FIRST

ANNUAL REPORT

OF

MISSISSIPPI MEDICAID COMMISSION

Fiscal Year

Ending June 30, 1970

MISSISSIPPI MEDICAID COMMISSION
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ALTON B. COBB, M.D., M.P.H.
DIRECTOR

November 1, 1970

Honorable John Bell Williams
Governor of Mississippi
and
Members of the Mississippi State Legislature
New Capitol Building
Jackson, Mississippi 39201

Dear Sirs:

We submit herewith the first Annual Report of the Mississippi Medicaid Commission, which is for the Fiscal Year ending June 30, 1970.

This Report is submitted in accordance with the requirements of Section 14 of the Medicaid Enabling Act, House Bill No. 2 of the 1969 Extraordinary Session of the Mississippi Legislature.

Respectfully submitted,

Earl Evans, Jr.
Chairman

Alton B. Cobb, M.D.
Director

EE,Jr:mts
Attachment

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CONTENTS

Mississippi's Medicaid Program

Introduction Medicaid is a program of medical assistance for the needy administered by the states in accordance with provisions of Title XIX of the Social Security Act.

Mississippi began participation in Medicaid on January 1, 1970. The State's Medicaid Program is administered by the Mississippi Medicaid Commission, which was established by House Bill No. 2 of the 1969 Extraordinary Session of the Mississippi Legislature. This law made the benefits of the Medicaid Program available to the following groups of needy persons:

Those who are qualified for public assistance grants under provisions of the following Titles of the Social Security Act as administered by Mississippi's State Department of Public Welfare:

Title I —Old Age Assistance
Title IV —Aid to Dependent Children
Title X —Aid to the Blind
Title XIV—Aid to the Permanently and Totally Disabled;

Children in foster homes or private institutions for whom Mississippi public agencies are assuming financial responsibility;

Children under twenty-one (21) years of age who, except for age or school attendance requirements, would be dependent children under the Aid to Dependent Children Program (ADC);

Persons who are patients in a medical facility and who, if they left such facility, would qualify for assistance (money) payments under Old Age Assistance, Aid to the Permanently and Totally Disabled, Aid to the Blind, or Aid to Dependent Children Programs.

There are approximately 200,000 persons in Mississippi eligible for Medicaid benefits. Benefits available to these persons under Medicaid include the following services:

Inpatient Hospital Services
Outpatient Hospital Services
Skilled Nursing Home Services
Physicians' Services
Laboratory and X-Ray Services
Pharmacy Services
Emergency Ambulance Services
Dental Services
Home Health Services
Eyeglasses Necessitated by Eye Surgery
Christian Science Sanatoria Care and Services
Periodic Screening and Diagnostic Services for Children.

Payments for these services are made with 83 percent Federal funds and 17 percent State funds. Participation in Medicaid is entirely voluntary for all providers of authorized medical services.

Hospitals, laboratories, skilled nursing homes, pharmacies, ambulance companies, and home health agencies must meet professional standards and sign a participation agreement in order to receive payment for services provided to Medicaid recipients.

A physician or dentist participates in Medicaid when authorized care is provided and a Medicaid claim is submitted for payment.

All medical personnel and institutions participating in the Medicaid Program must be licensed by their respective State licensing agencies.

Report Summary This report reviews the first six months' operation of the Mississippi Medicaid Program — a period during which a claims system was being designed and implemented, not all authorized services were operational, and not all Medicaid recipients were identified and certified as eligible for the Program.

No program of the size and complexity of the Medicaid Program can be initiated without many problems in claims administration and coordination of benefits with providers and recipients. We have tried to resolve these problems promptly and to administer the Medicaid Program as effectively and efficiently as possible. A few administrative "rough spots" remain to be fully resolved. Solutions for these problems are under continuous staff effort by the Medicaid Commission, State Department of Public Welfare, and other concerned agencies.

For the most part, the health providers in our State, clients, and others concerned with the operation of the Medicaid Program have been most cooperative and understanding during the organizational period required to implement the Program. The Commission and its staff appreciate the assistance and cooperation of all concerned in bringing the Program to a fully operational level.

Operation of the Mississippi Medicaid Program

for the Fiscal Year Ending June 30, 1970

History On October 10, 1969, Governor John Bell Williams signed House Bill No. 2 of the 1969 Extraordinary Session of the Mississippi Legislature into law, making it possible for Mississippi to participate in Medicaid. Approval of H.B. No. 2 culminated many months of work by a Public Health Advisory Committee composed of Legislators and State health leaders. The Committee studied the effect the Medicaid Program would have on State public health activities and recommended that the Program be enacted in Mississippi.

