Office of the Governor

Division of Medicaid

FY 2002 Annual Report

Rica Lewis-Payton, Executive Director

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

RICA LEWIS-PAYTON
EXECUTIVE DIRECTOR

May 6, 2003

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

Governor Musgrove and Members of the Legislature:

It is my pleasure to submit to you the FY 2002 Annual Report of the Medicaid Program. 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 Departments of Human Services, Health, Mental Health, and Rehabilitation Services to the ongoing administration of Mississippi's Medicaid Program. In addition, we acknowledge the continued commitment of our providers to deliver quality healthcare to the Medicaid population. Investment in the Medicaid Program is an investment in the health status of our citizens.

If we can ensure quality healthcare services to our most vulnerable citizens, they will have the opportunity to be more productive. A healthier Mississippi is a more productive Mississippi.

On behalf of the 709,260 Mississippians who were enrolled in the Medicaid program in FY 2002, thank you for your continuing support of the Medicaid Program.

Respectfully,

Rica Lewis-Payton

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Mission

Medicaid Executive Director Rica Lewis-Payton and Governor Ronnie Musgrove

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

Values

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

Vision Statements

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

Performance Categories

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

Slogan

- Quality Healthcare Service, Improving Lives

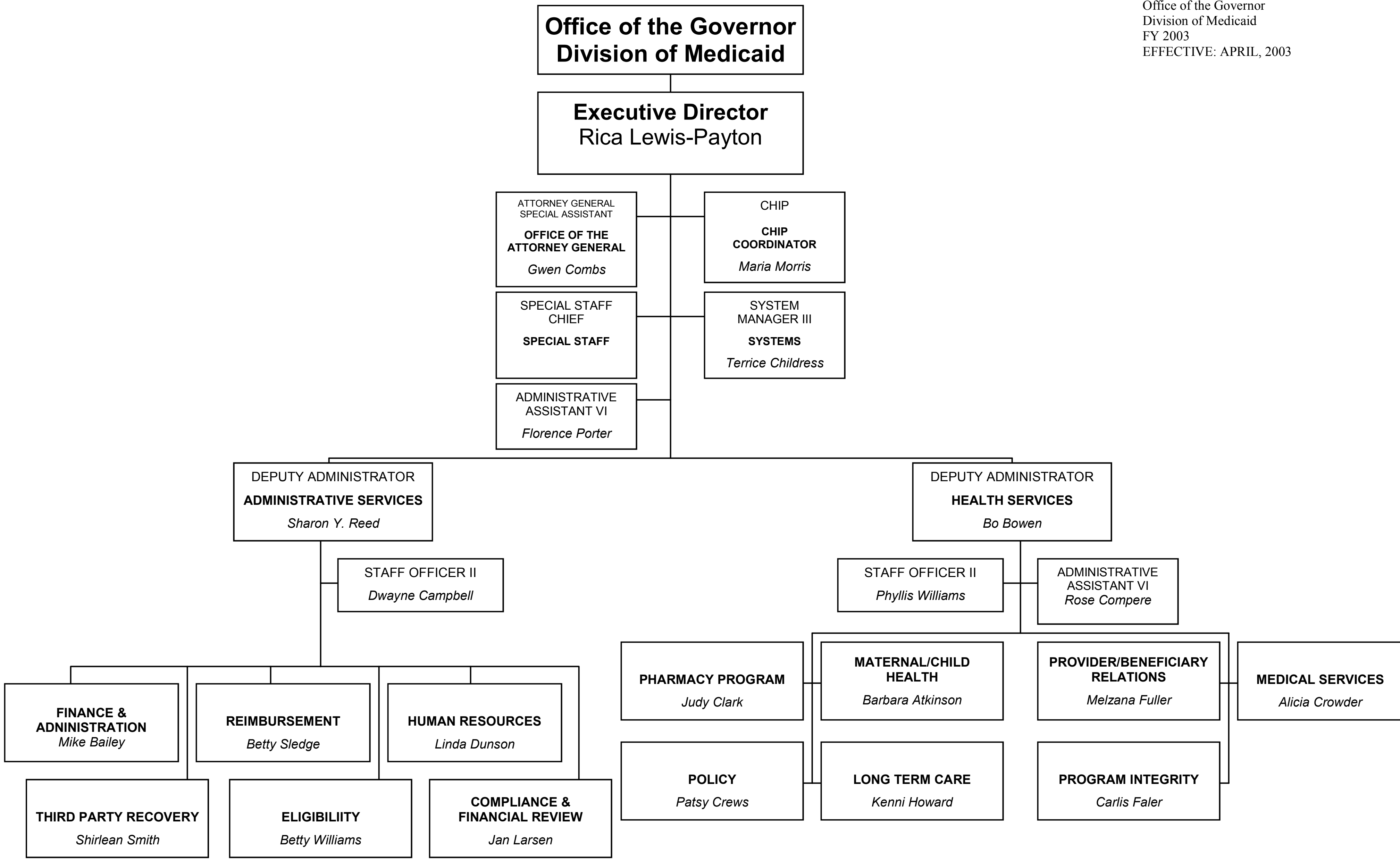
MEDICAID ELIGIBLES BY COUNTY AND PERCENTAGE OF TOTAL COUNTY POPULATION

DESOTO 11,159 9.76%
MARSHALL 9,276 26.26%
BENTON 2,634 24.26%
TIPPAH 5,741 27.43%
ALCORN 8,668 25.04%
TISHOMINGO 4,192 21.99%
PRENTISS 5,613 22.03%
TUNICA 3,597 38.41%
TATE 5,239 20.45%
PANOLA 11,310 32.60%
LAFAYETTE 5,262 13.55%
UNION 4,986 19.34%
LEE 15,488 20.20%
ITAWAMBA 4,266 18.53%
PONTOTOC 4,929 18.22%
COAHOMA 13,277 44.10%
QUITMAN 4,319 42.91%
YALOBUSHA 3,890 29.23%
CALHOUN 4,267 28.64%
CHICKASAW 5,182 26.71%
MONROE 8,807 23.14%
TALLAHATCHIE 5,439 37.15%
BOLIVAR 15,718 39.14%
GRENADA 6,129 26.72%
CLAY 6,422 29.42%
LEFLORE 14,672 39.32%
CARROLL 2,606 24.26%
WEBSTER 2,869 27.80%
MONTGOMERY 3,745 31.06%
LOWNDES 14,685 24.10%
SUNFLOWER 12,113 35.70%
OKTIBBEHA 8,117 19.20%
CHOCTAW 2,696 27.90%
WASHINGTON 25,067 40.54%
HOLMES 10,787 50.23%
HUMPHREYS 4,953 45.32%
ATTALA 5,784 29.43%
WINSTON 5,599 27.82%
NOXUBEE 5,096 40.70%
SHARKEY 2,897 45.14%
ISSAQUENA 634 35.60%
YAZOO 9,900 35.60%
MADISON 13,316 17.36%
LEAKE 5,791 27.39%
NESHOBA 7,579 26.58%
KEMPER 2,844 27.18%
WARREN 12,416 25.16%
HINDS 62,293 24.97%
RANKIN 16,573 13.91%
SCOTT 8,080 28.53%
NEWTON 5,330 24.17%
LAUDERDALE 19,545 25.25%
CLAIBORNE 3,933 33.27%
COPIAH 8,411 29.12%
SIMPSON 7,286 26.43%
SMITH 3,801 23.51%
JASPER 5,260 28.69%
CLARKE 4,189 23.43%
JEFFERSON 3,574 36.86%
LINCOLN 8,342 24.83%
LAWRENCE 3,424 25.59%
JEFFERSON DAVIS 4,623 33.37%
COVINGTON 5,381 27.56%
JONES 16,618 25.75%
WAYNE 6,040 28.50%
ADAMS 10,485 30.93%
FRANKLIN 2,503 29.88%
WILKINSON 3,628 35.11%
AMITE 3,628 26.86%
PIKE 12,969 33.29%
WALTHALL 4,929 32.05%
MARION 7,954 31.38%
LAMAR 6,951 17.17%
FORREST 18,114 24.85%
PERRY 3,380 27.54%
GREENE 2,892 21.62%
PEARL RIVER 11,352 22.72%
STONE 3,518 20.43%
GEORGE 4,636 23.67%
JACKSON 23,005 17.32%
HARRISON 36,913 19.49%
HANCOCK 8,153 18.52%

Source: Medicaid Eligibles RSO-10-4-A (06/02)

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

Office of the Governor
Division of Medicaid
FY 2003
EFFECTIVE: APRIL, 2003



Agency Overview

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

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

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

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

(Continued)

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

Bureau of Eligibility ~ The State Office staff manages the following functions: policy and on-line system development; administration of 25 Regional Offices; State level appeals of eligibility decisions; eligibility staff training; the Buy-In of Medicare premiums for all dually eligible beneficiaries and incoming calls from the KIDS NOW hotline. State level staff also have oversight responsibility for the electronic transmission of eligibility for over 150,000 SSI eligibles who automatically receive Medicaid and policy oversight for the Medicaid coverage groups certified by the State Department of Human Services (474,000 eligibles).
The Medicaid Regional Office staff is responsible for eligibility determinations for over 85,000 aged or disabled recipients living in private and long term care settings and for determining the cost of care calculations for each recipient in a nursing facility.

Special Staff ~ Responsible for responding to public information requests in accordance with Division of Medicaid Policy and the Access to Public Records Act; supporting the Executive Director by attending key meetings of other state agencies and legislative bodies, and ascertaining from these meetings information needed by participants, and coordinates with appropriate agency personnel the collection of this information; and performing other tasks related to special projects as assigned by the Executive Director. The Special Staff includes: Planning and Development, Program Analysis, and Public Relations.

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

Reward and recognition is an important part of the Division of Medicaid's staff culture. Above (left to right), Executive Director Rica Lewis-Payton and Deputy Administrators Sharon Y. Reed and Bo Bowen, present the "Employee of the Month Award" to three outstanding staff members.

(Continued)

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

The Institutional Long Term Care Division is responsible for monitoring the Licensure and Certification Branch of the State Department of Health. Licensure and Certification (L&C) surveys nursing facilities and Intermediate Care Facilities for the Mentally Retarded (ICF/MR). DOM imposes recommendations from L&C on nursing facilities and ICF/MRs that are out of compliance with the federal regulations. The agency Division has the discretion of imposing civil and monetary penalties and other remedies when recommended. This Division is responsible for enforcing policy set forth in the Medicaid provider manuals and federal certification requirements established by the Centers for Medicare and Medicaid. Staff is also responsible for the Case Mix program, which ensures accuracy of nursing facility resident assessment data used to establish resident classification and subsequent reimbursement payment rates for nursing facilities.

The Mental Health Services Division is responsible for administering both inpatient psychiatric and community-based mental health services. Mental Health Services staff are responsible for approving services, setting Medicaid policy for mental health, monitoring programs for utilization and compliance with State and Federal regulations, processing claims for administrative services, and assisting providers and beneficiaries with mental health related questions. Inpatient psychiatric programs for which this Division is responsible include Psychiatric Residential Treatment Facilities, Freestanding Psychiatric Hospitals and Psychiatric programs within general hospitals. Community-based mental health services for which this Division is responsible include Community Mental Health Services provided by the Regional Mental Health Centers, mental health services for children covered under Expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) psychiatric services. The Division is also responsible for the Pre-Admission Screening and Resident Review (PASRR) program for nursing facilities and Intermediate Care Facilities for the Mentally retarded admissions.

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

Bureau of Policy & Medical Services ~ The Bureau of Policy and Medical Services consists of two divisions, the Policy Division and the Medical Services Division. The primary function of the Policy Division is to research new and existing policy issues through the analysis of state and federal laws, medical standards of care, and related data for the purpose of developing and distributing written policy to all Medicaid providers which can be consistently applied in order to facilitate proper utilization of services and funding for the Medicaid programs and to ensure quality services are delivered to the beneficiaries. In addition, the Policy Division coordinates the prior authorizations for solid organ and bone marrow transplants and oversees the Peer Review Organization contract which handles certifications of inpatient days for hospitals, swing beds, and psychiatric residential treatment facilities, prior authorization of durable medical equipment, home health agency visits, and private duty nursing services for beneficiaries under age 21 and medical necessity reviews for transplants.

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

Bureau of Program Integrity ~ The Bureau of Program Integrity consists of four divisions: Investigations, Medical Review, Beneficiary Recoupment, and Medicaid Eligibility Quality Control. The Bureau conducts investigations of providers and beneficiaries suspected of fraud and/or abuse, monitors both providers' and beneficiaries' utilization of Medicaid benefits, and determines the accuracy of Medicaid eligibility decisions.

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

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

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

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

(Continued)

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

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

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

Program Analysis Unit ~ This Unit is responsible for performing data analysis and running queries and reports to determine if the Medicaid programs are providing the most benefit to beneficiaries. The unit conducts "data mining" of Medicaid's vast databases, searching for patterns in the data. This includes discovering utilization patterns, identifying underserved populations and uncovering the progression of one service event to another. The unit also conducts research to support policy-making as well as aiding in program development and management.

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

Public Relations ~ This Office is responsible for formulating, directing, and administering the Public Relations operations for the Division of Medicaid (DOM) through DOM's bureau and division directors. This Office maintains working relationships with the press, various advertising agencies, other state agencies and the Office of the Governor . This Office works with DOM staff in the development of brochures and other information materials for distribution to public officials and the general public.

International Diplomats (above) visit the Division of Medicaid to learn about the Mississippi program from DOM officials.

Administrators from the Centers for Medicare and Medicaid Services with DOM and the Governor's staff members.

Program Overview

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

There are three main categories of Medicaid services:

Those mandated by federal law:

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

Waiver programs offering additional enhanced services:

1) Primary care case management services

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

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

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

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

6) Home and community-based services for individuals with traumatic brain injuries and spinal cord injuries

(Continued)

Optional services the state elects to provide:

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

Pictured above is our Brandon Regional Office. One of 25 Medicaid Regional Offices (RO's) located across our state, this RO is Supervised by Pam Kelly (center). Pictured right, the Brandon RO staff.

Home and Community Based Services (HCBS)

HCBS program goals:

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

Waiver for the Elderly and Disabled:

The Elderly and Disabled Home and Community-Based Services Waiver provides services to individuals, who but for the provisions of such services, would require placement in a nursing facility. This waiver is statewide and operated directly through the Division of Medicaid. Beneficiaries of this waiver must be Medicaid eligible as SSI recipients, Poverty Level, Aged or Disabled, or meet the requirements for the special income category, which allows income level up to 300% of the SSI federal benefit rate. Services available are Case Management, Institutional Respite, In-Home Respite, Homemaker Services, Home Delivered Meals, Adult Day Care, Escorted Transportation and Expanded Home Health Services. Referrals for this program can be made through the Community Long Term Care Division of the Long Term Care Bureau of the Division Medicaid or through the various Area Agencies on Aging throughout the state. For FY 2002, there were 9,204 individuals enrolled in this waiver.

During FY 2002, the Elderly and Disabled Waiver shows a 40% growth in the number of individuals served in this program. There has been the following growth in providers for this Waiver: (15) Homemaker providers; (1) Adult Day Services providers; (11) In-Home Respite providers; (5) Institutional Respite providers, and (3) Escorted Transportation providers.

