STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

HELEN WETHERBEE, J.D., M.P.H.
EXECUTIVE DIRECTOR

Honorable Kirk Fordice
Governor of the State of Mississippi
and
Members of the Mississippi State Legislature

Ladies and Gentlemen:

It is my pleasure to submit to you the 26th Annual Report of the Division of Medicaid for Fiscal Year 1997. 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 State Department of Human Services and the State Department of Health to the ongoing administration of Mississippi's Medicaid program. In addition, we acknowledge the continued commitment of Medicaid providers throughout the state who provide the necessary health care to those who would otherwise go without.

On behalf of the nearly 530,000 Mississippians who are being helped through the Medicaid program, we wish to thank the Governor and the members of the Legislature for continuing to make these services available.

Respectfully,

Helen Wetherbee

Helen Wetherbee, J.D., M.P.H.
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Office of the Governor

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Mississippi Division of Medicaid
Annual Report
Fiscal Year 1997
July 1, 1996 – June 30, 1997

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Ronnie Musgrove, Lieutenant Governor
Helen Wetherbee, J.D., M.P.H., Executive Director

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THE MISSION of the Mississippi Division of Medicaid is to provide all medically necessary services to children living below specified levels of poverty (well above the thresholds for AFDC and SSI); provide medical assistance to aged or disabled adults living below specified levels of poverty; develop programs demonstrating innovative services or service delivery to increase the benefits of services and/or reduce their cost; purchase insurance in lieu of providing services when cost-effective; and develop the capacity to gather and analyze information necessary for the development of state health policy and health care reform.

INTRODUCTION

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:

- Physician services
- Home health services
- Nurse midwife services
- Nursing facility services
- Family planning services
- Laboratory/X-ray services
- Inpatient hospital services
- Rural health clinic services
- Nurse practitioner services
- Outpatient hospital services
- Federally qualified health clinic services
- Transportation services, emergency & non-emergency
- Early and Periodic Screening, Diagnosis & Treatment (EPSDT) services

waivered projects offering additional enhanced services:

- Managed care services
- Home and community based services for aged and disabled
- Home and community based services for independent living
- Home and community based services for the mentally retarded/ developmentally disabled

optional services the state elects to provide:

- Dental services
- Hospice services
- Prescribed drugs
- Podiatry services
- Eyeglasses services
- Mental health services
- Birthing center services
- Christian Science Sanatoria services
- Durable medical equipment & supplies
- Chiropractic services (effective March 16, 1998)

- Intermediate care facilities for the mentally retarded
- Inpatient psychiatric services for under 21 years of age
- Nurse practitioner services including nurse anesthetist services

FUNDING

Source of Funds and Percentage of Distribution for FY 1997

Throughout the nation, Medicaid is funded with federal dollars matched by individual state contributions. In FY 1997, Mississippi's overall matching rate, which is determined by the state's per capita income, decreased from 78.07 percent in FY 1996 to 77.22 percent in FY 1997. Even with this decrease, a single state dollar invested brought into the state an additional $3.39 through federal matching funds.

For FY 1997, federal contributions amounted to $1,105,736,873, which, when combined with state dollars, provided for total medical expenditures of $1,431,930,683. Over 97 percent of this total was paid to Mississippi providers for services to Medicaid recipients 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 1997, the total administrative expenses were $37,596,553, with federal contributions of $23,161,100, or 61.60 percent. Mississippi's administrative expenses for FY 1997, which continue to be among the lowest in the Southeastern region, amounted to only 2.09 percent of the total budget.

ELIGIBILITY

In Mississippi, eligibility for Medicaid is determined by three separate agencies. Depending on an applicant's needs, he or she may apply for Medicaid benefits through offices of the Mississippi Department of Human Services, the Social Security Administration, or the Division of Medicaid.

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

- Persons who are eligible for Aid to Families with Dependent Children (AFDC). AFDC means the program as it existed on July 16, 1996, when Congress passed its welfare reform legislation in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

- Pregnant women who would be eligible for AFDC if the child were born and living with the mother.

- 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 18 and pregnant women, including those from intact families, whose family incomes and resources do not exceed the allowable limits for the AFDC need standards.

- Pregnant women and children under age six whose family income is equal to or below 133 percent of the federal poverty level.

- Pregnant women and children under age one whose family income is between 133 percent and 185 percent of the federal poverty level.

- Pregnant women and children born after September 30, 1983 whose family income is equal to or below 100 percent of the federal poverty level.

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) checks.

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

- Infants, up to age one, born to Medicaid-eligible mothers, provided the mother was eligible during pregnancy and the child lives with her.

- Persons in medical facilities who, if they left such facilities, 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 would qualify for SSI except for certain Social Security cost-of-living increases.

- Persons who are age 65 or over or disabled whose income is below 100 percent of the federal poverty level whose resources are at SSI levels.
- Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income is below 100 percent of the federal poverty level whose resources are no more than double the SSI resources limit. (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), a category originating January 1, 1993, which includes individuals/couples whose income does not exceed 120 percent of the federal poverty levels and whose resources do not exceed twice the SSI limits. 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 as certified by DOM.

The Division of Medicaid operates 24 Regional Offices throughout the state to offer local accessibility for these eligibility determinations.

REGIONAL OFFICES

Listed below are the address and telephone number for each office.

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

Clarksdale
325 Lee Drive
Clarksdale, MS 38614
(601) 627-1493

Cleveland
201 E. Sunflower, Suite 5
Cleveland, MS 38932
(601) 843-7753

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

Columbus
2207 5th Street North
Columbus, MS 39701
(601) 329-2190

Corinth
2907 Highway 72 West
Corinth, MS 38834
(601) 286-8091

Greenville
Village Shopping Center
1427 S. Main, Suite 161
Greenville, MS 38701
(601) 332-9370

Greenwood
919 Highway 49 W
82 Bypass
Greenwood, MS 38930
(601) 455-1053

Grenada
1321 C Sunset Plaza
Grenada, MS 38901
(601) 226-4406

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

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

Holly Springs
695 Highway 4 East
Holly Springs, MS 38635
(601) 252-3439

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

Kosciusko
207 North Madison
Kosciusko, MS 39090
(601) 289-4477

Laurel
1104 West 1st Street, Suite 1
Laurel, MS 39440
(601) 425-3175

McComb
312 Kendall Street
McComb, MS 39648
(601) 249-2071

Meridian
2502 9th Street
Meridian, MS 39302
(601) 483-9944

Natchez
116 South Canal Street
Natchez, MS 39121-1225
(601) 445-4971

Newton
102 North School Street
Newton, MS 39345
(601) 683-2581

Pascagoula
3203 Pascagoula Street
Suite 202
Pascagoula, MS 39567
(228) 762-9591

Philadelphia
301 Main Street
Philadelphia, MS 39350
(601) 656-3131

Starkville
LaGallerie Shopping Center
500 Russell Street, Suite 15
Starkville, MS 39759
(601) 323-3688

Tupelo
1830 North Gloster Street
Tupelo, MS 38801
(601) 844-5304

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

Information on eligibility numbers by specific categories can be found in Tables 1, 2, and 3 of this report. (In reviewing information throughout this report, it is important to note the difference between the terms “eligible” and “recipient.” A person who has met the basic eligibility requirements for income and resource is referred to as an “eligible.”