The Mississippi Medicaid Commission held its first organizational staff meeting in October of 1969. Within a period of a few weeks prior to January 1, 1970, a State Plan for Title XIX was written and approved, a fiscal intermediary was selected through normal bid processes, claim forms were in the hands of eligible providers, and an identification system was established for Medicaid clients.

A Medicaid Program covering the major services required by law for Federal funding was implemented on January 1, 1970. These major services offered as of January 1, 1970, included:

Inpatient and Outpatient Hospital Services (including tuberculosis institutions)
Physicians' Services
Skilled Nursing Home Services
Laboratory and X-Ray Services

An agreement was also made with the State Board of Health for that agency to provide periodic screening and diagnostic services for Medicaid eligible children under age twenty-one (21).

Since January 1, 1970, participation in the Medicaid Program by institutional and professional providers of health services in Mississippi has been generally good. In a few communities, provider participation is low. Most professional providers participating in the Program do so at less than their usual charges. During the 1970 fiscal year, over 1,000 physicians (about 65 per cent of the State's physicians in full-time, private practice) filed claims for services rendered to Medicaid clients, and all but a few hospitals and skilled nursing homes eligible to participate in the Program did so.

Identification and Certification of Clients Under requirements of Federal and State law, the State Department of Public Welfare is responsible for determining eligibility for Medicaid benefits. Many difficulties have been experienced in this regard due primarily to the short time available to set up an automated computer system to certify Medicaid eligibility data as of January 1, 1970 (and each month thereafter).

On January 1, 1970, the State Department of Public Welfare could only certify Medicaid eligibility for persons on the Old Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled Programs. In February 1970, eligibility was certified for persons on the Aid to Dependent Children Program. The number of clients, certified initially in each assistance category, is shown in Table 1. These persons receive monthly identification cards to facilitate their obtaining needed medical services.

Table 1.—Number of Persons Initially Certified as Eligible and Date of Certification by Program Category

Program Category	Persons Certified	Date Certified
Total	192,100	
Old Age Assistance	74,000	January 1970
Aid to the Blind	2,100	January 1970
Aid to Permanently and Totally Disabled	22,000	January 1970
Aid to Dependent Children	94,000	February 1970

There are two additional categories of eligible persons who have not been certified by the State Department of Public Welfare. Approximately 20,000 children between sixteen and twenty-one years of age are, by law, eligible for Medicaid benefits but have not been identified and certified by the Welfare Department. Over 1,000 children in foster homes are also eligible for Medicaid benefits but have not been certified. The State Department of Public Welfare has applied all available staff to the problem of certification of Medicaid clients and has utilized a team of data processing consultants to set up a system for monthly computer tape updates of eligibility certification.

The number of public assistance recipients who are also Medicaid clients totals over 200,000. The exact total of Medicaid clients, the total number of applications made, the number of applications approved, and the number of applications denied, as called for in Sec. 14 (a), (c), (d), and (e) of H.B. No. 2 of the 1969 Extraordinary Session, must come from the State Department of Public Welfare, which, by law, has the responsibility of determining eligibility. This information will be included in the 1970 annual report of the State Department of Public Welfare.

Utilization of Program Utilization of services covered under the Medicaid Program did not reach expected levels until several months after the Program began. For example, in January, the first month the Medicaid Program was operational, 5,356 claims were filed for services provided to Medicaid recipients; in June, 37,245 claims were filed.

During the period January - June, 1970, 45 percent of all certified clients received one or more services (including payment of Part B premiums) under the Medicaid Program, as shown in Table 2. Utilization by Old Age Assistance clients is greatest because premiums for Medicare Part B were paid for all clients whose Medicare eligibility could be verified by the Social Security Administration. As would be expected, clients in the Aid to the Permanently and Totally Disabled category utilized the Medicaid services more than clients in the Aid to the Blind or Aid to Dependent Children categories.

Table 2.—Rate of Utilization by Program Category
January - June 1970

Program Category	Percent of Certified Eligibles Served
Total of all categories	45.0
Old Age Assistance	91.2
Aid to the Blind	25.0
Aid to Permanently and Totally Disabled	34.0
Aid to Dependent Children	12.3

FY 1970 Expenditures for Services

A total of $8,249,089 was expended for services provided during January - June, 1970, as illustrated in Table 3. The largest amount was spent for skilled nursing home services with over 32 percent or 2.6 million dollars of the total amount of provider payments expended for this particular service. Over 28 percent of the funds or 2.3 million dollars were paid out for hospital services. The remaining 3.2 million dollars were expended for physicians' services, the payment of Medicare Part B premiums, screening and diagnostic services, and laboratory and x-ray services.

