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 27th Annual Report of the Division of Medicaid for Fiscal Year 1998. 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 522,000 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.
Executive Director
Division of Medicaid
Office of the Governor

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Mississippi Division of Medicaid
Annual Report
Fiscal Year 1998
July 1, 1997 – June 30, 1998

Kirk Fordice, Governor
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 TANF 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 and non-emergency
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services

waivered projects offering additional enhanced services:

- Managed care services
- Home and community based services for the elderly and disabled
- Home and community based services for the neurologically or orthopedically impaired
- 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 and 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 1998

Throughout the nation, Medicaid is funded with federal dollars matched by individual state contributions. In FY 1998, Mississippi's overall matching rate, which is determined by the state's per capita income, decreased from 77.22 percent in FY 1997 to 77.09 percent in FY 1998. Even with this decrease, a single state dollar invested brought into the state an additional $3.36 through federal matching funds.

For FY 1998, federal contributions amounted to $1,113,766,890, which, when combined with state dollars, provided for total medical expenditures of $1,444,761,824. Over 97 percent of this total was paid to Mississippi providers for services to Medicaid beneficiaries and thereby recycled into local economies throughout the state.

Within the Medicaid program, individual matching rates may vary depending upon the specific funding area. During FY 1998, the total administrative expenses were $53,964,518, with federal contributions of $33,648,571, or 62.35 percent. Mississippi's administrative expenses for FY 1998, which continue to be among the lowest in the Southeastern region, amounted to only 3.02 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:

- Low income families with children who meet the income limits of the 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.

- Qualifying Individuals (QI's), categories of eligibles originating January 1, 1998, which includes individuals/couples whose income is between 120%-175% of the federal poverty level. Medicaid benefits are limited to payment of the Part B premium for those with income between 120%-135% of poverty and partial payment of the Part B premium for those with income between 135%-175% of poverty.

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
1721 W. 10th Street, Suite C
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
2035 Old Mobile Avenue
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 "beneficiary." 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 "beneficiary" is a person who has received Medicaid benefits. Throughout Fiscal Year 1998, 480,007 Mississippians benefited from one or more of the health care services covered by Medicaid.

Program Highlights for FY 1998

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 an additional 19 counties. By June 30, 1997, 33 counties were participating in the HealthMACS program.

By April of 1998, HealthMACS was implemented in every county of the state (total of 82 counties). HealthMACS was included in the State Plan Amendment 98-03 which was approved by HCFA in August 1998, effective June 28,1998. Mississippi was the first state in the nation to have an approved State Plan which included a primary care case management program.

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 a limited number of counties.

During FY 1997, the Division contracted with four HMOs to provide services to Medicaid beneficiaries: 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 beneficiaries in Warren County on December 1, 1996, and in Hancock and Harrison Counties on February 1, 1997.

In fiscal year 1998, the Division contracted with five HMOs to provide services to Medicaid beneficiaries: American Medical Plans of Mississippi, Care 3, Family HealthCare Plus, Mississippi Managed Care Network and Phoenix Healthcare of Mississippi. The Capitated Managed Care Program was implemented in Washington County on August 1, 1997; in Lauderdale County on September 1, 1997; and in Forrest County on October 1, 1997.

Traditional Medicaid staff were supplemented by the addition of new types of workers required by this new program. Client Field Representatives were established and trained to work with beneficiaries, 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. CFRs 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.

Two hotlines were established and staffed to field questions from beneficiaries 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.

In 1998, the Beneficiary Education Unit of the Managed Care Division of the Division of Medicaid traveled the entire state of Mississippi educating our beneficiaries about the managed care programs. Over 120 seminars and meetings were conducted in different arenas throughout the state, reaching the majority of our beneficiaries face to face. Managed care literature and visual aids were distributed at these events to provide reinforcement and to supplement our beneficiaries' understanding of the programs.

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. Beneficiaries of this waiver must qualify for Medicaid as SSI recipients. This statewide program is limited to 2,600 unduplicated beneficiaries 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 beneficiary must be capable of directing his/her own care and possess some rehabilitation potential. Beneficiaries are also provided Case Management Services. These services enable beneficiaries to remain at home rather than be placed in a nursing facility. This statewide program is limited to a maximum of 175 unduplicated beneficiaries per waiver year (July 1, 1997 – June 30, 1998). Beneficiaries 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 beneficiaries per waiver year (July 1, 1997 – June 30, 1998). Beneficiaries 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; Pre-vocational 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 monitor-

ing 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 1998 amount to $1,444,761,824, which represents an increase of 0.90 percent from FY 1997. The highest expenditures continue to be for nursing facility and inpatient hospital services.

EXPENDITURES BY ELIGIBILITY GROUP

Approximately 27 percent of the total expenditures for medical services in Fiscal Year 1998, or about $384 million, were for services to the categorically "Aged." Only nine percent of our total eligibles, 46,980, were so classified. Even more dramatic is the fact that $311 million, or 22 percent of our total expenditures, were for regular nursing facility services to 18,758 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 beneficiary and the major medical expenditures for Fiscal Years 1997 and 1998.