Although a person may have been determined to be eligible for Medicaid, that person may not have actually received any service. A “recipient” is a person who has received Medicaid benefits. Throughout Fiscal Year 1997, 509,303 Mississippians benefited from one or more of the health care services covered by Medicaid.

Program Highlights for FY 1997

MANAGED CARE - HealthMACS

HealthMACS (Health through Medicaid Managed Access to Care and Services) is a program of primary care case management. The program was implemented in October of 1993. By the end of fiscal year 1994, HealthMACS had been implemented in seven counties – Claiborne, Covington, Jefferson, Jefferson Davis, Lawrence, Warren, and Washington.

In fiscal years 1995 and 1996, the following counties were added to the HealthMACS program: Bolivar, Clarke, Copiah, Hancock, Harrison, Lincoln, Simpson, and Sunflower.

During fiscal year 1997, a request was submitted to the Health Care Financing Administration (HCFA) to amend the 1915(b) waiver for the HealthMACS program to be implemented statewide. In late September, DOM received HCFA approval for statewide implementation of HealthMACS. Implementation of HealthMACS in additional counties began in February 1997. As of June 30, 1997, HealthMACS had been implemented in the following additional counties: Adams, Amite, Coahoma, Franklin, George, Greene, Jackson, Lamar, Leflore, Marion, Pearl River, Perry, Pike, Quitman, Tallahatchie, Tunica, Walthall, and Wilkinson. By June 30, 1997, 33 counties were participating in the HealthMACS program.

In February, HCFA conducted a focused review of the 1915(b) waiver. The findings of the focused review were that staff have been effective in improving the overall operation of the HealthMACS program, specifically in the areas of training and education for both providers and recipients and with program monitoring and data tracking.

CAPITATED MANAGED CARE

During the 1995 Regular Legislative Session, the Division of Medicaid received a mandate to implement capitated managed care. In compliance with this mandate, the Division designed a program and incorporated it into a model contract which was submitted to HCFA in October 1995. In January 1996, HCFA approved the model HMO contract and the capitated rates.

During the 1996 Regular Legislative Session, the mandate was revised, and capitated managed care was restricted to the following 11 counties: Bolivar, Coahoma, Hancock, Harrison, Humphreys, Leflore, Sunflower, Tallahatchie, Warren, Washington, and Yazoo. The Legislature also established a Legislative Oversight Committee to review the managed care activities of Division of Medicaid and to make recommendations in December 1996 for the 1997 Legislative Session regarding the future direction of Medicaid and managed care.

The Division contracted with four HMOs to provide services to Medicaid recipients: AmeriCan Medical Plans of Mississippi, Apex Healthcare of Mississippi, Family Health Care Plus, and Mississippi Managed Care Network. The four HMOs had a sufficient provider network to begin providing services to Medicaid recipients in Warren County on December 1, 1996, and in Hancock and Harrison Counties on February 1, 1997.

Traditional Medicaid staff were supplemented by the addition of new types of workers required by this new program. Client Field Services Representatives were established in each county and trained to work with recipients, providing health education and emphasizing the importance of accessing medical services through the primary care provider, as well as the appropriate use of hospital emergency rooms. CFSRs also follow up on broken appointments and providers' instructions.

Provider representatives were also added and dedicated to the issues and problems of participating providers. In addition to organizing workshops and enrollment fairs, these workers recruit primary care providers, assist all providers in working with HMOs, and provide technical assistance with respect to claims payment.

Finally, two hotlines were established and staffed to field questions from recipients and providers. All calls are logged and reviewed to identify problems that need to be addressed or activities that need to be undertaken by these representatives.

HOME AND COMMUNITY BASED SERVICES

Waiver for the Elderly and Disabled:

The Elderly and Disabled Waiver provides services to individuals over the age of 21 who, but for the provision of such services, would require the level of care provided in a nursing facility. Recipients of this waiver must qualify for Medicaid as SSI recipients. This statewide program is limited to 2,600 unduplicated recipients during the waiver year (July 1, 1997 – June 30, 1998). This waiver is operated through the Department of Human Services, Division of Aging and Adult Services. The services available through this program are: Case Management, Adult Day Care, Home Delivered Meals, Escorted Transportation, Institutional Respite, Homemaker Services, and Extended Home Health Visits (visits in excess of those allowed in the regular Medicaid program). Referrals for this program can be made through the Long Term Care Unit of Medicaid, the Division of Aging and Adult Services of DHS, or the waiver case managers at each Area Agency on Aging.

Waiver for Independent Living:

The Independent Living Waiver was created to assist severely orthopedically and/or neurologically impaired individuals, 21 – 64 years of age, to live independently through the services of a Personal Care Attendant. The recipient must be capable of directing his/her own care and possess some rehabilitation potential. Recipients are also provided Case Management Services. These services enable recipients to remain at home rather than be placed in a nursing facility. This statewide program is limited to a maximum of 175 unduplicated recipients per waiver year (July 1, 1997 – June 30, 1998). Recipients of this waiver must be Medicaid eligible as SSI recipients or must meet the requirements for the handicapped coverage group, which allows an income level up to 300 percent 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.

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 or persons with related conditions (ICF/MR). This statewide program is limited to 450 unduplicated recipients per waiver year (July 1, 1997 – June 30, 1998). Recipients of this waiver must be Medicaid eligible through one of three eligibility categories: 1) SSI Recipients, 2) AFDC Recipients, or 3) Disabled Child Living at Home. This waiver is operated through the Department of Mental Health, Bureau of Mental Retardation. Currently the services available are: In-home Respite; Group Home Respite; ICF/MR Respite; Residential Habilitation; Personal Care Aide; Day Habilitation; Prevocational Services; Supported Employment; Physical Therapy; Occupational Therapy; and Speech, Language, and Hearing Services. Referrals for this program can be made through the Long Term Care Unit of Medicaid, the Bureau of Mental Retardation, or the waiver case managers at each of the Regional ICF/MRs.

CASE MIX IN MISSISSIPPI

Mississippi is one of six states participating in the federal Multistate Nursing Home Case Mix Payment and Quality Demonstration. This project was designed for the mutual benefit of providers and patients to develop a payment and quality monitoring system for the Medicaid and Medicare programs. The Mississippi Medicaid Case

Mix System establishes a facility-specific payment rate based on a facility's case mix of residents. Quality of care is assured by paying facility-specific rates based on cost as well as the acuity level of the residents. This allows staff to assure that residents' health care requirements are being fulfilled at the optimal level. This system was designed to produce the following:

- a resident classification system based on the characteristics of facility residents;
- a quality monitoring system to create resident data-specific facility profiles for detecting quality of care changes; and
- a case mix payment system that is facility-specific based on the case mix of residents.

