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 28th Annual Report of the Division of Medicaid for Fiscal Year 1999. 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 518,000 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 1999
July 1, 1998–June 30, 1999

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
- 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
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- Certified nurse practitioners, pediatric and family

waivered projects offering additional enhanced services:

- Primary care case management 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:

- ICF/MRs
- Pediatric skilled nursing services
- Prescription drugs
- Dental services
- Eyeglasses
- Clinic services: ambulatory surgical centers, birthing centers, freestanding dialysis centers
- Mental health services
- Psychiatric residential treatment facilities
- Inpatient psychiatric services

- Non-emergency transportation
- Chiropractic services
- Perinatal risk management services
- Emergency ambulance
- Home health
- Christian science sanatoria services
- Durable medical equipment
- Hospice
- Managed care services
- Targeted case management services for children with special needs
- Ambulatory services: state department of health clinic services, federally qualified health centers, mandated services
- Podiatrist services
- Disease management services

FUNDING

Source of Funds and Percentage of Distribution for FY 1999

Throughout the nation, Medicaid is funded with federal dollars matched by individual state contributions. In FY 1999, Mississippi's overall matching rate, which is determined by the state's per capita income, decreased from 77.09% in FY 1998 to 76.78% in FY 1999. Even with this decrease, a single state dollar invested brought into the state an additional $3.09 through federal matching funds.

For FY 1999, federal contributions amounted to $1,198,746,882, which, when combined with state dollars, provided for total medical expenditures of $1,561,274,918. Over 97% 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 1999, the total administrative expenses were $52,608,148, with federal contributions of $32,348,760, or 61.50%. Mississippi's administrative expenses for FY 1999, which continue to be among the lowest in the Southeastern region, amounted to only 2.78% 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 receive Medicaid-only or TANF (Temporary Assistance for Needy Families) cash assistance.

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

- Children receiving subsidized adoption payments.

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

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

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

Offices of the Social Security Administration determine eligibility for:

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

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

- 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 are age 65 or over or disabled whose income does not exceed 100% of the federal poverty level and whose resources do not exceed $2,000 for an individual and $3,000 for a couple.

- Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income is below 100% of the federal poverty level, and 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) who are entitled to Medicare Part A whose income does not exceed 120% of the federal poverty level 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.

- Individuals who meet the qualifications for participation in the Home and Community-Based Waiver Programs whose income and resources do not exceed 300% of the SSI limit.

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

- Qualifying Individuals (QI's) qualify for payment or partial payment of their Medicare Part B premium, provided the individual has Medicare Part A. QI-1's can have income between 120% to 135% of the federal poverty level for payment of their Medicare Part B premium. QI-2's can have income from 135% to 175% of the federal poverty level for partial payment of Medicare Part B premiums.

The Division of Medicaid operates 25 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.

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

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

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

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

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

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

Corinth
2907 Highway 72 West
Corinth, MS 38834-9399
(662) 286-8091

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

Greenwood
805 West Park Avenue, Suite 6
Greenwood, MS 38930-2727
(662) 455-1053

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

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

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

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

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

Kosciusko
207 North Madison
Kosciusko, MS 39090-3341
(662) 289-4477

Laurel
1721 W. 10th Street, Suite C
Laurel, MS 39440-4357
(601) 425-3175

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

Meridian
2502 9th Street
Meridian, MS 39302-4939
(601) 483-9944

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

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

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

Philadelphia
1120 East Main Street
Eastgate Plaza, Suite 12
Philadelphia, MS 39350-2300
(601) 656-3131

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

Tupelo
1830 North Gloster Street
Tupelo, MS 38801-1218
(662) 844-5304

Vicksburg
2734 Washington Street
Vicksburg, MS 39180-4656
(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 1999, 486,660 Mississippians benefited from one or more of the health care services covered by Medicaid.

Program Highlights for Fiscal Year 1999

MANAGED CARE – HealthMACS

HealthMACS (Health through Medicaid Managed Access to Care and Services) is the Primary Care Case Management Program of the Division of Medicaid (DOM). The program was implemented in October of 1993. By the end of Fiscal Year 1994, HealthMACS had been implemented in seven counties – Washington, Covington, Jefferson, Lawrence, Claiborne, Jefferson Davis, and Warren.

In Fiscal Years 1995 and 1996, nine counties were added to the HealthMACS program.

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. By June 30, 1997, 34 counties were participating in the HealthMACS program.

In Fiscal Year 1998, implementation of HealthMACS in all 82 counties was completed by April.

Since no counties or additional groups of Medicaid eligibles were added to HealthMACS during Fiscal Year 1999, Division of Medicaid staff spent time making revisions to improve the program. HealthMACS primary care providers (PCP) were surveyed regarding possible changes. As a result of this survey, changes were made to the program, included increasing the age assignment to pediatricians from birth through 13 years of age to birth through 18 years of age and discontinuing the HealthMACS report of services rendered by the primary care provider(PCP). Also, during this fiscal year, program changes were made for hospital emergency rooms. One was to pay for a medical assessment. Another was to discontinue prior authorization before treating non-emergent/non-urgent cases and replace it with post-authorization from the PCP.

In April 1999, the HealthMACS program was incorporated into the Mississippi Medicaid State Plan and no longer operated under the 1915(b) waiver program. It is believed that Mississippi was the first state to implement the state plan option for a Primary Care Case Management Program.

CAPITATED MANAGED CARE

During the 1995 Regular Legislative Session, DOM was mandated to implement capitated managed care in an urban and rural area. In compliance with this mandate, DOM staff developed a model for contracting with health maintenance organizations (HMO). The model HMO contract 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, DOM was authorized to implement a program of capitated managed care in the following 11 counties – Bolivar, Coahoma, Hancock, Harrison, Humphreys, Leflore, Sunflower, Tallahatchie, Warren, Washington, and Yazoo.

For Fiscal Year 1997, DOM contracted with four health maintenance organizations (HMOs) to provide services to Medicaid beneficiaries. 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, DOM contracted with four HMOs that continued to provide services in Hancock, Harrison, and Warren Counties. During this fiscal year, the HMO program was expanded to Forrest, Lauderdale, and Washington Counties.

In Fiscal Year 1999, DOM had contracts with four HMOs. Soon after the beginning of the fiscal year, one of the HMOs was put in rehabilitation by the Department of Insurance. With the three remaining HMOs, the program was expanded to Covington, Lamar, Pearl River, and Perry Counties.

