	55,941	22.76%	Stone	13,488	3,228	23.93%
Holmes	21,562	10,349	48.00%	Sunflower	33,257	11,745	35.32%
Humphreys	11,214	4,764	42.48%	Tallahatchie	14,587	5,233	35.87%
Issaquena	1,635	607	37.13%	Tate	24,417	4,609	18.88%
Itawamba	21,085	3,797	18.01%	Tippah	21,069	5,181	24.59%
Jackson	133,120	19,743	14.83%	Tishomingo	18,742	3,832	20.45%
Jasper	18,110	4,870	26.89%	Tunica	7,935	3,108	39.17%
Jefferson	8,385	3,414	40.72%	Union	24,121	4,509	18.69%
Jefferson Davis	13,770	4,360	31.66%	Walthall	14,211	4,747	33.40%
Jones	63,054	15,166	24.05%	Warren	49,148	11,567	23.54%
Kemper	10,487	2,590	24.70%	Washington	64,265	23,660	36.82%
Lafayette	34,914	4,724	13.53%	Wayne	20,637	5,588	27.08%
Lamar	38,127	6,042	15.85%	Webster	10,633	2,564	24.11%
Lauderdale	75,978	17,629	23.20%	Wilkinson	9,042	3,518	38.91%
Lawrence	13,066	3,322	25.42%	Winston	19,253	5,143	26.71%
Leake	19,602	5,193	26.49%	Yalobusha	12,627	3,588	28.42%
Lee	75,211	13,894	18.47%	Yazoo	25,208	9,345	37.07%

Source: Medicaid Eligibles RSO-10-4-A (06/01)

Source: County Population, U.S.Census Bureau Population Estimate Program Release Date 3/9/2000

TABLE 3

Recipients of Services by Program Category for Fiscal Year 2001

Program Category	Total Number of Recipients	Percent of Total *
Total	587,341	100.00%
Money Payment Eligibles		
Aged	25,211	4.29%
Blind	1,298	0.22%
Disabled	117,639	20.03%
Low Income Families	45,976	7.83%
IV-E Foster Care	2,022	0.34%
CWS Foster Care	949	0.16%
Medicaid Only		
Aged	14,186	2.42%
Blind	9	0.00%
Disabled	2,878	0.49%
Disabled Children at home	749	0.13%
Working Disabled	98	0.02%
Low Income Families	2,961	0.50%
Poverty Level Pregnant Women & Children		
At 100% Federal Poverty Level	147,627	25.13%
At 133% Federal Poverty Level	34,260	5.83%
At 185% Federal Poverty Level	58,312	9.93%
Optional & Mandatory Phased-in Children Under Age 18	52,714	8.98%
Qualified Medicare Beneficiary		
Aged	164	0.03%
Blind	19	0.00%
Disabled	43	0.01%
Qualified Individuals		
Aged	0	0.00%
Blind	0	0.00%
Disabled	0	0.00%
Poverty Level		
Aged	28,747	4.89%
Disabled	22,807	3.88%
Hospice		
Aged	299	0.05%
Blind	0	0.00%
Disabled	122	0.02%
Other Medical Assitance Only		
Automatic Infants	27,999	4.77%

TABLE 4

Recipients of Medical Services by Type of Service for Fiscal Years 2000 and 2001

Type of Service	Recipients FY 2000	Recipients FY 2001	% of Incr. Or Decr.
Total	512,956	587,341	14.50%
Inpatient Hospital	58,340	70,266	20.44%
Outpatient Hospital	224,723	277,407	23.44%
Laboratory/X-Ray	59,667	109,155	82.94%
Nursing Facility	19,786	19,582	-1.03%
Physician	340,748	403,977	18.56%
EPSDT	106,000	129,411	22.09%
EPSDT Dental	81,722	104,523	27.90%
EPSDT Vision	46,082	60,051	30.31%
EPSDT Hearing	4,561	4,281	-6.14%
Rural Health Clinic	92,065	104,194	13.17%
Federally Qualified Health Centers	55,186	63,602	15.25%
Home Health	5,639	7,812	38.54%
Transportation	33,088	39,405	19.09%
Prescribed Drugs	443,685	521,735	17.59%
Dental	24,876	30,567	22.88%
Eyeglasses	12,240	46,063	276.33%
Intermediate Care Facility - Mentally Retarded	3,145	2,973	-5.47%
Per Capita Managed Care	9,573	676	-92.94%
Buy-in, Parts A & B, Medicare	271,597	289,388	6.55%
Mental Health Clinic	38,675	42,058	8.75%
Home & Community Based Waiver	4,783	9,944	107.90%
Durable Medical Equipment	17,006	22,072	29.79%
Therapy	1,961	2,983	52.12%
Inpatient Residential Psychiatric	1,040	686	-34.04%
Inpatient Psychiatric Hospital	3,207	2,121	-33.86%
Nurse Practitioner	58,584	84,018	43.41%
Ambulatory Surgical Center	2,737	4,099	49.76%
Personal Care	0	0	0.00%
Hospice	621	1,099	76.97%
Outpatient Psychiatric Hospital	2	1	-50.00%
Private Mental Health Centers	1,082	961	-11.18%
Family Planning Drugs	19,807	24,081	21.58%
Dialysis	549	593	8.01%