The Division of Medicaid has worked closely with the Mississippi Case Mix Advisory Committee, composed of nursing facility administrators, owners, nurses, accountants, social workers, and geriatric specialists, to develop the best payment system for Mississippi. The Mississippi Medicaid Case Mix Payment System was implemented July 1, 1993.

Through Case Mix, the Division of Medicaid has gained a system which:

- assures quality care for all residents;
- establishes a payment system that equitably reimburses providers for the level of care required for the individual resident and represents the level of effort and professional supervision required to care for the individual residents in the facility; and
- provides residents with the benefit of improved, more accessible care.

MEDICAL EXPENDITURES

Total medical expenditures for FY 1997 amount to $1,431,930,683, which represents an increase of 8.37 percent from FY 1996. The highest expenditures continue to be for nursing facility and inpatient hospital services.

EXPENDITURES BY ELIGIBILITY GROUP

Approximately 26 percent of the total expenditures for medical services in Fiscal Year 1997, or about $367 million, were for services to the categorically "Aged." Fewer than nine percent of our total eligibles, 46,630, were so classified. Even more dramatic is the fact that $300 million, or 20 percent of our total expenditures, were for services to 18,637 persons, or 3.6 percent of the eligible population.

Tables 4 through 16 provide the medical services expenditures broken out by the average cost per recipient and the major medical expenditures for Fiscal Years 1996 and 1997.

Long-Term Care Facilities

Long-term care facilities in Mississippi are classified as either Nursing Facilities (NF), Psychiatric Residential Treatment Facilities (PRTF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

During FY 1997, 168 nursing facilities in Mississippi participated in the Medicaid Program providing long-term care to 18,637 Medicaid recipients. There were 13 Intermediate Care Facilities for the Mentally Retarded that provided care to 2,607 Medicaid recipients.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early Periodic Screening, Diagnosis and Treatment Program was amended in 1989 to require that all medically necessary services identified through periodic screenings be provided to Medicaid children. The EPSDT Unit for the DOM processed and approved expanded services for 15,950 Medicaid eligible children ages 0-21 years old during FY 1997. These expanded services included orthotic and prosthetic devices, custom wheel chairs, enteral feedings, additional physician office visits, and prescriptions. The primary goals of the program are to:

- increase the frequency of screening examinations to identify and treat preventable health problems;
- facilitate entry into the health care delivery system;
- improve provider participation in the program; and
- expand the package of diagnosis and treatment to which children are entitled under the program.

EPSDT Screening and Related Services are now offered in 105 schools. DOM and schools throughout the state are working together to ensure access to preventive health and medical services for Medicaid eligible children in our state. The number of treatments, by program category, received as a result of problems diagnosed during the screening are found in Table 17 of this report.

Vaccine for Children Program

This federally funded immunization program has provided vaccines for Medicaid eligible, underinsured, and uninsured children since October 1994. In FY 1997, 20,270 Medicaid eligible children received 98,337 doses of vaccine from private Medicaid providers in the state. This represents 20 percent of all immunizations administered in the state.

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 for certain Medicaid eligible pregnant/postpartum women and infants. The multidisciplinary team of physicians, nurse practitioners, registered nurses, licensed nutritionists/dietitians, and licensed social workers provides enhanced services for this targeted population; these services include case management, nutritional assessment/counseling, psychosocial assessment/counseling, home visits, and health education.

The DOM has 12 private providers and 67 county health department providers participating in the PHRM/ISS program. The DOM is actively recruiting new providers of PHRM/ISS.

Dental Services

Dental care was provided to 28,336 recipients during Fiscal Year 1997 with expenditures amounting to $3,065,135.

Inpatient Hospital Services

During Fiscal Year 1997, Medicaid provided for 428,346 days of inpatient hospital care. The average length of hospital stay was 1.4 days. Table 18 shows the number of Medicaid recipients who received inpatient hospital service benefits, the number of discharges, the total days of care, and the average length of stay per recipient by program during Fiscal Year 1997.

Outpatient Hospital Services

A total of 594,733 outpatient visits were provided to 230,148 Medicaid recipients during Fiscal Year 1997, with an average of 2.58 visits per outpatient recipient.

Administrative Highlights of FY 1997

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

While the Division of Medicaid (DOM) is responsible for the administration of the Medicaid program, DOM contracts with a fiscal agent for operation of the Medicaid Management Information System (MMIS) which maintains provider and recipient eligibility records, processes claims, and maintains reporting systems which enable DOM to monitor the program and enforce its policies and procedures, as well as aid in agency decision-making. EDS has been the fiscal agent since 1994. Claims processed through the MMIS during FY 1997 were 22,685,443. Approximately 87 percent of all claims were filed electronically.

The Division of Medicaid visualized the Mississippi Medicaid Management Information Retrieval System (MMIRS) as a way to provide enhanced data access to allow Division of Medicaid personnel to better manage the current fee-for-service, primary care provider (PCP) managed care, and capitated managed care programs and to intelligently plan for the future of its rapidly changing Medicaid program. Key features of the reporting platform will increase the state's ability to manage the program by facilitating data analysis and reporting. In addition, the availability of the MMIS data for interactive analysis will promote "discovery" of the value of the data and will allow the Division to make program decisions based upon analysis of current data.

THIRD PARTY LIABILITY

In accordance with Title XIX of the Social Security Act as well as state law, Medicaid is a "payor of last resort," which means that Medicaid reimbursement is available only when other third party benefits have been exhausted. Third party resources are any entities, individuals, or programs who are legally responsible for paying the medical expenses of Medicaid recipients. Mississippi's Medicaid Third Party Liability (TPL) Unit is responsible for identifying any third party resources 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.

Mississippi's Medicaid TPL Unit 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. Mississippi Medicaid also pays Medicare premiums for qualified Medicare eligibles, enabling avoided costs of Medicare covered services. Further, as a result of the requirements of OBRA '93, 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 FY 1997, third party savings in the form of cost avoided or recovered payments from both public and private resources totaled over $518 million. As a graphic example of the effectiveness of the TPL Unit, $20 was recovered for every one dollar invested in salaries of the Medicaid auditors responsible for 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 primary payer are returned to the providers to file Medicare. The MMIS also contains segments that allow for the monitoring of payment of Medicare premiums for qualified individuals. In FY 1997, 25 percent of the Mississippi population also had Medicare coverage. The claims payment edits and buy-in program yielded $482 million in Medicare cost avoidance.

Private Health Insurance Resources

Approximately four percent of the Mississippi Medicaid population was covered by some form of private health insurance in FY 1997. Through cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment), the Medicaid agency saved slightly more than $31 million. Through post-payment recovery (the Medicaid agency bills the third party for reimbursement), the TPL Unit collected $4.6 million.