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 1998, 168 nursing facilities in Mississippi participated in the Medicaid Program providing long-term care to 18,758 Medicaid beneficiaries. There were 13 Intermediate Care Facilities for the Mentally Retarded that provided care to 2,690 Medicaid beneficiaries.

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 94,092 Medicaid eligible children ages 0-21 years old during FY 1998. 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/or 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 1998,

Medicaid eligible children received 161,861 doses of vaccine from public and private Medicaid providers 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 and is offered throughout the state. 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.

This targeted case management program resulted in a 7% decrease in the average cost per service among participants.

Dental Services

Dental care was provided to 25,615 beneficiaries during Fiscal Year 1998 with expenditures amounting to $2,875,349.

Inpatient Hospital Services

During Fiscal Year 1998, Medicaid provided for 437,457 days of inpatient hospital care. The average length of hospital stay was 1.1 days. Table 18 shows the number of Medicaid beneficiaries who received inpatient hospital service benefits, the number of discharges, the total days of care, and the average length of stay per beneficiary by program category during Fiscal Year 1998.

Outpatient Hospital Services

A total of 516,997 outpatient visits were provided to 204,810 Medicaid beneficiaries during Fiscal Year 1998, with an average of 2.72 visits per outpatient beneficiary.

Administrative Highlights of FY 1998

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 beneficiary 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 1998 were 23,286,604. 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 beneficiaries. 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 1998, third party savings in the form of cost avoided or recovered payments from both public and private resources totaled over $543 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 1998, 29 percent of the Mississippi population also had Medicare coverage. The claims payment edits and buy-in program yielded $494 million in Medicare cost avoidance.

Private Health Insurance Resources

Slightly more than four percent of the Mississippi Medicaid population was covered by some form of private health insurance in FY 1998. Through cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment), the Medicaid agency saved slightly less than $30 million. Through post-payment recovery (the Medicaid agency bills the third party for reimbursement), the TPL Unit collected $5.9 million.

Casualty/Tort Resources

A significant number of Medicaid beneficiaries receive medical care each month as the result of injuries or accident. Medicaid is responsible for identifying those beneficiaries whose medical care for these injuries may be the liability of another party and pursue recovery. These resources are identified through the MMIS edits and referrals from outside entities such as insurance companies, providers, and attorneys. In FY 1998, the TPL Unit collected $1.7 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 1998.

Estate Recovery

As a result of OBRA 1993, the state enacted legislation allowing recovery of medical payments from the estates of certain beneficiaries who were residents of nursing facilities at the time of death. In FY 1998, the Estate Recovery program returned more than a $750,000.

PROGRAM INTEGRITY

The Division of Medicaid is responsible for monitoring both provider and beneficiary 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 beneficiaries 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 beneficiaries also provide information to warrant investigations. Program Integrity also handles complaints regarding beneficiaries 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 beneficiaries. Beneficiary management reviews are also conducted to make certain that beneficiaries 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 beneficiary recoupment. Approximately 200 cases per month are received from the Department of Human Services and Medicaid Regional Offices. These cases involve beneficiaries 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 beneficiaries and a payment plan is initiated. Investigators make field visits to all beneficiaries owing $500 or more.

Explanation of Medicaid Benefits (EOMB) audits are conducted to obtain confirmation that a beneficiary did or did not receive the services for which the Division of Medicaid made payment. Approximately 400 questionnaires per month are sent to beneficiaries 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 beneficiaries who have no other means of transportation. The Division of Medicaid provides ground and air non-emergency transportation services for eligible beneficiaries. Commercial air and air ambulance services are available when ground

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

The majority of NET services provided to Medicaid beneficiaries in FY 1998 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 beneficiaries who needed NET services and for arranging transportation assistance with local providers. Transportation assistance was available to transport beneficiaries to local providers as well as to those outside the beneficiaries' communities. In FY 1998, more than 258,982 transports were funded for Medicaid beneficiaries through the Division of Medicaid's individual drivers and contractual agreements with group providers.

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. These reviews assist management in ensuring that the contractor provided the required services in a manner that was in compliance with all federal and state laws and regulations, and that the contractor was properly reimbursed for only those services actually performed for the Division. The CMU provides management with a written report detailing any programmatic concerns and recommendations to correct those concerns. In addition, when identified, the CMU will recommend to management to recover funds reimbursed to the contractor if services were found to have not been provided in accordance with the contract.

During FY 1998, the CMU completed 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. In addition, the CMU completed a review of the FY 1993 through FY 1997 Survey and Certification contracts with the Mississippi State Department of Health.