Source: MAM260-A0

TABLE 5

Paid Claims by Type of Service for Fiscal Years 2000 and 2001

Type of Service	Claims FY 2000	Claims FY 2001	% of Incr. Or Decr.
Total	25,230,115	32,117,417	27.30%
Inpatient Hospital	456,673	454,735	-0.42%
Outpatient Hospital	1,429,013	2,169,133	51.79%
Laboratory/X-Ray	556,752	1,088,302	95.47%
Nursing Facility	561,237	477,812	-14.86%
Physician	4,565,477	5,027,115	10.11%
EPSDT	383,115	776,845	102.77%
EPSDT Dental	629,540	796,621	26.54%
EPSDT Vision	321,537	432,031	34.36%
EPSDT Hearing	11,033	11,823	7.16%
Rural Health Clinic	937,250	863,595	-7.86%
Federally Qualified Health Centers	555,023	568,842	2.49%
Home Health	66,723	90,359	35.42%
Transportation	211,460	319,512	51.10%
Prescribed Drugs	8,713,889	10,456,747	20.00%
Dental	149,121	192,780	29.28%
Eyeglasses	26,437	345,189	1205.70%
Intermediate Care Facility - Mentally Retarded	152,686	129,491	-15.19%
Per Capita Managed Care	71,595	1,634	-97.72%
Buy-in, Parts A & B, Medicare	5,276,242	5,744,866	8.88%
Mental Health Clinic	1,025,195	1,100,781	7.37%
Home & Community Based Waiver	118,178	261,429	121.22%
Durable Medical Equipment	144,669	167,469	15.76%
Therapy	65,038	103,436	59.04%
Inpatient Residential Psychiatric	7,818	9,716	24.28%
Inpatient Psychiatric Hospital	8,291	6,804	-17.94%
Nurse Practitioner	334,465	404,483	20.93%
Ambulatory Surgical Center	6,740	11,262	67.09%
Personal Care	0	0	0.00%
Hospice	4,735	9,016	90.41%
Outpatient Psychiatric Hospital	4	6	50.00%
Private Mental Health Centers	20,419	17,868	-12.49%
Family Planning Drugs	56,184	68,280	21.53%
Dialysis	5,627	9,435	67.67%

Source: MRO-08

TABLE 6

Total Expenditures for Medical Services, Total Number of Recipients, Average Expenditure per Recipient and Percentage by Program Category for Fiscal Year 2001

Program Category	Amount of Expenditures	Percent of Total	Recipients	Percent of Total	Average per Recipient
Total	$2,089,495,383	100.00%	587,341	100.00%	$3,558
Money Payment Eligibles					
Aged	101,421,836	4.85%	25,211	4.29%	4,023
Blind	7,813,421	0.37%	1,298	0.22%	6,020
Disabled	724,503,157	34.67%	117,369	19.98%	6,173
Low Income Families	57,768,816	2.76%	45,976	7.83%	1,256
IV-E Foster Care	8,207,803	0.39%	2,022	0.34%	4,059
CWS Foster Care	4,681,692	0.22%	949	0.16%	4,933
Medicaid Only					
Aged	358,351,762	17.15%	14,186	3.07%	25,261
Blind	155,861	0.01%	9	0.00%	17,318
Disabled	123,088,043	5.89%	2,878	0.62%	42,769
Disabled Children at home	6,022,290	0.29%	749	0.16%	8,040
Working Disabled	343,545	0.02%	98	0.02%	3,506
Low Income Families	4,832,430	0.23%	2,961	0.64%	1,632
Poverty Level Pregnant Women & Children					
At 100% Federal Poverty Level	81,466,035	3.90%	147,627	31.99%	552
At 133% Federal Poverty Level	36,247,614	1.73%	34,260	7.42%	1,058
At 185% Federal Poverty Level	161,744,417	7.74%	58,312	12.64%	2,774
Optional & Mandatory Phased-in Children Under Age 18	137,340,534	6.57%	52,714	11.42%	2,605
Qualified Medicare Beneficiary					
Aged	139,548	0.01%	164	0.04%	851
Blind	5,953	0.00%	19	0.00%	313
Disabled	28,352	0.00%	43	0.01%	659
Qualified Individuals					
Aged	0	0.00%	0	0.00%	0
Blind	0	0.00%	0	0.00%	0
Disabled	0	0.00%	0	0.00%	0
Poverty Level					
Aged	86,991,370	4.16%	28,747	4.89%	3,026
Disabled	117,817,132	5.64%	22,807	3.88%	5,166
Hospice					
Aged	2,447,788	0.12%	299	0.05%	8,187
Blind	0	0.00%	0	0.00%	0
Disabled	1,496,817	0.07%	122	0.02%	12,269
Other Medical Assitance Only					
Automatic Infants	64,069,062	3.07%	27,999	4.77%	2,288
Specified Low Income Medicare Beneficiaries					
Aged	0	0.00%	0	0.00%	0
Blind	0	0.00%	0	0.00%	0
Disabled	0	0.00%	0	0.00%	0
Handicapped					
Aged	189,899	0.01%	71	0.01%	2,675
Blind	185,865	0.01%	41	0.01%	4,533
Disabled	2,134,341	0.10%	140	0.02%	15,245

Source: RS-O-10-2 (06/01)

* Percentage column may not total 100% due to rounding

TABLE 7

Expenditures for Medical Services by Type of Service for Fiscal Years 2000 and 2001

Type of Service	Expenditures FY 2000	Expenditures FY 2001	% of Incr. Or Decr.
Total	$1,729,994,752	$2,089,495,383	20.78%
Inpatient Hospital	$300,367,752	$353,715,319	17.76%
Outpatient Hospital	88,032,588	106,749,858	21.26%
Laboratory/X-Ray	4,343,575	8,993,901	107.06%
Nursing Facility	355,601,316	379,215,684	6.64%
Physician	132,250,593	166,098,569	25.59%
EPSDT	4,951,106	8,289,706	67.43%
EPSDT Dental	19,923,868	26,675,648	33.89%
EPSDT Vision	7,000,324	10,081,802	44.02%
EPSDT Hearing	350,138	409,997	17.10%
Rural Health Clinic	15,434,583	20,442,020	32.44%
Federally Qualified Health Centers	16,163,733	18,834,874	16.53%
Home Health	7,116,857	10,915,766	53.38%
Transportation	21,200,274	23,523,726	10.96%
Prescribed Drugs	339,685,539	463,063,558	36.32%
Dental	4,405,099	5,792,369	31.49%
Eyeglasses	834,726	7,366,637	782.52%
Intermediate Care Facility - Mentally Retarded	153,199,951	164,441,513	7.34%
Per Capita Managed Care	3,179,220	-1,916,847	-160.29%
Buy-in, Parts A & B, Medicare	126,319,769	136,319,130	7.92%
Mental Health Clinic	53,642,432	69,800,366	30.12%
Home & Community Based Waiver	19,022,096	40,650,741	113.70%
Durable Medical Equipment	10,358,196	12,534,680	21.01%
Therapy	1,183,536	2,061,666	74.20%
Inpatient Residential Psychiatric	14,165,957	16,962,030	19.74%
Inpatient Psychiatric Hospital	8,651,502	7,453,010	-13.85%
Nurse Practitioner	7,865,910	10,913,160	38.74%
Ambulatory Surgical Center	1,232,393	1,817,468	47.47%
Personal Care	0	0	0.00%
Hospice	4,578,052	7,149,750	56.17%
Outpatient Psychiatric Hospital	879	7	-99.20%
Private Mental Health Centers	486,720	390,500	-19.77%
Family Planning Drugs	1,778,382	2,254,494	26.77%
Dialysis	6,667,686	8,494,281	27.39%