Casualty/Tort Resources

A significant number of Medicaid recipients receive medical care each month as the result of injuries or accident. Medicaid is responsible for identifying those recipients 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 FY 1997, the TPL Unit collected $2.2 million from casualty/tort resources.

Prescribed Drug Recovery Program

In 1985, the Mississippi Division of Medicaid 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 resources. The TPL Unit reported a recoupment of slightly more than $1 million in the drug program in FY 1997.

Estate Recovery

As a result of OBRA 1993, the state enacted legislation allowing recovery of medical payments from the estates of certain recipients who were residents of nursing facilities at the time of death. In FY 1997, the Estate Recovery program returned more than a half-million dollars .

PROGRAM INTEGRITY

The Division of Medicaid is responsible for monitoring both provider and recipient utilization of Medicaid services. State and federal laws require periodic checks of provider records in order to verify actual receipt of services for which payment has been made and to investigate any cases suggestive of program abuse, misuse, or fraud. This is accomplished through the Program Integrity Division.

With the assistance of a computerized surveillance and utilization reporting system (SURS), Program Integrity is able to maintain practice and service profiles on all Medicaid providers and on recipients who receive services through the Medicaid program. These profiles provide indicators of possible fraudulent activities or abuse of program benefits and are an important source of information upon which investigators in Program Integrity base their investigations. Referrals from other providers or recipients also provide information to warrant investigations. Program Integrity also handles complaints regarding recipients loaning their cards to ineligible persons. After investigation, these cases are presented to local law enforcement authorities for disposition.

Medical personnel conduct physician reviews to determine the medical necessity and appropriateness of procedures performed and to ensure that quality health care is being provided to Mississippi Medicaid recipients. Recipient management reviews are also conducted to make certain that recipients are receiving only health care services which are medically necessary, as well as to control misutilization of Medicaid services.

Investigations of providers by the Program Integrity Division may result in monetary recovery, termination as a provider of Medicaid services, or referral to the Medicaid Fraud Control Unit of the Office of Attorney General. Medical review

findings may be referred to the local peer review organization for their recommendation or to the State Board of Medical Licensure for corrective action.

During the course of routine investigations, Program Integrity monitors the provider's billing practices and the fiscal agent's payment of claims to ensure policy guidelines are met and also makes suggestions for policy changes to the Medical Policy Division. Due to the visibility of Program Integrity's nurses and investigators in the medical community, they also act as liaison between the Division of Medicaid and the providers.

In July of 1995, Program Integrity became actively involved in a Federal/State Fraud Task Force that includes the United States Attorney, FBI, Office of Inspector General, Postal Inspector's Office, State Attorney General's Office, and various other agencies. This task force is currently involved in several joint investigations and has expedited the referrals of suspected fraud cases.

Program Integrity also handles recipient recoupment. Approximately 200 cases per month are received from the Department of Human Services and Medicaid Regional Offices. These cases involve recipients who have received Medicaid benefits during a period in which they were ineligible. Upon determination of the amount of overpayment, letters of explanation are sent to recipients and a payment plan is initiated. Investigators make field visits to all recipients owing $500 or more.

Explanation of Medicaid Benefits (EOMB) audits are conducted to obtain confirmation that a recipient did or did not receive the services for which the Division of Medicaid made payment. Approximately 400 questionnaires per month are sent to recipients by the fiscal agent. Program Integrity responds to all negative replies and conducts an investigation when warranted.

The existence of the Program Integrity Division continues to serve as an invaluable deterrent to potential fraud and abuse of benefits throughout the Medicaid program. Activities in this area continue to expand along with growth of the program.

CONTRACTS MONITORING

The Division of Contracts Monitoring includes two units – the Non-Emergency Transportation Program and the Contracts Monitoring Unit.

The Non-Emergency Transportation Program

To ensure access by Medicaid-eligible persons to covered services, the Mississippi Medicaid program provides non-emergency transportation (NET) services for Medicaid clients who have no other means of transportation. The Division of Medicaid provides ground and air non-emergency transportation services for eligible recipients. Commercial air and air ambulance services are available when ground

transportation is inappropriate because of the recipient's condition or the distance to the receiving medical provider. Ground ambulance services are also available as required by the condition of the recipients requiring transportation assistance.

The majority of NET services provided to Medicaid clients in FY 1997 was offered through a contractual agreement between the Division of Medicaid and the Department of Human Services. Through this agreement, NET coordinators in the county offices of the Department of Human Services were responsible for serving as the contact points for Medicaid clients who needed NET services and for arranging transportation assistance with local providers. Transportation assistance was available to transport clients to local providers as well as to those outside the clients' communities. In FY 1997, more than 126,000 transports were funded for Medicaid clients through the Division of Medicaid's contractual agreement with the Department of Human Services.

The Contracts Monitoring Unit

The Division of Medicaid contracts with a number of organizations and individuals who provide assistance to the Division in the administration of the Medicaid program. The Contracts Monitoring Unit (CMU) conducts program and financial reviews on these contractors based upon requests by Division management.

During FY 1997, the CMU completed reviews of the contracts for Electronic Submission of Claims, Transportation Services, Perinatal High Risk Management, Pharmacy Services, and Healthy Futures with the State Department of Health. In addition, the CMU began a review of the FY 1995 through FY 1997 contracts for Eligibility Certification with the Mississippi Department of Human Services. This review was expanded to cost settle transportation expenses for the period FY 1992 through FY 1997. CMU staff completed the field work portion of the Eligibility Determination review in June 1997 and will complete the field work for Transportation Services by mid FY 1998.

TABLE 1

Certified Eligibles by Eligibility Category for Fiscal Year 1997

Program Category	Total Number of Eligible Persons	Percent of Total
Total	543,560	100.00%
Aged	48,443	8.91%
Blind	1,597	0.29%
Disabled	125,788	23.14%
Aid to Families With Dependent Children (AFDC)	167,575	30.83%
CWS Foster Care	1,534	0.28%
Optional Categorically Needy-Pregnant Women & Children		
At 100% Federal Poverty Level	68,257	12.56%
At 133% Federal Poverty Level	38,194	7.03%
At 185% Federal Poverty Level	21,301	3.92%
Qualified Medicare Beneficiary		
Aged	73	0.01%
Blind	20	0.00%
Disabled	9	0.00%
Poverty Level		
Aged	15,897	2.92%
Disabled	11,545	2.12%
Under age 18	8,848	1.63%
Katie Beckett	752	0.14%
Automatic Infants	33,727	6.20%

Source: MAM 290-R1
MAM Y-T-D, Monthly

TABLE 2

Bureau of Census Population for Mississippi Counties and Number of Medicaid Eligibles by County for Fiscal Year 1997