TABLE 1

Certified Eligibles by Eligibility Category for Fiscal Year 1998

Program Category	Total Number of Eligible Persons	Percent of Total
Total	521,753	100.00%
Aged	46,980	9.00%
Blind	1,543	0.30%
Disabled	126,972	24.34%
Aid to Families With Dependent Children (AFDC)	127,383	24.41%
CWS Foster Care	1,424	0.27%
Optional Categorically Needy-Pregnant Women & Children		
At 100% Federal Poverty Level	83,656	16.03%
At 133% Federal Poverty Level	36,745	7.04%
At 185% Federal Poverty Level	22,662	4.34%
Under age 18	9,636	1.85%
Qualified Medicare Beneficiary		
Aged	65	0.01%
Blind	28	0.01%
Disabled	9	0.00%
Poverty Level		
Aged	15,868	3.04%
Disabled	12,132	2.33%
Other Medical Assistance Only		
Disabled Children Living at Home	757	0.15%
Automatic Infants	35,893	6.88%

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 1998

County	County Population	Number of Medicaid Eligibles	Percent of Population	County	County Population	Number of Medicaid Eligibles	Percent of Population
Adams	35,356	8,329	23.56%	Leflore	37,341	12,666	33.92%
Alcorn	31,722	6,005	18.93%	Lincoln	30,278	5,760	19.02%
Amite	13,328	2,669	20.03%	Lowndes	59,308	11,451	19.31%
Attala	18,481	4,293	23.23%	Madison	53,794	10,249	19.05%
Benton	8,046	1,768	21.97%	Marion	25,544	6,154	24.09%
Bolivar	41,875	14,282	34.11%	Marshall	30,361	7,143	23.53%
Calhoun	14,908	3,121	20.94%	Monroe	36,582	6,111	16.70%
Carroll	9,237	1,749	18.93%	Montgomery	12,388	3,000	24.22%
Chickasaw	18,085	3,680	20.35%	Neshoba	24,800	5,221	21.05%
Choctaw	9,071	1,941	21.40%	Newton	20,291	3,895	19.20%
Claiborne	11,370	3,161	27.80%	Noxubee	12,604	4,288	34.02%
Clarke	17,313	2,728	15.76%	Oktibbeha	38,375	6,049	15.76%
Clay	21,120	5,208	24.66%	Panola	29,996	8,068	26.90%
Coahoma	31,665	11,499	36.31%	Pearl River	38,714	7,556	19.52%
Copiah	27,592	6,576	23.83%	Perry	10,865	2,509	23.09%
Covington	16,527	3,805	23.02%	Pike	36,882	9,333	25.31%
DeSoto	67,910	6,344	9.34%	Pontotoc	22,237	3,112	13.99%
Forrest	68,314	12,865	18.83%	Prentiss	23,278	3,879	16.66%
Franklin	8,377	1,846	22.04%	Quitman	10,490	3,794	36.17%
George	16,673	2,715	16.28%	Rankin	87,161	10,263	11.77%
Greene	10,220	2,088	20.43%	Scott	24,137	5,487	22.73%
Grenada	21,555	4,906	22.76%	Sharkey	7,066	2,542	35.98%
Hancock	31,760	5,130	16.15%	Simpson	23,953	5,178	21.62%
Harrison	165,365	25,925	15.68%	Smith	14,798	2,894	19.56%
Hinds	254,441	45,054	17.71%	Stone	10,750	2,675	24.88%
Holmes	21,604	8,921	41.29%	Sunflower	32,867	10,427	31.72%
Humphreys	12,134	4,179	34.44%	Tallahatchie	15,210	4,596	30.22%
Issaquena	1,909	562	29.44%	Tate	21,432	3,679	17.17%
Itawamba	20,017	2,587	12.92%	Tippah	19,523	3,975	20.36%
Jackson	115,243	15,811	13.72%	Tishomingo	17,683	2,775	15.69%
Jasper	17,114	3,854	22.52%	Tunica	8,164	2,560	31.36%
Jefferson	8,653	2,794	32.29%	Union	22,085	3,527	15.97%
Jefferson Davis	14,051	3,588	25.54%	Walthall	14,352	3,831	26.69%
Jones	62,031	11,799	19.02%	Warren	47,880	9,556	19.96%
Kemper	10,356	1,959	18.92%	Washington	67,935	21,037	30.97%
Lafayette	31,826	3,578	11.24%	Wayne	19,517	4,624	23.69%
Lamar	30,424	4,518	14.85%	Webster	10,222	2,083	20.38%
Lauderdale	75,555	13,906	18.41%	Wilkinson	9,678	2,966	30.65%
Lawrence	12,458	2,471	19.83%	Winston	19,433	4,011	20.64%
Leake	18,436	3,818	20.71%	Yalobusha	12,033	3,114	25.88%
Lee	65,581	9,860	15.03%	Yazoo	25,506	7,698	30.18%