Source: MAM250-R1 (06/01)

TABLE 8

Expenditures for Medical Services by Type of Service, Number of Recipients by Service, and Average Spent for Fiscal Year 2000

Type of Service	Expenditures FY 2001	Recipients FY 2001	Avg. per Recipient
Total	$2,089,495,383	587,341	$3,558
Inpatient Hospital	$353,715,319	70,266	5,034
Outpatient Hospital	106,749,858	277,407	385
Laboratory/X-Ray	8,993,901	109,155	82
Nursing Facility	379,215,684	19,582	19,366
Physician	166,098,569	403,977	411
EPSDT	8,289,706	129,411	64
EPSDT Dental	26,675,648	104,523	255
EPSDT Vision	10,081,802	60,051	168
EPSDT Hearing	409,997	4,281	96
Rural Health Clinic	20,442,020	104,194	196
Federally Qualified Health Centers	18,834,874	63,602	296
Home Health	10,915,766	7,812	1,397
Transportation	23,523,726	39,405	597
Prescribed Drugs	463,063,558	521,735	888
Dental	5,792,369	30,567	189
Eyeglasses	7,366,637	46,063	160
Intermediate Care Facility - Mentally Retarded	164,441,513	2,973	55,312
Per Capita Managed Care	-1,916,847	676	-2,836
Buy-in, Parts A & B, Medicare	136,319,130	289,388	471
Mental Health Clinic	69,800,366	42,058	1,660
Home & Community Based Waiver	40,650,741	9,944	4,088
Durable Medical Equipment	12,534,680	22,072	568
Therapy	2,061,666	2,983	691
Inpatient Residential Psychiatric	16,962,030	686	24,726
Inpatient Psychiatric Hospital	7,453,010	1,123	6,637
Nurse Practitioner	10,913,160	84,018	130
Ambulatory Surgical Center	1,817,468	4,099	443
Personal Care	0	0	0
Hospice	7,149,750	1,099	6,506
Outpatient Psychiatric Hospital	7	1	7
Private Mental Health Centers	390,500	961	406
Family Planning Drugs	2,254,494	24,081	94
Dialysis	8,494,281	593	14,324

Source: MAM250-R1 (06/00)

TABLE 8-A

Expenditures for Medical Services by Type of Service, Average cost per Recipient for Fiscal Years 2000 and 2001

Type of Service	FY 2000	FY 2001	% of Incr. Or Decr.
Total	$3,373	$3,558	5.47%
Inpatient Hospital	5,149	5,034	-2.23%
Outpatient Hospital	392	385	-1.83%
Laboratory/X-Ray	73	82	12.87%
Nursing Facility	17,972	19,366	7.75%
Physician	388	411	5.97%
EPSDT	47	64	36.29%
EPSDT Dental	244	255	4.60%
EPSDT Vision	152	168	10.45%
EPSDT Hearing	77	96	24.38%
Rural Health Clinic	168	196	16.78%
Federally Qualified Health Centers	293	296	1.07%
Home Health	1,262	1,397	10.72%
Transportation	641	597	-6.87%
Prescribed Drugs	766	888	15.87%
Dental	177	189	7.06%
Eyeglasses	68	160	135.18%
Intermediate Care Facility - Mentally Retarded	48,712	55,312	13.55%
Per Capita Managed Care	332	-2,836	-954.09%
Buy-in, Parts A & B, Medicare	465	471	1.30%
Mental Health Clinic	1,387	1,660	19.66%
Home & Community Based Waiver	3,977	4,088	2.79%
Durable Medical Equipment	609	568	-6.75%
Therapy	604	691	14.43%
Inpatient Residential Psychiatric	13,621	24,726	81.53%
Inpatient Psychiatric Hospital	2,698	6,637	145.99%
Nurse Practitioner	134	130	-3.07%
Ambulatory Surgical Center	450	443	-1.47%
Personal Care	0	0	0.00%
Hospice	7,372	6,506	-11.75%
Outpatient Psychiatric Hospital	440	7	-98.41%
Private Mental Health Centers	450	406	-9.70%
Family Planning Drugs	90	94	4.02%
Dialysis	12,145	14,324	17.94%

Source: MAM250-R1 (06/01)
MAM260-A0 (06/01)