County	County Population	Number of Medicaid Eligibles	Percent of Population	County	County Population	Number of Medicaid Eligibles	Percent of Population
Adams	35,356	8,614	24.36%	Leflore	37,341	13,211	35.38%
Alcorn	31,722	6,002	18.92%	Lincoln	30,278	6,010	19.85%
Amite	13,328	3,885	29.15%	Lowndes	59,308	11,828	19.94%
Attala	18,481	4,398	23.80%	Madison	53,794	10,750	19.98%
Benton	8,046	1,814	22.55%	Marion	25,544	6,443	25.22%
Bolivar	41,875	14,784	35.31%	Marshall	30,361	7,534	24.81%
Calhoun	14,908	3,151	21.14%	Monroe	36,582	6,307	17.24%
Carroll	9,237	1,807	19.56%	Montgomery	12,388	3,080	24.86%
Chickasaw	18,085	3,664	20.26%	Neshoba	24,800	5,341	21.54%
Choctaw	9,071	1,952	21.52%	Newton	20,291	4,033	19.88%
Claiborne	11,370	3,373	29.67%	Noxubee	12,604	4,293	34.06%
Clarke	17,313	2,805	16.20%	Oktibbeha	38,375	6,452	16.81%
Clay	21,120	5,327	25.22%	Panola	29,996	8,364	27.88%
Coahoma	31,665	12,039	38.02%	Pearl River	38,714	8,072	20.85%
Copiah	27,592	6,851	24.83%	Perry	10,865	2,603	23.96%
Covington	16,527	3,904	23.62%	Pike	36,882	9,807	26.59%
DeSoto	67,910	6,514	9.59%	Pontotoc	22,237	3,184	14.32%
Forrest	68,314	13,494	19.75%	Prentiss	23,278	3,887	16.70%
Franklin	8,377	1,875	22.38%	Quitman	10,490	3,938	37.54%
George	16,673	2,965	17.78%	Rankin	87,161	10,531	12.08%
Greene	10,220	2,257	22.08%	Scott	24,137	5,627	23.31%
Grenada	21,555	5,012	23.25%	Sharkey	7,066	2,683	37.97%
Hancock	31,760	5,508	17.34%	Simpson	23,953	5,294	22.10%
Harrison	165,365	27,055	16.36%	Smith	14,798	2,946	19.91%
Hinds	254,441	48,920	19.23%	Stone	10,750	2,792	25.97%
Holmes	21,604	9,253	42.83%	Sunflower	32,867	10,841	32.98%
Humphreys	12,134	4,341	35.78%	Tallahatchie	15,210	4,863	31.97%
Issaquena	1,909	533	27.92%	Tate	21,432	3,895	18.17%
Itawamba	20,017	2,563	12.80%	Tippah	19,523	4,104	21.02%
Jackson	115,243	16,450	14.27%	Tishomingo	17,683	2,879	16.28%
Jasper	17,114	3,862	22.57%	Tunica	8,164	2,722	33.34%
Jefferson	8,653	2,992	34.58%	Union	22,085	3,643	16.50%
Jefferson Davis	14,051	3,747	26.67%	Walthall	14,352	3,976	27.70%
Jones	62,031	12,090	19.49%	Warren	47,880	9,832	20.53%
Kemper	10,356	2,093	20.21%	Washington	67,935	21,718	31.97%
Lafayette	31,826	3,703	11.64%	Wayne	19,517	4,905	25.13%
Lamar	30,424	4,451	14.63%	Webster	10,222	2,186	21.39%
Lauderdale	75,555	14,505	19.20%	Wilkinson	9,678	2,994	30.94%
Lawrence	12,458	2,646	21.24%	Winston	19,433	4,226	21.75%
Leake	18,436	4,165	22.59%	Yalobusha	12,033	3,039	25.26%
Lee	65,581	9,984	15.22%	Yazoo	25,506	7,896	30.96%

TABLE 3

Recipients of Services by Program Category for Fiscal Year 1997

Program Category	Total Number of Recipients	Percent of Total
Total	509,303	100.00%
Money Payment Eligibles		
Aged	46,630	9.16%
Blind	1,482	0.29%
Disabled	118,717	23.31%
Aid to Families With Dependent Children (AFDC)	151,337	29.71%
CWS Foster Care	1,497	0.29%
Poverty Level Pregnant Women & Children		
At 100% Federal Poverty Level	61,475	12.07%
At 133% Federal Poverty Level	37,635	7.39%
At 185% Federal Poverty Level	24,607	4.83%
Optional & Mandatory Phased-in Children Under Age 18	7,114	1.40%
Qualified Medicare Beneficiary		
Aged	55	0.01%
Blind	17	0.00%
Disabled	9	0.00%
Poverty Level		
Aged	16,388	3.22%
Disabled	11,793	2.32%
Katie Beckett	727	0.14%
Hospice		
Aged	52	0.01%
Blind	1	0.00%
Disabled	107	0.02%
Other Medical Assistance Only		
Automatic Infants	29,660	5.82%

* Percentage column may not total 100% due to rounding

Source: MAM 260-R1

TABLE 4

Recipients of Medical Services by Type of Service for Fiscal Years 1996 and 1997

Type of Service	Recipients FY 1996	Recipients FY 1997	% of Incr. or Decr.
Total	510,226	509,303	-0.18%
Inpatient Hospital	63,058	62,883	-0.28%
Outpatient Hospital	263,988	230,148	-12.82%
Laboratory/X-Ray	79,345	103,937	30.99%
Nursing Facility	18,651	18,637	-0.08%
Physician	353,623	346,640	-1.97%
EPSDT	113,564	125,727	10.71%
EPSDT Dental	77,088	79,887	3.63%
EPSDT Vision	38,625	40,011	3.59%
EPSDT Hearing	1,359	2,465	81.38%
Rural Health Clinic	88,778	91,508	3.08%
Federally Qualified Health Centers	56,304	53,058	-5.77%
Home Health	6,713	7,651	13.97%
Transportation	26,375	30,195	14.48%
Prescribed Drugs	443,758	431,932	-2.66%
Dental	27,919	28,336	1.49%
Eyeglasses	9,854	10,814	9.74%
Intermediate Care Facility - Mentally Retarded	2,436	2,607	7.02%
Per Capita Managed Care	0	8,790	100.00%
Buy-in, Parts A & B, Medicare	150,395	149,337	-0.70%
Mental Health Clinic	34,106	33,668	-1.28%
Home & Community Based Waiver	1,133	2,179	92.32%
Durable Medical Equipment	12,178	13,095	7.53%
Therapy	1,436	1,456	1.39%
Inpatient Residential Psychiatric	456	605	32.68%
Inpatient Psychiatric Hospital	1,726	1,877	8.75%
Nurse Practitioner	25,749	32,787	27.33%
Ambulatory Surgical Center	4,231	1,685	-60.17%
Personal Care	0	0	0.00%
Hospice	390	432	10.77%
Outpatient Psychiatric Hospital	17	28	100.00%
Private Mental Health Centers	981	1,165	18.76%
Family Planning Drugs	19,226	19,128	-0.51%
Dialysis	402	538	33.83%