TABLE 3

Beneficiaries of Services by Program Category for Fiscal Year 1998

Program Category	Total Number of Beneficiaries	Percent of Total *
Total	480,007	100.00%
Money Payment Eligibles		
Aged	44,359	9.24%
Blind	1,442	0.30%
Disabled	118,469	24.68%
Aid to Families With Dependent Children (AFDC)	110,018	22.92%
CWS Foster Care	1,322	0.28%
Optional Categorically Needy – Pregnant Women & Children		
At 100% Federal Poverty Level	8,193	1.71%
At 133% Federal Poverty Level	35,802	7.46%
At 185% Federal Poverty Level	26,114	5.44%
Optional & Mandatory Phased-in Children Under Age 18	73,839	15.38%
Qualified Medicare Beneficiary		
Aged	52	0.01%
Blind	22	0.00%
Disabled	6	0.00%
Poverty Level		
Aged	16,289	3.39%
Disabled	12,353	2.57%
Hospice		
Aged	97	0.02%
Blind	0	0.00%
Disabled	105	0.02%
Other Medical Assistance Only		
Disabled Children Living at Home	730	0.15%
Automatic Infants	30,795	6.42%

* Percentage column may not total 100% due to rounding

Source: MAM 260-R1

TABLE 4

Beneficiaries of Medical Services by Type of Service for Fiscal Years 1997 and 1998

Type of Service	Beneficiaries FY 1997	Beneficiaries FY 1998	Percent Increase or Decrease
Total	509,303	480,007	-5.75%
Inpatient Hospital	62,883	59,241	-5.79%
Outpatient Hospital	230,148	204,810	-11.01%
Laboratory/X-Ray	103,937	83,718	-19.45%
Nursing Facility	18,637	18,758	0.65%
Physician	346,640	316,962	-8.56%
EPSDT	125,727	94,062	-25.19%
EPSDT Dental	79,887	70,838	-11.33%
EPSDT Vision	40,011	36,032	-9.94%
EPSDT Hearing	2,465	1,896	-23.08%
Rural Health Clinic	91,508	85,094	-7.01%
Federally Qualified Health Center	53,058	49,840	-6.07%
Home Health	7,651	7,268	-5.01%
Transportation	30,195	28,302	-6.27%
Prescribed Drugs	431,932	415,801	-3.73%
Dental	28,336	25,615	-9.60%
Eyeglasses	10,814	10,164	-6.01%
Intermediate Care Facility - Mentally Retarded	2,607	2,690	3.18%
Per Capita Managed Care	8,790	18,738	113.17%
Buy-in, Parts A & B, Medicare	149,337	148,598	-0.49%
Mental Health Clinic	33,668	34,617	2.82%
Home & Community Based Waiver	2,179	2,781	27.63%
Durable Medical Equipment	13,095	13,929	6.37%
Therapy	1,456	1,324	-9.07%
Inpatient Residential Psychiatric	605	809	33.72%
Inpatient Psychiatric Hospital	1,877	1,885	0.43%
Nurse Practitioner	32,787	34,181	4.25%
Ambulatory Surgical Center	1,685	1,728	2.55%
Personal Care	0	0	0.00%
Hospice	432	484	12.04%
Outpatient Psychiatric Hospital	28	15	-46.43%
Private Mental Health Center	1,165	1,291	10.82%
Family Planning Drugs	19,128	17,318	-9.46%
Dialysis	538	484	-10.04%

Source: MAM 260-R1

TABLE 5

Paid Claims by Type of Service for Fiscal Years 1997 and 1998

Type of Service	Claims FY 1997	Claims FY 1998	Percent Increase or Decrease
Total	22,685,443	23,283,633	2.64%
Inpatient Hospital	393,253	483,132	22.86%
Outpatient Hospital	856,752	922,696	7.70%
Laboratory/X-Ray	973,764	713,460	-26.73%
Nursing Facility	401,757	619,846	54.28%
Physician	4,333,074	4,212,889	-2.77%
EPSDT	370,206	425,679	14.98%
EPSDT Dental	596,312	499,427	-16.25%
EPSDT Vision	261,864	242,908	-7.24%
EPSDT Hearing	5,214	4,254	-18.41%
Rural Health Clinic	720,329	765,520	6.27%
Federally Qualified Health Center	428,771	466,105	8.71%
Home Health	140,046	173,335	23.77%
Transportation	338,574	223,223	-34.07%
Prescribed Drugs	7,180,650	7,230,642	0.70%
Dental	164,061	145,459	-11.34%
Eyeglasses	24,803	22,676	-8.58%
Intermediate Care Facility - Mentally Retarded	163,841	63,681	-61.13%
Per Capita Managed Care	37,156	115,069	209.69%
Buy-in, Parts A & B, Medicare	4,062,718	4,606,301	13.38%
Mental Health Clinic	719,969	839,772	16.64%
Home & Community Based Waiver	74,100	76,326	3.00%
Durable Medical Equipment	126,762	153,374	20.99%
Therapy	30,676	26,617	-13.23%
Inpatient Residential Psychiatric	2,226	4,974	123.45%
Inpatient Psychiatric Hospital	18,277	10,893	-40.40%
Nurse Practitioner	163,762	154,208	-5.83%
Ambulatory Surgical Center	4,271	3,925	-8.10%
Personal Care	0	0	0.00%
Hospice	2,841	3,471	22.18%
Outpatient Psychiatric Hospital	114	31	-72.81%
Private Mental Health Center	19,304	17,174	-11.03%
Family Planning Drugs	55,861	49,884	-10.70%
Dialysis	14,135	6,682	-52.73%