Independent Living Waiver:

The Independent Living Waiver was created to assist severely orthopedically and/or neurologically impaired individuals, to live as independently as possible through the services of a Personal Care Attendant. The beneficiary must be capable of communicating effectively with caregivers, personal care attendants, case managers, and others involved in their care, and they must be medically stable. Beneficiaries are also provided Case Management Services. These services enable beneficiaries to remain at home rather that be placed in a nursing facility. This statewide program is administered by The Department of Rehabilitation Services. Beneficiaries of this waiver must be Medicaid eligible as SSI recipients or must met the requirements for a disability coverage group, which allows an income level up to 300% of the SSI federal benefit rate. Referrals for this program can be made through the Department of Rehabilitation Services or through the Community Long Term Care Division of the Long Term Care Bureau at the Division of Medicaid. During FY 2002, the Independent Living Waiver served 424 individuals, a 20% increase over FY 2001. (Continued)

Waiver for the Mentally Retarded/Developmentally Disabled:

The Mentally Retarded/Developmentally Disabled Waiver provides services to individuals who, but for the provision of such services, would require placement in an intermediate care facility for the mentally retarded (ICF/MR) or persons with related conditions. The Department of Mental Health, Division of Mental Retardation, administers this statewide program. Beneficiaries of this waiver must be Medicaid eligible as a SSI recipient; TANF recipient, Disabled Child Living at Home or under the special HCBS category, which allows income, limits up to 300% of the federal benefit rate. Services available under this waiver include: Support coordination; in-home respite; community respite; ICF/MR respite; residential habilitation; attendant care services; day habilitation; pre-vocational services; supported employment; physical, occupational or speech, language and hearing therapy services; specialized medical supplies; behavioral support and intervention. Referrals for this waiver program may be made through the Community Long Term Care Division of the Bureau of Long Term Care at the Division of Medicaid or through the waiver support coordinators at one of the five (5) state operated Regional ICF/MRs.

During FY 2002, the Mentally Retarded/Developmentally Disabled Waiver served 1474 individuals, less than 1% increase over FY 2001.

Waiver for Assisted Living:

The Assisted Living Waiver provides services in a home-like environment in a setting that is licensed by the State Department of Health as a Level Two Personal Care Home. These are supportive services, provided while the beneficiary resides in such a facility, by trained staff that involves one or more of the following primary duties: personal care services, homemaker services, chore services, attendant care, medication oversight, therapeutic, social and recreational programming, 24 hour on-site response staff to met scheduled or unpredictable needs in a way to promote maximum dignity and independence, as well as to provider supervision, safety and security. Additionally, other services, which may be provided, include medication administration, intermittent skilled nursing services, transportation and attendant call systems. Medicaid pays for services only, and payment will not be made for 24 hour skilled care, supervision or room and board.

This program is administered directly by the Division of Medicaid. Beneficiaries of this waiver must be Medicaid eligible as SSI recipients, Poverty Level, Aged or Disabled, or meet the requirements for the special income category, which allows income level up to 300% of the SSI federal benefit rate.

This waiver is currently a pilot program, limited to Bolivar, Forrest, Harrison, Hinds, Lee, Newton and Sunflower counties. For FY 2002, there are 4 providers and 52 beneficiaries enrolled in this program, an increase of 1040% increase over FY 2001.

Waiver for Traumatic Brain/Spinal Cord Injuries (TBI/SCI):

The TBI/SCI waiver provides services to individuals with a traumatic (acquired from an **external** cause) brain or spinal cord injury. Individuals must be medically stable to participate in this program. The Department of Rehabilitation Services administers this statewide program. Beneficiaries of this waiver must be Medicaid eligible as SSI recipients, Poverty Level, Aged or Disabled, or meet the requirements for the special income category, which allows income level up to 300% of the SSI federal benefit rate. Services available include: Case Management, Attendant Care, Institutional or In-Home respite, Home Modifications and Specialized Medical Equipment and/or supplies. Referrals for this program may be made through the Department of Rehabilitation Services or the Community Long Term Care Division of the Long Term Care Bureau at the Division of Medicaid.

This waiver was federally approved effective July 1, 2001 and for FY 2002 served 126 individuals.

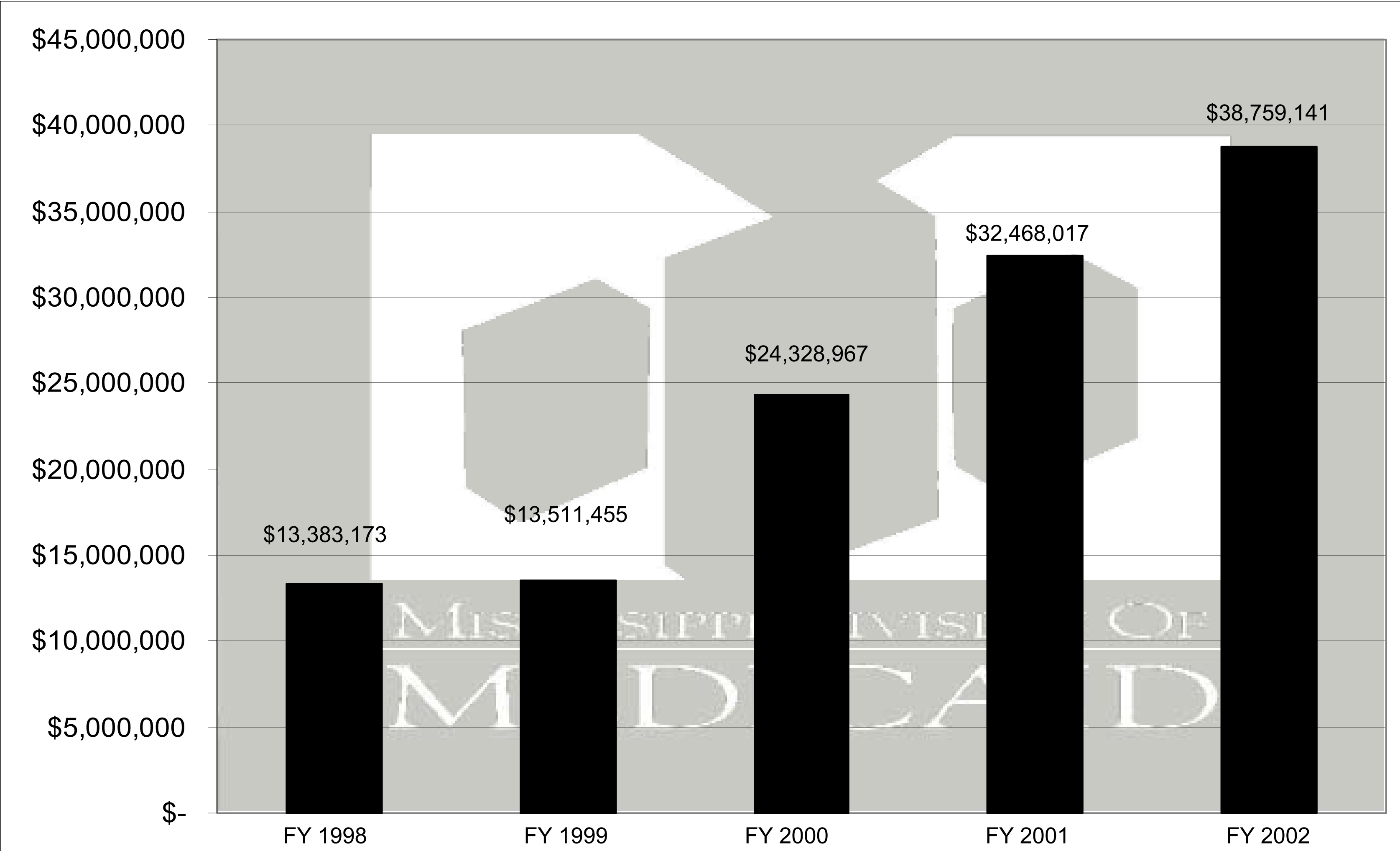
Dental Services
(Early and Periodic Screening, Diagnosis and Treatment Dental Services Included)

In Fiscal Year 2002, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) dental services were rendered to a total of 124,621 beneficiaries at a cost of $38,759,141. A total of 35,731 adults were treated with costs reaching $6,620,412. Providers rendering services totaled 464.

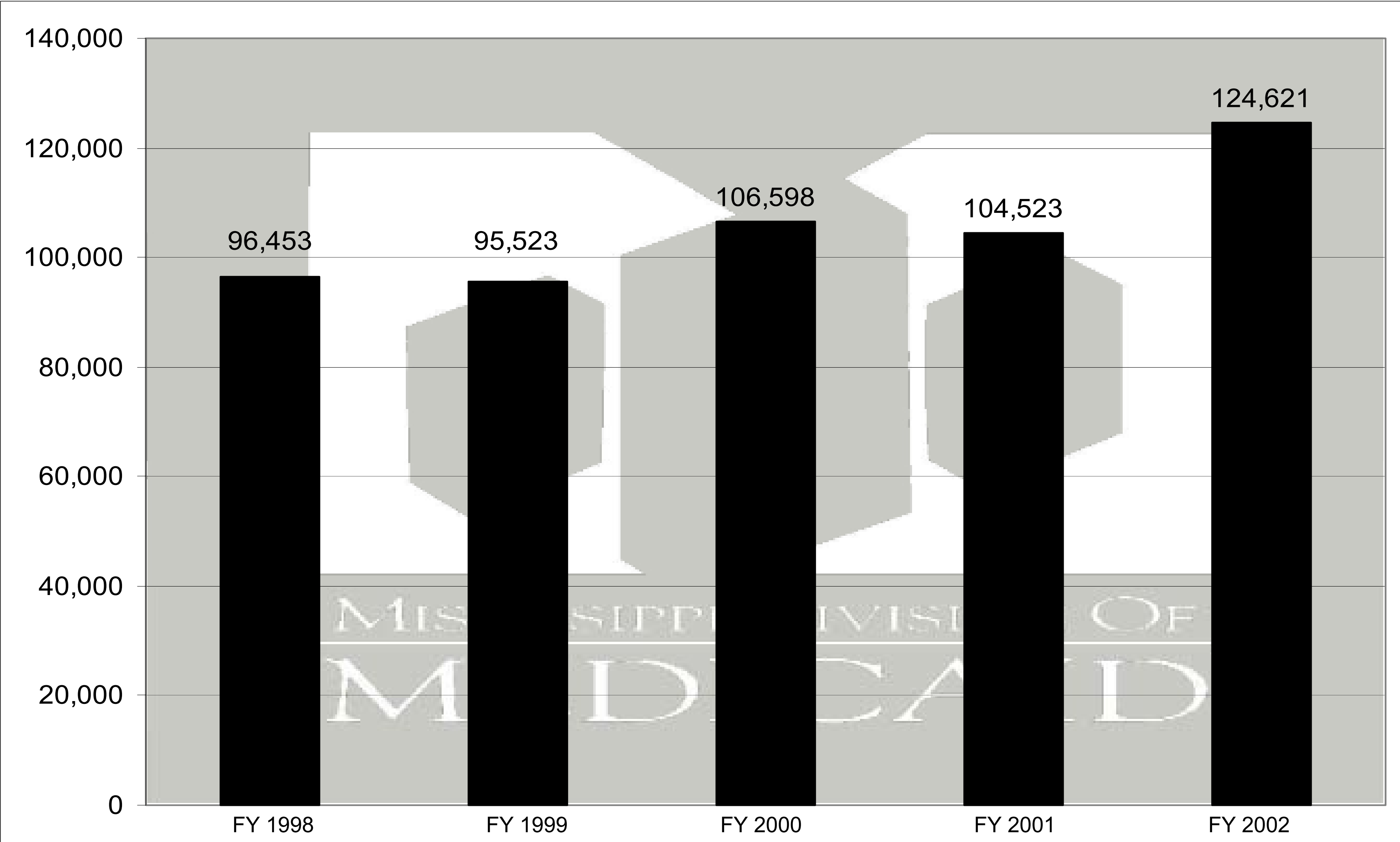
In comparison, during Fiscal Year 2001 EPSDT dental services were rendered to a total of 104,523 beneficiaries at a cost of $32,468,017. A total of 30,567 adults were treated with costs reaching $5,792,369. Providers rendering services totaled 457.

The Office of the Governor, Division of Medicaid, is located in the Robert E. Lee Building (above right) at 239 North Lamar Street, Jackson, Mississippi 39201-1399.

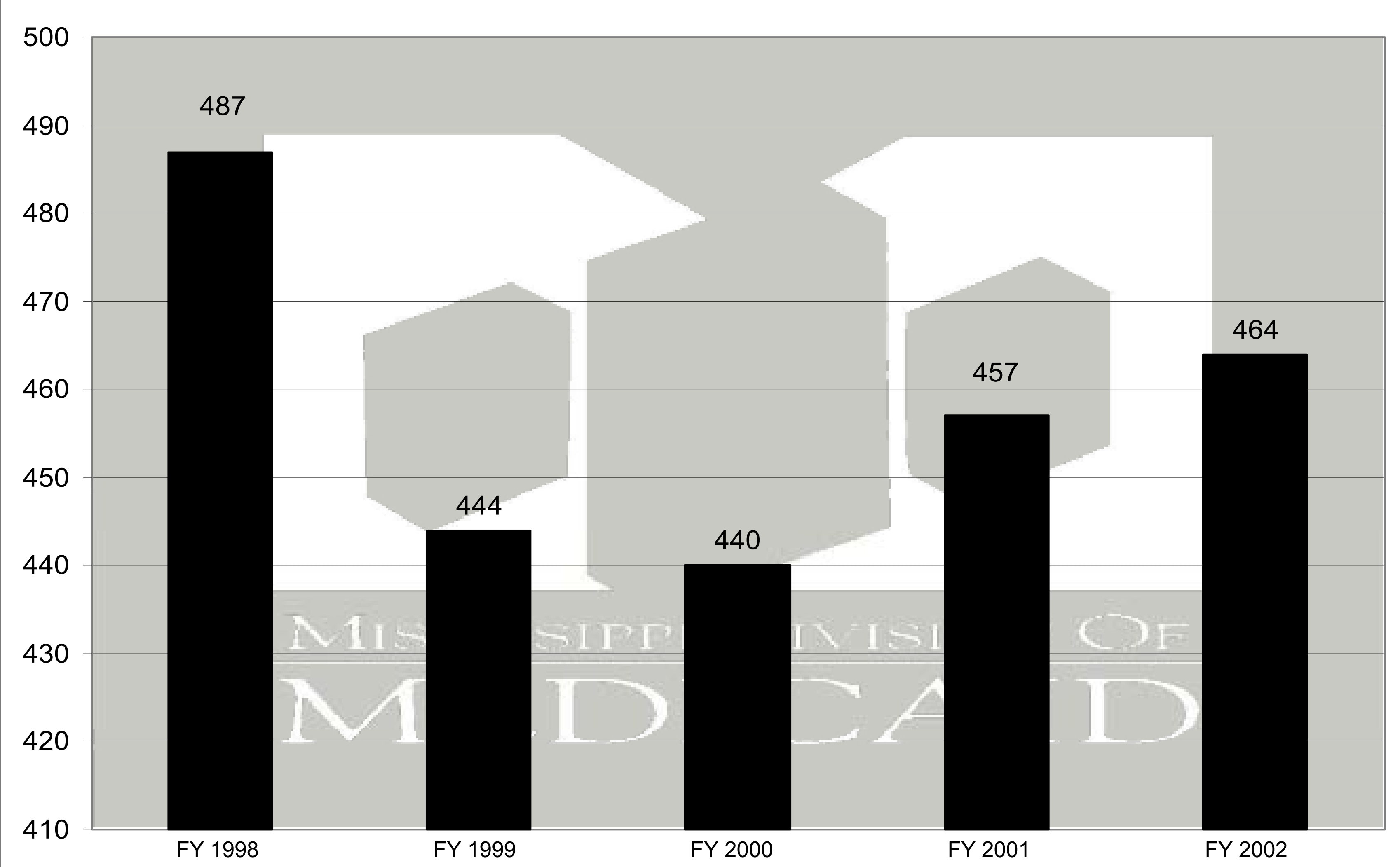
Dental Expenditures (Adult/Children)



EPSDT Dental Beneficiaries



Dental Billing Providers



Hospital Services
Physician Services

Inpatient Hospital Services

Inpatient Hospital Services

During Fiscal Year 2002, Medicaid provided for 414,634 days of inpatient hospital care, with total discharges equaling 178,218. In contrast, during Fiscal Year 2001, a total of 414,905 days of inpatient care were provided and total discharges were 375,365. In Fiscal Year 2002, inpatient hospital services expenditures were $383,241,958 for services rendered to 71,910 beneficiaries. This is compared to Fiscal Year 2001, in which inpatient hospital services expenditures were $353,715,319 rendered to 70,266 beneficiaries. Expenditures increased by 8% from Fiscal Year 2001 to Fiscal Year 2002. Beneficiaries increased by 2% from Fiscal Year 2001 to Fiscal Year 2002, as compared to a 17% increase from Fiscal Year 2000 to Fiscal Year 2001.