Source: MAM 260-R1

TABLE 5

Paid Claims by Type of Service for Fiscal Years 1996 and 1997

Type of Service	Claims FY 1996	Claims FY 1997	% of Incr. or Decr.
Total	20,698,904	22,685,443	9.60%
Inpatient Hospital	389,568	393,253	0.95%
Outpatient Hospital	833,974	856,752	2.73%
Laboratory/X-Ray	605,576	973,764	60.80%
Nursing Facility	426,181	401,757	-5.73%
Physician	4,080,260	4,333,074	6.20%
EPSDT	354,268	370,206	4.50%
EPSDT Dental	546,448	596,312	9.13%
EPSDT Vision	249,305	261,864	5.04%
EPSDT Hearing	2,989	5,214	74.44%
Rural Health Clinic	761,535	720,329	-5.41%
Federally Qualified Health Center	442,492	428,771	-3.10%
Home Health	50,757	140,046	175.91%
Transportation	351,514	338,574	-3.68%
Prescribed Drugs	7,114,981	7,180,650	0.92%
Dental	154,324	164,061	6.31%
Eyeglasses	22,593	24,803	9.78%
Intermediate Care Facility - Mentally Retarded	89,595	163,841	82.87%
Per Capita Managed Care	0	37,156	100.00%
Buy-in, Parts A & B, Medicare	3,170,877	4,062,718	28.13%
Mental Health Clinic	647,313	719,969	11.22%
Home & Community Based Waiver	43,960	74,100	68.56%
Durable Medical Equipment	105,982	126,762	19.61%
Therapy	26,085	30,676	17.60%
Inpatient Residential Psychiatric	5,533	2,226	-59.77%
Inpatient Psychiatric Hospital	11,981	18,277	52.55%
Nurse Practitioner	111,958	163,762	46.27%
Ambulatory Surgical Center	16,729	4,271	-74.47%
Personal Care	0	0	0.00%
Hospice	1,794	2,841	58.36%
Outpatient Psychiatric Hospital	36	114	216.67%
Private Mental Health Centers	19,312	19,304	-0.04%
Family Planning Drugs	53,285	55,861	4.83%
Dialysis	7,699	14,135	83.60%

Source: MR-0-08

TABLE 6

Total Expenditures for Medical Services, Total Number of Recipients, Average Expenditure per Recipient, and Percentage by Program Category for Fiscal Year 1997

Program Category	Amount of Expenditures	Percent of Total*	Recipients	Percent of Total*	Average per Recipient
Total	$1,431,930,683	100.00%	509,303	100.00%	$2,812
Money Payment Eligibles					
Aged	367,211,791	25.64%	46,630	9.16%	7,875
Blind	6,200,668	0.43%	1,482	0.29%	4,184
Disabled	584,074,981	40.79%	118,717	23.31%	4,920
AFDC	158,643,695	11.08%	151,337	29.71%	1,048
CWS Foster Care	7,503,689	0.52%	1,497	0.29%	5,012
Poverty Level Pregnant Women & Children					
At 100% Federal Poverty Level	56,323,513	3.93%	61,475	12.07%	916
At 133% Federal Poverty Level	53,539,826	3.74%	37,635	7.39%	1,423
At 185% Federal Poverty Level	55,701,838	3.89%	24,607	4.83%	2,264
Optional & Mandatory Phased-in Children	8,060,343	0.56%	7,114	1.40%	1,133
Qualified Medicare Beneficiary					
Aged	39,415	0.00%	55	0.01%	717
Blind	7,758	0.00%	17	0.00%	456
Disabled	5,837	0.00%	9	0.00%	649
Poverty Level					
Aged	33,105,288	2.31%	16,388	3.22%	2,020
Disabled	42,734,327	2.98%	11,793	2.32%	3,624
Katie Beckett	3,366,666	0.24%	727	0.14%	4,631
Hospice					
Aged	500,973	0.03%	52	0.01%	9,634
Blind	20,657	0.00%	1	0.00%	20,657
Disabled	1,020,000	0.07%	107	0.02%	9,533
Other Medical Assistance Only					
Automatic Infants	53,869,418	3.76%	29,660	5.82%	1,816

* Percentage columns may not total 100% due to rounding
Source: MAM 250-R1

TABLE 7

Expenditures for Medical Services by Type of Service for Fiscal Years 1996 and 1997

Type of Service	Expenditures FY1996	Expenditures FY1997	% of Incr. or Decr.
Total	$1,321,346,060	$1,431,930,683	8.37%
Inpatient Hospital	$271,297,327	$276,915,091	2.07%
Outpatient Hospital	98,197,974	98,083,245	-0.12%
Laboratory/X-Ray	5,237,635	7,561,924	44.38%
Nursing Facility	282,938,033	299,961,995	6.02%
Physician	110,826,739	112,435,663	1.45%
EPSDT	8,637,628	9,707,209	12.38%
EPSDT Dental	11,523,017	12,326,827	6.98%
EPSDT Vision	4,946,356	5,203,274	5.19%
EPSDT Hearing	189,713	248,269	30.87%
Rural Health Clinic	17,661,663	19,966,646	13.05%
Federally Qualified Health Centers	14,401,231	13,778,564	-4.32%
Home Health	12,636,203	11,144,004	-11.81%
Transportation	10,866,568	11,770,668	8.32%
Prescribed Drugs	177,046,940	202,628,325	14.45%
Dental	3,063,818	3,065,135	0.04%
Eyeglasses	520,462	587,771	12.93%
Intermediate Care Facility - Mentally Retarded	99,508,248	114,647,934	15.21%
Per Capita Managed Care	0	6,710,959	100.00%
Buy-in, Parts A & B, Medicare	108,825,960	127,049,620	16.75%
Mental Health Clinic	36,142,933	39,016,670	7.95%
Home & Community Based Waiver	2,578,229	8,708,672	237.78%
Durable Medical Equipment	8,947,002	8,956,166	0.10%
Therapy	599,079	653,288	9.05%
Inpatient Residential Psychiatric	10,240,619	9,099,568	-11.14%
Inpatient Psychiatric Hospital	12,978,660	13,935,540	7.37%
Nurse Practitioner	3,552,081	3,347,802	-5.75%
Ambulatory Surgical Center	453,916	789,065	73.84%
Personal Care	0	0	0.00%
Hospice	2,317,090	3,264,865	40.90%
Outpatient Psychiatric Hospital	19,547	98,979	406.36%
Private Mental Health Centers	387,389	587,520	51.66%
Family Planning Drugs	1,621,324	1,657,375	2.22%
Dialysis	3,182,676	8,022,050	152.05%

Source: MAM 250-R1 and MAM 260-R1

TABLE 8

Expenditures for Medical Services by Type of Service, Number of Recipients by Service, and Average Spent for Fiscal Year 1997