Table 3.—Expenditures for Service and Percentage Distribution, by Type of Service
January - June 1970

Type of Service	Amount Spent	Percent
Total	$8,249,089	100.00
Skilled Nursing Home	2,683,205	32.53
Inpatient Hospital	2,219,508	26.91
Outpatient Hospital	95,041	1.15
Physician	1,632,297	19.79
Part B, Medicare, Buy-In*	1,611,416	19.53
Tuberculosis Institution	5,016	.06
Screening and Diagnostic	1,720	.02
Laboratory and X-Ray	886	.01

*Payment of the Medicare Part B premium for clients in the Old Age Assistance category.

Using the total payments made as of June 30, 1970, some conclusions may be drawn regarding average expenditures per recipient and per unit of service. Tables 4, 5, and 6 illustrate payments made per recipient during January - June, 1970. Additional payments for services rendered in this period were made after June 30, 1970, but were not tabulated with a recipient count or units of service.

Payments were made to skilled nursing homes for 2,484 different recipients during the period January - June, 1970. They received 295,943 days of care, for an average length of stay of 119.1 days and an average cost of $826.98 per recipient or an average per day of $6.94 as shown in Table 4.

The Mississippi Medicaid Commission pays the premium for Part B of Medicare for all recipients who are 65 years of age and older and meet the requirements of the Social Security Administration. During this report period the premium was $4.00 monthly; therefore, the reported expenditure of $1,611,416 for Part B Buy-In represents an average of 67,142 Old Age Assistance recipients a month for whom Part B Medicare benefits (physicians' services and others) were made available. Medicaid also pays the Part B deductible and 20 percent co-insurance. For those recipients in the OAA category who have Medicare Part A, Medicaid pays the deductible applicable to inpatient hospital services. Recipients of Medicare Parts A and B services are not included in the reports of recipient utilization of hospital and physicians' services that follow.

For the 17,762 recipients for whom payment was made for physicians' services during January - June, 1970, an average of $25.98 per recipient for physicians' services was spent, as shown in Table 5. A total of 59,821 visits were made to physicians by the recipients in the Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Dependent Children Programs. This represented 3.4 visits per recipient at an average cost of $7.87 per visit. For reporting purposes, no distinction is made between surgical fees and office visits.

During January - June, 1970, payments were made for 2,910 hospital discharges of recipients in the Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Dependent Children categories with 20,876 days of care provided for an average length of stay of 7.2 days. The average cost per day for these three categories of recipients was $44.21 and an average of $317.15 per discharge was spent for the recipients requiring hospitalization as shown in Table 6.

Table 4.—Recipients of Skilled Nursing Home Care, Days of Care and Average per Recipient, and Average Spent per Recipient and per Day, by Program Category

January - June 1970

Program Category	Recipients	Days of Care		Average Amount Spent	
		Total	Average per Recipient	Per Recipient	Per Day
Total of all categories	2,484	295,943	119.1	$ 826.98	$6.94
Old Age Assistance	2,308	275,871	119.5	830.14	6.95
Aid to the Blind	5	717	143.4	1,003.80	7.00
Aid to Permanently and Totally Disabled	171	19,355	113.1	779.27	6.88
Aid to Dependent Children	- 0 -	- 0 -	- 0 -	- 0 -	- 0 -

Table 5.—Recipients of Physicians' Services, Total Visits and Average per Recipient, and Average Expenditure per Recipient and per Visit, by Program Category

January - June 1970

Program Category	Recipients	Number of Visits		Average Amount Spent	
		Total	Average per Recipient	Per Recipient	Per Visit
Total of all categories	17,762	59,821	3.4	$25.98	$7.87
Aid to the Blind	447	2,181	4.9	40.62	8.33
Aid to Permanently and Totally Disabled	6,517	36,214	5.7	41.58	7.48
Aid to Dependent Children	10,798	21,426	2.0	16.83	8.48

Table 6.—Inpatient Hospital Discharges, Total Days of Care and Average Length of Stay, and Average Expenditure per Discharge and per Day, by Program Category

January - June 1970

Program Category	Number of Discharges	Days of Care		Average Amount Spent	
		Total Days of Care	Average Length of Stay	Average Spent Per Discharge	Average Spent Per Day
Total of all categories	2,910	20,876	7.2	$317.15	$44.21
Aid to the Blind	116	913	7.9	377.52	47.97
Aid to Permanently and Totally Disabled	2,107	16,493	7.8	345.04	44.08
Aid to Dependent Children	687	3,470	5.0	221.40	43.86

Of the amount expended for medical services during January - June, 1970, about 70 percent was paid for services rendered to Old Age Assistance recipients, as shown in Figure 1. These OAA recipients represent over 75 percent of the clients for whom one or more services was provided. Services provided to this group include the payment of the Medicare Part B premium.