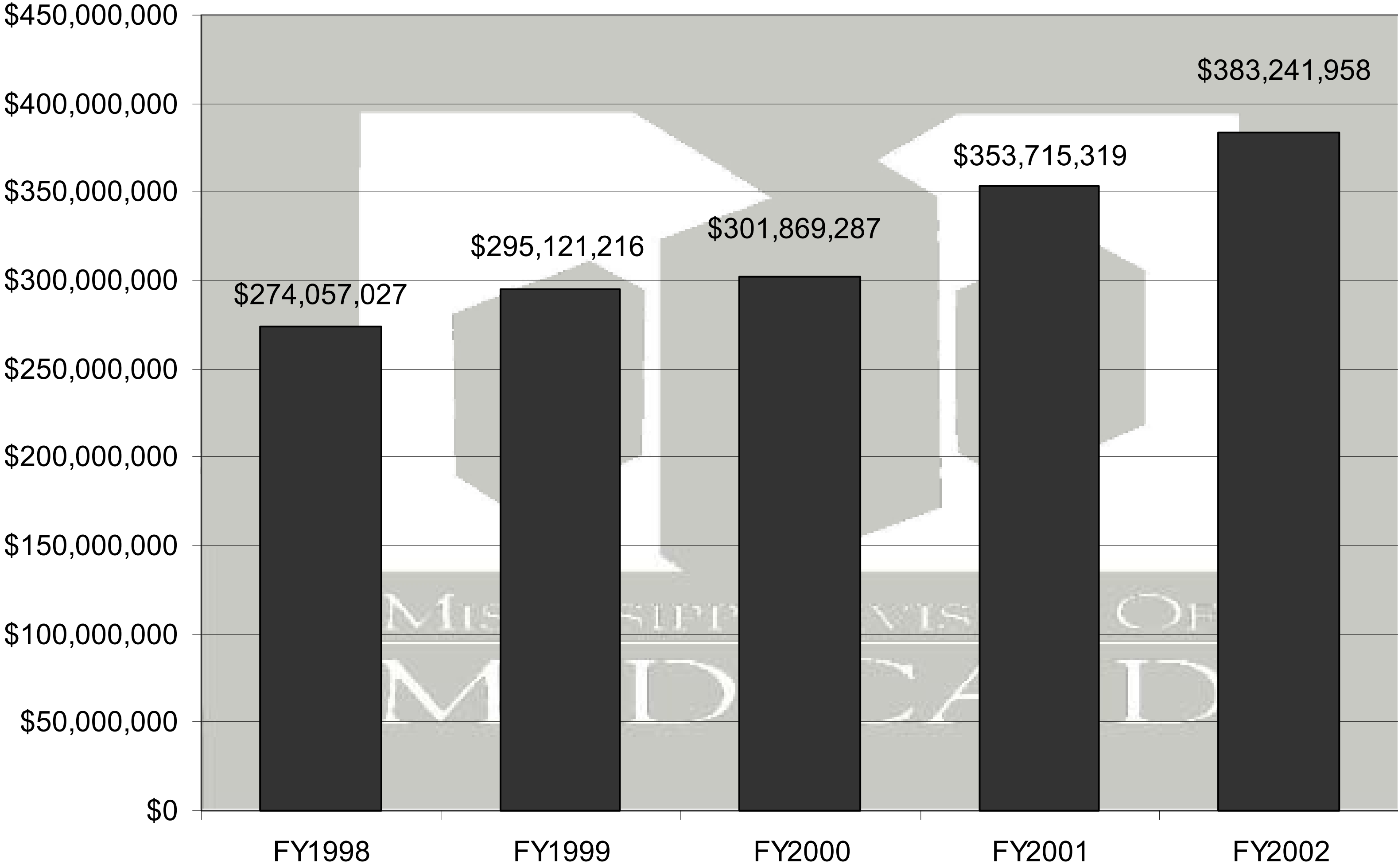
Outpatient Hospital Services

Outpatient Hospital Services were provided to 349,671 beneficiaries during Fiscal Year 2002. There was a total of 841,912 outpatient visits, a 23% increase from the previous Fiscal Year where there were 688,223 visits. For Fiscal Year 2002, the average number of visits per beneficiary was 2.41, decreasing slightly from the year before when the average was 2.48. Expenditures for outpatient services were $146,253,170 during Fiscal Year 2002, as compared to $106,749,858 during Fiscal Year 2001, or a 37% increase.

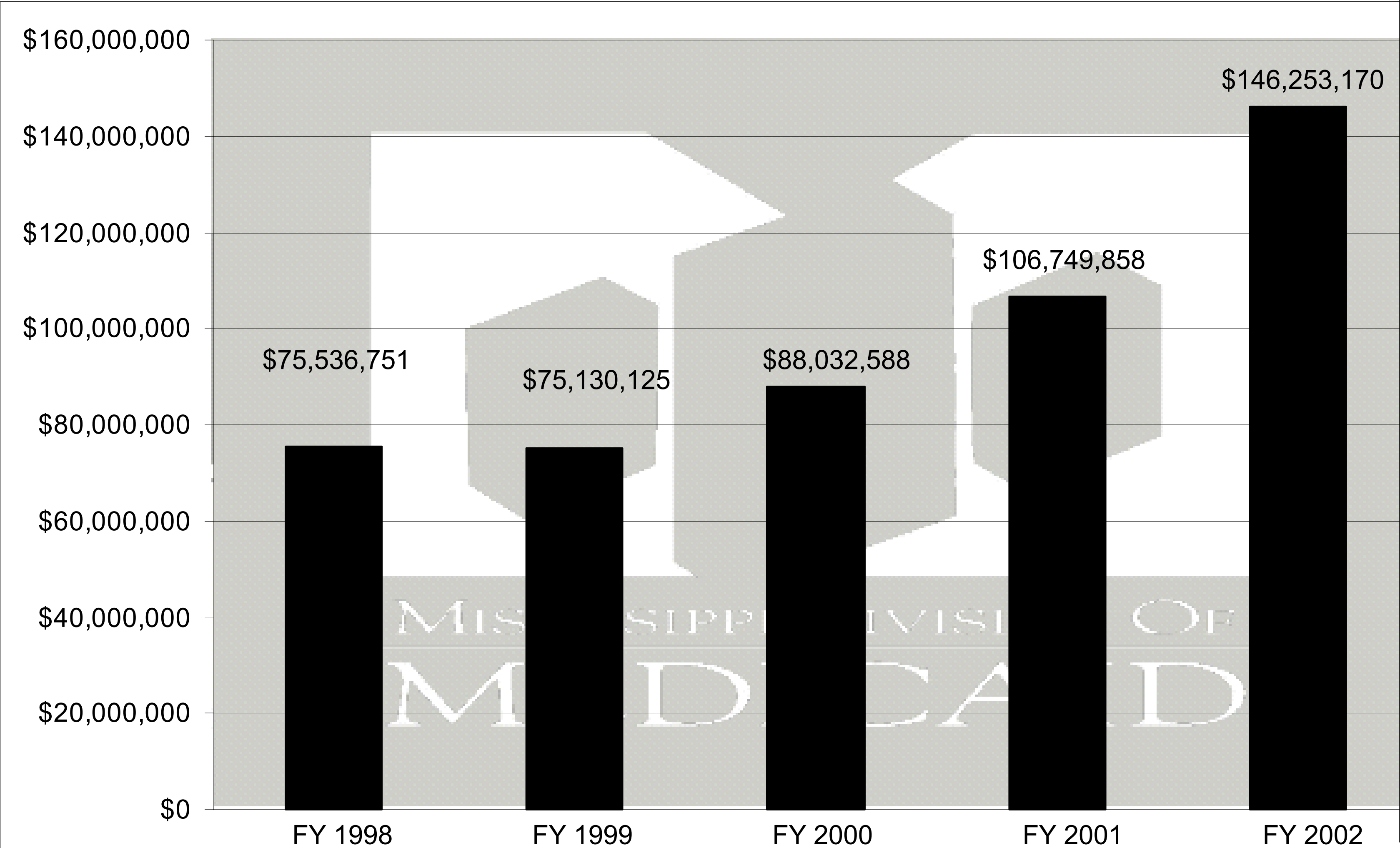
Physician Services

In Fiscal Year 2002, there was a 17.6% increase in the number of beneficiaries receiving physician services. 474,961 beneficiaries received physician services compared to 403,977 in Fiscal Year 2001. In addition, there was a 15% increase in physician visits from 6,076,682 in Fiscal Year 2001 to 6,986,087 visits in Fiscal Year 2002. The number of billing physician providers increased 8% from 3,684 providers in Fiscal Year 2001 to 3,979 providers in Fiscal Year 2002. Physician Service expenditures increased from $166,098,569 in Fiscal Year 2001 to $197,371,563 in Fiscal Year 2002. This represents an 18.8% increase.