Type of Service	Total Expenditures	Number of Recipients	Avg. per Recipient
Total	1,431,930,683	509,303	$2,812
Inpatient Hospital	$276,915,091	61,414	4,509
Outpatient Hospital	98,083,245	230,148	426
Laboratory/X-Ray	7,561,924	103,937	73
Nursing Facility	299,961,995	18,637	16,095
Physician	112,435,663	346,640	324
EPSDT	9,707,209	125,727	77
EPSDT Dental	12,326,827	79,887	154
EPSDT Vision	5,203,274	40,011	130
EPSDT Hearing	248,269	2,465	101
Rural Health Clinic	19,966,646	91,508	218
Federally Qualified Health Centers	13,778,564	53,058	260
Home Health	11,144,004	7,651	1,457
Transportation	11,770,668	30,195	390
Prescribed Drugs	202,628,3254	31,932	469
Dental	3,065,135	28,336	108
Eyeglasses	587,771	10,814	54
Intermediate Care Facility - Mentally Retarded	114,647,9	342,607	43,977
Family Planning	6,710,959	8,790	0
Buy-in, Parts A & B, Medicare	127,049,620	149,337	851
Mental Health Clinic	39,016,670	33,668	1,159
Home & Community Based Waiver	8,708,672	2,179	3,997
Durable Medical Equipment	8,956,166	13,095	684
Therapy	653,288	1,456	449
Inpatient Residential Psychiatric	9,099,568	605	15,041
Inpatient Psychiatric Hospital	13,935,540	1,877	7,424
Nurse Practitioner	3,347,802	32,787	102
Ambulatory Surgical Center	789,065	1,685	468
Personal Care	0	0	0
Hospice	3,264,865	432	7,558
Outpatient Psychiatric Hospital	98,979	28	0
Private Mental Health Centers	587,520	1,165	504
Family Planning Drugs	1,657,375	19,128	87
Dialysis	8,022,050	538	14,911

Source: MAM 250-R1 and MAM 260-R1

TABLE 8-A

Expenditures for Medical Services by Type of Service, Average Cost per Recipient for Fiscal Years 1996 and 1997

Type of Service	FY 1996	FY 1997	% of Incr. or Decr.
Total	$2,590	$2,812	8.57%
Inpatient Hospital	4,302	4,509	4.81%
Outpatient Hospital	414	426	2.90%
Laboratory/X-Ray	66	73	10.61%
Nursing Facility	15,170	16,095	6.10%
Physician	313	324	3.51%
EPSDT	76	77	1.32%
EPSDT Dental	149	154	3.36%
EPSDT Vision	128	130	1.56%
EPSDT Hearing	140	101	-27.86%
Rural Health Clinic	199	218	9.55%
Federally Qualified Health Centers	256	260	1.56%
Home Health	1,882	1,456	-22.64%
Transportation	412	390	-5.34%
Prescribed Drugs	399	469	17.54%
Dental	110	108	-1.82%
Eyeglasses	53	54	1.89%
Intermediate Care Facility - Mentally Retarded	40,849	43,977	7.66%
Per Capita Managed Care	0	763	100.00%
Buy-in, Parts A & B, Medicare	724	851	17.54%
Mental Health Clinic	1,060	1,159	9.34%
Home & Community Based Waiver	2,276	3,997	75.62%
Durable Medical Equipment	735	684	-6.94%
Therapy	417	449	7.67%
Inpatient Residential Psychiatric	22,475	15,041	-33.08%
Inpatient Psychiatric Hospital	7,520	7,424	-1.28%
Nurse Practitioner	138	102	-26.09%
Ambulatory Surgical Center	107	468	337.38%
Personal Care	0	0	0.00%
Hospice	5,941	7,558	27.21%
Outpatient Psychiatric Hospital	0	0	0.00%
Private Mental Health Centers	395	504	27.59%
Family Planning Drugs	84	87	3.57%
Dialysis	7,917	14,911	88.34%

Source: MAM 250-R1 and MAM 260-R1

TABLE 9

Expenditures for Major Medical Services by Program Category for Fiscal Year 1997

Program Category	Inpt. Hosp.	Outpt. Hosp.	Nursing Fac.	Physicians	EPSDT	Drugs	Dental
Total	$276,915,091	$98,083,245	$299,961,995	$112,435,66	$9,707,209	$202,628,325	$3,065,135
Aged	610,598	127,909	254,790,380	139,551	49	47,115,208	318,577
Blind	703,580	389,868	825,054	313,234	521	1,146,366	15,372
Disabled	121,684,479	39,365,909	44,299,114	34,681,356	472,007	92,531,497	1,476,379
AFDC	44,959,396	26,996,699	0	26,142,182	3,435,122	16,763,255	754,786
CWS Foster Care	2,061,124	463,027	28,286	672,866	69,223	465,420	0
Optional Categorically Needy-Pregnant Women & Children							
At 100% Federal Poverty Level	15,809,901	8,666,245	0	10,670,196	1,391,148	5,133,045	37,255
At 133% Federal Poverty Level	20,519,605	8,301,450	0	12,426,285	1,405,252	3,208,256	46,971
At 185% Federal Poverty Level	25,061,149	6,883,026	0	14,860,814	793,142	1,437,245	63,950
Optional & Mandatory Phased-in Children Under Age 18	2,520,038	1,003,408		1,191,846	116,750	649,830	1,208
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
Poverty Level							
Aged	107,988	70,584	10,981	67,585	14	16,854,057	136,671
Disabled	7,583,835	2,287,833	5,009	2,129,823	1,378	14,316,781	212,775
Katie Beckett	970,860	398,697		0 208,350	5,039	881,823	0
Hospice							
Aged	5,311	0	2,382	126	0	336,497	381
Blind	0	576	0	468	0	197	0
Disabled	209,265	27,382	789	32,732	0	63,024	810
Other Medical Assistance Only							
Automatic Infants	34,107,962	3,100,632	0	8,898,249	2,017,564	1,725,824	0

Source: MAM 250-R1

TABLE 10

Amount Paid to State Health Agencies and Institutions by Source of Funds for Fiscal Years 1995 - 1997