Recipients of Aid to the Permanently and Totally Disabled Program represented less than 10 percent of the total number of recipients for whom medical payments were made and accounted for about 20 percent of the expenditures for medical services.

The number of recipients and dollars spent in the ADC Program were both low. As previously noted, this group did not receive Medicaid Identification Cards at the beginning of the fiscal year. Additionally, two other groups of children; *i.e.*, those in foster homes and those 16 years of age and older who, except for age or school attendance, would be eligible ADC, have not as yet received Medicaid Identification Cards.

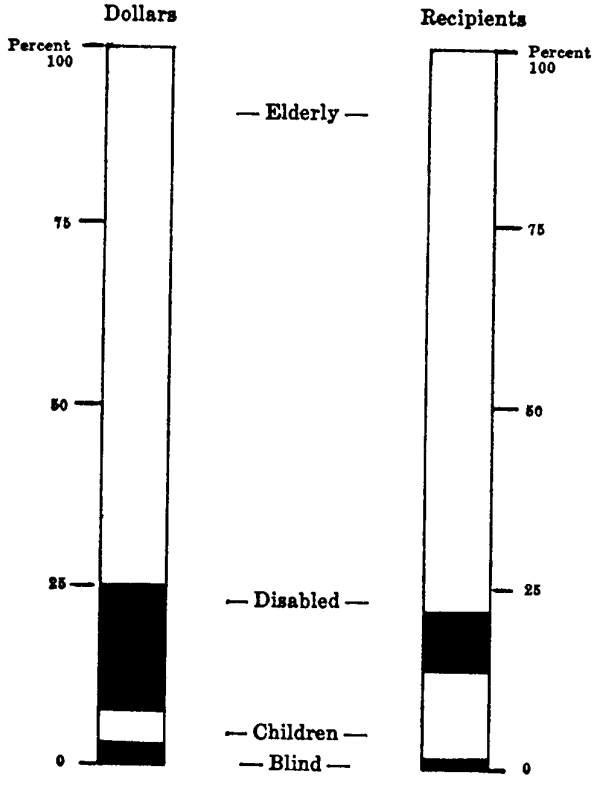

Figure 1.—Percentage Distribution for Dollars and Recipients for whom Medical Services were Provided

Lapsed Funds A total of $1,256,879.59 in State funds was available, but not expended, for medical services under the Medicaid Program in FY 1970. This amount, matched by Federal funds, would have totaled $7,393,409.37. Failure to spend these funds was due to eligibility certification problems, time required for recipient and provider understanding of a new program, and the impossibility of obtaining a fiscal intermediary for several services prior to July 1, 1970.

It was impossible to obtain a qualified fiscal intermediary to administer a claims program for all Medicaid services authorized and funded by the Legislature for implementation on January 1, 1970; therefore, a total of $508,050.00 in State funds for these non-implemented services lapsed at the end of the 1970 fiscal year, as illustrated in Table 7.

Table 7.—Amount of State Appropriation for Non-Implemented Services January - June 1970

Type of Service	Amount of State Appropriation
Total	$508,050.00
Drugs	470,200.00
Dental	21,000.00
Home Health	8,350.00
Eyeglasses	4,250.00
Ambulance	4,250.00

In addition, some of the funds available for services authorized and implemented on January 1, 1970, lapsed at the end of the 1970 fiscal year as required by State law. These funds, as shown in Table 8, lapsed because of low utilization in the introductory period of the Program. Although recipient utilization of services covered under the Medicaid Program did not reach expected levels until several months after the Program began, utilization is increasing at the expected rate, and it is anticipated that Program expenditures will closely approximate available funds for the fiscal year ending June 30, 1971.