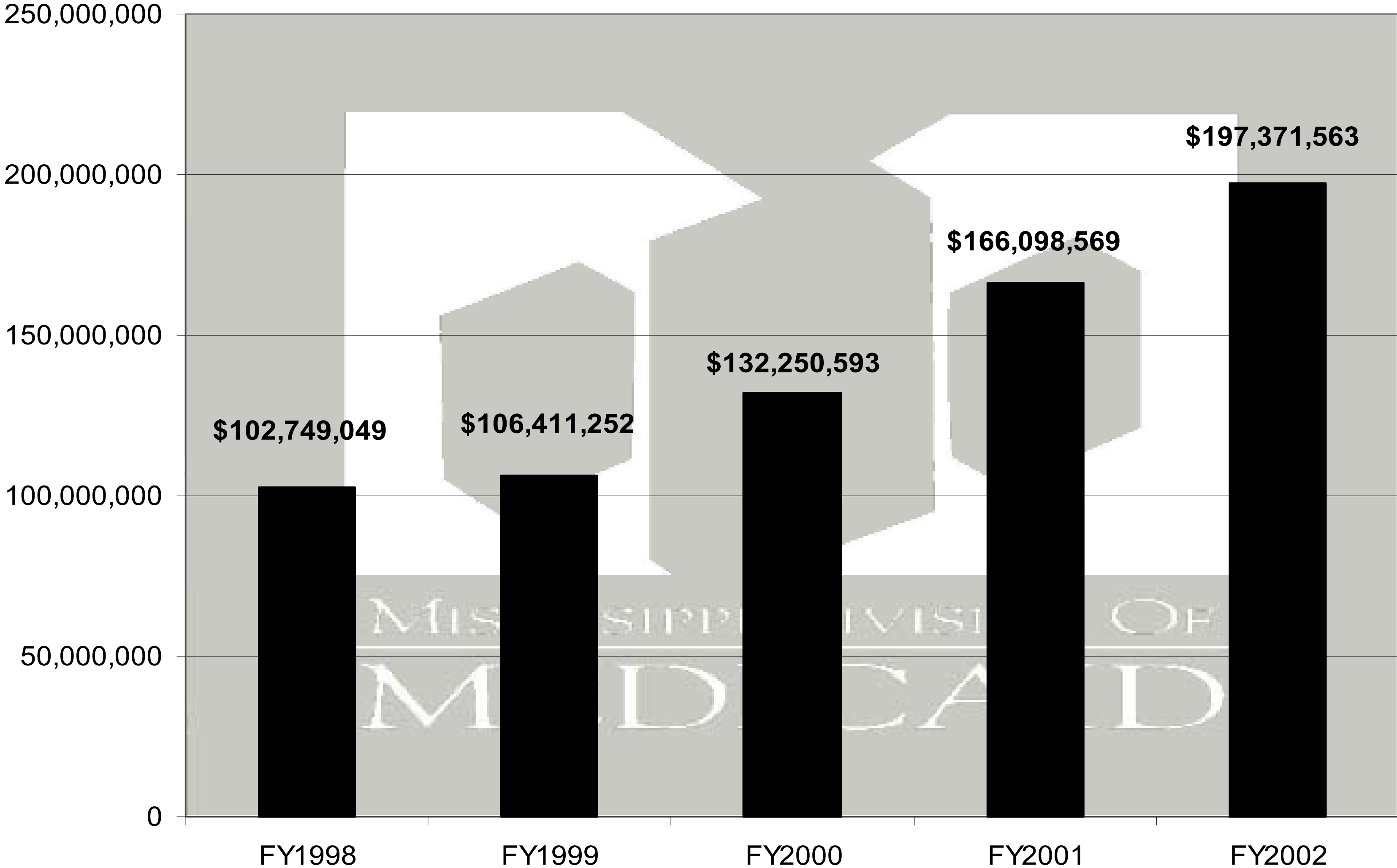
In-Patient Hospital Expenditures



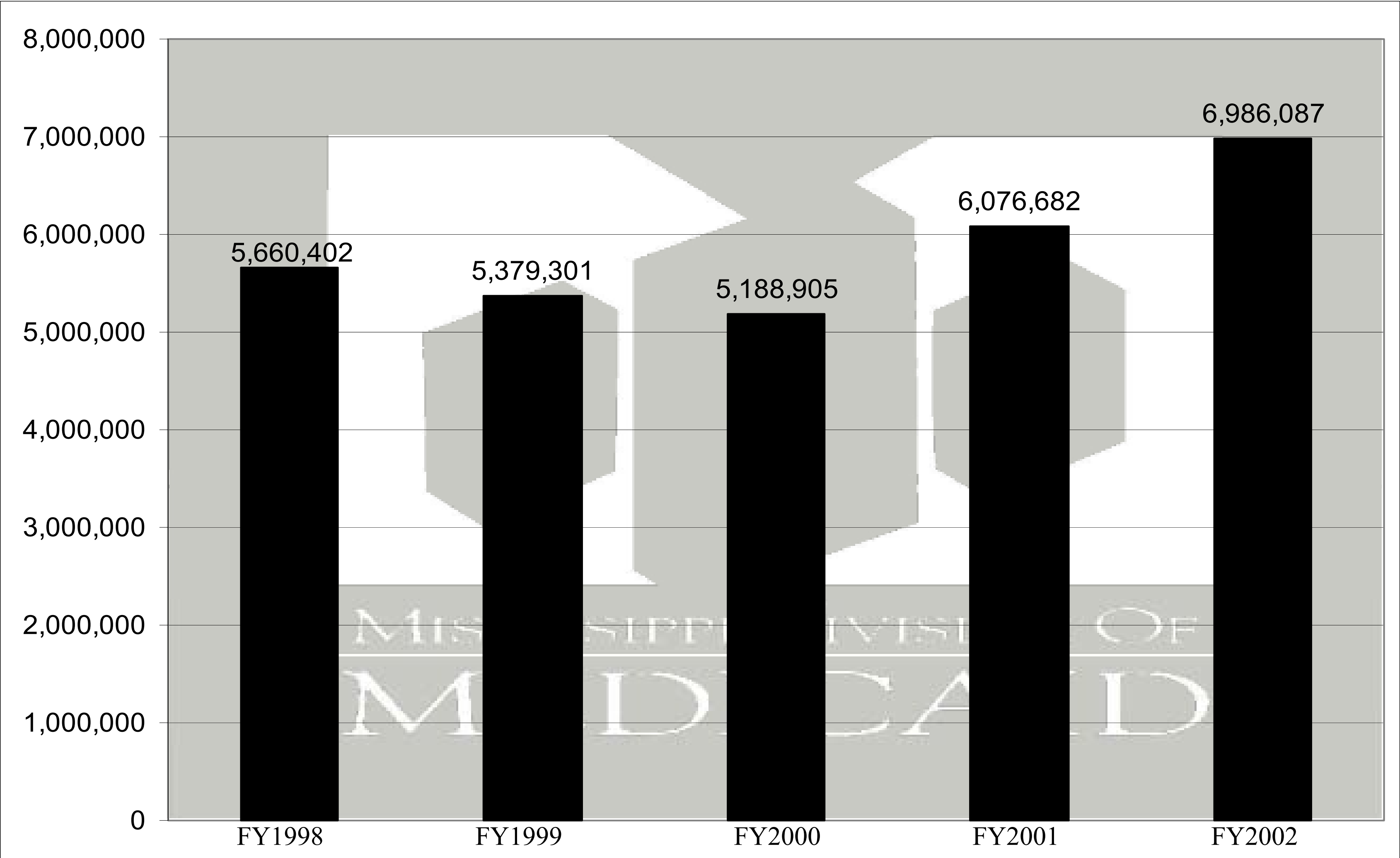
Out-Patient Hospital Expenditures



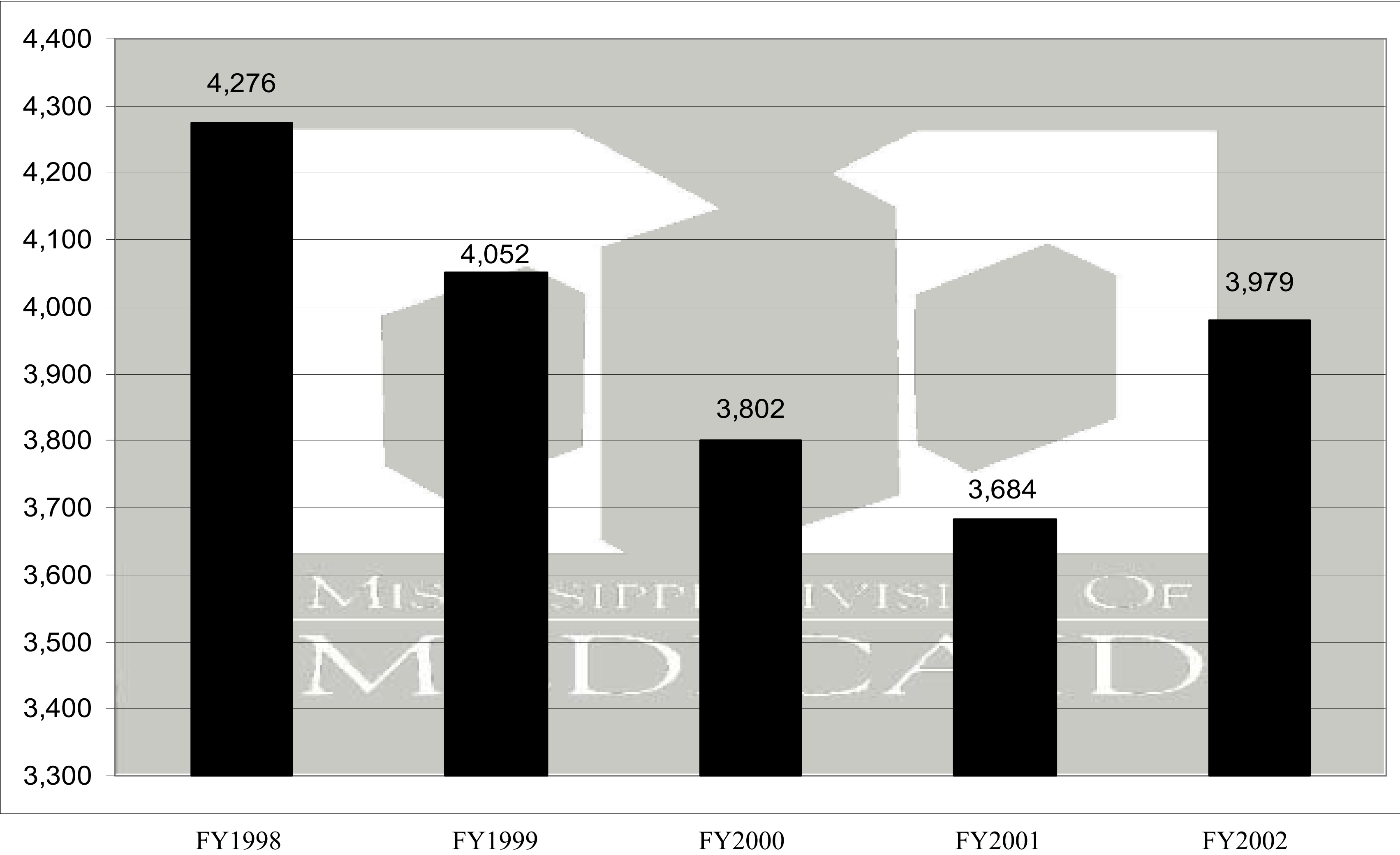
Physician Expenditures



Physician Visits



Physician Billing Providers



Pharmacy

In FY 2002, Pharmacy Program expenditures were approximately $565 million dollars, representing 23% of the overall budget, and a 21.99% increase over FY 2001 expenditures of a little over $100 million dollars.

The number of Medicaid beneficiaries receiving prescription drugs increased from 521,735 in FY 2001 to 589,269 in FY 2002, an increase of 12.94%, which contributed to a total increase in prescriptions of 14.05%, from 10,456,747 in FY 2001 to 11,925,651 in FY 2002.

Approximately $106 million in rebates were received from drug manufacturers in FY 2002 with $81 million dollars returned to CMS as the federal share. The Division of Medicaid retained $25 million.

It is the goal of the Division of Medicaid to ensure the appropriate use and maximum cost effectiveness of drug therapy without restriction of needed and medically justifiable benefits for our Medicaid beneficiaries.

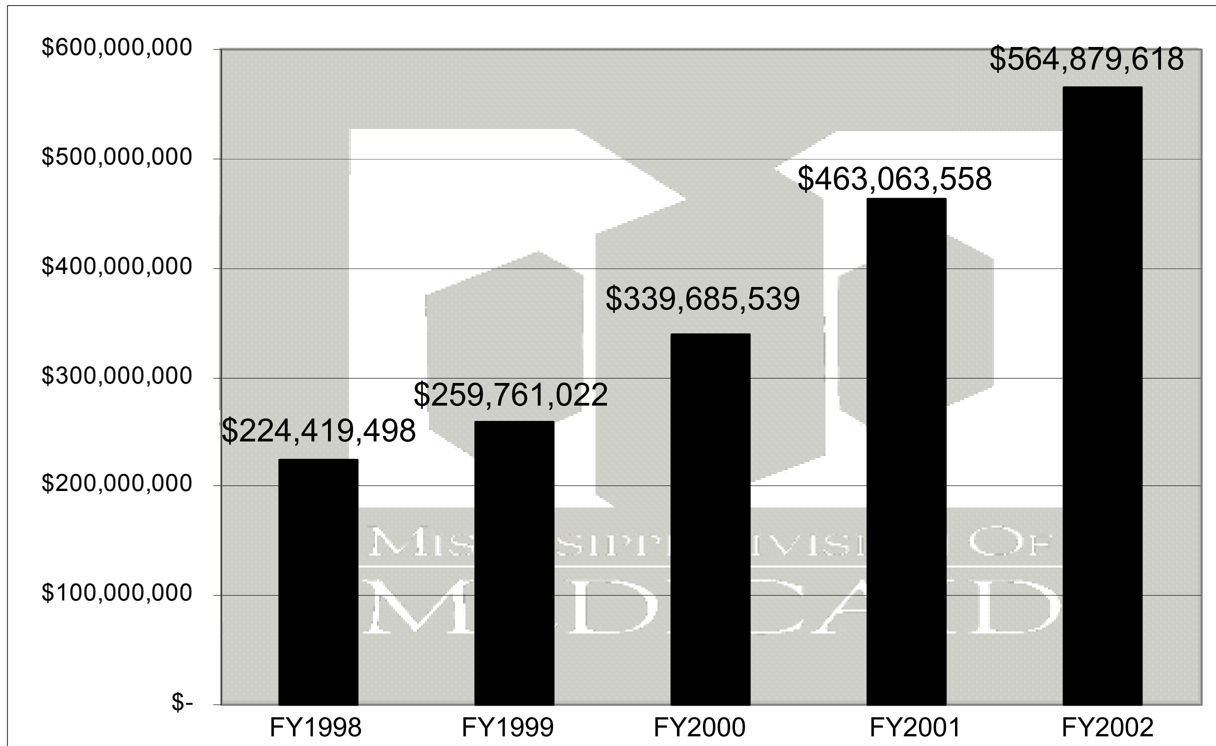
In an effort to provide for increased management, both clinical and financial, of our pharmacy program the Division of Medicaid contracted with Health Information Designs, Inc. in January 2002 to provide pharmacy benefits management and drug utilization review. Under this contract, Health Information Designs, Inc. seeks to ensure that Medicaid beneficiaries receive appropriate and cost-effective drug therapy.

In addition, many changes for the Pharmacy Program were mandated in the 2002 Legislative Session. Some of the following changes implemented by Division of Medicaid are noted as follows:

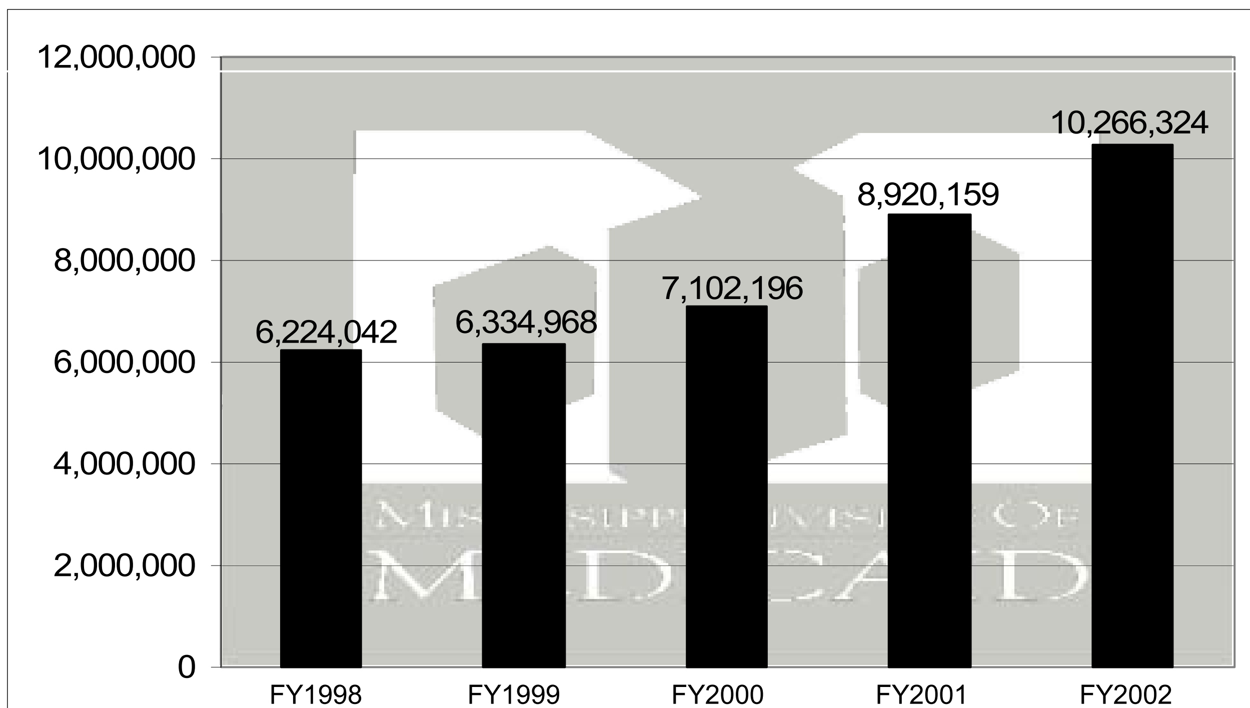
- The dispensing fee was decreased $1.00 from $4.91 to $3.91.
- The reimbursement rate was decreased from AWP-10% to AWP-12%.
- The co-pay was increased from $1.00 to $3.00 for brand name prescriptions.
- The pharmacy benefit per beneficiary was decreased from 10 prescriptions per month to 5 and with prior approval for 2 additional prescriptions: exemptions include beneficiaries less than 21 years of age and LTC residents.
- Mandate that all prescriptions will be filled generically when equally effective generic equivalents exist and are less costly.
- Prior authorizations requirement for certain classes of medications
- The quantity dispensed per prescription became limited to a 34-day supply.

Require all Medicare covered drugs to be billed to Medicare prior to submission to Medicaid for payment.