EXPANDED ROLE OF FISCAL AGENT, EDS

DOM continued the expanded scope of the contract with its fiscal agent, EDS, to provide additional managed care services. Included in the expanded scope was the provision to hire Client Field Services Representatives (CFSR). The primary role of the CFSR is beneficiary education about the HealthMACS program, the importance of accessing medical services through the primary care provider (PCP), and appropriate use of hospital emergency rooms. CFSRs are also available to PCPs to assist with beneficiaries who are not keeping office appointments, misusing the emergency room or not following through with PCP instructions. The CFSRs have assisted with education of Medicaid beneficiaries in the counties in which the Capitated Managed Care Program has been implemented. They have helped educate Medicaid beneficiaries about the choices of HMOs, HealthMACS, and traditional Medicaid. The CFSRs have been available in offices of local community services agencies to provide this education and to assist with completion of enrollment forms.

EDS has also hired Provider Representatives devoted to provider issues regarding managed care. The managed care provider representatives have recruited primary care providers (PCP) for the HealthMACS program as well as assisted with provider issues related to implementation of the Capitated Managed Care Program. These provider representatives have been responsible for arranging provider workshops for both HealthMACS and the Capitated Managed Care Program. They have also been responsible for organizing enrollment fairs in the Capitated Managed Care counties. The enrollment fairs have been held in Lauderdale and Washington

Counties to give Medicaid beneficiaries an opportunity to meet representatives of each of the HMOs and to enroll with an HMO, if the beneficiary chooses to do so.

The Managed Care Hotline and enrollment lines are staffed by EDS telephone representatives. The telephone representatives answer questions from providers and beneficiaries related to both managed care programs. They handle requests from HealthMACS enrollees to select or change PCPs. An enrollment staff at EDS is responsible for processing HMO enrollment forms to enroll Medicaid beneficiaries in an HMO.

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 3,200 unduplicated beneficiaries during the waiver year (July 1, 1998–June 30, 1999). 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 180 unduplicated beneficiaries per waiver year (July 1, 1998–June 30, 1999). Beneficiaries of this waiver must be Medicaid eligible as SSI recipients or must meet the requirements for the disability coverage group, which allows an income level up to 300% 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 550 unduplicated beneficiaries per waiver year (July 1, 1998–June 30, 1999). Beneficiaries of this waiver must be Medicaid eligible through one of three eligibility categories: 1) SSI Recipients, 2) TANF 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 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 Fiscal Year 1999 amount to $1,561,274,918, which represents an increase of 8.06% from Fiscal Year 1998. The highest expenditures continue to be for nursing facility, inpatient hospital services, and pharmacy services.

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 Fiscal Year 1999, 169 nursing facilities in Mississippi participated in the Medicaid Program providing long-term care to 19,687 Medicaid beneficiaries. There were 13 Intermediate Care Facilities for the Mentally Retarded that provided care to 3,145 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 106,502 Medicaid-eligible children ages 0–21 years old during Fiscal Year 1999. 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 diagnostic and treatment services 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. During Fiscal Year 1999 there were 220,786 doses of vaccine administered to Medicaid-eligible beneficiaries between the ages of birth to 18 years old. Of this age group, 83% received immunizations through the VFC program.

For Fiscal Year 1999, there were 257,896 Medicaid beneficiaries who were eligible for the VFC program. Of the eligible population, 236,973 or 92% received VFC immunizations.

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

The Perinatal High Risk Management/Infant Services System (PHRM/ISS) Program is a multidisciplinary enhanced case management program established to improve access to health care and to provide enhanced services to certain Medicaid-eligible pregnant/postpartum women and infants. The multidisciplinary team of physicians, nurse practitioners, certified-nurse midwives, registered nurses, licensed nutritionists/dietitians, and licensed social workers provide enhanced services for this targeted population. These services include case management, nutritional assessment/counseling, psychosocial assessment/counseling, home visits, and health education. Even though participation in this program is voluntary, enhanced services were provided to 11,700 Medicaid-eligible beneficiaries during Fiscal Year 1999. This represents a 32% increase over last fiscal year's participation.

The Division of Medicaid has ten private providers and 84 county health department providers participating in the PHRM/ISS Program. The Division of Medicaid is actively recruiting new providers for the PHRM/ISS Program.

EPSDT Health-Related Services for Schools (Medicaid School Program)

The Medicaid School Program is also known as EPSDT Health-Related Services for Schools. Medicaid beneficiaries through age 21 with disabilities, as identified by IDEA and a subsequent IEP (Individualized Educational Plan) which identifies health-related services students need, are eligible to participate. Participating school

districts provide physical therapy evaluation and treatment, occupational therapy evaluation and treatment, language speech evaluation and treatment, and psychological evaluation and psychotherapy.

Although the program has been in existence for a number of years, there has been significant growth within the past year. Currently there are 27 school districts participating as Medicaid providers. Despite the fact that not all of the districts are Medicaid providers, during Fiscal Year 1999, 324 students received 14,206 units of service, and school districts were reimbursed $94,806.00. Medicaid reimbursed approximately $300.00 per student.

Dental Services

Dental care was provided to 25,794 beneficiaries during Fiscal Year 1999 with expenditures amounting to $2,721,440.

Inpatient Hospital Services

During Fiscal Year 1999, Medicaid provided for 429,420 days of inpatient hospital care. The average length of hospital stay was 1.6 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 1999.

Outpatient Hospital Services

A total of 585,417 outpatient visits were provided to 207,787 Medicaid beneficiaries during Fiscal Year 1999, with an average of 2.81 visits per outpatient beneficiary.

Administrative Highlights of Fiscal Year 1999

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 Fiscal Year 1999 were 25,259,375. Approximately 88% of all claims were filed electronically.

The Division of Medicaid is preparing for the new millennium by upgrading the MMIS to be Y2K compliant and ensuring operations continue as usual through careful planning. Evaluation and analysis of Mississippi Medicaid's business processes identified two highly critical functions to be addressed in our contingency planning for potential Year 2000 (Y2K) problems. These critical functions are (1) ensuring beneficiaries are not denied medical services due to the inability to verify eligibility by Medicaid providers and (2) reimbursing Medicaid providers for these services. The loss of these business functions would prohibit the Division of Medicaid's ability to accomplish its responsibilities and support the essential operations and programs within the DOM.

THIRD PARTY LIABILITY

In accordance with Title XIX of the Social Security Act as well as state law, Medicaid is a "payer 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 Bureau of Third Party Recovery 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 Bureau of Third Party Recovery operates a successful program which has saved Mississippi taxpayers millions of dollars through cost avoidance and post-payment recovery of private health and casualty insurance resources. 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 Fiscal Year 1999, third party savings in the form of cost avoided or recovered payments from both public and private resources totaled over $530 million. As a graphic example of the effectiveness of the Bureau of Third Party Recovery, $24 was recovered for every one dollar invested in salaries of the Medicaid investigators involved in the in-house recoveries.