Table 8.—Amount of State Appropriation Unused for Implemented Services January - June 1970

Type of Service	Amount of Unused State Appropriation
Total	$748,829.59
Inpatient and Outpatient Hospital	108,101.56
Skilled Nursing Home	79,355.12
Physicians	346,068.69
Laboratory and X-Ray	110,449.41
Tuberculosis Institutions	50,147.28
Screening and Diagnostic	54,707.53

Federal Funds Regulations of Title XIX of the Social Security Act provide that Mississippi shall receive Federal funds for 83 percent of the cost of provider services, 75 percent of the cost of professional staffing and related administrative costs, and 50 percent of other administrative costs, as shown in Figure 2. This results in 79.3 percent of Medicaid expenditures being Federal funds.

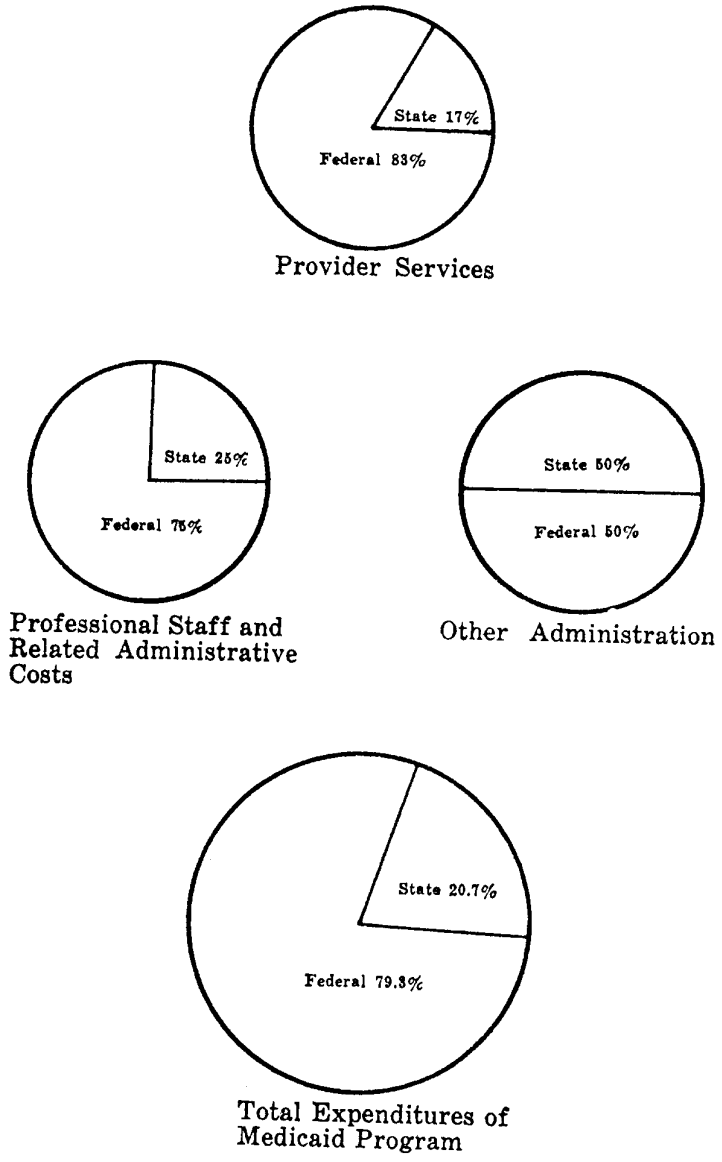

Figure 2.—Source of Funds by Type of Expense and Percentage Distribution of State and Federal Funds

As illustrated earlier in this report, a total of $8,249,089 was expended for provider services. Of this amount, the Federal share was $6,846,744; the State share was $1,399,701; and $2,644 was funds collected from "third-party sources."

In accordance with the State Plan for Title XIX, the Mississippi Medicaid Commission requires reimbursement for authorized services where there is third party liability. At the time of a recipient's admission to a hospital and at each of his visits to a doctor's office or other provider of service, a determination is made as to whether the recipient has third party coverage. The Medicaid Program will allow a provider to file a Medicaid claim before a third party payment has been received. However, since the Medicaid liability is always secondary, it is required that any third party payments be used to reduce Medicaid liability and cost and the provider is required to declare and refund any and all collections. A total of $2,644 was collected in this manner and was used to reduce the cost of provider services from $8,249,089 to $8,246,445. Expenditures for professional staffing and related administrative costs totaled $124,792 in Federal funds and $62,426 in State funds. Other administrative expenditures totaled $491,433 in Federal funds and $491,433 in State funds.

Total administrative expenditures reached $1,170,084. Of this amount, $710,014.00 or 7.5 percent of total Program expenditures was for professional and administrative costs and $460,070.00 or 4.9 percent of total expenditures was for non-recurring capital outlays. Title to all office equipment, computer programs, and other capital outlays necessary to effectively and efficiently operate the Medicaid Program rests with the State of Mississippi.