TABLE 9

Expenditures for Major Medical Services by Program Category for Fiscal Year 2001

Program Category	Inpt. Hosp.	Outpt. Hosp.	Nursing Fac.	Physician	EPSDT	Drugs*	Dental
Total	$353,715,319	$106,749,858	$379,215,684	$166,098,569	$8,289,706	$463,063,558	$5,792,369
Money Payment Eligibles							
Aged	343,095	85,056	24,153,257	149,982	0	39,698,765	283,793
Blind	952,222	340,741	911,455	463,466	600	1,938,157	28,846
Disabled	137,151,383	43,250,276	39,479,941	49,338,650	309,572	195,246,846	2,581,429
Low Income Families	16,045,043	6,591,463	9,038	9,809,703	844,647	8,293,789	330,419
IV-E Foster Care	1,342,696	312,127	0	522,173	43,144	813,304	169
CWS Foster Care	939,429	128,269	0	249,962	15,724	450,340	0
Medicaid Only							
Aged	217,510	33,884	286,797,593	58,784	0	40,674,255	100,493
Blind	352	74	50,035	244	0	18,409	318
Disabled	4,445,996	447,658	27,761,733	672,796	2,114	7,935,235	54,731
Disabled Children at home	858,934	462,281	0	312,317	4,311	1,672,305	52
Working Disabled	56,000	21,116	0	29,288	0	182,944	2,218
Low Income Families	1,818,839	558,824	0	858,507	124,315	553,734	21,186
Poverty Level Pregnant Women & Children							
At 100% Federal Poverty Level	21,324,074	11,110,019	0	12,956,815	786,348	15,675,837	826,151
At 133% Federal Poverty Level	10,830,487	5,506,802	1,845	7,545,649	1,050,899	5,781,766	28,625
At 185% Federal Poverty Level	77,015,795	14,136,901	0	43,282,307	1,590,467	7,717,587	356,323
Optional & Mandatory Phased-in Children U	26,306,407	16,004,646	0	19,560,646	2,109,236	22,051,315	6,627
Qualified Medicare Beneficiary							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Qualified Individuals							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Poverty Level							
Aged	177,481	109,537	21,288	230,998	0	52,828,948	403,835
Disabled	14,662,290	5,006,575	420	6,020,381	1,331	57,443,315	760,059
Hospice							
Aged	461	-113	11,348	2,304	0	367,441	249
Blind	0	0	0	0	0	0	0
Disabled	172,768	43,420	1,301	75,519	0	219,809	3,219
Other Medical Assitance Only							
Automatic Infants	38,996,590	2,568,763	16,430	13,933,061	1,406,998	2,987,852	0
Specified Low Income Medicare Beneficiaries							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Handicapped							
Aged	0	5	0	124	0	66,372	174
Blind	16,575	8,147	0	4,871	0	69,228	0
Disabled	40,892	23,387	0	20,022	0	376,005	3,453

Source:MAM250-R10

TABLE 10

Amount Paid to State Health Agencies and Insitutions by Source of Funds for Fiscal Years 1999-2001

Name of Agency or Institution	Fiscal Year	Total Amount of Payment	From Federal Funds	From State Funds
Total	FY1999	359,023,939	275,658,580	83,365,359
	FY2000	399,937,083	307,151,680	92,785,403
	FY2001	405,859,938	311,781,604	94,078,334
East Miss. State Nursing Home	FY1999	5,144,267	3,949,768	1,194,499
(Meridian)	FY2000	8,092,241	6,214,841	1,877,400
	FY2001	8,610,779	6,614,800	1,995,979
Ellisville State School	FY1999	38,302,897	29,408,964	8,893,933
(Ellisville)	FY2000	43,269,465	33,230,949	10,038,516
	FY2001	43,833,712	33,673,058	10,160,654
Miss. State Dept. of Health	FY1999	14,548,693	11,170,486	3,378,207
	FY2000	15,459,232	11,872,690	3,586,542
	FY2001	19,747,641	15,170,138	4,577,503
North Miss. Regional Center	FY1999	23,652,840	18,160,651	5,492,189
(Oxford)	FY2000	25,702,235	19,739,316	5,962,919
	FY2001	29,265,947	22,482,100	6,783,847
South Miss. Regional Center	FY1999	17,010,196	13,060,428	3,949,768
(Long Beach)	FY2000	21,373,144	16,414,575	4,958,569
	FY2001	21,228,646	16,307,846	4,920,800
Hudspeth Center	FY1999	23,930,595	18,373,911	5,556,684
(Whitfield)	FY2000	25,776,831	19,796,606	5,980,225
	FY2001	27,769,602	21,332,608	6,436,994
Miss. State Hospital-Nursing Facility	FY1999	12,030,932	9,237,350	2,793,582
(Whitfield)	FY2000	20,257,389	15,557,675	4,699,714
	FY2001	20,681,322	15,887,392	4,793,930
Miss. State Hospital	FY1999	4,057,484	3,115,336	942,148
(Whitfield)	FY2000	5,766,771	4,428,880	1,337,891
	FY2001	6,188,672	4,754,138	1,434,534
Boswell Regional Center	FY1999	10,621,658	8,155,309	2,466,349
(Sanatorium)	FY2000	13,379,014	10,275,083	3,103,931
	FY2001	14,295,095	10,981,492	3,313,603
Miss. Department of Mental Health	FY1999	49,646,892	38,118,884	11,528,008
	FY2000	53,698,398	41,240,370	12,458,028
	FY2001	69,871,156	53,675,022	16,196,134
University Medical Center	FY1999	156,730,154	120,337,412	36,392,742
(Jackson)	FY2000	166,704,151	128,028,788	38,675,363
	FY2001	144,367,366	110,903,011	33,464,355
Miss. Dept of Human Services	FY1999	3,347,331	2,570,081	777,250
	FY2000	458,212	351,907	106,305
	FY2001	0	0	0

Source Provider History Report

TABLE 11

Total Number of Eligibles, Numbers Using Physician Services by Program Category for Fiscal Year 2001

Program Category	Total Number of Eligibles	Recipients Using Service	Percent of Total
Total	646,925	403,977	62.45%
Aged	34,056	26,155	76.80%
Blind	1,781	1,203	67.53%
Disabled	146,497	101,312	69.16%
Low Income Families - Children	215,122	116,822	54.31%
Low Income Families - Adults	151,533	91,828	60.60%
CWS Foster Care	1,484	1,327	89.43%
Optional Categorically Needy	96,452	65,330	67.73%

Source:HCFA 2082 (06/01)

TABLE 12

Amount of Expenditures with Percentage Distribution for Physician Services by Program Category for Fiscal Year 2001

Program Category	Expenditures	Percent of Total
Total	166,098,568	100.00%
Aged	36,831,367	22.17%
Blind	1,876,318	1.13%
Disabled	88,457,570	53.26%
Low Income Families - Children	3,958,468	2.38%
Low Income Families - Adults	4,385,851	2.64%
CWS Foster Care	794,630	0.48%
Optional Categorically Needy	29,794,364	17.94%

Source:HCFA 2082 (06/01)

TABLE 13

Amount of Expenditures with Percentage Distribution for Physician

Age in Years	Expenditures	Percent of Total*
Total	166,098,568	100.00%
Birth to age 1	13,933,061	8.39%
Ages 1 to 3	3,730,731	2.25%
Ages 3 to 5	5,140,950	3.10%
Ages 5 to 6	1,236,383	0.74%
Ages 6 to 8	2,775,351	1.67%
Ages 8 to 19	30,255,973	18.22%
Ages 19 to 21	10,804,184	6.50%
Ages 21 to 64	95,400,649	57.44%
Ages 64 and Over	2,821,286	1.70%