Medicare Buy-In

Because some Medicaid eligibles are also eligible for Medicare, it is necessary to have some means by which this group may be identified. The MMIS includes edits for Medicare coverage to ensure that claims which are submitted to Medicaid as 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 Fiscal Year 1999, 27% of the Mississippi population also had Medicare coverage. The claims payment edits and buy-in program yielded $510 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 Fiscal Year 1999. Through cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment), the Medicaid agency saved approximately $21.6 million. Through post-payment recovery (the Medicaid agency bills the third party for reimbursement), the Bureau of Third Party Recovery collected $2.6 million.

Casualty/Tort Resources

A significant number of Medicaid beneficiaries receive medical care each month as the result of injuries or accident. Medicaid is responsible for identifying those beneficiaries whose medical care for these injuries may be the liability of another party and pursue recovery. These resources are identified through the MMIS edits and referrals from outside entities such as insurance companies, providers, and attorneys. In Fiscal Year 1999, the Bureau of Third Party Recovery collected $3.1 million from casualty/tort resources.

Prescribed Drug Recovery Program

The Mississippi Division of Medicaid has obtained a federal waiver which allows Medicaid to reimburse pharmacists participating in the program, even if the MMIS contains a record of third party liability. Medicaid then pursues recovery from the third party resources. The Bureau of Third Party Recovery reported a recoupment of approximately $1.2 million in the drug program in Fiscal Year 1999.

Estate Recovery

As a result of OBRA 1993, the state enacted legislation allowing recovery of medical payments from the estates of certain beneficiaries who were residents of nursing facilities at the time of death. In Fiscal Year 1999, the Estate Recovery program returned more than $1.1 million.

BUREAU OF PROGRAM INTEGRITY

The mission of the Bureau of Program Integrity is to identify and stop fraud and abuse in the Medicaid program, to identify weak areas in policy and the Medicaid Management Information System, to make recommendations for change and improvement, and to determine the accuracy of Medicaid eligibility decisions.

The Bureau of Program Integrity conducts investigations of providers and beneficiaries suspected of fraud or abuse and monitors both provider and beneficiary utilization of Medicaid benefits. The Bureau also determines the State Error Rate in regard to making eligibility decisions and assists the Department of Human Services and Division of Medicaid Eligibility Bureau in the development of corrective action measures when error patterns are detected. The Bureau of Program Integrity serves as invaluable deterrents to fraud and abuse of benefits in the Medicaid Program.

Four separate units comprise the Bureau of Program Integrity. They are Investigations, Beneficiary Recoupment, Medical Review, and Medicaid Eligibility Quality Control.

Investigations Unit

The Division of Medicaid is required, under state and federal laws, to conduct periodic checks of provider records in order to verify actual receipt of service for which payment has been made and to investigate any cases of possible fraud or abuse. This unit is responsible for conducting on-site investigations of providers and for monitoring their utilization in the Medicaid Program.

With the assistance of a computerized surveillance and utilization reporting system, the Bureau of Program Integrity is able to maintain practice and service profiles on all providers of service and beneficiaries who participate in or 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 investigations are based. Exceptional reporting techniques are used to identify the unusual or exceptional profiles.

Each investigation consists of a review of the records in the provider's office and actual contact with beneficiaries for verification of billed services. Cases involving suspected fraud are referred to the Medicaid Fraud Control Unit, Office of the Attorney General. When warranted by the findings of the investigations, referrals are made to the appropriate regulatory agencies such as the Board of Medical Licensure, Dental Board, or the Board of Pharmacy for their information and for any action they deem appropriate.

Provider investigations could result in monetary recovery, termination as a provider of Medicaid services, or criminal prosecution. Providers who are convicted are automatically disqualified as providers by state law.

Beneficiary Recoupment Unit

The responsibility of ensuring compliance with state and federal policy in the area of beneficiary usage of Medicaid benefits has been assigned to the Beneficiary Recoupment Unit. This section of Program Integrity is responsible for investigating reports of improper payments, reviewing claims, and contacting beneficiaries. Improper payment reports are written accounts from Medicaid Regional Offices or county Department of Human Services offices which indicate that beneficiaries have received Medicaid benefits during periods of ineligibility. The unit's primary function is to reconcile improper payment and recover funds from beneficiaries who were not Medicaid eligible and received Medicaid benefits.

A Medicaid Investigator conducts statewide field investigations of Medicaid beneficiaries who received services during an ineligible period of time. Ineligibility, in most instances, is caused by the beneficiary's concealing facts that, if known, would have made him or her ineligible. In addition, the investigator investigates cases of explanation of Medicaid benefits denials that require an on-site visit.

A Medicaid Auditor II receives all new cases involving ineligible beneficiaries from the Department of Human Services and the Medicaid Regional Offices. This person also handles all responses to the explanation of Medicaid benefits letters. Approximately 400 of these letters are mailed monthly by Medicaid's fiscal agent. All negative replies are thoroughly reviewed, and the beneficiary is contacted by telephone or letter in an effort to determine if the services were actually received by the beneficiary. Negative replies requiring further investigation are assigned to a Medicaid Investigator.

An Accounting Auditing Technician is responsible for inputting and updating

daily payment transactions, generating reports and overdue letters, and maintaining the reports generated from the Beneficiary Recoupment Subsystem.

Medical Review Unit

This unit is responsible for investigating provider/beneficiary referrals received from outside sources, medical necessity referrals from Medicaid Investigators, and SURS excepted data. Registered Nurses analyze data histories to make qualified medical decisions regarding the appropriateness of services rendered to ensure quality of care is appropriate.

The nurses conduct desk reviews analyzing all data. In cases where provider data appears questionable, an on-site audit is performed and all needed medical records are copied and/or microfilmed. If warranted after a thorough review by the nurses, copies of these records are forwarded to Physician Consultants for further review. Results can lead to a peer review and possible sanction or a corrective action plan with a follow-up review. In regard to questionable beneficiary data, contact letters are sent to providers alerting them of possible abuse and/or overutilization of Medicaid services. An educational letter is sent to the beneficiary assisting him or her in receiving optimal quality of care.

In addition to the investigative duties, this unit prepares reports requested by the Bureau Directors, Medicaid Investigators, and outside agencies (US Attorney General's Office, OIG, MFCU, etc.), utilizing the MMIS Computer System. The Medical Review unit is also responsible for compiling, organizing, and reviewing data produced by the Surveillance Utilization Subsystem (SURS). The unit produces its own data needed from support systems such as Pandora and Business Objects, as well as providing consultations to other Program Integrity staff when a medical opinion is essential.

Medicaid Eligibility Quality Control Unit

Medicaid Eligibility Quality Control (MEQC) is a federally mandated program whose purpose is to determine the accuracy of Medicaid eligibility decisions. The two primary responsibilities of the MEQC Unit are to determine the State Error Rate and to assist the state Department of Human Services (DHS) and the Division of Medicaid Eligibility Bureau in the development of corrective action measures when error patterns or trends are noted during the course of MEQC reviews.