Based upon a percentage of total Program expenditures, administrative costs have shown a monthly decline from 14.7 percent in the first month of claims payment to 6.1 percent in June, the final month of the fiscal year.

Administrative Activities The Mississippi Medicaid Commission has held regularly scheduled monthly meetings and additional meetings during fiscal year 1970 for planning, reviewing, and approving all operational aspects of the Medicaid Program. During FY 1970, the Commission had eleven professional and five secretarial staff members.

Fiscal Intermediary Under provisions of the State's Medicaid Enabling Act, the administration of the Medicaid claims payment system may be performed either by the Commission or by an insurance company under the supervision of the Commission. When the Commission was formally organized in October 1969, it was apparent that it would be impossible for the Commission to staff and operate a claims payment system by January 1, 1970. The services of an insurance company were, therefore, sought by means of the 21-day bidding process authorized in the Medicaid Enabling Act. The Commission retained the services of a nationally recognized management consultant firm to assist in formulating bid specifications for operation of the Medicaid Program and evaluating bid and cost proposals in this regard.

The Commission received several expressions of interest in administering the Medicaid claims payment system from outstanding insurance companies. Only one of these companies, the Mississippi Hospital and Medical Service, was willing to make a firm bid proposal to undertake the operation of the Medicaid claims payment system on January 1, 1970.

The Mississippi Hospital and Medical Service is a non-profit medical and hospital service corporation organized under the laws of the State of Mississippi. The company serves as the Federal Government's intermediary for Part A of Medicare, the hospital portion of the Civilian Health and Medical Program of the Uniformed Armed Services, and the Federal Employees Insurance Program.

The Commission's contract with the Mississippi Hospital and Medical Service provides for reimbursement of administrative expenses based upon actual audited reasonable costs. Cost reimbursement principles for this purpose are well established under the Medicare Program.

The contract is for an annual period of time and monthly advances of administrative funds are made to the Mississippi Hospital and Medical Service based upon a reasonable projection of administrative costs over the annual period. The monthly advances are subject to adjustment based upon actual cost experience.

Utilization Reporting System

Over-utilization of health services and fraud have been two of the most highly publicized aspects of Medicaid Programs in other states. In most instances, adequate information on utilization of health services has been lacking. The Mississippi Medicaid Commission has established a system to detect over-utilization of health services provided under Medicaid and fraud.

Medicaid's utilization reporting system includes information on both providers and recipients. The system establishes a set of standard indices against which services rendered by each provider or the service received by each recipient may be measured to determine if further investigation is required.

Each report contains several types of data items. A summary data item entry is produced for each provider or recipient falling within the scope of the exception criteria when that item is compared against a matching exception criteria. The number of data items in the exception criteria varies with the type of provider. All items reflect activity for both the current month and the year to date.

The items for review of provider utilization are designed to show total visits, number of referrals, number of admissions, length of stay, percentage of admissions requiring extensions, ratio of injections to number of visits, and related information.

The items for review of recipient utilization are designed to show number of visits to a physician, number of different physicians seen, number of surgical procedures, total days of hospital confinement, total days of nursing home confinement, and related information on other services.

If a detailed review of the claims history of a particular provider or recipient is desired, data items of each claim for that provider or recipient can be printed by computer.

At the end of each utilization review report, a set of total entries is printed as a summary. This summary is reviewed by the Commission and its staff and appropriate investigative action is taken. The provider and recipient in question are contacted, and every effort is made to resolve the problem.

Additionally, all complaints and reports of alleged fraudulent practices by either clients or providers are investigated.

Payments to Individual Providers

The Medicaid Enabling Act requires that the Commission annually report the names of professional and institutional providers of health services who receive payments of $5,000 or more. The providers are listed in Appendixes A, B, and C. This listing of providers receiving Medicaid payments should be viewed in the light of such factors as scope and duration of services authorized, the number of providers participating in the Program, the number of recipients in the providers' practice area, and the type of institutional provider or specialty of the professional provider. Proper utilization review of health services considers all of these factors, and they are reflected in the Medicaid utilization review reporting system discussed previously in this report.

Conclusion

The Mississippi Medicaid Commission regards the first six months' operation of the Medicaid Program as a satisfactory beginning of a new Federal-State program which makes payments to professional and institutional providers of health services for covered services rendered to the States' most needy citizens. This Program, hopefully, will not only result in additional dollars being spent for health care for the State's most needy citizens, but will improve the general well-being and productivity of many of our people as well. Inquiries regarding the operation and management of the Mississippi Medicaid Program are welcome.