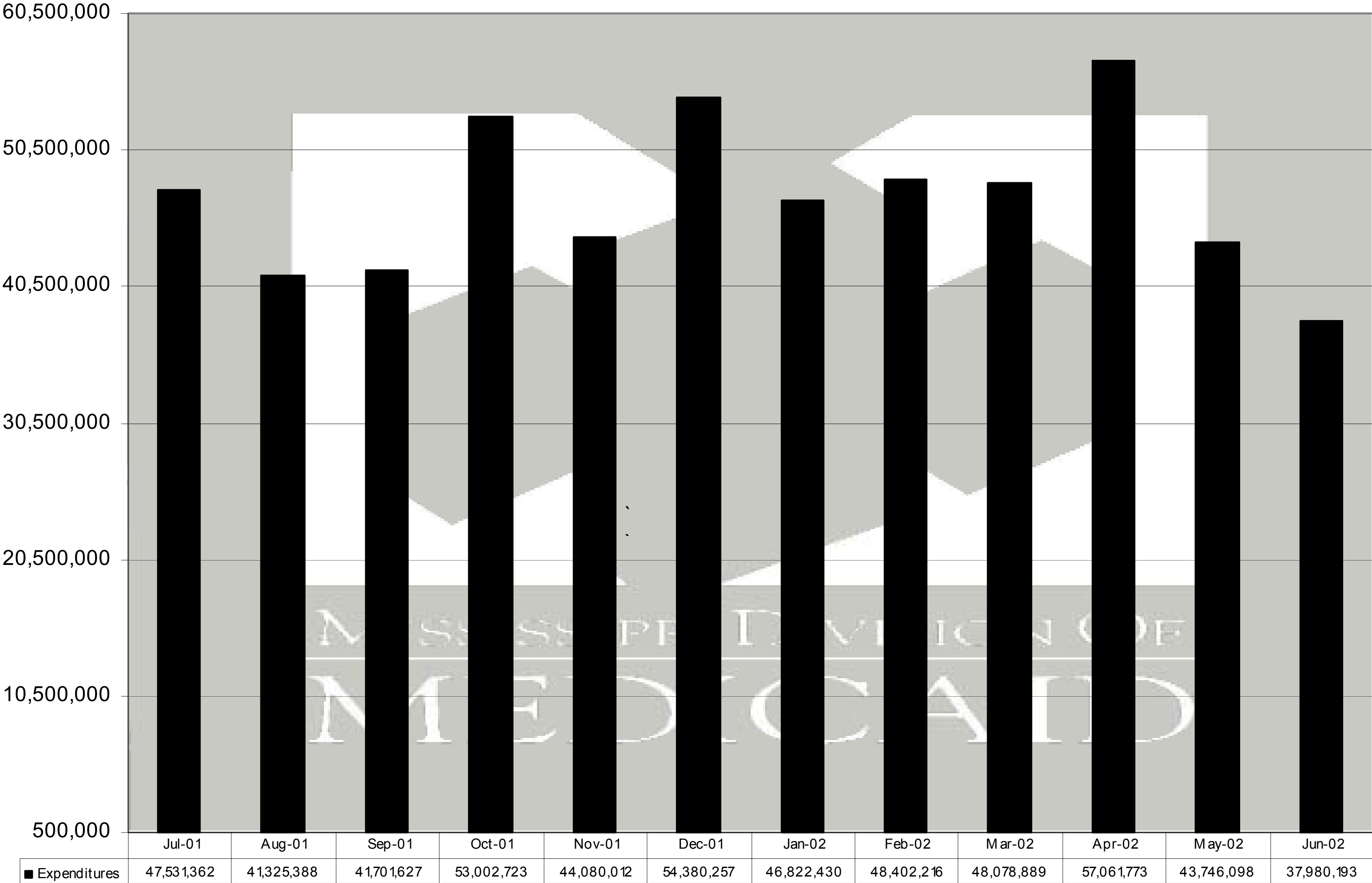
Pharmacy - Total Expenditures



Pharmacy - Total Prescriptions

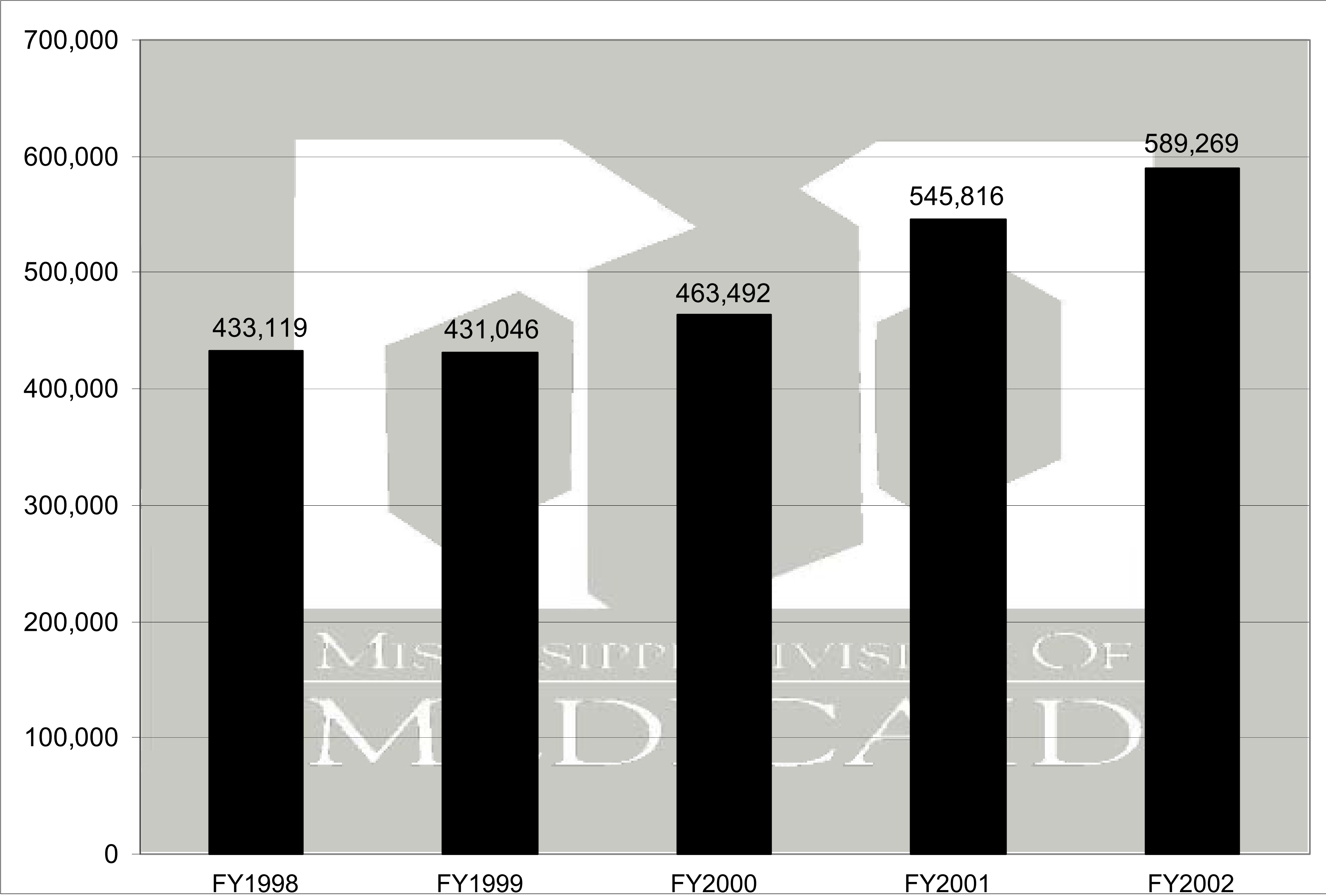


Pharmacy - Expenditures Monthly



	Jul-01	Aug-01	Sep-01	Oct-01	Nov-01	Dec-01	Jan-02	Feb-02	Mar-02	Apr-02	May-02	Jun-02
■ Expenditures	47,531,362	41,325,388	41,701,627	53,002,723	44,080,012	54,380,257	46,822,430	48,402,216	48,078,889	57,061,773	43,746,098	37,980,193

Pharmacy - Total Recipients



Maternal and Child Health

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment preventive health program requires the screening of Medicaid eligible children twenty-one (21) years of age and under for physical, mental and developmental defects and provides for the necessary health care to correct or ameliorate those defects.

Through the EPSDT program abnormal conditions such as hypertension, heart conditions, bronchitis, diabetes, skin disorders, dental, vision, and hearing disorders have been detected and treated. Currently there are 368 provider sites and 611 individual providers of EPSDT services. These include health departments, federally qualified health centers, rural health clinics, private physicians, nurse practitioners and some approved nurse run clinics. The Division of Medicaid is actively recruiting new providers for the EPSDT Program.

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

The Early and Periodic Screening, Diagnosis and Treatment Program was amended in 1989 to require that all medically necessary expanded services identified through periodic screening be provided to Medicaid eligible children. The EPSDT unit processed and approved approximately 798 Prior Authorization (PA's) request per month for Medicaid eligible children 0-21 years of age during FY 2002. This is a 23% increased of PA's approved for FY 2002. These expanded services included office visits, outpatient visits, therapies (speech, occupational and physical) specialized medical treatment, limited enteral feeding and DME supplies.

(Continued)

EPSDT Program Goals:

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

EPSDT Program Goal Accomplishments:

1) FY 2002 Medicaid approved 12 nurses to run EPSDT clinic sites in the school setting as a result of a grant funded by The Bower Foundation to the Mississippi State Department of Health. The expectation is the number of Medicaid eligible school aged children and youth screened will increase due to accessibility of these additional sites located in various sections of the state.
2) FY 2002 the EPSDT Program increased provider participation by one hundred and ten (110) new providers. Of the one hundred (110), ninety-eight (98) were individual and facilities on-site and twelve (12)were off-site providers, which offer an alternate entry to access the system.
3) FY 2002 the Division of Medicaid continues to provide for increased services limits for children twenty-one (21) and under initiated in FY 2001 for the following services: office visits from twelve (12) to twenty-four (24), prescriptions limit from five (5) to ten (10), and outpatient visits from six (6) to twelve (12).
4) As a part of the School Program staff outreach efforts, FY 2002 had a 1% increase in Medicaid approved school providers.

Expanded School-Related Services Program

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

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

During FY 2002 there were 21 school districts participating as Medicaid providers. Four hundred twenty-one (421) students received services, and school districts were reimbursed $ 107,683.72. Medicaid reimburses approximately $ 255.78 per student.

The Centers for Medicare and Medicaid approved two new school-related services programs, Early Intervention/Targeted Case Management and Administrative Claiming. Both will become fully operational in 2003.

Vaccine for Children Program (VFC)

This federally funded immunization program has provided vaccines for Medicaid eligible, under insured, and uninsured children since October 1994. The Mississippi State Department of Health FY 2002 survey showed a completion rate of 88.6 % for Medicaid eligible beneficiaries between 0-27 months. This is a 2.2% increase from the prior year.

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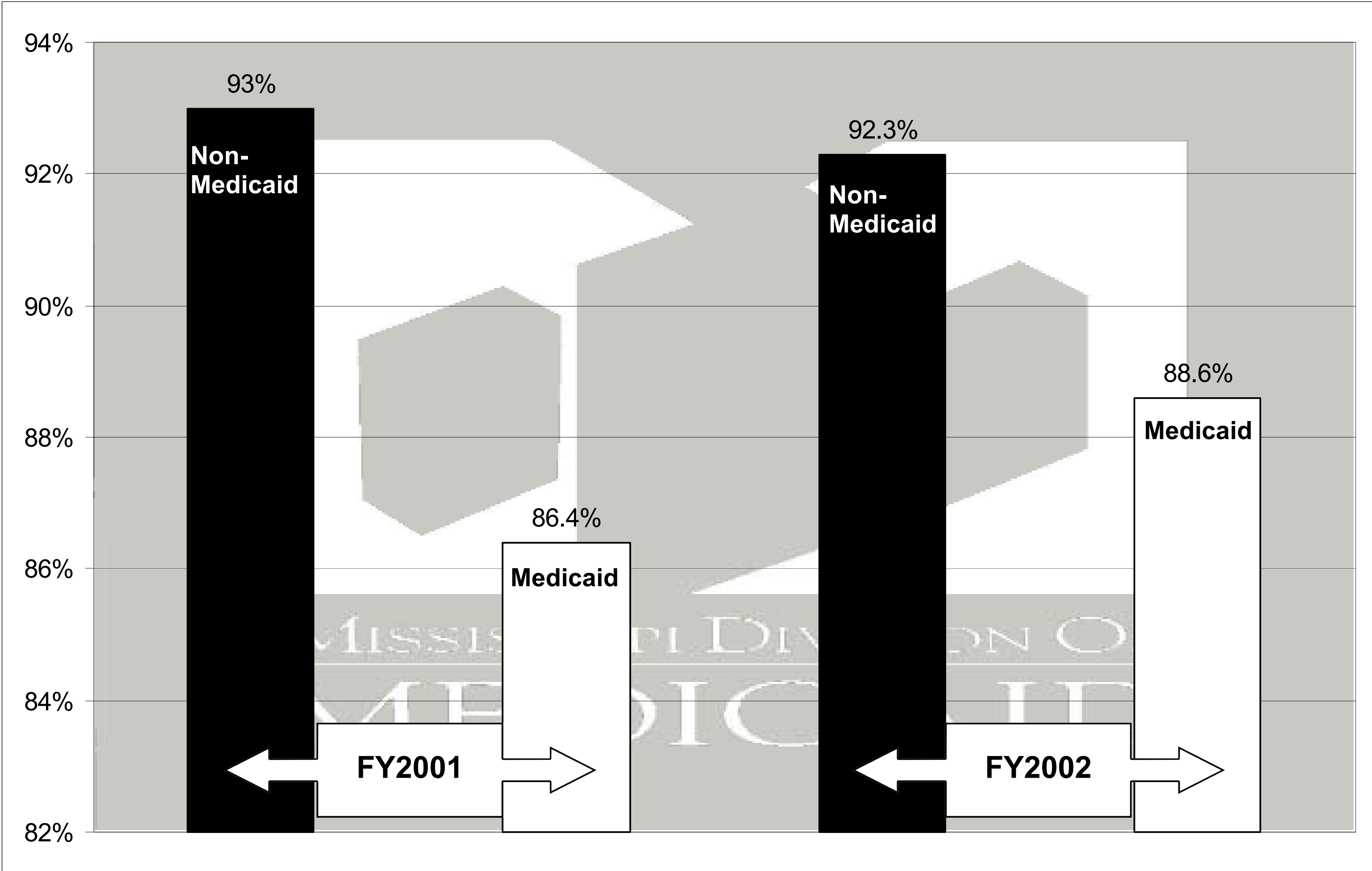
Immunization Rate for Children Up to 27 Months (Medicaid vs. Non-Medicaid)



Disabled Child Living at Home (DCLH)

The Disabled Child Living at Home Program is a program that began in 1989 to make benefits available to children ages 18 and under who live at home and have qualified as disabled. The DCLH program provides necessary services to children who would not otherwise be eligible for Medicaid. This program enables services for the physically handicapped, severely emotionally disturbed as well as many conditions that may otherwise cause a family to become financially devastated. According to current expenditure reports Medicaid spends an average of $ 7,424 per child for services rendered under this program. During FY 2002 MCH processed over 722 DCLH applications for children 18 and under who met the criteria.

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

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

During Fiscal Year 2002, 21,224 Medicaid eligible beneficiaries were enrolled in the PHRM/ISS program. The majority of the enrollees receiving enhanced services (68%) were pregnant/postpartum women (14,335) of the 15,885 pregnant women who were identified as at risk and met the requirements to receive enhanced services; 14,335 (91%) of the 15,585 women received enhanced services even though the program is voluntary. Of the 21,224 eligible beneficiaries 6,889 (32%) of the 21,224 enrollees were infants.

Currently, the Division of Medicaid has eight (8) federally qualified health clinics, one rural health clinic, one Choctaw tribal clinic, one private provider and eighty-four (84) county health departments participating in the PHRM/ISS program. The Division of Medicaid is actively recruiting new providers for the program.

Non-Emergency Transportation

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

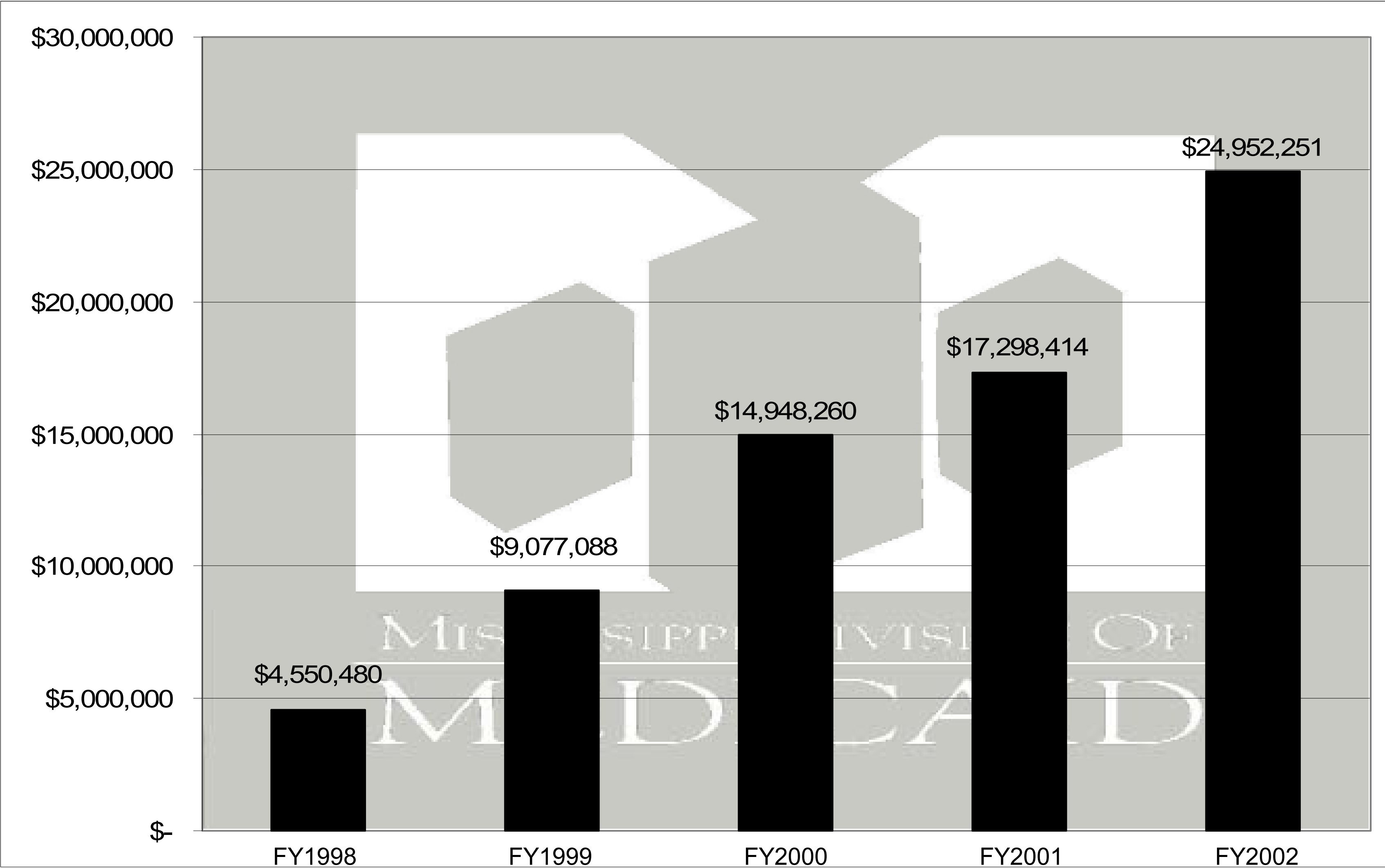
Transportation assistance is made available through agreements between the Division of Medicaid and individual providers or group providers which offer transportation services. The individual and group providers offer demand-response, door-to-door transportation assistance to Medicaid beneficiaries.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

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

The utilization of NET services by Medicaid beneficiaries continues to grow. During FY 2002, over 465,000 transports were provided by individual and group providers.