The TEFRA law allows a 3% error tolerance per federal fiscal year (October – September). Anytime the State's lower limit error rate exceeds 3%, the State is subject to a disallowance of federal funds. The disallowance is based upon the weighted error rate for both six-month sample periods within the federal fiscal year, not upon each

individual sample period. During Federal Fiscal Year 1998, the MEQC lower limit error rate for October–March was 0.0695%; April–September was 0.2488%. The most recently reported lower limit error rate was 1.1677% for the period October–March 1999. Error rates in Mississippi have remained consistently low.

MEQC determines the accuracy of eligibility decisions made by Medicaid Regional Offices and DHS county offices by utilizing two separate review processes. In the Active Case Review, MEQC verifies that persons receiving benefits are actually eligible. A minimum of 350 cases is selected annually using a random selection process. An independent audit is conducted on each case to determine the accuracy of the eligibility decision by analyzing each factor of eligibility and for ruling on the eligibility and/or liability of each case. The next phase of the active MEQC eligibility process is the claims payment summary. Since the eligibility error rate as determined by MEQC is based on misspent dollars and not on case errors, it is necessary to tabulate Medicaid payments for services rendered in the review month on all selected beneficiaries included in the six-month sample.

In the Negative Case Action Review, MEQC examines cases where benefits have been terminated or denied to ensure that no persons are refused Medicaid benefits to which they are entitled. A minimum of 210 cases is audited annually.

Strict federal time frames are required for the MEQC process, and federal reporting is required for both types of reviews.

Per federal regulations, a state must take action to correct errors found in the MEQC process. Administrative action to prevent or reduce incidence of errors must also be taken. The Corrective Action Committee, which consists of representatives from MEQC, DHS, and DOM eligibility staff, meet annually to review and discuss MEQC Active Case and Negative Case Action findings. The committee develops corrective action measures that the Eligibility Bureaus implement.

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 provided non-emergency transportation (NET) services for Medicaid beneficiaries who had no other means of transportation. The Division of Medicaid provided ground and air non-emergency transportation services for eligible beneficiaries. Commercial air and air ambulance services were available when ground transportation was inappropriate because of the beneficiaries' conditions or

the distance to the receiving medical providers. Ground ambulance services were also available as required by the conditions of the beneficiaries in need of transportation assistance.

Most transportation services made available to Medicaid beneficiaries were arranged by 30 NET coordinators who were located at various Medicaid regional offices throughout the state. The coordinators served as the contact points for Medicaid beneficiaries, handling requests from individuals who required NET assistance and arranging transportation assistance for these persons with local transporters. Transportation assistance was available to transport beneficiaries to local medical providers as well as to those providers outside the beneficiaries' communities. In Fiscal Year 1999, more than 400,000 trips were arranged and funded for Medicaid beneficiaries through the Division of Medicaid's NET program.

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 on requests by Division management. These reviews assist management in ensuring the contractors provided the required services in a manner that was in compliance with all federal and state laws and regulations, and that the contractors were properly paid 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 paid to the contractor if services were not provided in accordance with the contract.

During Fiscal Year 1999, the CMU completed a review of the Fiscal Year 1993 through Fiscal Year 1997 Survey and Certification contracts with the Mississippi State Department of Health. In addition, the CMU began a review of the Home and Community-Based Services Waiver administered by the Department of Human Services. This review will cover contracts for Fiscal Year 1994 through Fiscal Year 1998.

TABLE 1

Certified Eligibles by Eligibility Category for Fiscal Year 1999

Program Category	Total Number of Eligible Persons	Percent of Total*
Total	517,693	100.00%
Money Payment Eligibles		
Aged	40,748	7.87%
Blind	1,484	0.29%
Disabled	126,646	24.46%
Low Income Families	80,379	15.53%
CWS Foster Care	3,386	0.65%
Poverty Level Pregnant Women & Children		
At 100% Federal Proverty Level	118,714	22.93%
At 133% Federal Proverty Level	35,106	6.78%
At 185% Federal Proverty Level	22,845	4.41%
Optional & Mandatory Phased-in Children Under Age 18	13,446	2.60%
Qualified Medicare Beneficiary		
Aged	61	0.01%
Blind	27	0.01%
Disabled	16	0.00%
Poverty Level		
Aged	15,992	3.09%
Disabled	12,691	2.45%
Katie Beckett	740	0.14%
Hospice		
Aged	85	0.02%
Blind	0	0.00%
Disabled	79	0.02%
Other Medical Assistance Only		
Automatic Infants	37,509	7.25%
Specified Low Income Medicare Beneficiaries		
Aged	5,247	1.01%
Blind	10	0.00%
Disabled	2,419	0.47%
Handicapped		
Aged	0	0.00%
Blind	0	0.00%
Disabled	63	0.01%

Source: RS-0-10-2 (06/99)

*Percentage column may not total 100% due to rounding

TABLE 2

Bureau of Census Population for Mississippi Counties and Number of Medicaid Eligibles by County for Fiscal Year 1999

County	County Population	Number of Medicaid Eligibles	Percent of Population	County	County Population	Number of Medicaid Eligibles	Percent of Population
Adams	33,657	8,194	24.35%	Leflore	36,816	12,243	33.25%
Alcorn	33,080	6,119	18.50%	Lincoln	32,105	5,888	18.34%
Amite	13,906	2,728	19.62%	Lowndes	60,527	11,205	18.51%
Attala	18,338	4,394	23.96%	Madison	74,562	10,088	13.53%
Benton	8,091	1,868	23.09%	Marion	26,538	6,204	23.38%
Bolivar	39,826	13,998	35.15%	Marshall	32,323	6,747	20.87%
Calhoun	14,891	3,034	20.37%	Monroe	38,230	6,356	16.63%
Carroll	9,967	1,685	16.91%	Montgomery	12,394	2,908	23.46%
Chickasaw	18,121	3,611	19.93%	Neshoba	27,639	5,358	19.39%
Choctaw	9,366	1,955	20.87%	Newton	21,741	3,962	18.22%
Claiborne	11,596	3,053	26.33%	Noxubee	12,497	4,329	34.64%
Clarke	18,445	2,780	15.07%	Oktibbeha	39,765	5,975	15.03%
Clay	21,657	5,025	23.20%	Panola	33,913	7,975	23.52%
Coahoma	31,094	11,067	35.59%	Pearl River	47,969	7,283	15.18%
Copiah	28,892	6,562	22.71%	Perry	12,039	2,527	20.99%
Covington	17,889	3,995	22.33%	Pike	37,910	9,392	24.77%
DeSoto	102,131	6,430	6.30%	Pontotoc	25,685	3,135	12.21%
Forrest	74,927	12,829	17.12%	Prentiss	24,497	3,863	15.77%
Franklin	8,160	1,866	22.87%	Quitman	9,780	3,758	38.43%
George	20,185	2,690	13.33%	Rankin	112,348	10,190	9.07%
Greene	12,630	2,036	16.12%	Scott	24,911	5,487	22.03%
Grenada	22,450	4,901	21.83%	Sharkey	6,543	2,583	39.48%
Hancock	41,518	5,249	12.64%	Simpson	25,375	5,226	20.60%
Harrison	178,567	25,930	14.52%	Smith	15,431	2,877	18.64%
Hinds	245,737	43,342	17.64%	Stone	13,488	2,557	18.96%
Holmes	21,562	8,963	41.57%	Sunflower	33,257	10,220	30.73%
Humphreys	11,214	4,102	36.58%	Tallahatchie	14,587	4,485	30.75%
Issaquena	1,635	537	32.84%	Tate	24,417	3,774	15.46%
Itawamba	21,085	2,685	12.73%	Tippah	21,069	3,989	18.93%
Jackson	133,120	14,663	11.01%	Tishomingo	18,742	2,984	15.92%
Jasper	18,110	3,788	20.92%	Tunica	7,935	2,558	32.24%
Jefferson	8,385	2,772	33.06%	Union	24,121	3,388	14.05%
Jefferson Davis	13,770	3,480	25.27%	Walthall	14,211	3,787	26.65%
Jones	63,054	12,095	19.18%	Warren	49,148	9,576	19.48%
Kemper	10,487	2,059	19.63%	Washington	64,265	20,254	31.52%
Lafayette	34,914	3,604	10.32%	Wayne	20,637	4,609	22.33%
Lamar	38,127	4,580	12.01%	Webster	10,633	2,058	19.35%
Lauderdale	75,978	13,838	18.21%	Wilkinson	9,042	2,935	32.46%
Lawrence	13,066	2,551	19.52%	Winston	19,253	4,098	21.28%
Leake	19,602	3,781	19.29%	Yalobusha	12,627	3,168	25.09%
Lee	75,211	10,228	13.60%	Yazoo	25,208	7,850	31.14%