APPENDIX A

Hospitals Receiving In Excess of $5,000

Aberdeen-Monroe County Hospital, Aberdeen
Belzoni Hospital, Belzoni
Calhoun County Hospital, Bruce
Choctaw County Hospital, Ackerman
Claiborne County Hospital, Port Gibson
Coahoma County Hospital, Clarksdale
East Bolivar County Hospital, Cleveland
Ellisville Municipal Hospital, Ellisville
Felix Long Memorial Hospital, Starkville
Field Memorial Community Hospital, Centreville
Forrest County General Hospital, Hattiesburg
Franklin County Memorial Hospital, Meadville
General Hospital, Greenville
George County Hospital, Lucedale
Greene County Hospital, Leakesville
Greenwood-Leflore Hospital, Greenwood
Grenada County Hospital, Grenada
Hardy Wilson Memorial Hospital, Hazlehurst
Hinds General Hospital, Jackson
Holmes County Community Hospital, Lexington
Houston Hospital, Houston
Howard Memorial Hospital, Biloxi
Humphreys County Memorial Hospital, Belzoni
Itawamba County Hospital, Fulton
Ivy Memorial Hospital, West Point
Jasper General Hospital, Bay Springs
Jefferson County Hospital, Fayette
Jefferson Davis County Hospital, Prentiss
Jefferson Davis Memorial Hospital, Natchez
Jones County Community Hospital, Laurel
Kemper County Hospital, DeKalb
King's Daughters Hospital, Brookhaven
Lawrence County Hospital, Monticello
Leake County Memorial Hospital, Carthage
Lowndes County General Hospital, Columbus
Lumberton Citizens Hospital, Lumberton
Madison General Hospital, Canton
Magnolia Hospital, Corinth
Marion County General Hospital, Columbia
Marshall County Hospital, Holly Springs
Memorial Hospital at Gulfport, Gulfport
Mercy Hospital-Street Memorial, Vicksburg
Methodist Hospital, Hattiesburg
Mississippi Baptist Hospital, Jackson
Montfort Jones Memorial Hospital, Kosciusko
Neshoba County General Hospital, Philadelphia
Newton Hospital, Newton
North Mississippi Medical Center, Tupelo
North Sunflower County Hospital, Ruleville
Northeast Mississippi Hospital, Booneville
Okolona Community Hospital, Okolona
Oxford-Lafayette County Hospital, Oxford
Perry County General Hospital, Richton
Pontotoc Community Hospital, Pontotoc
Rankin General Hospital, Brandon
S. E. Lackey Memorial Hospital, Forrest
Sharkey-Issaquena Hospital, Rolling Fork
Shelby Community Hospital, Shelby
Simpson General Hospital, Mendenhall
Singing River Hospital, Pascagoula
South Sunflower County Hospital, Indianola
Southwest Mississippi General Hospital, McComb
St. Dominic-Jackson Memorial Hospital, Jackson
St. Joseph Hospital, Meridian
Tallahatchie General Hospital, Charleston
Thaggard Hospital, Madden
Tippah County Hospital, Ripley
Tishomingo County Hospital, Iuka
Tunica County Hospital, Tunica
Tyler Holmes Memorial Hospital, Winona
Union County General Hospital, New Albany
University Hospital, Jackson
Vicksburg Hospital, Inc., Vicksburg
Wayne General Hospital, Waynesboro
Webster General Hospital, Eupora
Winston County Community Hospital, Louisville
Yalobusha General Hospital, Water Valley

APPENDIX B

Physicians Receiving In Excess of $5,000

Raymond W. Browning, M.D., Greenwood
Harry Cosby, Jr., M.D., Iuka
Gene E. Crick, M.D., Minter City
Otis B. Crocker, M.D., Bruce
John G. Downer, M.D., Lexington
John D. Dyer, M.D., Houston
Ralph D. Ford, M.D., Ripley
Patrick H. Gill, M.D., Macon
L. C. Henson, M.D., Kilmichael
J. Edward Hill, M.D., Hollandale
George Leroy Howell, M.D., Starkville
Clarence Hull, M.D., Hollandale
Joseph A. Hull, M.D., Indianola
William A. Middleton, M.D., Winona
William E. Moak, M.D., Richton
Brantley B. Pace, M.D., Monticello
Milton T. Person, Jr., M.D., Greenwood
W. H. Rose, M.D., Indianola
Samuel C. Sugg, M.D., Isola
J. E. Warrington, M.D., Shelby
David T. Wilson, M.D., Louisville