Source: MR-0-08

TABLE 6

Total Expenditures for Medical Services, Total Number of Beneficiaries, Average Expenditure per Beneficiary, and Percentage by Program Category for Fiscal Year 1998

Program Category	Total Expenditures	Percent of Total*	Number of Beneficiaries	Percent of Total*	Average per Beneficiary
Total	$1,444,761,824	100.00%	480,007	100.00%	$3,010
Money Payment Eligibles					
Aged	$384,306,273	26.60%	44,359	9.24%	$8,664
Blind	6,511,339	0.45%	1,442	0.30%	4,515
Disabled	605,459,629	41.91%	118,469	24.68%	5,111
AFDC	113,135,980	7.83%	110,018	22.92%	1,028
CWS Foster Care	4,261,020	0.29%	1,322	0.28%	3,223
Optional Categorically Needy – Pregnant Women & Children					
At 100% Federal Poverty Level	8,330,388	0.58%	8,193	1.71%	1,017
At 133% Federal Poverty Level	50,939,737	3.53%	35,802	7.46%	1,423
At 185% Federal Poverty Level	60,646,004	4.20%	26,114	5.44%	2,322
Optional & Mandatory Phased-in Children Under Age 18	66,252,057	4.59%	73,839	15.38%	897
Qualified Medicare Beneficiary					
Aged	36,234	0.00%	52	0.01%	697
Blind	5,702	0.00%	22	0.00%	259
Disabled	3,308	0.00%	6	0.00%	551
Poverty Level					
Aged	36,607,823	2.53%	16,289	3.39%	2,247
Disabled	47,478,353	3.29%	12,353	2.57%	3,843
Hospice					
Aged	586,635	0.04%	97	0.02%	6,048
Blind	0	0.00%	0	0.00%	0
Disabled	931,643	0.06%	105	0.02%	8,873
Other Medical Assistance Only					
Automatic Infants	55,645,176	3.85%	30,795	6.42%	1,807
Disabled Children Living at Home	3,624,523	0.25%	730	0.15%	4,965

* 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 1997 and 1998

Type of Service	Expenditures FY1997	Expenditures FY1998	Percent Increase or Decrease
Total	$1,431,930,683	$1,444,761,824	0.90%
Inpatient Hospital	$276,915,091	$260,394,924	-5.97%
Outpatient Hospital	98,083,245	75,536,752	-22.99%
Laboratory/X-Ray	7,561,924	5,927,324	-21.62%
Nursing Facility	299,961,995	311,146,718	3.73%
Physician	112,435,663	102,749,048	-8.62%
EPSDT	9,707,209	7,454,339	-23.21%
EPSDT Dental	12,326,827	10,507,826	-14.76%
EPSDT Vision	5,203,274	4,821,552	-7.34%
EPSDT Hearing	248,269	212,552	-14.39%
Rural Health Clinic	19,966,646	15,303,203	-23.36%
Federally Qualified Health Center	13,778,564	13,706,293	-0.52%
Home Health	11,144,004	12,615,991	13.21%
Transportation	11,770,668	11,515,897	-2.16%
Prescribed Drugs	202,628,325	224,419,498	10.75%
Dental	3,065,135	2,875,349	-6.19%
Eyeglasses	587,771	540,170	-8.10%
Intermediate Care Facility - Mentally Retarded	114,647,934	123,831,653	8.01%
Per Capita Managed Care	6,710,959	21,541,980	221.00%
Buy-in, Parts A & B, Medicare	127,049,620	133,764,091	5.28%
Mental Health Clinic	39,016,670	42,748,364	9.56%
Home & Community Based Waiver	8,708,672	9,869,419	13.33%
Durable Medical Equipment	8,956,166	9,166,488	2.35%
Therapy	653,288	610,867	-6.49%
Inpatient Residential Psychiatric	9,099,568	13,187,946	44.93%
Inpatient Psychiatric Hospital	13,935,540	14,312,771	2.71%
Nurse Practitioner	3,347,802	3,494,771	4.39%
Ambulatory Surgical Center	789,065	816,163	3.43%
Personal Care	0	0	0.00%
Hospice	3,264,865	3,936,425	20.57%
Outpatient Psychiatric Hospital	98,979	3,584	-96.38%
Private Mental Health Center	587,520	514,298	-12.46%
Family Planning Drugs	1,657,375	1,447,947	-12.64%
Dialysis	8,022,050	5,787,621	-27.85%