During FY 2002, two beneficiary satisfaction surveys were conducted. Over 1,500 beneficiaries responded to these surveys and 89% rated the service provided as either excellent or good. The Division of Medicaid will continue to monitor the NET program for opportunities to improve the quality of service available to the beneficiaries while managing the cost of these services. The agency will also work toward ensuring that Medicaid beneficiaries who need NET assistance are informed about its availability.

Non-Emergency Transportation Expenditures



Third Party Recovery (TPR)

Federal and state laws and regulations require that Medicaid program liability be secondary to any third party benefits to which a Medicaid beneficiary is entitled. Third Party is defined as any individual, institution, corporation, or public or private agency that is liable to pay for all or part of the medical cost of injury, disease, or disability for a Medicaid beneficiary.

By law, it is a condition of Medicaid eligibility that beneficiaries furnish required third party information and assign all rights to any third party resources to the Division of Medicaid. Federal law also requires that the third party information be integrated with the Medicaid claims payment system in order to avoid payment of claims when a third party is known to be liable; to recover from the third party source when its existence is learned after the fact; and to pay for those services that the states are mandated by federal law to pay and then seek recovery from the known third party sources.

In accordance with Title XIX of the Social Security Act as well as state law, Medicaid is the payer of last resort which means that Medicaid reimbursement is available only when other third party benefits have been exhausted. Third party sources are any entities, individuals, or programs who are legally responsible for paying the medical expenses of Medicaid beneficiaries.

The Bureau of Third Party Recovery is responsible for identifying any third party sources and for incorporating this information into the Medicaid Management Information System (MMIS) so that when a claim is filed, payment is avoided. This third party information is also directed to the medical provider.

The Bureau of Third Party Recovery operates a successful program which has saved Mississippi taxpayers millions of dollars through cost avoidance and post-payment recovery of private health and casualty insurance resources. Medicaid also pays Medicare premiums for qualified Medicare eligibles, enabling avoided costs of Medicare covered services. Further, as a result of the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), the state enacted legislation requiring the pursuit of medical support in the form of cash or insurance from absent parents. This 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 2002, third party savings in the form of cost avoided or recovered payments from both public and private sources totaled over $709 million. As an example of the effectiveness of the Bureau of Third Party Recovery, almost $20 was recovered for every one dollar invested in salaries of the Medicaid investigators involved in the in-house recoveries.

(Continued)

Medicare Buy-In

Because some Medicaid eligibles are also eligible for Medicare, it is necessary to have some means by which this group may be identified. The MMIS includes edits for Medicare coverage to ensure that claims which are submitted to Medicaid as the primary payer are returned to providers to file with Medicare.

The MMIS also contains segments that allow for the monitoring of payment of Medicare premiums for qualified individuals. In Fiscal Year 2002, 44% of the Mississippi Medicaid population also had Medicare coverage. Claims payment edits and the buy-in program yielded $701 million in Medicaid cost avoidance.

Private Health Insurance Resources

Slightly more than three (3) percent of the state Medicaid population was covered by some form of private health insurance in Fiscal Year 2002. Through cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment), the Medicaid agency saved approximately $31 million. Through post-payment recovery (the Medicaid agency bills the third party for reimbursement), the Bureau of Third Party Recovery collected slightly less than $1 million.

Casualty/Tort Resources

A significant number of Medicaid beneficiaries receive medical care each month as the result of injuries or accident. Medicaid is responsible for identifying those beneficiaries whose medical care for these injuries may be the liability of another party and pursue recovery. These resources are identified through the MMIS edits and referrals from outside entities such as insurance companies, providers, and attorneys. In Fiscal Year 2002, the Bureau of Third Party Recovery collected $3.3 million from casualty/tort resources.

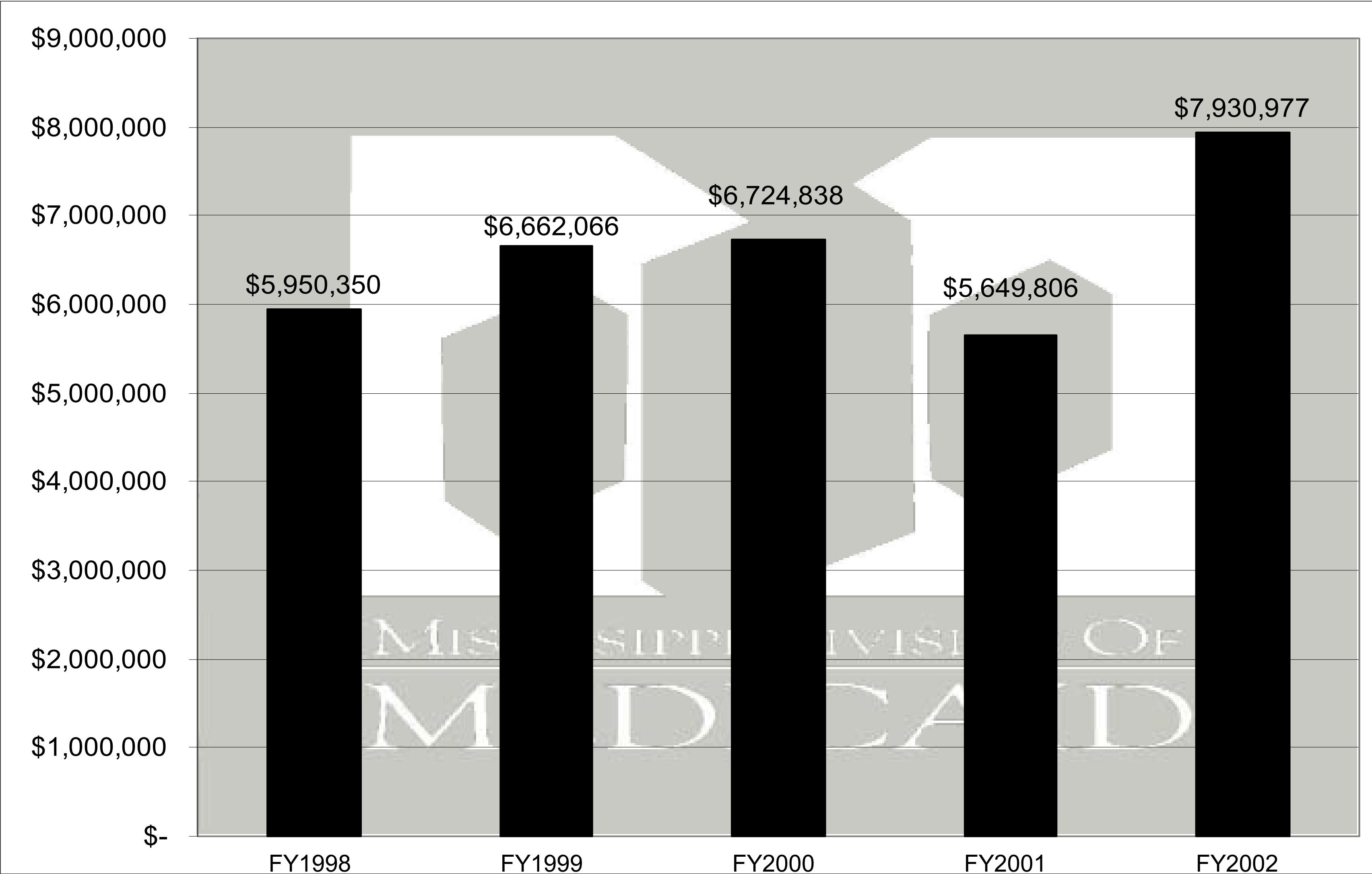
Prescribed Drug Recovery Program

The Division of Medicaid has obtained a federal waiver which allows Medicaid to reimburse pharmacists participating in the program, even if the MMIS contains a record of third party liability. Medicaid then pursues recovery from the third party sources. The Bureau of Third Party Recovery reported a recoupment of $1.7 million in the drug program in Fiscal Year 2002.

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 2002, the Estate Recovery program returned slightly more than $1.5 million.

Third Party Recovery Collections



Funding

Source of Funds and Percentage of Distribution for FY 2001

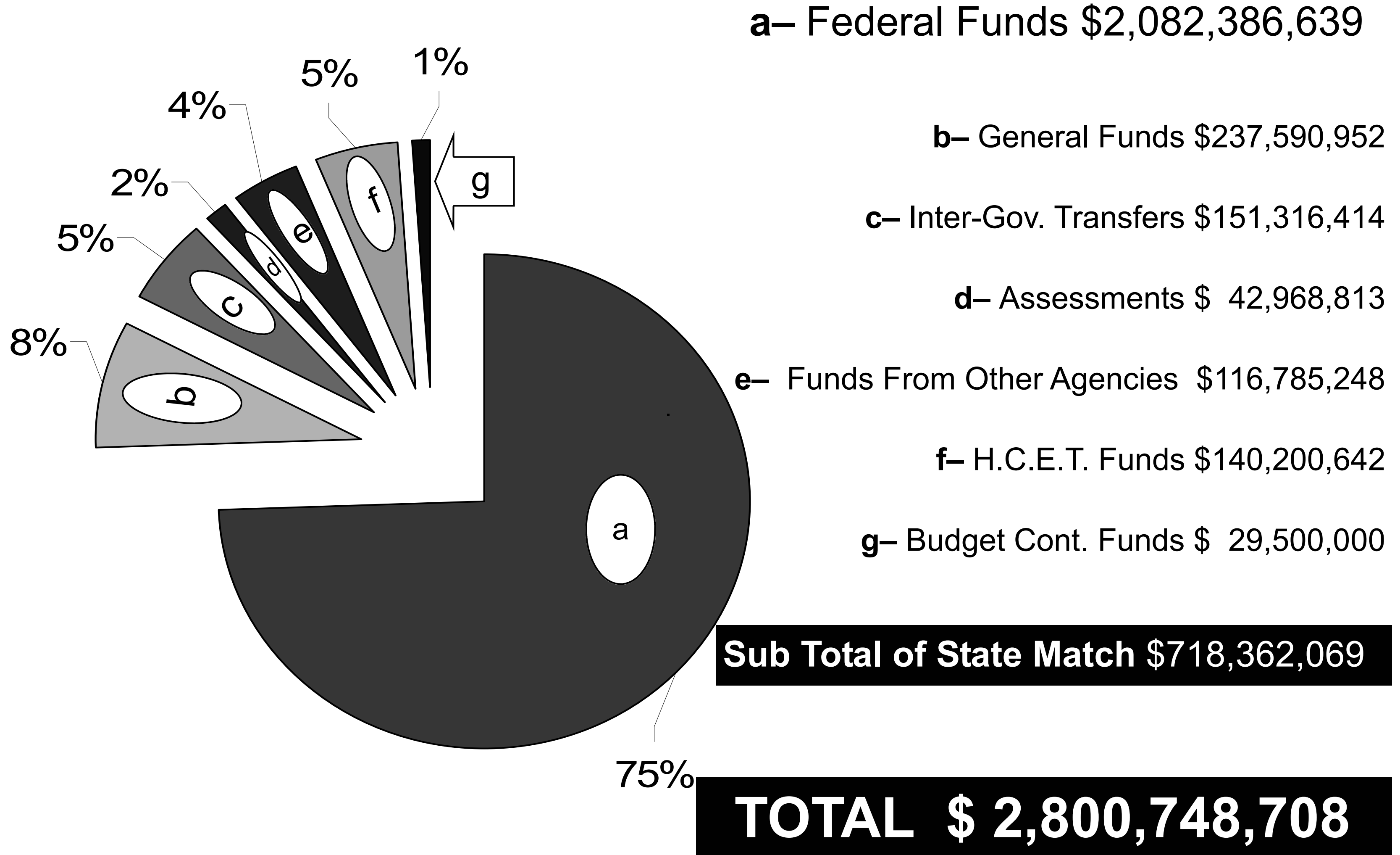
Throughout the nation, Medicaid is funded with federal dollars matched by individual state contributions. In FY 2002, Mississippi's medical service matching rate, which is determined by the state's per capita income, decreased from 76.82% in FY 2001 to 76.09%. With this matching rate, a single state dollar invested brought into the state an additional $3.18 through federal matching funds.

For FY 2002, federal contributions amounted to $2,082,386,639 which, when combined with state dollars, provided for total expenditures of $2,800,748,708. Over 97% of this total was paid to Mississippi providers for medical services to Medicaid beneficiaries and thereby recycled into local economies throughout the state.

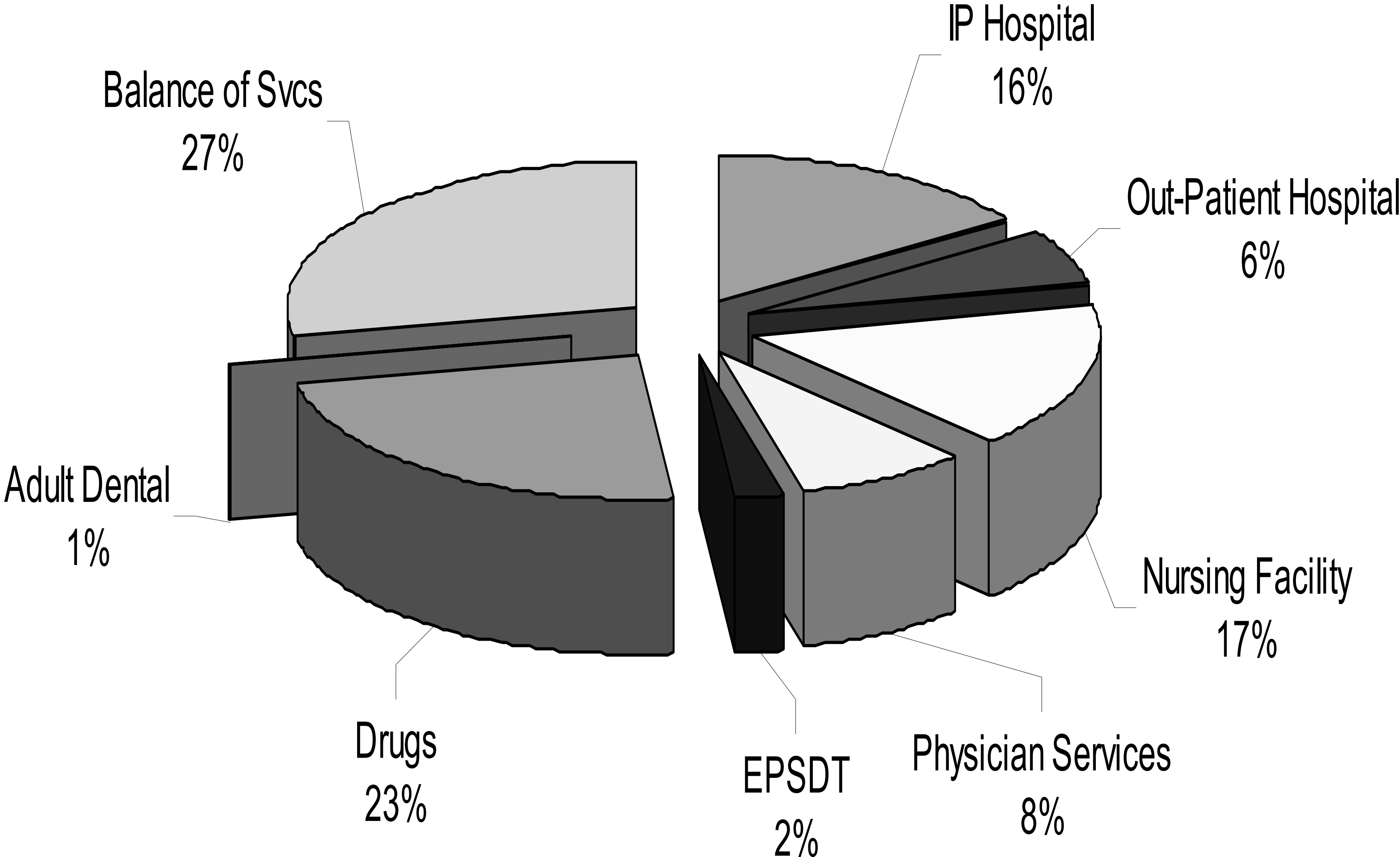
Within the Medicaid program, individual matching rates may vary depending upon the specific funding area. During FY 2002, total administrative expenses were $82,510,752 with federal contributions $48,961,880 or 59.34%. Administrative expenses for FY 2002, which continue to be among the lowest in the nation, amounted to only 2.9% of the total budget.