*Percentage columns may not total 100% due to rounding
Source:MAM250-R1 (06/01)

TABLE 14

Number of Physician Visits by Place of Visit for Fiscal Year 2001

Place of Visit	Number of Visits	Percent of Total
Total	2,686,274	100.00%
Physician's Office	1,660,091	61.80%
Hospital	447,597	16.66%
Nursing Home	11,916	0.44%
Emergency Room	303,328	11.29%
Consultations	261,875	9.75%
House Calls	1,467	0.05%

*Percentage columns may not total 100% due to rounding
Source:SU-O-1-10 (10/01)

TABLE 15

Number of Prescriptions, Number of Recipients, and Average Number of Prescriptions per Recipient by Program Category for Fiscal Year 2001

Program Category	Prescriptions	Percent of Total	Number of Recipients*	Percent of Total	Average Number of Prescriptions Per Recipient
Total	8,920,159	100.00%	521,735	100.00%	17.1
Aged	826,531	9.27%	31,797	6.09%	26.0
Blind	37,248	0.42%	1,561	0.30%	23.9
Disabled	3,240,459	36.33%	134,379	25.76%	24.1
Low Income Families - Children	830,191	9.31%	156,865	30.07%	5.3
Low Income Families - Adults	731,495	8.20%	110,464	21.17%	6.6
CWS Foster Care	27,500	0.31%	1,643	0.31%	16.7
Optional Categorically Needy	3,226,735	36.17%	85,026	16.30%	37.9

Source:HCFA 2082 (06/01)

* - Does not include Family Planning Drugs

TABLE 16

Number of Recipients and Number of Days of Care for Nursing Facilities by Program Category for Fiscal Year 2001

	Nursing Facility		Intermediate Care Facilities - MR		Psychiatric Residential Treatment Facility	
Program Category	Recipients	Days of Care	Recipients	Days of Care	Recipients	Days of Care
Total	19,582	4,798,763	2,973	912,503	2,121	90,366
Aged	1,671	332,702	18	5,767	0	0
Blind	50	11,025	18	6,271	0	0
Disabled	2,153	460,806	1,421	430,335	803	32,892
AFDC Children	2	319	17	2,924	853	37,882
AFDC Adults	3	22	3	52	184	4,703
*CWS Foster Care - Not Available	0	0	22	2,766	102	7,502
Optional Categorically Needy	15,703	3,993,889	1,474	464,388	179	7,387

Source:HCFA 2082 (06/01)

TABLE 17

Number of Children Receiving Treatment by Category of Service for Fiscal Year 2001

Place of Visit	Number of Children	
Total	94,882	100.00%
Dental	77,305	81.47%
Corrective Treatment Referrals which includes Vision and Hearing	17,577	18.53%

Source:MRO 416 Y-T-D dated 8/23/2001

TABLE 18

Number of Recipients, Number of Discharges, and Total Days of Hospital Care and Average Length of Hospital Stay by Program Category for Fiscal Year 2001

Program Category	Number of Recipients	Number of Discharges	Days of Care	Average Length of Hospital Stay
Total	70,266	375,365	404,905	1.1
Aged	60	354	858	2.4
Blind	119	848	1,160	1.4
Disabled	16,520	122,399	168,094	1.4
Low Income Families - Children	13,780	61,352	80,935	1.3
Low Income Families - Adults	32,846	153,707	116,058	0.8
CWS Foster Care	270	1,823	2,650	1.5
Optional Categorically Needy	6,671	34,882	35,150	1.0

Source:HCFA 2082 (06/01)

WORK PLAN AND IMPLEMENTATION STATUS REPORT

OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID

2001 Legislative Session

BILL NUMBER	CODE SECTION	LANGUAGE ADDED/CHANGED/DELETED	IMPLEMENTATION STATUS AS OF 8/10/01
HB 444: Provides for presumptive eligibility for children under age 19 for Medicaid and CHIP.	**§41-86-15(3) §43-13-115.1.(1)**	**(3) There will be presumptive eligibility under this chapter for children under nineteen (19) years of age, in accordance with the following provisions:** **(a) A child will be deemed to be presumptively eligible for covered benefits and services under this chapter if a qualified entity as defined under federal law (42 USCS Section 1396r-1a) determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the plan.** **(b) A child will be presumptively eligible under this chapter from the date that the qualified entity determines that the child is presumptively eligible until the earlier of either: (i) The date on which a determination is made with respect to the eligibility of the child for covered benefits and services under this chapter, or** **(ii) The last day of the month following the month in which presumptive eligibility is determined, if an application has not been filed on behalf of the child by that day.** **(c) For the period during which a child is presumptively eligible under this chapter, the child will be eligible to receive all covered benefits and services under this chapter.** **(d) If a child is determined to be presumptively eligible under this chapter, the child's parent, guardian or caretaker relative must submit a completed application for assistance under the program no later than the last day of the month following the month in which presumptive eligibility is determined. The qualified entity shall inform the parent, guardian or caretaker relative of this requirement at the time the qualified entity makes the determination of presumptive eligibility.** **(e) The qualified entity shall notify the Division of**	**State Plan Amendment was submitted to CMS 07/05/01** **Current status of SPA: on 8/10/ 01, CMS submitted a letter requesting additional info regarding the 60 day PE period, required info needed at PE intake, and PE provider completing PE application. The response was returned on 08/10 via e-mail.** **Implementation status: The web-based application has been developed and testing is underway.** **Meetings have been held with the administrative staff of FQHC's, Dept Health and DSH where they were informed of the PE process and their roles in the process. Two providers - Jackson Hinds and UMC- staff have been trained. When the web-based application is finalized, these staff person will be given a refresher training before actually going live.** **EDS has completed software development for MMIS processing, however, ACS, the new fiscal agent, will need to modify the system to allow day specific eligibility. (Estimated completion date, 4/02.)**