Source: MAM 250-R1 and MAM 260-R1

TABLE 8

Expenditures for Medical Services by Type of Service, Number of Beneficiaries by Service, and Average Spent for Fiscal Year 1998

Type of Service	Total Expenditures	Number of Beneficiaries	Avgerage per Beneficiary
Total	$1,444,761,824	480,007	$3,010
Inpatient Hospital	$260,394,924	59,241	$4,396
Outpatient Hospital	75,536,752	204,810	369
Laboratory/X-Ray	5,927,324	83,718	71
Nursing Facility	311,146,718	18,758	16,587
Physician	102,749,048	316,962	324
EPSDT	7,454,339	94,062	79
EPSDT Dental	10,507,826	70,838	148
EPSDT Vision	4,821,552	36,032	134
EPSDT Hearing	212,552	1,896	112
Rural Health Clinic	15,303,203	85,094	180
Federally Qualified Health Center	13,706,293	49,840	275
Home Health	12,615,991	7,268	1,736
Transportation	11,515,897	28,302	407
Prescribed Drugs	224,419,498	415,801	540
Dental	2,875,349	25,615	112
Eyeglasses	540,170	10,164	53
Intermediate Care Facility - Mentally Retarded	123,831,653	2,690	46,034
Per Capita Managed Care	21,541,980	18,738	1,150
Buy-in, Parts A & B, Medicare	133,764,091	148,598	900
Mental Health Clinic	42,748,364	34,617	1,235
Home & Community Based Waiver	9,869,419	2,781	3,549
Durable Medical Equipment	9,166,488	13,929	658
Therapy	610,867	1,324	461
Inpatient Residential Psychiatric	13,187,946	809	16,302
Inpatient Psychiatric Hospital	14,312,771	1,885	7,593
Nurse Practitioner	3,494,771	34,181	102
Ambulatory Surgical Center	816,163	1,728	472
Personal Care	0	0	0
Hospice	3,936,425	484	8,133
Outpatient Psychiatric Hospital	3,584	15	239
Private Mental Health Center	514,298	1,291	398
Family Planning Drugs	1,447,947	17,318	84
Dialysis	5,787,621	484	11,958

Source: MAM 250-R1 and MAM 260-R1

TABLE 8-A

Expenditures for Medical Services by Type of Service, Average Cost per Beneficiary for Fiscal Years 1997 and 1998

Type of Service	FY 1997	FY 1998	Percent Increase or Decrease
Total	$2,812	$3,010	7.04%
Inpatient Hospital	$4,509	$4,626	2.59%
Outpatient Hospital	426	369	-13.38%
Laboratory/X-Ray	73	71	-2.74%
Nursing Facility	16,095	16,587	3.06%
Physician	324	324	0.00%
EPSDT	77	79	2.60%
EPSDT Dental	154	148	-3.90%
EPSDT Vision	130	134	3.08%
EPSDT Hearing	101	112	10.89%
Rural Health Clinic	218	180	-17.43%
Federally Qualified Health Centers	260	275	5.77%
Home Health	1,456	1,736	19.23%
Transportation	390	407	4.36%
Prescribed Drugs	469	540	15.14%
Dental	108	112	3.70%
Eyeglasses	54	53	-1.85%
Intermediate Care Facility - Mentally Retarded	43,977	46,034	4.68%
Per Capita Managed Care	763	1,150	50.72%
Buy-in, Parts A & B, Medicare	851	900	5.76%
Mental Health Clinic	1,159	1,235	6.56%
Home & Community Based Waiver	3,997	3,549	-11.21%
Durable Medical Equipment	684	658	-3.80%
Therapy	449	461	2.67%
Inpatient Residential Psychiatric	15,041	16,302	8.38%
Inpatient Psychiatric Hospital	7,424	7,593	2.28%
Nurse Practitioner	102	102	0.00%
Ambulatory Surgical Center	468	472	0.85%
Personal Care	0	0	0.00%
Hospice	7,558	8,133	7.61%
Outpatient Psychiatric Hospital	3,353	239	-93.24%
Private Mental Health Centers	504	398	-21.03%
Family Planning Drugs	87	84	-3.45%
Dialysis	14,911	11,958	-19.80%