Source: Medicaid Eligibles RSO-10-4-A (06/99)

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

TABLE 3

Beneficiaries of Services by Program Category for Fiscal Year 1999

Program Category	Total Number of Beneficiaries	Percent of Total*
Total	486,660	100.00%
Money Payment Eligibles		
Aged	43,122	8.86%
Blind	1,378	0.28%
Disabled	119,333	24.52%
Low Income Families	72,412	14.88%
CWS Foster Care	2,972	0.61%
Poverty Level Pregnant Women & Children		
At 100% Federal Proverty Level	11,390	2.34%
At 133% Federal Proverty Level	36,047	7.41%
At 185% Federal Proverty Level	29,035	5.97%
Optional & Mandatory Phased-in Children Under Age 18	105,524	21.68%
Qualified Medicare Beneficiary		
Aged	80	0.02%
Blind	23	0.00%
Disabled	13	0.00%
Poverty Level		
Aged	16,726	3.44%
Disabled	13,141	2.70%
Katie Beckett	701	0.14%
Hospice		
Aged	142	0.03%
Blind	0	0.00%
Disabled	105	0.02%
Other Medical Assistance Only		
Automatic Infants	34,451	7.08%
Specified Low Income Medicare Beneficiaries		
Aged	0	0.00%
Blind	0	0.00%
Disabled	0	0.00%
Handicapped		
Aged	0	0.00%
Blind	0	0.00%
Disabled	65	0.01%

Source: MAM260-A0 (06/99)

*Percentage column may not total 100% due to rounding

TABLE 4

Beneficiaries of Medical Services by Type of Service for Fiscal Years 1998 and 1999

Type of Service	Beneficiaries FY 1998	Beneficiaries FY 1999	Percent Increase or Decrease
Total	480,007	486,660	1.39%
Inpatient Hospital	58,432	58,934	0.86%
Outpatient Hospital	204,810	207,787	1.45%
Laboratory/X-Ray	83,718	73,420	-12.30%
Nursing Facility	18,758	19,031	1.46%
Physician	316,962	321,290	1.37%
EPSDT	94,062	106,502	13.23%
EPSDT Dental	70,838	71,729	1.26%
EPSDT Vision	36,032	38,870	7.88%
EPSDT Hearing	1,896	2,757	45.41%
Rural Health Clinic	85,094	84,689	-0.48%
Federally Qualified Health Centers	49,840	50,206	0.73%
Home Health	7,268	5,228	-28.07%
Transportation	28,302	27,432	-3.07%
Drugs	415,801	413,742	-0.50%
Dental	25,615	23,794	-7.11%
Eyeglasses	10,164	10,669	4.97%
Intermediate Care Facility – Mentally Retarded	2,690	2,747	2.12%
Per Capita Managed Care	18,738	16,771	-10.50%
Buy-in, Parts A & B, Medicare	148,598	324,740	118.54%
Mental Health Clinic	34,617	36,012	4.03%
Home & Community Based Waiver	2,781	3,541	27.33%
Durable Medical Equipment	13,929	14,682	5.41%
Therapy	1,324	1,343	1.44%
Inpatient Residential Psychiatric	809	909	12.36%
Inpatient Psychiatric Hospital	1,885	3,503	85.84%
Nurse Practitioner	34,181	44,716	30.82%
Ambulatory Surgical Center	1,728	1,942	12.38%
Personal Care	0	0	0.00%
Hospice	484	528	9.09%
Outpatient Psychiatric Hospital	15	10	-33.33%
Private Mental Health Centers	1,291	1,068	-17.27%
Family Planning Drugs	17,318	17,304	-0.08%
Dialysis	484	514	6.20%

Source: MAM260-A0 (06/98)
and MAM260-A0 (06/99)

TABLE 5

Paid Claims by Type of Service for Fiscal Years 1998 and 1999

Type of Service	Claims FY 1998	Claims FY 1999	Percent Increase or Decrease
Total	23,283,633	25,230,115	8.36%
Inpatient Hospital	478,191	349,016	-27.01%
Outpatient Hospital	922,696	956,228	3.63%
Laboratory/X-Ray	713,460	653,818	-8.36%
Nursing Facility	619,846	658,911	6.30%
Physician	4,212,889	4,184,385	-0.68%
EPSDT	425,679	390,051	-8.37%
EPSDT Dental	499,427	537,957	7.71%
EPSDT Vision	242,908	267,995	10.33%
EPSDT Hearing	4,254	7,158	68.27%
Rural Health Clinic	765,520	808,549	5.62%
Federally Qualified Health Centers	466,105	509,524	9.32%
Home Health	173,335	91,601	-47.15%
Transportation	223,223	189,644	-15.04%
Drugs	7,230,642	7,495,556	3.66%
Dental	145,459	139,329	-4.21%
Eyeglasses	22,676	25,321	11.66%
Intermediate Care Facility – Mentally Retarded	63,681	206,274	223.92%
Per Capita Managed Care	115,069	115,649	0.50%
Buy-in, Parts A & B, Medicare	4,606,301	6,021,731	30.73%
Mental Health Clinic	839,772	1,031,521	22.83%
Home & Community Based Waiver	76,326	98,193	28.65%
Durable Medical Equipment	153,374	148,664	-3.07%
Therapy	26,617	30,000	12.71%
Inpatient Residential Psychiatric	4,974	4,254	-14.48%
Inpatient Psychiatric Hospital	10,893	10,862	-0.28%
Nurse Practitioner	154,208	216,550	40.43%
Ambulatory Surgical Center	3,925	4,871	24.10%
Personal Care	0	0	0.00%
Hospice	3,471	4,170	20.14%
Outpatient Psychiatric Hospital	31	47	51.61%
Private Mental Health Centers	17,174	18,462	7.50%
Family Planning Drugs	49,884	48,052	-3.67%
Dialysis	6,682	5,772	-13.62%