WORK PLAN AND IMPLEMENTATION STATUS REPORT

OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID

2001 Legislative Session

BILL NUMBER	CODE SECTION	LANGUAGE ADDED/CHANGED/DELETED	IMPLEMENTATION STATUS AS OF 8/10/01
		Medicaid of the determination of presumptive eligibility within five (5) working days after the date on which the determination is made. (f) The Division of Medicaid shall provide qualified entities with such forms as are necessary for an application to be made on behalf of a child for eligibility under this chapter. The Division of Medicaid shall make those application forms and the application process itself as simple as possible.	
HB 444: Extended dental benefits for CHIP consumers.	§41-86-17(1)	41-86-17..... The program also may cover other dental services including amalgam and composite restorations, extractions, space maintainers, stainless steel crowns, sealants, pulpotomies, pulpectomies, and treatment of periodontal disease. The program may exclude from participation in the program any health care providers who do not agree to hold the families of recipients harmless for charges in excess of plan payments for covered benefits.	DFA working with BC/BS is the process of developing a provider directory of dentists who are willing accept BC/BS's CHIP payment as payment as full payment for services rendered and not balance bill the patient. A CHIP recipient will be able to receive expanded dental services as of 01/01/02.
HB 444: Removes Repealer	Section 10 Chapter 572, Laws of 1998	This act shall take effect and be in force from and after its passage * * *.	
HB 767: Adolescent psychiatric beds; authorize CON for additional in Lauderdale County.	§41-7-191(1) (b)	CHANGED: (b) The relocation of a health care facility or portion thereof, or major medical equipment, unless such relocation of a health care facility or portion thereof, or major medical equipment, which does not involve a capital expenditure by or on behalf of a health care facility, is within five thousand two hundred eighty (5,280) feet from the main entrance of the health care facility;	No effect on Medicaid at this time.
30 Medicaid nursing beds for Lowndes County	§41-7-191(2) (k)	CHANGED: From and after July 1, 2001, the prohibition on the facility participating in the Medicaid program (Section 43-13-101 et seq.) that was a condition of issuance of the certificate of need under this paragraph (k) shall be revised as follows:	No action required by Medicaid. State Department of Health tracks these beds.

WORK PLAN AND IMPLEMENTATION STATUS REPORT

OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID

2001 Legislative Session

BILL NUMBER	CODE SECTION	LANGUAGE ADDED/CHANGED/DELETED	IMPLEMENTATION STATUS AS OF 8/10/01
HB 767 (Continued)		**The nursing facility may participate in the Medicaid program from and after July 1, 2001, if the owner of the facility on July 1, 2001, agrees in writing that no more than thirty (30) of the beds at the facility will be certified for participation in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than thirty (30) patients in the facility in any month or for any patient in the facility who is in a bed that is not Medicaid-certified. This written agreement by the owner of the facility shall be a condition of licensure of the facility, and the agreement shall be fully binding on any subsequent owner of the facility if the ownership of the facility is transferred at any time after July 1, 2001. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than thirty (30) of the beds in the facility for participation in the Medicaid program. If the facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than thirty (30) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the written agreement.**	
Gives priority to county owned nursing facilities in the counties of Yalobusha, Newton and Tallahatchie for increasing nursing home beds in case of multiple applications for a CON.	**§41-7-191(2) (q) (vi)**	**ADDED: (vi) If more than one (1) application is made for a certificate of need for nursing home facility beds available under this paragraph (q), in Yalobusha, Newton or Tallahatchie County, and one (1) of the applicants is a county-owned hospital located in the county where the nursing facility beds are available, the department shall give priority to the county-owned hospital in granting the certificate of need if the following conditions are met:**	**No action required by Medicaid. State Department of Health tracks these beds.**

WORK PLAN AND IMPLEMENTATION STATUS REPORT

OFFICE OF THE GOVERNOR, DIVISION OF MEDICAID

2001 Legislative Session

BILL NUMBER	CODE SECTION	LANGUAGE ADDED/CHANGED/DELETED	IMPLEMENTATION STATUS AS OF 8/10/01
HB 767 (Continued)		**1. The county-owned hospital fully meets all applicable criteria and standards required to obtain a certificate of need for the nursing facility beds; and** **2. The county-owned hospital's qualifications for the certificate of need, as shown in its application and as determined by the department, are at least equal to the qualifications of the other applicants for the certificate of need.**	
Updates total PRTF beds for state	**§41-7-191(3)**	**CHANGED: .....The total number of beds which may be authorized by such certificates of need shall not exceed three hundred thirty-four (334) beds for the entire state.**	**Reimbursement maintains a bed count spreadsheet to monitor CONs as they come to the agency to ensure the number of beds approved does not exceed the number authorized by law.**
Sets deadline for Warren County to construct or convert to PRTF beds (30 Medicaid)	**§41-7-191(3)(b)**	**ADDED: ..... If by January 1, 2002, there has been no significant commencement of construction of the beds authorized under this paragraph (b), or no significant action taken to convert existing beds to the beds authorized under this paragraph, then the certificate of need that was previously issued under this paragraph shall expire. If the previously issued certificate of need expires, the department may accept applications for issuance of another certificate of need for the beds authorized under this paragraph, and may issue a certificate of need to authorize the construction, expansion or conversion of the beds authorized under this paragraph.**	**Facility states that they will begin construction before January 1, 2002.**
HB 767 Provides a CON to a certain hospital in Lauderdale County for an additional 60 child/adolescent PRTF beds. Priority shall be given to patients who otherwise would require out-	**§41-7-191(3)(f)**	**ADDED: (f) The department shall issue a certificate of need to a one-hundred-thirty-four-bed specialty hospital located on twenty-nine and forty-four one-hundredths (29.44) commercial acres at 5900 Highway 39 North in Meridian (Lauderdale County), Mississippi, for the addition, construction or**	**Facility plans to open in early Spring 2002, however their problem is deciding whether to construct the beds or convert existing beds from their Medical/Surgery facility. We cannot comply with the notification of parents section of this statute without violating federal regulations. We can give the number of kids out of state but not their names.**