Name of Agency or Institution	Fiscal Year	Total Amount Of Payment	From Federal Funds	From State Funds
Total	FY 1995	$212,761,096	$167,187,669	$45,573,427
	FY 1996	213,757,848	166,880,752	46,877,096
	FY 1997	242,966,253	188,075,416	54,890,837
East Miss. State Nursing Home (Meridian)	FY 1995	5,232,129	4,111,407	1,120,722
	FY 1996	5,305,730	4,142,183	1,163,547
	FY 1997	5,289,340	4,084,428	1,204,912
Ellisville State School (Ellisville)	FY 1995	24,267,937	19,069,745	5,198,192
	FY 1996	25,237,901	19,703,229	5,534,672
	FY 1997	29,638,463	22,886,821	6,751,642
Miss. State Dept. of Health	FY 1995	17,859,024	14,033,621	3,825,403
	FY 1996	16,286,230	12,714,660	3,571,570
	FY 1997	18,973,110	14,651,036	4,322,074
North Miss. Retardation Center (Long Beach)	FY 1995	14,571,109	11,449,977	3,121,132
	FY 1996	17,228,521	13,450,306	3,778,215
	FY 1997	17,719,371	13,682,898	4,036,473
South Miss. Retardation Center (Whitfield)	FY 1995	9,293,055	7,302,483	1,990,572
	FY 1996	12,890,310	10,063,465	2,826,845
	FY 1997	15,014,427	11,594,141	3,420,286
Hudspeth Retardation Center (Whitfield)	FY 1995	16,402,714	12,889,253	3,513,461
	FY 1996	16,862,241	13,164,352	3,697,889
	FY 1997	19,358,309	14,948,486	4,409,823
Miss. State Hospital-Nursing Facility (Whitfield)	FY 1995	9,434,938	7,413,974	2,020,964
	FY 1996	9,778,949	7,634,425	2,144,524
	FY 1997	11,091,986	8,659,513	2,432,473
Miss. State Hospital (Whitfield)	FY 1995	1,752,557	1,377,159	375,398
	FY 1996	644,415	503,095	141,320
	FY 1997	3,613,511	2,821,068	792,443
Boswell Retardation Center (Sanatorium)	FY 1995	5,845,510	4,593,402	1,252,108
	FY 1996	8,257,931	6,446,967	1,810,964
	FY 1997	9,414,537	7,269,905	2,144,632
Miss. Department of Mental Health	FY 1995	36,653,851	28,802,596	7,851,255
	FY 1996	36,199,485	28,260,938	7,938,547
	FY 1997	39,044,543	30,482,075	8,562,468
University Medical Center (Jackson)	FY 1995	68,144,172	53,547,690	14,596,482
	FY 1996	61,023,375	47,640,949	13,382,426
	FY 1997	71,439,216	55,165,363	16,273,853
Miss. Dept. of Human Services	FY 1995	3,304,100	2,596,362	707,738
	FY 1996	4,042,760	3,156,183	886,577
	FY 1997	2,369,440	1,829,682	539,758

Source: Provider History Report

TABLE 11

Total Number of Eligibles, Number Using Physician Services by Program Category for Fiscal Year 1997

Program Category	Total Number of Eligibles	Recipients Using Service	Percent of Total
Total	543,560	346,640	63.77%
Aged	32,765	26,405	80.59%
Blind	1,569	1,129	71.96%
Disabled	121,639	84,854	69.76%
AFDC Children	226,484	129,375	57.12%
AFDC Adults	101,753	63,723	62.63%
*CWS Foster Care	1,576	1,125	71.38%
Optional Categorically Needy	57,774	40,029	69.29%

Source: HCFA 2082

TABLE 12

Amount of Expenditures with Percentage Distribution for Physician Services by Program Category for Fiscal Year 1997

Program Category	Expenditures	Percent of Total
Total	$112,453,663	100.00%
Aged	$10,821,012	17.24%
Blind	$497,495	0.48%
Disabled	$36,210,036	28.57%
AFDC Children	$23,877,142	20.18%
AFDC Adults	$19,535,844	28.19%
*CWS Foster Care	$2,664,426	0.27%
Optional Categorically Needy	$18,829,708	5.07%

Source: HCFA 2082

TABLE 13

Amount of Expenditures with Percentage Distribution for Physician Services by Age Groups for Fiscal Year 1997

Age in Years	Expenditures	Percent of Total*
Total	$112,435,663	100.00%
Birth to age 1	8,898,249	7.91%
Ages 1 to 3	1,540,791	1.37%
Ages 3 to 5	2,929,672	2.61%
Ages 5 to 6	656,143	0.58%
Ages 6 to 8	1,469,392	1.31%
Ages 8 to 19	26,377,632	23.46%
Ages 19 to 21	8,389,261	7.46%
Ages 21 to 64	60,617,464	53.91%
Ages 64 and Over	1,557,059	1.38%

*Percentage columns may not total 100% due to rounding
Source: MAM 250-R1

TABLE 14

Number of Physician Visits by Place of Visit for Fiscal Year 1997

Place of Visit	Number of Visits	Percent of Total*
Total	1,942,012	100.00%
Physician's Office	1,161,526	59.81%
Hospital	481,584	24.80%
Nursing Home	11,499	0.59%
Emergency Room	243,698	12.55%
Consultations	42,479	2.19%
House Calls	1,226	0.06%

*Percentage columns may not total 100% due to rounding
Source: SU-0-1-10

TABLE 15

Number of Prescriptions, Number of Recipients, and Average Number of Prescriptions per Recipient by Program Category for Fiscal Year 1997

Program Category	Prescriptions	Percent of Total	Number of Recipients	Percent of Total	Average Number of Prescriptions per Recipient
Total	6,308,306	100.00%	431,932	100.00%	14.6
Aged	865,214	13.72%	32,902	7.62%	26.3
Blind	33,223	0.53%	1,407	0.33%	23.6
Disabled	2,373,717	37.63%	105,732	24.48%	22.5
AFDC Children	967,978	15.34%	166,022	17.46%	5.8
AFDC Adults	434,979	6.90%	74,589	38.24%	5.8
*CWS Foster Care	5,641	0.09%	1,402	0.32%	4.0
Optional Categorically Needy	1,627,554	25.80%	49,878	11.55%	32.6

* Prescriptions for Foster Care Children were estimated. Prescription data was not available.

Source: HCFA 2082

TABLE 16

Number of Recipients and Number of Days of Care for Nursing Facilities by Program Category for Fiscal Year 1997

	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	18,637	4,776,544	2,607	792,679	605	107,629
Aged	15,722	4,082,105	81	24,875	0	0
Blind	41	11,713	24	8,679	0	0
Disabled	1,733	397,594	1,418	384,972	369	66,679
AFDC Children	0	0	2	925	103	19,458
AFDC Adults	4	310	2	414	0	0
CWS Foster Care	0	0	0	0	73	14,116
Optional Categorically Needy	1,137	284,822	1,080	372,814	60	7,376

Source: HCFA 2082

TABLE 17

Number of Children Receiving Treatment by Category of Service for Fiscal Year 1997

Program Category	Number of Children
Dental	56,827
Vision	30,437
Hearing	15,895
Corrective Treatment Referrals	18,774

Source: HCFA 416 Y-T-D

TABLE 18

Number of Recipients, Number of Discharges, Total Days of Hospital Care, and Average Length of Hospital Stay by Program Category for Fiscal Year 1997

Program Category	Number of Recipients*	Number of Discharges	Days of Care	Average Length of Hospital Stay
Total	62,883	312,207	428,346	1.4
Aged	78	322	1,175	3.6
Blind	120	841	1,697	2.0
Disabled	18,098	111,411	191,765	1.7
AFDC Children	17,614	98,308	106,455	1.1
AFDC Adults	15,620	87,178	94,403	1.1
CWS Foster Care	not available	not available	not available	not available
Optional Categorically Needy	11,353	14,147	32,851	2.3

*Does not include Medicaid Recipients who are covered under Medicare Part A
Source: HCFA 2082