Source: MRO-08 (06/98) and MRO-08 (06/99)

TABLE 6

Total Expenditures for Medical Services, Total Number of Beneficiaries, Average Expenditure per Beneficiary and Percentage by Program Category for Fiscal Year 1999

Program Category	Amount of Expenditures	Percent of Total	Number of Beneficiaries	Percent of Total	Average per Beneficiary
Total	$1,561,274,918	100.00%	486,660	100.00%	$3,208
Money Payment Eligibles					
Aged	405,502,110	25.97%	43,122	8.86%	9,404
Blind	7,157,296	0.46%	1,378	0.28%	5,194
Disabled	664,866,587	42.58%	119,333	24.52%	5,572
Low Income Families	71,175,080	4.56%	72,412	14.88%	983
CWS Foster Care	12,737,129	0.82%	2,972	0.61%	4,286
Poverty Level Pregnant Women & Children					
At 100% Federal Proverty Level	13,646,892	0.87%	11,390	2.34%	1,198
At 133% Federal Proverty Level	51,750,630	3.31%	36,047	7.81%	1,436
At 185% Federal Proverty Level	64,164,544	4.11%	29,035	6.29%	2,210
Optional & Mandatory Phased-in Children under 18	102,956,454	6.59%	105,524	22.87%	976
Qualified Medicare Beneficiary					
Aged	59,645	0.00%	80	0.02%	746
Blind	7,753	0.00%	23	0.00%	337
Disabled	17,955	0.00%	13	0.00%	1,381
Poverty Level					
Aged	41,021,363	2.63%	16,726	3.62%	2,453
Disabled	53,564,000	3.43%	13,141	2.85%	4,076
Katie Beckett	4,542,879	0.29%	701	0.15%	6,481
Hospice					
Aged	988,789	0.06%	142	0.03%	6,963
Blind	0	0.00%	0	0.00%	0
Disabled	974,867	0.06%	105	0.02%	9,284
Other Medical Assistance Only					
Automatic Infants – K-Babies	65,032,480	4.17%	34,451	7.08%	1,888
Specified Low Income Medicare Beneficiaries					
Aged	0	0.00%	0	0.00%	0
Blind	0	0.00%	0	0.00%	0
Disabled	0	0.00%	0	0.00%	0
Handicapped					
Aged	0	0.00%	0	0.00%	0
Blind	0	0.00%	0	0.00%	0
Disabled	1,108,465	0.07%	65	0.01%	17,053

Source:MAM250R10 (06/99)
Source:MAM260-A0 (06/99)

TABLE 7

Expenditures for Medical Services by Type of Service for Fiscal Years 1998 and 1999

Type of Service	Expenditures FY 1998	Expenditures FY 1999	Percent Increase or Decrease
Total	$1,444,761,824	$1,561,274,918	8.06%
Inpatient Hospital	$260,394,924	$280,025,156	7.54%
Outpatient Hospital	75,536,752	75,130,125	-0.54%
Laboratory/X-Ray	5,927,324	5,391,914	-9.03%
Nursing Facility	311,146,718	333,733,346	7.26%
Physician	102,749,048	106,411,252	3.56%
EPSDT	7,454,339	4,921,871	-33.97%
EPSDT Dental	10,507,826	10,790,015	2.69%
EPSDT Vision	4,821,552	5,367,739	11.33%
EPSDT Hearing	212,552	245,997	15.73%
Rural Health Clinic	15,303,203	13,545,157	-11.49%
Federally Qualified Health Centers	13,706,293	14,025,881	2.33%
Home Health	12,615,991	6,188,836	-50.94%
Transportation	11,515,897	14,293,518	24.12%
Drugs	224,419,498	259,761,022	15.75%
Dental	2,875,349	2,721,440	-5.35%
Eyeglasses	540,170	581,515	7.65%
Intermediate Care Facility – Mentally Retarded	123,831,653	141,316,463	14.12%
Per Capita Managed Care	21,541,980	27,524,561	27.77%
Buy-in, Parts A & B, Medicare	133,764,091	133,493,985	-0.20%
Mental Health Clinic	42,748,364	49,579,470	15.98%
Home & Community Based Waiver	9,869,419	14,022,770	42.08%
Durable Medical Equipment	9,166,488	9,467,658	3.29%
Therapy	610,867	711,152	16.42%
Inpatient Residential Psychiatric	13,187,946	14,900,452	12.99%
Inpatient Psychiatric Hospital	14,312,771	18,273,848	27.68%
Nurse Practitioner	3,494,771	4,971,076	42.24%
Ambulatory Surgical Center	816,163	890,431	9.10%
Personal Care	0	0	0.00%
Hospice	3,936,425	4,241,610	7.75%
Outpatient Psychiatric Hospital	3,584	2,419	-32.51%
Private Mental Health Centers	514,298	422,222	-17.90%
Family Planning Drugs	1,447,947	1,454,697	0.47%
Dialysis	5,787,621	6,867,320	18.66%

Source: MAM250-R1 (06/99)

TABLE 8

Expenditures for Medical Services by Type of Service, Number of Beneficiaries by Service, and Average Spent for Fiscal Year 1999