DOM's staff members attend many hearings pertaining to DOM at the State Capitol during the months our Legislature is in session. Pictured above, Deputy Administrator Sharon Y. Reed, Finance and Administration Office Director Dr. Michael Bailey, and Special Assistant Attorney General Gwen Combs join Executive Director Rica Lewis-Payton in sharing DOM data with key lawmakers last November.

Medicaid FY2002 Funding Sources



Expenditures for Medical Services - FY2002



Eligibility

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

- Persons in medical facilities who would qualify for SSI except for their institutional status.
- Persons in institutions who are eligible under a special income level who remain institutionalized for 30 consecutive days or longer.
- Persons who are age 65 or over or disabled whose income does not exceed 135% of the federal poverty level and whose resources do not exceed $4,000 for an individual and $6,000 for a couple.
- Qualified Medicare Beneficiaries (QMBs) who are entitled to Medicare Part A, whose income is below 100% of the federal poverty level. There is no resource test for this group. (This group is eligible for Medicare cost-sharing only.)
- Certain former SSI eligibles who are "deemed" Medicaid eligible because of specified circumstances.
- Certain qualified working disabled persons who are only eligible for Medicaid to pay their Part A Medicare premiums.
- Certain disabled children under age 18 who live at home but who would be eligible if they lived in a medical institution as certified by DOM.
- Specified Low-Income Medicare Beneficiaries (SLMBs) who are entitled to Medicare Part A whose income does not exceed 120% of the federal poverty level. There is no resource test for this group. The only benefit paid by Medicaid for this group is the Medicare Part B premium. (These individuals must be entitled to Part A Medicare benefits under their own coverage, as Medicaid does not pay the Part A premium for them.)
- Individuals receiving hospice services who would be eligible for Medicaid if they were living in a Medicaid-certified institution.
- Individuals who meet the qualifications for participation in the Home and Community-Based Waiver Programs whose income and resources do not exceed the institutional income limit.

(Continued)

- Working disabled individuals whose earnings do not exceed 250% of the federal poverty level and whose unearned income does not exceed 135% of the federal poverty limit. Disabled workers qualify for full Medicaid benefits but may have to pay a premium to buy-in to Medicaid if countable earnings exceed 150% of the poverty level.

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

- Women who have been diagnosed with breast or cervical cancer through the Center for Disease Control (CDC) Breast & Cervical Cancer Early Detection Program administered by the MS State Department of Health (MSDH). Women under age 65, with no other creditable health insurance coverage, whose income is below 250% of the poverty level and who are diagnosed through the MSDH screening program are eligible for Medicaid during the course of their cancer treatment.

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

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

- Children in licensed foster homes or private child-care institutions for whom public agencies in Mississippi are assuming financial responsibility. Foster children who leave foster care after turning age 18 are continuously covered by Medicaid until reaching age 21 without regard to any change in circumstances.

- Children receiving subsidized adoption payments.

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

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

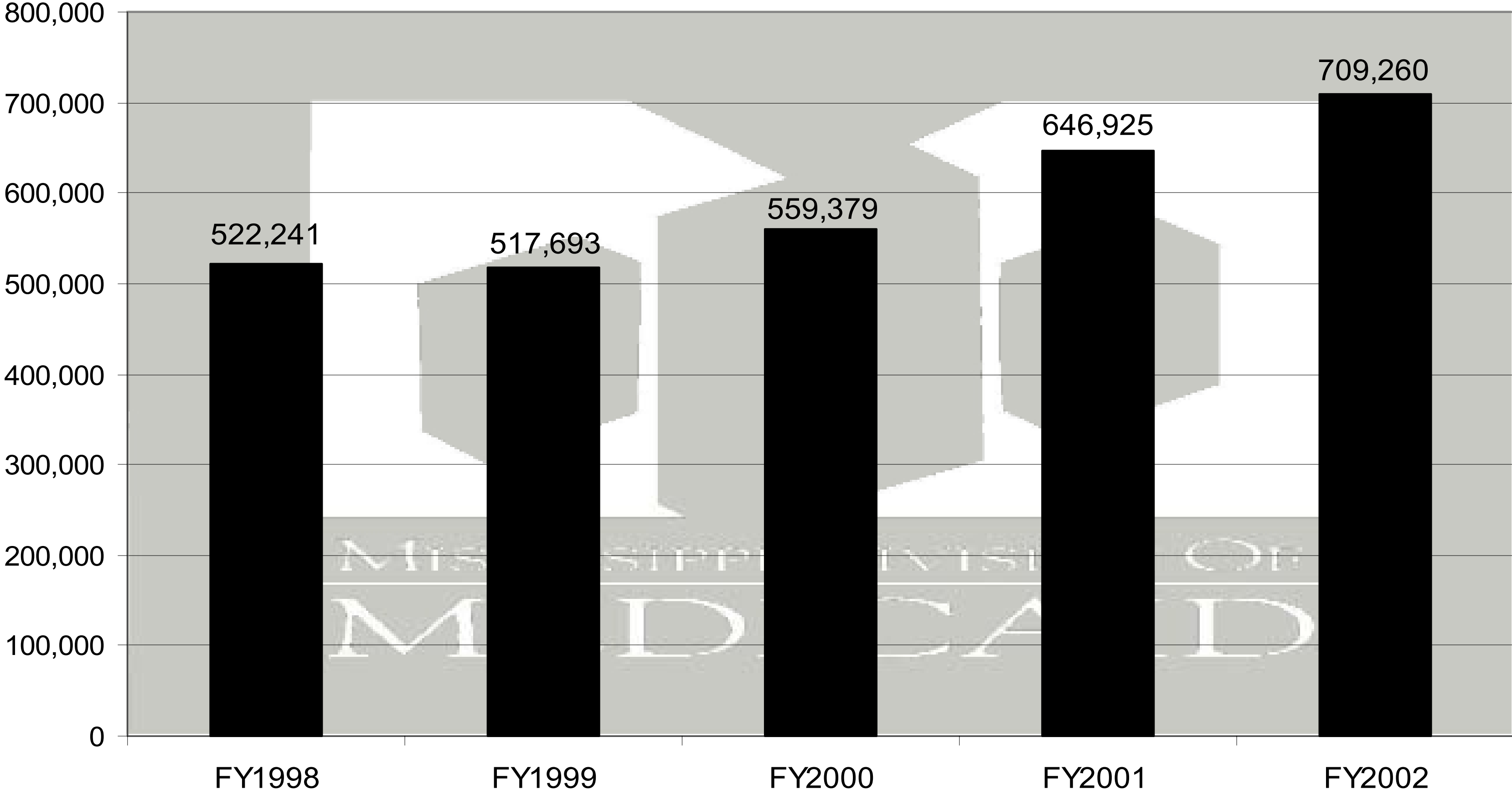
- Children under age 19 whose family income does not exceed 100% of the federal poverty level. Children born prior to 10/01/83 who are under age 19 are eligible under the Children's Health Insurance Program (CHIP) Medicaid expansion.

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

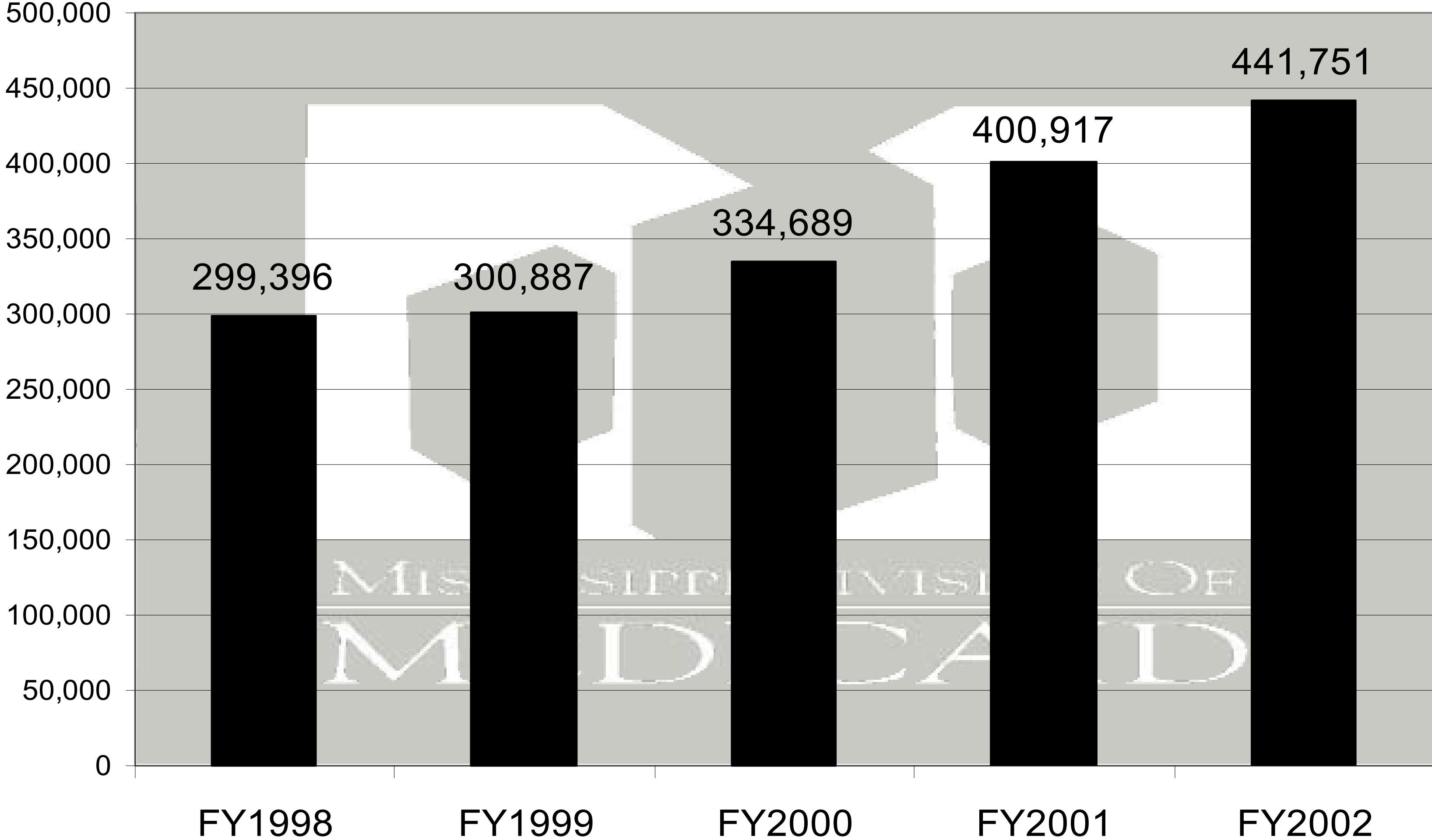
Offices of the Social Security Administration determine eligibility for:

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

Total Medicaid Certified Eligibles



Medicaid Eligibles - Under Age 21



Regional Offices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Vicksburg
2734 Washington Street
Vicksburg, MS 39180-4656
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Mississippi Health Benefits (CHIP)

Mississippi originally implemented its State Children's Health Insurance Program (SCHIP) in July 1998 with a Medicaid expansion program for children born before September 30, 1983 at 100% of the Federal Poverty Level (FPL). This phase ended in October 2002. Mississippi further expanded SCHIP with the implementation of Phase II in January 2000. CHIP Phase II expanded health coverage to children under age 19 years of age in families with income under 200% FPL. This coverage is provided under a separate health insurance plan administered by Blue Cross Blue Shield of Mississippi.

During FY 2002, the Mississippi Health Benefits Program, the State's Children's Health Insurance Program (CHIP), aggressively advanced the accomplishment of its mission: "To ensure that every eligible child in the state of Mississippi has access to quality health care." As noted in the "Mississippi Health Benefit Enrollment by County Tables" (that directly follow this narrative) we have made significant progress in providing healthcare coverage to uninsured children ages 0 through 19. In the spring of 2002, the Division of Medicaid/CHIP staff worked with state agencies, advocates, healthcare providers, businesses, communities, and faith-based groups to establish a Statewide Coalition to enhance outreach, enrollment, retention, and coordination of health programs for the MS Health Benefit Program. With the support of this coalition, DOM submitted a proposal to Robert Wood Johnson for a five-year Covering Kids and Families Grant. If awarded, this grant would not only provide additional funds to enhance outreach and enrollment activities, but also provide additional staff and support the establishment of two local coalitions.

Mississippi Health Benefits Program (CHIP) Program Goals:
To enroll all eligible children in the Mississippi Health Benefits Program.

Objective 1: To increase public awareness of Mississippi Health Benefits Program (MHB).
Progress: In October 2000, the Division of Medicaid increased the CHIP staff to four persons: the CHIP Administrator and three CHIP Coordinators. This staff's primary function is to provide ongoing trainings, presentations and updates to the public upon demand. During FY 2002, the CHIP staff has been able to accommodate 100% of its requests from the public for trainings, presentations, and participation in public events.

Objective 2: To increase community-based MHB program activities focused on increased outreach and enrollment.
Progress: Forty-seven new positions were approved by the 2002 Legislature to establish the Out-stationed Eligibility Program in federally qualified health centers (FQHCs) . With the implementation of this program, applicants will be able to have their applications processed at the point of service at FQHCs from intake to approval. The partnership with the Mississippi State Department of Health to make applications and information readily available at the local level is on-going. A contract with Catholic Charities Children's Health Matters that was established in April 2000 and approved by the Governor was renewed in FY 2002.

(Continued)

This group continues to function as a hub to provide training and dissemination of information on Medicaid and CHIP enrollment; to coordinate efforts focused on removing barriers from the application to access; to provide technical support to local outreach initiatives; to continue to serve as a catalyst for improving linkages between the private and public sector; and to develop statewide networks in the Medicaid/CHIP application-to-access process. As a result of the statewide, door-to-door outreach and enrollment campaign, county DHS Offices showed a significant increase in applications across the state from May – October 2001. The Public Schools and HeadStart Outreach Incentive Program that was initiated in August 2000 by Governor Ronnie Musgrove has been retained during FY 2002. As of June 30,2002 a total of $11,460 has been paid to public schools and $8,740.00 to Head Start programs for an overall total of $20,200.

Objective 3: By June 30, 2002, to increase CHIP II enrollment to 50,000.
Progress: Total CHIP II enrollment as of June 30,2002 equaled 50,634. As of June 30,2002 the total enrollment for Mississippi Health Benefits (Medicaid and CHIP children ages 0-19) equaled 247,411.

Objective 4: To identify and resolve identified barriers to enrollment in MHB.
Progress: The major barriers, i.e., the six month waiting period and child support related activities were retained during FY 02, although self-declaration of income was eliminated in June 2002. MS's State Plan Amendment to implement presumptive eligibility was approved by the Center for Medicare and Medicaid Services (CMS) in July 2001. Due to financial constraints, the State chose not to advance forward with this option in February 2002. The CHIP staff and the Statewide Coalition continue our joint effort to identify and resolve barriers to the application and enrollment process for MBH.

Objective 5: Develop a mechanism for extending time limits on expenditure of CHIP Funds.
Progress: Of the $24,087,312 unspent allocation from FY 1999, $10,098,560 was returned to Mississippi resulting in a $13,988,752 net loss in federal funds.

Objective 6: To ensure that all children enrolled in MHB have access to primary care providers.
Progress: As of April 2002, the HealthMacs, mandated Medicaid managed care was eliminated. Children enrolled in CHIP received their health services through a Blue Cross Blue Shield provider network. Upon enrollment, the beneficiaries are mailed an identification card, benefit and provider books. According to the contract with the insurer, health providers must be within a 15 mile radius in urban/suburban areas and 25 mile radius in rural areas. The Department of Finance and Administration monitors all contractual requirements with the insurer. No areas of noncompliance have been reported.