APPENDIX C

Skilled Nursing Homes Receiving In Excess of $5,000

Aletha Lodge Nursing Home, Booneville
Arnold Avenue Nursing Home, Greenville
Azalea Gardens Nursing Home, Wiggins
Beech Haven Rest Home, Jackson
Billdora Nursing Home, Tylertown
Briar Hill Rest Home, Florence
Brook Manor Nursing Center, Brookhaven
Care Inn, Cleveland
Care Inn, Clinton
Care Inn, Corinth
Care Inn, Greenwood
Care Inn, Grenada
Care Inn, Indianola
Carter Guest Home, Jackson
Compere Nursing Home, Jackson
Crawford Nursing Home, Jackson
Crossgate Manor, Jackson
Dixie White House Nursing Home, Pass Christian
Floadrian Nursing Home, Columbia
Floy Dyer Extended Care Center, Houston
Gracelands Convalescent Center, Oxford
Green Forest Convalescent Home, Hattiesburg
Greenbough Nursing Center, Clarksdale
Greenville Convalescent Home, Greenville
Gulf Coast Nursing Home, Pascagoula
Gulf View Haven, Inc., Bay St. Louis
Happy Acres Convalescent Home, Inc., Hattiesburg
Hearthside Haven, Inc., Laurel
Heritage Manor, Meridian
Inglewood Nursing Home ECF, Jackson
Jefferson Davis County ECF, Prentiss
Jones County Home, Ellisville
Laurel Convalescent Center, Laurel
Madison County Nursing Home, Canton
Magnolia Manor Nursing Home, Columbus
McComb Extended Care Facility & Nursing Home, McComb
Meridian Nursing Center, Meridian
Miramar Village, Inc., Pass Christian
Mississippi Nursing Home, Inc., Jackson
Mothers & Fathers Memorial Home, Philadelphia
North Mississippi Medical Center ECF, Tupelo
North Mississippi Retirement Home, Grenada
Oakview Rest Home, Baldwyn
Picayune Convalescent Home, Picayune
Pine Crest Guest Home, Hazlehurst
Restful Acres Nursing Home, Waynesboro
Riddell Nursing Home, Winona
Roselawn Retirement Home, New Albany
Shady Lawn Nursing Home, Vicksburg
Shearer Richardson Nursing Home, Okolona

Using the total payments made as of June 30, 1970, some conclusions may be drawn regarding average expenditures per recipient and per unit of service. Tables 4, 5, and 6 illustrate payments made per recipient during January - June, 1970. Additional payments for services rendered in this period were made after June 30, 1970, but were not tabulated with a recipient count or units of service.

Payments were made to skilled nursing homes for 2,484 different recipients during the period January - June, 1970. They received 295,943 days of care, for an average length of stay of 119.1 days and an average cost of $826.98 per recipient or an average per day of $6.94 as shown in Table 4.

The Mississippi Medicaid Commission pays the premium for Part B of Medicare for all recipients who are 65 years of age and older and meet the requirements of the Social Security Administration. During this report period the premium was $4.00 monthly; therefore, the reported expenditure of $1,611,416 for Part B Buy-In represents an average of 67,142 Old Age Assistance recipients a month for whom Part B Medicare benefits (physicians' services and others) were made available. Medicaid also pays the Part B deductible and 20 percent co-insurance. For those recipients in the OAA category who have Medicare Part A, Medicaid pays the deductible applicable to inpatient hospital services. Recipients of Medicare Parts A and B services are not included in the reports of recipient utilization of hospital and physicians' services that follow.

For the 17,762 recipients for whom payment was made for physicians' services during January - June, 1970, an average of $25.98 per recipient for physicians' services was spent, as shown in Table 5. A total of 59,821 visits were made to physicians by the recipients in the Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Dependent Children Programs. This represented 3.4 visits per recipient at an average cost of $7.87 per visit. For reporting purposes, no distinction is made between surgical fees and office visits.

During January - June, 1970, payments were made for 2,910 hospital discharges of recipients in the Aid to the Blind, Aid to the Permanently and Totally Disabled, and Aid to Dependent Children categories with 20,876 days of care provided for an average length of stay of 7.2 days. The average cost per day for these three categories of recipients was $44.21 and an average of $317.15 per discharge was spent for the recipients requiring hospitalization as shown in Table 6.