Type of Service	Total Expenditures	Number of Beneficiaries	Average per Beneficiary
Total	$1,561,274,918	486,660	$3,208
Inpatient Hospital	$280,025,156	58,934	4,752
Outpatient Hospital	75,130,125	207,787	362
Laboratory/X-Ray	5,391,914	73,420	73
Nursing Facility	333,733,346	19,031	17,536
Physician	106,411,252	321,290	331
EPSDT	4,921,871	106,502	46
EPSDT Dental	10,790,015	71,729	150
EPSDT Vision	5,367,739	38,870	138
EPSDT Hearing	245,997	2,757	89
Rural Health Clinic	13,545,157	84,689	160
Federally Qualified Health Centers	14,025,881	50,206	279
Home Health	6,188,836	5,228	1,184
Transportation	14,293,518	27,432	521
Drugs	259,761,022	413,742	628
Dental	2,721,440	23,794	114
Eyeglasses	581,515	10,669	55
Intermediate Care Facility – Mentally Retarded	141,316,463	2,747	51,444
Per Capita Managed Care	27,524,561	16,771	1,641
Buy-in, Parts A & B, Medicare	133,493,985	324,740	411
Mental Health Clinic	49,579,470	36,012	1,377
Home & Community Based Waiver	14,022,770	3,541	3,960
Durable Medical Equipment	9,467,658	14,682	645
Therapy	711,152	1,343	530
Inpatient Residential Psychiatric	14,900,452	909	16,392
Inpatient Psychiatric Hospital	18,273,848	3,503	5,217
Nurse Practitioner	4,971,076	44,716	111
Ambulatory Surgical Center	890,431	1,942	459
Personal Care	0	0	0
Hospice	4,241,610	528	8,033
Outpatient Psychiatric Hospital	2,419	10	242
Private Mental Health Centers	422,222	1,068	395
Family Planning Drugs	1,454,697	17,304	84
Dialysis	6,867,320	514	13,361

Source: MAM250-R1 (06/99)

TABLE 8-A

Expenditures for Medical Services by Type of Service, Average cost per Beneficiary for Fiscal Years 1998 and 1999

Type of Service	FY 1998	FY 1999	Percent Increase or Decrease
Total	$3,010	$3,208	6.58%
Inpatient Hospital	$4,626	$4,752	2.72%
Outpatient Hospital	369	362	-1.90%
Laboratory/X-Ray	71	73	2.82%
Nursing Facility	16,587	17,536	5.72%
Physician	324	331	2.16%
EPSDT	79	46	-41.77%
EPSDT Dental	148	150	1.35%
EPSDT Vision	134	138	2.99%
EPSDT Hearing	112	89	-20.54%
Rural Health Clinic	180	160	-11.11%
Federally Qualified Health Centers	275	279	1.45%
Home Health	1,736	1,184	-31.80%
Transportation	407	521	28.01%
Drugs	540	628	16.30%
Dental	112	114	1.79%
Eyeglasses	53	55	3.77%
Intermediate Care Facility – Mentally Retarded	46,034	51,444	11.75%
Per Capita Managed Care	1,150	1,641	42.70%
Buy-in, Parts A & B, Medicare	900	411	-54.33%
Mental Health Clinic	1,235	1,377	11.50%
Home & Community Based Waiver	3,549	3,960	11.58%
Durable Medical Equipment	658	645	-1.98%
Therapy	461	530	14.97%
Inpatient Residential Psychiatric	16,302	16,392	0.55%
Inpatient Psychiatric Hospital	7,593	5,217	-31.29%
Nurse Practitioner	102	111	8.82%
Ambulatory Surgical Center	472	459	-2.75%
Personal Care	0	0	0.00%
Hospice	8,133	8,033	-1.23%
Outpatient Psychiatric Hospital	239	242	1.26%
Private Mental Health Centers	398	395	-0.75%
Family Planning Drugs	84	84	0.00%
Dialysis	11,958	13,361	11.73%

Source: MAM250-R1 (06/98 & 06/99)
Source: MAM260-A0 (06/98 & 06/99)

TABLE 9

Expenditures for Major Medical Services by Program Category for Fiscal Year 1999

Program Category	Inpatient Hospital	Outpatient Hospital	Nursing Facility	Physicians	EPSDT	Drugs	Dental
Total	$280,025,156	$75,130,125	$333,733,346	$106,411,252	$4,921,871	$259,761,022	$2,721,440
Money Payment Eligibles							
Aged	580,880	183,012	280,047,826	119,297	37	58,224,330	292,637
Blind	947,144	280,710	990,427	330,765	1,192	1,416,138	23,443
Disabled	116,827,655	34,936,649	52,639,499	35,924,402	289,638	124,969,110	1,506,753
Low Income Families	21,223,184	8,880,991	0	11,401,088	861,936	8,844,820	306,127
CWS Foster Care	6,492,338	337,836	0	696,146	36,708	858,918	0
Poverty Level Pregnant Women & Children							
At 100% Federal Proverty Level	29,403,269	11,147,107	2,264	15,844,050	1,208,373	10,645,002	57,937
At 133% Federal Proverty Level	19,537,865	6,116,158	0	10,754,577	722,202	3,653,956	44,806
At 185% Federal Proverty Level	28,784,968	6,243,707	0	15,705,573	497,491	1,932,484	73,359
Optional & Mandatory Phased-in Children under 18	4,114,742	1,665,117	0	1,844,991	121,096	1,825,875	61,019
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	51,620	55,077	28,564	39,076	100	21,848,598	115,190
Disabled	7,918,451	2,004,317	3,273	2,076,926	536	21,505,042	237,868
Katie Beckett	1,241,173	308,790	0	255,571	2,821	1,111,496	0
Hospice							
Aged	1,234	35	21,261	339	0	63,500	651
Blind	0	0	0	0	0	0	0
Disabled	133,496	27,964	232	36,905	52	86,322	386
Other Medical Assistance Only							
Automatic Infants - K-Babies	42,767,137	2,935,302	0	11,381,243	1,179,689	2,555,412	
Specified Low Income Medicare Beneficiaries							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Handicapped							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	7,353	0	303	0	220,019	1,264

Source:MAM250-R10 (06/99)

TABLE 10

Amount Paid to State Health Agencies and Insitutions by Source of Funds for Fiscal Years 1997-1999