Source: MAM 250-R1 and MAM 260-R1

TABLE 9

Expenditures for Major Medical Services by Program Category for Fiscal Year 1998

Program Category	Inpatient Hospital	Outpatient Hospital	Nursing Facility	Physicians	EPSDT	Drugs	Dental
Total	$260,389,924	$75,536,752	$311,146,718	$102,749,048	$7,454,339	$224,419,498	$2,875,349
Aged	$481,328	$193,031	$264,093,393	$110,582	$633	$51,872,299	$293,376
Blind	747,806	336,697	842,679	327,908	863	1,207,959	19,518
Disabled	112,381,508	33,377,678	46,168,535	33,765,092	443,158	106,109,293	1,544,416
AFDC	33,322,392	15,105,792	0	17,215,362	1,924,785	13,428,277	511,767
CWS Foster Care	2,042,090	140,389	0	351,757	25,848	290,245	0
Optional Categorically Needy-Pregnant Women & Children							
At 100% Federal Poverty Level	2,590,853	872,331	0	1,168,404	116,865	780,272	1,711
At 133% Federal Poverty Level	19,936,048	6,380,319	0	11,164,873	1,079,819	3,246,469	45,346
At 185% Federal Poverty Level	26,375,857	6,253,151	0	14,857,576	820,853	1,679,290	68,359
Optional & Mandatory Phased-in Children Under Age 18	18,083,925	7,860,910	0	11,438,210	1,215,601	6,742,180	42,183
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	132,947	70,155	16,649	49,904	289	18,668,536	129,386
Disabled	7,984,256	2,027,215	6,701	2,047,470	4,533	17,283,237	218,760
Hospice							
Aged	0	0	15,581	264	0	131,306	156
Blind	0	576	0	0	0	0	0
Disabled	131,193	36,304	3,180	35,986	0	84,438	371
Other Medical Assistance Only							
Automatic Infants	35,359,925	2,500,205	0	9,984,913	1,815,339	1,884,805	0
Disabled Children Living at Home	819,796	381,999	0	230,747	5,753	1,010,892	0

Source: MAM 250-R1

TABLE 10

Amount Paid to State Health Agencies and Institutions by Source of Funds for Fiscal Years 1996 - 1998

Name of Agency or Institution	Fiscal Year	Total Amount of Payment	From Federal Funds	From State Funds
Total	FY 1996	$275,681,336	$215,224,419	$60,456,917
	FY 1997	321,812,154	248,503,345	73,308,809
	FY 1998	318,576,055	245,590,281	72,985,774
East Miss. State Nursing Home (Meridian)	FY 1996	$5,305,730	$4,142,183	$1,163,547
	FY 1997	5,289,340	4,084,428	1,204,912
	FY 1998	5,453,031	4,203,742	1,249,289
Ellisville State School (Ellisville)	FY 1996	25,237,901	19,703,229	5,534,672
	FY 1997	29,638,463	22,886,821	6,751,642
	FY 1998	33,528,601	25,847,199	7,681,402
Miss. State Dept. of Health	FY 1996	16,286,230	12,714,660	3,571,570
	FY 1997	18,973,110	14,651,036	4,322,074
	FY 1998	15,186,710	11,707,435	3,479,275
North Miss. Retardation Center (Oxford)	FY 1996	17,228,521	13,450,306	3,778,215
	FY 1997	17,719,371	13,682,898	4,036,473
	FY 1998	19,253,865	14,842,805	4,411,060
South Miss. Retardation Center (Long Beach)	FY 1996	12,890,310	10,063,465	2,826,845
	FY 1997	15,014,427	11,594,141	3,420,286
	FY 1998	15,450,232	11,910,584	3,539,648
Hudspeth Retardation Center (Whitfield)	FY 1996	16,862,241	13,164,352	3,697,889
	FY 1997	19,358,309	14,948,486	4,409,823
	FY 1998	21,480,073	16,558,988	4,921,085
Miss. State Hospital-Nursing Facility (Whitfield)	FY 1996	9,778,949	7,634,425	2,144,524
	FY 1997	11,091,986	8,565,232	2,526,754
	FY 1998	11,199,500	8,633,695	2,565,805
Miss. State Hospital (Whitfield)	FY 1996	644,415	503,095	141,320
	FY 1997	3,613,511	2,790,353	823,158
	FY 1998	4,074,843	3,141,296	933,547
Boswell Retardation Center (Sanatorium)	FY 1996	8,257,931	6,446,967	1,810,964
	FY 1997	9,414,537	7,269,905	2,144,632
	FY 1998	1,001,777	772,270	229,507
Miss. Department of Mental Health	FY 1996	36,199,485	28,260,938	7,938,547
	FY 1997	39,044,543	30,150,196	8,894,347
	FY 1998	42,792,430	32,988,684	9,803,746
University Medical Center* (Jackson)	FY 1996	122,946,863	95,984,616	26,962,247
	FY 1997	150,285,117	116,050,167	34,234,950
	FY 1998	146,905,469	113,249,426	33,656,043
Miss. Dept. of Human Services	FY 1996	4,042,760	3,156,183	886,577
	FY 1997	2,369,440	1,829,682	539,758
	FY 1998	2,249,524	1,734,158	515,366

Source: Provider History Report

* Includes disproportionate share hospital payments

TABLE 11

Total Number of Eligibles, Number Using Physician Services by Program Category for Fiscal Year 1998