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of-state placement. **HB 767 (Continued)**		**expansion of child/adolescent psychiatric residential treatment facility beds in Lauderdale County. As a condition of issuance of the certificate of need under this paragraph, the facility shall give priority in admissions to the child/adolescent psychiatric residential treatment facility beds authorized under this paragraph to patients who otherwise would require out-of-state placement. The Division of Medicaid, in conjunction with the Department of Human Services, shall furnish the facility a list of all out-of-state patients on a quarterly basis. Furthermore, notice shall also be provided to the parent, custodial parent or guardian of each out-of-state patient notifying them of the priority status granted by this paragraph. For purposes of this paragraph, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of child/adolescent psychiatric residential treatment facility beds that may be authorized under the authority of this paragraph shall be sixty (60) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this paragraph or for the beds converted pursuant to the authority of that certificate of need.**	
HB 767 Transfer of 60 hospital beds from North Panola to South Panola.	**§41-7-191(15)**	**ADDED: (15) The State Department of Health may authorize the transfer of hospital beds, not to exceed sixty (60) beds, from the North Panola Community Hospital to the South Panola Community Hospital. The authorization for the transfer of those beds shall be exempt from the certificate of need review process.**	**The Health Department has issued a letter stating the transfer is exempt from CON review and may proceed. South Panola currently has the beds on hold.**

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HB 881: Technical Amendments Services for special needs children in non-Title IV-E adoption assistance. Category of service for treatment of women with Breast and Cervical Cancer. Provides Medicaid eligibility for foster children in the custody of DHS on their 18th birthday to be extended until their 21st birthday. Provides for Reimbursement for covered prescription drugs and over-the-counter drugs to individuals who would be eligible for services in a nursing home but who live in a non-institutional setting and who spend 50% of their monthly income on prescription drugs and over-the-counter drugs. Authorizes civil money penalties. Provides that recipients found to have misused benefits may be restricted to one physician and/or pharmacy for purposes as to appropriate access to health care. Clarifies Medicaid reimbursement for implantable programmable pumps. Additional technical amendments are included in this bill as well.	§43-13-115(6)	ADDED: .....including special needs children in non Title IV-E adoption assistance.	Coverage Group implemented; Currently waiting on State Plan Amendment approval by CMS. We have been notified that the approval has been authorized by their central office. We expect to receive official approval within next two weeks.
	§43-13-115(11)	DELETED: (a) Until December 31, 1999, whose income does not exceed one hundred percent (100%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually, and from and after January 1, 2000, INSERTED: ,and whose resources do not exceed those established by the Division of Medicaid.	
	§43-13-115(13)(a)	ADDED: Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums.	This was acknowledged.
	§43-13-115(23)	ADDED: (23) Children certified by the Mississippi Department of Human Services for whom the state and county human services agency has custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their twenty-first birthday.	State Plan Amendment approved by CMS on 8/14/01 with an effective date of 7/01/01.
	§43-13-115(24)	ADDED: (24) Individuals who have not attained age sixty-five (65), are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of that act and who need treatment for breast or cervical cancer. Eligibility of individuals under this paragraph	Coverage Group implemented; State Plan Amendment approved by CMS on 8/14/01 with an effected date of 7/01/01.

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		(24) shall be determined by the Division of Medicaid.	
HB 881 (Continued) Xref HB 1238: 50% of income spent on prescription drugs medicaid eligible.	§43-13-115(25)	(25) Individuals who would be eligible for services in a nursing home but who live in a noninstitutional setting, whose income does not exceed the amount prescribed by federal regulation for nursing home care, and who regularly expend more than fifty percent (50%) of their monthly income on prescription drugs and over-the-counter drugs. The eligibility of individuals covered under this paragraph (25) shall be determined by the Division of Medicaid. The individuals determined eligible shall be eligible only for prescription drugs and over-the-counter drugs covered under Section 43-13-117(9) and not for any other services covered under Section 43-13-117. The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (25). The provisions of this paragraph (25) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.	Researching the possibilities for different types of waivers. CMS has indicated that any waiver/program implemented by states prior to a CMS Prescription Drug program may be required to be funded with state dollars only. This needs to be confirmed.
Precertification of inpatient days	§43-13-117(1)(a)	ADDED: Precertification of inpatient days must be obtained as required by the division.	No action required, (current practice)
Implantable programmable pumps	§43-13-117(1)(c)	CHANGED: Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity which is implanted	State Plan Amendment 2001-17 updating the plan's reference to implantable pumps was approved by CMS on 9/24/01 with an effective date of 7/01/01.

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	§43-13-117(4)(a)	on an inpatient basis. .... This paragraph (c) shall stand repealed on July 1, 2005. DELETED: ..... However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.	System changes are completed and providers have been notified. Update of Medicaid Policy Manual is required. Several sections ar affected by this.
HB 881 Deletes certain limitations on reimbursement for management fees and home office costs for nursing facilities, intermediate care facilities and PRTFs	§43-13-117(4)(b)	DELETED: The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows: A maximum of up to three percent (3% shall be allowed where centralized managerial and administrative services are provided by the management company or home office. A maximum of up to five percent (5% shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided. A maximum of up to seven percent (7% shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.	No action necessary.

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Physician Visits	**§43-13-117(6)**	**Physician's services. The division shall allow twelve (12) physician visits annually.**	
Pre-certification	**§43-13-117(7)(a)**	**ADDED: All home health visits must be precertified as required by the division.**	
Prescription Drug Limits without prior approval	**§43-13-117(9)**	**CHANGED: The division shall allow ten (10) prescriptions per month for noninstitutionalized Medicaid recipients. * * ***	
Deletes requirement for authorization to be filled with DOM	**§43-13-117(12)(a)**	**DELETE: .....However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.**	**System changes are completed and providers have been notified. Update of Medicaid Policy Manual is required. Several sections ar affected by this.**
Pre-certification of DME	**§43-13-117(17)**	**CHANGED: ....Precertification of durable medical equipment and medical supplies must be obtained as required by the division.**	**Clean-up language, (no action required)**
Pre-certification of inpatient and residential treatment days	**§43-13-117(23)**	**CHANGED: .....Precertification of inpatient days and residential treatment days must be obtained as required by the division. *** **	**Clean-up language, (no action required)**
Reimbursement of Physician Assistant Services	**§43-13-117(45)**	**ADDED: (45) Physician assistant services. Services furnished by a physician assistant who is licensed by the State Board of Medical Licensure and is practicing with physician supervision under regulations adopted by the board, under regulations**	**Changes have been completed to allow this provider type. Provider Relations has completed its work on this task. State Plan Amendment is under development for submission to CMS.**