Name of Agency or Institution	Fiscal Year	Total Amount of Payment	From Federal Funds	From State Funds
Total	FY1997	321,812,154	248,503,345	73,308,809
	FY1998	318,576,055	245,590,282	72,985,773
	FY1999	359,023,939	275,658,580	83,365,359
East Miss. State Nursing Home	FY1997	5,289,340	4,084,428	1,204,912
(Meridian)	FY1998	5,453,031	4,203,742	1,249,289
	FY1999	5,144,267	3,949,768	1,194,499
Ellisville State School	FY1997	29,638,463	22,886,821	6,751,642
(Ellisville)	FY1998	33,528,601	25,847,199	7,681,402
	FY1999	38,302,897	29,408,964	8,893,933
Miss. State Dept. of Health	FY1997	18,973,110	14,651,036	4,322,074
	FY1998	15,186,710	11,707,435	3,479,275
	FY1999	14,548,693	11,170,486	3,378,207
North Miss. Regional Center	FY1997	17,719,371	13,682,898	4,036,473
(Oxford)	FY1998	19,253,865	14,842,805	4,411,060
	FY1999	23,652,840	18,160,651	5,492,189
South Miss. Regional Center	FY1997	15,014,427	11,594,141	3,420,286
(Long Beach)	FY1998	15,450,232	11,910,584	3,539,648
	FY1999	17,010,196	13,060,428	3,949,768
Hudspeth Center	FY1997	19,358,309	14,948,486	4,409,823
(Whitfield)	FY1998	21,480,073	16,558,988	4,921,085
	FY1999	23,930,595	18,373,911	5,556,684
Miss. State Hospital-Nursing Facility	FY1997	11,091,986	8,565,232	2,526,754
(Whitfield)	FY1998	11,199,500	8,633,695	2,565,805
	FY1999	12,030,932	9,237,350	2,793,582
Miss. State Hospital	FY1997	3,613,511	2,790,353	823,158
(Whitfield)	FY1998	4,074,843	3,141,296	933,547
	FY1999	4,057,484	3,115,336	942,148
Boswell Regional Center	FY1997	9,414,537	7,269,905	2,144,632
(Sanatorium)	FY1998	1,001,777	772,270	229,507
	FY1999	10,621,658	8,155,309	2,466,349
Miss. Department of Mental Health	FY1997	39,044,543	30,150,196	8,894,347
	FY1998	42,792,430	32,988,684	9,803,746
	FY1999	49,646,892	38,118,884	11,528,008
University Medical Center	FY1997	150,285,117	116,050,167	34,234,950
(Jackson)	FY1998	146,905,469	113,249,426	33,656,043
	FY1999	156,730,154	120,337,412	36,392,742
Miss. Dept of Human Services	FY1997	2,369,440	1,829,682	539,758
	FY1998	2,249,524	1,734,158	515,366
	FY1999	3,347,331	2,570,081	777,250

Source Provider History Report

TABLE 11

Total Number of Eligibles, Numbers Using Physician Services by Program Category for Fiscal Year 1999

Program Category	Total Number of Eligibles	Beneficiaries Using Service	Percent of Total
Total	517,693	321,290	62.06%
Aged	28,479	23,071	81.01%
Blind	1,465	1,041	71.06%
Disabled	122,858	84,115	68.47%
Low Income Families – Children	158,515	82,061	51.77%
Low Income Families – Adults	138,647	85,740	61.84%
CWS Foster Care	2,613	1,530	58.55%
Optional Categorically Needy	65,116	43,732	67.16%

Source:HCFA 2082 (06/99)

TABLE 12

Amount of Expenditures with Percentage Distribution for Physician Services by Program Category for Fiscal Year 1999

Program Category	Expenditures	Percent of Total
Total	106,411,252	100.00%
Aged	18,932,612	17.79%
Blind	1,738,853	1.63%
Disabled	74,145,964	69.68%
Low Income Families – Children	3,326,003	3.13%
Low Income Families – Adults	4,260,570	4.00%
CWS Foster Care	789,724	0.74%
Optional Categorically Needy	3,217,526	3.02%

Source:HCFA 2082 (06/99)

TABLE 13

Amount of Expenditures with Percentage Distribution for Physician Services by Age Groups for Fiscal Year 1999

Age in Years	Total Expenditures	Percent of Total*
Total	106,411,252	100.00%
Birth to age 1	11,381,243	10.70%
Ages 1 to 3	1,735,069	1.63%
Ages 3 to 5	3,141,996	2.95%
Ages 5 to 6	749,018	0.70%
Ages 6 to 8	1,801,488	1.69%
Ages 8 to 19	22,083,293	20.75%
Ages 19 to 21	7,937,312	7.46%
Ages 21 to 64	56,089,762	52.71%
Ages 64 and Over	1,492,071	1.40%

*Percentage columns may not total 100% due to rounding

Source:MAM250-R1 (06/99)

TABLE 14

Number of Physician Visits by Place of Visit for Fiscal Year 1999

Place of Visit	Number of Visits	Percent of Total*
Total	2,133,270	100.00%
Physician's Office	1,453,241	68.12%
Hospital	285,540	13.39%
Nursing Home	11,043	0.52%
Emergency Room	177,202	8.31%
Consultations	205,813	9.65%
House Calls	431	0.02%

Source:SU-O-1-10

TABLE 15

Number of Prescriptions, Number of Beneficiaries, and Average Number of Prescriptions per Beneficiary by Program Category for Fiscal Year 1999

Program Category	Prescriptions	Percent of Total	Number of Beneficiaries	Percent of Total	Average Number of Prescriptions Per Beneficiary
Total	6,334,968	100.00%	413,742	100.00%	15.3
Aged	774,913	12.23%	28,770	6.95%	26.9
Blind	32,397	0.51%	1,367	0.33%	23.7
Disabled	2,505,079	39.54%	113,485	27.43%	22.1
Low Income Families – Children	570,523	9.01%	107,678	26.03%	5.3
Low Income Families – Adults	639,605	10.10%	104,612	25.28%	6.1
CWS Foster Care	23,019	0.36%	1,941	0.47%	11.9
Optional Categorically Needy	1,789,432	28.25%	55,889	13.51%	32.0

Source:HCFA 2082 (06/99)

TABLE 16

Number of Beneficiaries and Number of Days of Care for Nursing Facilities by Program Category for Fiscal Year 1999

	Nursing Facility		Intermediate Care Facilities - MR		Psychiatric Residential Treatment Facility	
Program Category	Beneficiaries	Days of Care	Beneficiaries	Days of Care	Beneficiaries	Days of Care
Total	19,031	4,790,787	2,747	863,466	909	132,099
Aged	1,731	350,846	22	6,951	43	267
Blind	52	12,845	19	6,028	1	1
Disabled	1,861	421,057	1,330	408,616	443	64,623
Low Income Families – Children	1	29	3	183	120	15,903
Low Income Families – Adults	1	10	1	174	133	15,639
CWS Foster Care	0	0	17	2,716	135	30,606
Optional Categorically Needy	15,385	4,006,000	1,355	438,798	34	5,060

Source:HCFA 2082 (06/99)

TABLE 17

Number of Children Receiving Treatment by Category of Service for Fiscal Year 1999

Program Category	Number of Children
Dental	66,629
Corrective Treatment Referrals (which included Vision and Hearing)	15,043

Source:HCFA 416 Y-T-D

TABLE 18

Number of Beneficiaries, Number of Discharges, and Total Days of Hospital Care and Average Length of Hospital Stay by Program Category for Fiscal Year 1999

Program Category	Number of Beneficiaries	Number of Discharges	Days of Care	Average Length of Hospital Stay
Total	58,934	275,895	429,420	1.6
Aged	4,514	250	707	2.8
Blind	187	642	1,207	1.9
Disabled	17,599	91,973	189,439	2.1
Low Income Families – Children	9,663	49,639	100,240	2.0
Low Income Families – Adults	16,484	120,455	95,186	0.8
CWS Foster Care	266	2,062	18,140	8.8
Optional Categorically Needy	10,221	10,874	24,501	2.3

Source:HCFA 2082 (06/99)