Program Category	Total Number of Eligibles	Beneficiaries Using Services	Percent of Total
Total	521,753	316,962	60.75%
Aged	30,721	24,145	78.59%
Blind	1,524	1,032	67.72%
Disabled	122,524	77,589	63.33%
AFDC Children	123,216	55,351	44.92%
AFDC Adults	182,224	121,215	66.52%
CWS Foster Care	1,424	1,028	72.19%
Optional Categorically Needy	60,120	36,602	60.88%

Source: HCFA 2082

TABLE 12

Amount of Expenditures with Percentage Distribution for Physician Services by Program Category for Fiscal Year 1998

Program Category	Total Expenditures	Percent of Total
Total	$102,749,048	100.00%
Aged	$9,949,914	17.24%
Blind	482,295	0.48%
Disabled	34,921,891	28.57%
AFDC Children	13,224,757	20.18%
AFDC Adults	22,847,654	28.19%
CWS Foster Care	238,325	0.27%
Optional Categorically Needy	21,084,212	5.07%

Source: HCFA 2082

TABLE 13

Amount of Expenditures with Percentage Distribution for Physician Services by Age Groups for Fiscal Year 1998

Age in Years	Total Expenditures	Percent of Total*
Total	$102,749,048	100.00%
Birth to age 1	$9,984,912	9.72%
Ages 1 to 3	1,500,482	1.46%
Ages 3 to 5	2,731,402	2.66%
Ages 5 to 6	684,930	0.67%
Ages 6 to 8	1,607,317	1.56%
Ages 8 to 19	22,942,178	22.33%
Ages 19 to 21	7,440,916	7.24%
Ages 21 to 64	54,468,916	53.01%
Ages 64 and Over	1,387,995	1.35%

* Percentage column may not total 100% due to rounding

Source: MAM 250-R1

TABLE 14

Number of Physician Visits by Place of Visit for Fiscal Year 1998

Place of Visit	Number of Visits	Percent of Total*
Total	1,927,100	100.00%
Physician's Office	1,168,598	60.64%
Hospital	506,935	26.31%
Nursing Home	12,246	0.64%
Emergency Room	196,362	10.19%
Consultations	42,017	2.18%
House Calls	942	0.05%

* Percentage column may not total 100% due to rounding

Source: SU-0-1-10

TABLE 15

Number of Prescriptions, Number of Beneficiaries, and Average Number of Prescriptions per Beneficiary by Program Category for Fiscal Year 1998

Program Category	Prescriptions	Percent of Total	Number of Beneficiaries	Percent of Total	Average Number of Prescriptions per Beneficiary
Total	6,224,042	100.00%	415,801	100.00%	15.0
Aged	816,480	13.12%	31,673	7.62%	25.8
Blind	32,639	0.52%	1,354	0.33%	24.1
Disabled	2,422,894	38.93%	101,784	24.48%	23.8
AFDC Children	435,395	7.00%	157,037	17.46%	2.8
AFDC Adults	813,865	13.08%	74,589	38.24%	10.9
CWS Foster Care*	3,534	0.06%	1,349	0.32%	2.6
Optional Categorically Needy	1,699,235	27.30%	48,015	11.55%	35.4

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

Source: HCFA 2082

TABLE 16

Number of Beneficiaries and Number of Days of Care for Nursing Facilities by Program Category for Fiscal Year 1998

	Nursing Facility		Intermediate Care Facilitiy - MR		Psychiatric Residential Treatment Facility	
Program Category	Beneficiaries	Days of Care	Beneficiaries	Days of Care	Beneficiaries	Days of Care
Total	18,758	4,767,697	2,690	834,494	809	148,098
Aged	16,082	4,074,709	93	28,076	0	0
Blind	49	11,755	20	7,300	0	0
Disabled	2,627	681,233	2,534	795,347	402	77,874
AFDC Children	0	0	5	1,080	153	24,713
AFDC Adults	0	0	0	0	0	0
CWS Foster Care	0	0	0	0	143	32,635
Optional Categorically Needy	0	0	38	2,691	111	12,876

Source: HCFA 2082

TABLE 17

Number of Children Receiving Treatment by Category of Service for Fiscal Year 1998

Program Category	Number of Children
Dental	50,324
Vision	28,791
Hearing	15,661
Corrective Treatment Referrals	16,074

Source: HCFA 416 Y-T-D

TABLE 18

Number of Beneficiaries, Number of Discharges, Total Days of Hospital Care, and Average Length of Hospital Stay by Program Category for Fiscal Year 1998

Program Category	Number of Beneficiaries*	Number of Discharges	Days of Care	Average Length of Hospital Stay
Total	59,241	398,213	437,457	1.1
Aged	4,502	424	823	1.9
Blind	201	1,109	1,931	1.7
Disabled	17,263	127,471	204,934	1.6
AFDC Children	8,353	60,060	82,721	1.4
AFDC Adults	20,077	191,620	108,291	0.6
CWS Foster Care	not available	not available	not available	not available
Optional Categorically Needy	8,845	17,529	38,757	2.2

* Does not include Medicaid Beneficiaries who are covered under Medicare Part A

Source: HCFA 2082