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		adopted by the division. Reimbursement for those services shall not exceed ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.	
Waiver for children with SED (See ICCCY bill)	§43-13-117(46)	ADDED: (46) The division shall make application to the federal Health Care Financing Administration for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.	First meeting of the ICCCY committee was held on August 7, 2001 A council will be formed and at that time DOM will request input in developing a mental health waiver.
Retention period of documentation to substantiate cost reports	§43-13-117(46)	ADDED : ..... Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the medical assistance program to keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report	It has been clarified that the Division will continue to make rate adjustments based on review findings once those reviews are completed, unaffected by the three-year retention requirement for documentation. The nursing facility policy manual is currently being rewritten, and the appropriate changes relative to this section will be included in the updated version. The processes for amending the State Plan and the provider agreements can also now be put into motion.
Recipients abusing medical assistance benefits may be locked into one provider.	§43-13-121(1)(l)	ADDED: ..... Recipients who are found to have misused or abused medical assistance benefits may be	CSR to modify MMIS for lock-in will not be executed by the current fiscal agent (EDS). ACS takes over in January 2002 and can start the CSR at that time.

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		locked into one (1) physician and/or one (1) pharmacy of the recipient's choice for a reasonable amount of time in order to educate and promote appropriate use of medical services, in accordance with federal regulations.	
Civil Money Penalties	§43-13-121(1)(o)	(o) The division shall impose penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the Department of Health and Human Services and/or the Health Care Financing Administration under federal regulations.	State Plan Amendment submitted; program currently in effect.
HB 929: Comprehensive Plan for Persons with Disabilities	New Act, pending codification	NEW: Designates DOM as lead agency; Requires development of a plan for the provision of services to persons with disabilities in the most integrated setting appropriate. Includes other state agencies, consumer groups, providers, etc...	MAC Plan completed and submitted to Legislature 9/30/01.
HB 1000: Nursing Facility Services for the Severely Disabled	§43-13-117(44)	ADDED: (44) Nursing facility services for the severely disabled. (a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients. (b) Those services must be provided in a long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities, and shall be reimbursed as a separate category of nursing facilities.	Reimbursement staff have been in regular contact with representatives of Methodist Rehab, and Methodist staff are working on pro forma data that will provide us the information required to determine the payment methodology for this unique facility. Once that data is in hand, we can proceed to amend the State Plan and develop a provisional rate to accommodate the provision of services.

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HB 1275: Interagency Coordinating Council for Children and Youth	**§§ 43-14-1 43-14-3 43-14-5 43-14-7**	**CHANGED: (1) The purpose of this chapter is to provide for the development and implementation of a coordinated interagency system of necessary services and care * * * for children and youth up to age twenty-one (21) with serious emotional/behavioral disorders, including, but not limited to, conduct disorders, or mental illness who require services from a multiple services and multiple programs system, and who can be successfully diverted from inappropriate institutional placement. This program is to be done in the most fiscally responsible (cost efficient) manner possible, based on an individualized plan of care which takes into account other available interagency programs, including, but not limited to, Early Intervention Act of Infants and Toddlers, Section 41-87-1 et seq., Early Periodic Screening Diagnosis and Treatment, Section 43-13-117(5), waivered program for home- and community-based services for developmentally disabled people, Section 43-13-117(29), and waivered program for targeted case management services for children with special needs, Section 43-13-117(31), those children identified through the federal Individuals with Disabilities Education Act of 1997 as having a serious emotional disorder (EMD), the Mississippi Children's Health Insurance Program Phase I and Phase II and waivered programs for children with serious emotional disturbances, Section 43-13-117(46), and is tied to clinically appropriate outcomes. Some of the outcomes are to reduce the number of inappropriate out-of-home placements inclusive of those out-of-state and to reduce the number of inappropriate school suspensions and expulsions for this population of children. From and after July 1, 2001, this coordinated interagency system of necessary services and care shall be named the System of Care program.**	**First meeting of the ICCCY committee was held on August 7, 2001 A council will be formed and at that time DOM will request input in developing a mental health waiver.**

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HB 1275 (Continued)		**Children to be served by this chapter who are eligible for Medicaid shall be screened through the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) and their needs for medically necessary services shall be certified through the EPSDT process. For purposes of this chapter, a "System of Care" is defined as a coordinated network of agencies and providers working as a team to make a full range of mental health and other necessary services available as needed by children with mental health problems and their families. The System of Care shall be: ..... (*Additional requirements in bill)***	
SB 2424: Upper Payments Limits Program for hospital Medicaid reimbursement.	**§ 43-13-117(18) (b)(c)**	**ADDED: (b) The division shall establish a Medicare Upper Payment Limits Program as defined in Section 1902 (a) (30) of the federal Social Security Act and any applicable federal regulations. The division shall assess each hospital for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. This assessment shall be based on Medicaid utilization, or other appropriate method consistent with federal regulations, and will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals for the Medicare Upper Payment Limits as defined in Section 1902 (a) (30) of the federal Social Security Act and any applicable federal regulations. This paragraph (b) shall stand repealed from and after July 1, 2005.** **(c) The division shall contract with the Mississippi Hospital Association to provide administrative support for the operation of the disproportionate share hospital program and the Medicare Upper Payment Limits Program. This paragraph (c) shall stand repealed from and after July 1, 2005.**	**State Plan Amendment 2001-12 establishing the UPL program was approved by CMS on 7-25-01, effective 4-01-01. Reimbursement staff have been working with the Mississippi Hospital Association (MHA) toward the implementation of this program. The state-owned hospitals have received upper payment limit adjustments for the period 10/1/00 to 3/31/01. This program is now well under way for UPL reimbursement for in-patient services. The "catch-up" payment was made in September, 2001, to all eligible hospitals for the period 4/1/01 through 9/30/01. The first payment for FFY 2002, was made on 11/29/01.**