Members of DOM's Children's Health Insurance staff participate in many community outreach activities. Pictured above (right) DOM's CHIP Coordinator Maria D. Morris explains the program's benefits to a parent as CHIP's Hal Shope (left of Maria) works with a community outreach staffer.

MISSISSIPPI HEALTH BENEFITS ENROLLMENT BY COUNTY

County Code	County	Number of Children Ages 0-18 Population	Mississippi Health Benefits Enrollment *	Percentage Of Children Enrolled
1	ADAMS	9,203	3,488	37.90 %
2	ALCORN	8,259	2,387	28.90 %
3	AMITE	3,536	1,341	37.92 %
4	ATTALA	5,092	2,027	39.81 %
5	BENTON	2,159	781	36.17 %
6	BOLIVAR	12,027	5,847	48.62 %
7	CALHOUN	3,797	1,350	35.55 %
8	CARROLL	2,638	981	37.19 %
9	CHICKASAW	5,560	1,624	29.21 %
10	CHOCTAW	2,713	1,016	37.45 %
11	CLAIBORNE	3,112	1,376	44.22 %
12	CLARKE	4,812	1,464	30.42 %
13	CLAY	6,330	2,148	33.93 %
14	COAHOMA	10,105	4,777	47.27 %
15	COPIAH	7,736	3,148	40.69 %
16	COVINGTON	5,589	2,017	36.09 %
17	DESOTO	30,230	3,928	12.99 %
18	FORREST	17,788	6,074	34.15 %
19	FRANKLIN	2,306	1,014	43.97 %
20	GEORGE	5,590	1,798	32.16 %
21	GREENE	2,793	1,226	43.90 %
22	GRENADA	6,328	2,089	33.01 %
23	HANCOCK	10,785	3,238	30.02 %
24	HARRISON	49,296	12,937	26.24 %
25	HINDS	69,973	22,959	32.81 %
26	HOLMES	6,936	3,954	57.01 %
27	HUMPHREYS	3,664	1,965	53.63 %
28	ISSAQUENA	630	274	43.49 %

(Continued)

MISSISSIPPI HEALTH BENEFITS ENROLLMENT BY COUNTY

County Code	County	Number of Children Ages 0-18 Population	Mississippi Health Benefits Enrollment*	Percentage Of Children Enrolled
29	ITAWAMBA	5510	1,530	27.77 %
30	JACKSON	36,403	8,460	23.24 %
31	JASPER	5,064	1,801	35.56 %
32	JEFFERSON	2,805	1,279	45.60 %
33	JEFF. DAVIS	3,965	1,766	44.54 %
34	JONES	16,759	5,272	31.46 %
35	KEMPER	2,655	935	35.22 %
36	LAFAYETTE	7,555	1,631	21.59 %
37	LAMAR	10,940	2,536	23.18 %
38	LAUDERDALE	20,791	6,301	30.31 %
39	LAWRENCE	3,619	1,266	34.98 %
40	LEAKE	5,633	2,007	35.63 %
41	LEE	20,984	4,794	22.85 %
42	LEFLORE	11,270	5,168	45.86 %
43	LINCOLN	8,855	2,892	32.66 %
44	LOWNDES	17,614	5,123	29.08 %
45	MADISON	21,357	5,005	23.43 %
46	MARION	7,115	2,768	38.90 %
47	MARSHALL	9,308	2,958	31.78 %
48	MONROE	10,340	3,044	29.44 %
49	MONTGOMERY	3,267	1,284	39.30 %
50	NESHOBA	8,087	2,616	32.35 %
51	NEWTON	5,726	1,709	29.85 %
52	NOXUBEE	3,852	1,713	44.47 %
53	OKTIBBEHA	9,009	2,653	29.45 %
54	PANOLA	10,077	3,867	38.37 %
55	PEARL RIVER	13,128	4,271	32.53 %
56	PERRY	3,483	1,284	36.86 %
57	PIKE	10,786	4,449	41.25 %
58	PONTOTOC	7,376	1,531	20.76 %

(Continued)

MISSISSIPPI HEALTH BENEFITS ENROLLMENT BY COUNTY

County Code	County	Number of Children Ages 0-18 Population	Mississippi Health Benefits Enrollment*	Percentage Of Children Enrolled
59	PRENTISS	6,389	1,686	26.39 %
60	QUITMAN	3,238	1,486	45.89 %
61	RANKIN	29,870	5,779	19.35 %
62	SCOTT	8,129	2,791	34.33 %
63	SHARKEY	2,171	1,070	49.29 %
64	SIMPSON	7,711	2,735	35.47 %
65	SMITH	4,450	1,380	31.01 %
66	STONE	3,651	1,284	35.17 %
67	SUNFLOWER	9,589	4,609	48.07 %
68	TALLAHATCHIE	4,471	2,125	47.53 %
69	TATE	6,875	1,730	25.16 %
70	TIPPAH	5,207	1,569	30.13 %
71	TISHOMINGO	4,446	1,242	27.94 %
72	TUNICA	2,907	1,278	43.96 %
73	UNION	6,569	1,450	22.07 %
74	WALTHALL	4,304	1,837	42.68 %
75	WARREN	14,149	3,994	28.23 %
76	WASHINGTON	19,838	8,566	43.18 %
77	WAYNE	6,795	2,173	31.98 %
78	WEBSTER	2,687	1,044	38.85 %
79	WILKINSON	2,661	1,335	50.17 %
80	WINSTON	5,403	2,188	40.50 %
81	YALOBUSHA	3,341	1,166	34.90 %
82	YAZOO	8,023	3,753	46.78 %

Mississippi Health Benefits Enrollment*
These county totals include CHIP and Medicaid recipients.

CHIP II Enrollment Monthly

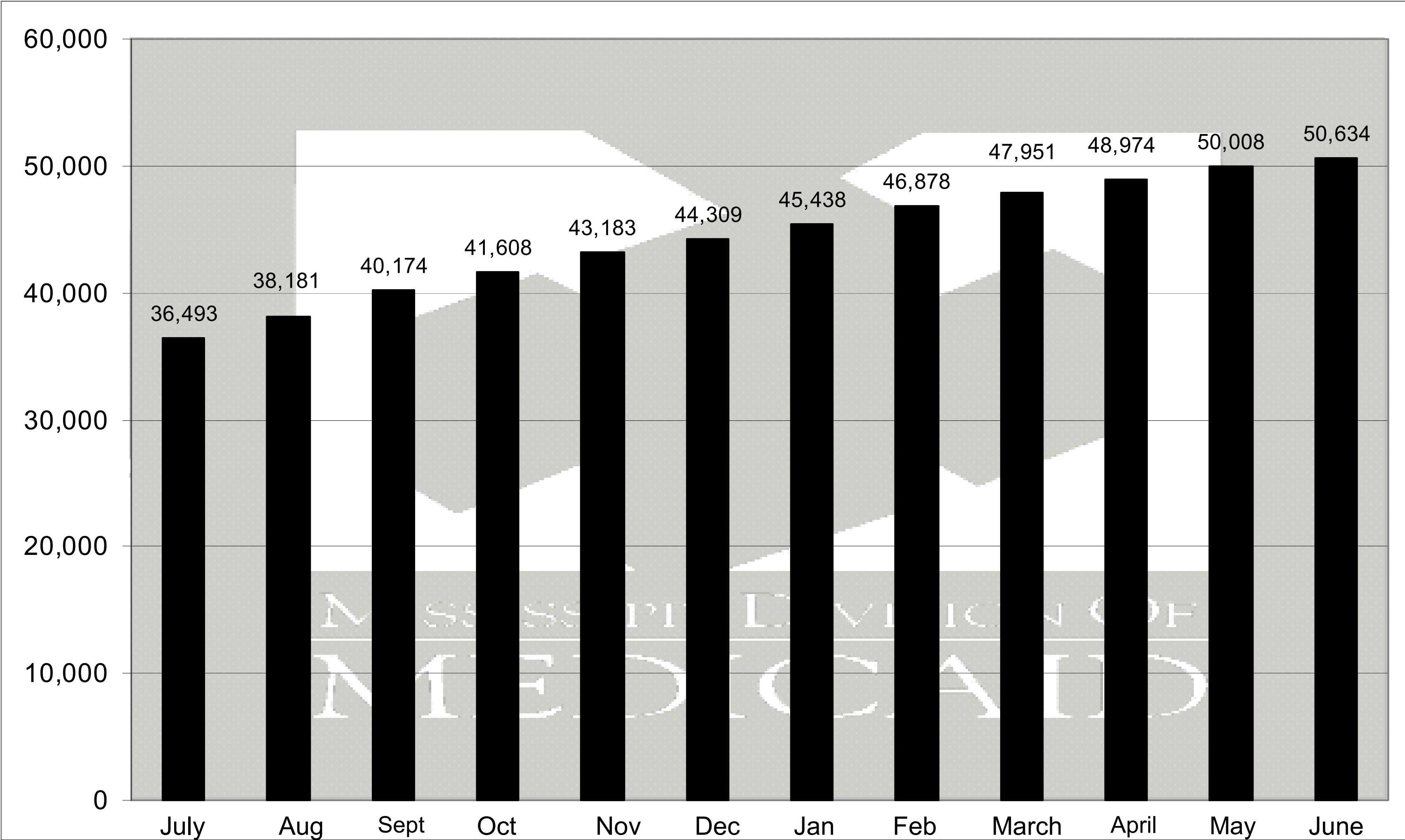

TABLE 1

Certified Eligibles by Eligibility Category for Fiscal Year 2002

Program Category	Total Number of Eligible Persons	Percent of Total *
Total	709,260	99.81%
Money Payment Eligibles		
Aged	22,356	3.15%
Blind	1,361	0.19%
Disabled	121,929	17.19%
Low Income Families	32,532	4.59%
IV-E Foster Care	1,619	0.23%
CWS Foster Care	1,386	0.20%
Medicaid Only		
Aged	12,258	1.73%
Blind	7	0.00%
Disabled	2,764	0.39%
Disabled Children at home	831	0.12%
Working Disabled	299	0.04%
Low Income Families	126,512	17.84%
Breast/Cervical Cancer	27	0.00%
Poverty Level Pregnant Women & Children		
At 100% Federal Poverty Level	191,338	26.98%
At 133% Federal Poverty Level	38,611	5.44%
At 185% Federal Poverty Level	63,276	8.92%
Qualified Medicare Beneficiary		
Aged	221	0.03%
Blind	20	0.00%
Disabled	110	0.02%
Qualified Individuals		
Aged	1,798	0.25%
Blind	2	0.00%
Disabled	974	0.14%
Poverty Level		
Aged	33,084	4.66%
Disabled	27,642	3.90%
Hospice		
Aged	227	0.03%
Blind	0	0.00%
Disabled	104	0.01%
Other Medical Assitance Only		
Automatic Infants	24,689	3.48%
Specified Low Income Medicare Beneficiaries		
Aged	1,505	0.21%
Blind	17	0.00%
Disabled	417	0.06%
Home and Community Based Services Waivers		
Assisted Living - Aged	4	0.00%
Assisted Living - Blind	0	0.00%
Assisted Living - Disabled	0	0.00%
Elderly	801	0.11%
Disabled	347	0.05%
Independent Living	192	0.03%

Money Payment Eligibles

* Percentage column may not total 100% due to rounding

TABLE 2

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

County	County Population	Number of Medicaid Eligibles	Percent of Population	County	County Population	Number of Medicaid Eligibles	Percent of Population
Adams	33,900	10,485	30.93%	Leflore	37,316	14,672	39.32%
Alcorn	34,612	8,668	25.04%	Lincoln	33,596	8,342	24.83%
Amite	13,509	3,628	26.86%	Lowndes	60,933	14,685	24.10%
Attala	19,655	5,784	29.43%	Madison	76,708	13,316	17.36%
Benton	7,950	2,634	33.13%	Marion	25,344	7,954	31.38%
Bolivar	40,155	15,718	39.14%	Marshall	35,329	9,276	26.26%
Calhoun	14,901	4,267	28.64%	Monroe	38,064	8,807	23.14%
Carroll	10,741	2,606	24.26%	Montgomery	12,056	3,745	31.06%
Chickasaw	19,400	5,182	26.71%	Neshoba	28,516	7,579	26.58%
Choctaw	9,663	2,696	27.90%	Newton	22,054	5,330	24.17%
Claiborne	11,823	3,933	33.27%	Noxubee	12,520	5,096	40.70%
Clarke	17,877	4,189	23.43%	Oktibbeha	42,286	8,117	19.20%
Clay	21,832	6,422	29.42%	Panola	34,697	11,310	32.60%
Coahoma	30,108	13,277	44.10%	Pearl River	49,969	11,352	22.72%
Copiah	28,886	8,411	29.12%	Perry	12,273	3,380	27.54%
Covington	19,527	5,381	27.56%	Pike	38,956	12,969	33.29%
DeSoto	114,352	11,159	9.76%	Pontotoc	27,053	4,929	18.22%
Forrest	72,890	18,114	24.85%	Prentiss	25,480	5,613	22.03%
Franklin	8,377	2,503	29.88%	Quitman	10,065	4,319	42.91%
George	19,582	4,636	23.67%	Rankin	119,141	16,573	13.91%
Greene	13,376	2,892	21.62%	Scott	28,317	8,080	28.53%
Grenada	22,938	6,129	26.72%	Sharkey	6,418	2,897	45.14%
Hancock	44,031	8,153	18.52%	Simpson	27,568	7,286	26.43%
Harrison	189,409	36,913	19.49%	Smith	16,168	3,801	23.51%
Hinds	249,495	62,293	24.97%	Stone	13,960	3,518	25.20%
Holmes	21,476	10,787	50.23%	Sunflower	33,930	12,113	35.70%
Humphreys	10,929	4,953	45.32%	Tallahatchie	14,640	5,439	37.15%
Issaquena	2,225	634	28.49%	Tate	25,617	5,239	20.45%
Itawamba	23,018	4,266	18.53%	Tippah	20,928	5,741	27.43%
Jackson	132,823	23,005	17.32%	Tishomingo	19,060	4,192	21.99%
Jasper	18,333	5,260	28.69%	Tunica	9,365	3,597	38.41%
Jefferson	9,695	3,574	36.86%	Union	25,782	4,986	19.34%
Jefferson Davis	13,855	4,623	33.37%	Walthall	15,380	4,929	32.05%
Jones	64,536	16,618	25.75%	Warren	49,343	12,416	25.16%
Kemper	10,464	2,844	27.18%	Washington	61,827	25,067	40.54%
Lafayette	38,834	5,262	13.55%	Wayne	21,193	6,040	28.50%
Lamar	40,482	6,951	17.17%	Webster	10,320	2,869	27.80%
Lauderdale	77,414	19,545	25.25%	Wilkinson	10,334	3,628	35.11%
Lawrence	13,379	3,424	25.59%	Winston	20,129	5,599	27.82%
Leake	21,145	5,791	27.39%	Yalobusha	13,308	3,890	29.23%
Lee	76,680	15,488	20.20%	Yazoo	27,809	9,900	35.60%

Source: Medicaid Eligibles RSO-10-4-A

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

TABLE 3

Recipients of Services by Program Category for Fiscal Year 2002

Program Category	Total Number of Recipients	Percent of Total *
Total	650,452	100.00%
Money Payment Eligibles		
Aged	23,501	3.61%
Blind	1,297	0.20%
Disabled	119,338	18.35%
Low Income Families	10,328	1.59%
IV-E Foster Care	1,561	0.24%
CWS Foster Care	1,200	0.18%
Medicaid Only		
Aged	13,832	2.13%
Blind	8	0.00%
Disabled	3,003	0.46%
Disabled Children at home	832	0.13%
Working Disabled	246	0.04%
Low Income Families	717	0.11%
Breast/Cervical Cancer	24	0.00%
Poverty Level Pregnant Women & Children		
At 100% Federal Poverty Level	286,442	44.04%
At 133% Federal Poverty Level	35,481	5.45%
At 185% Federal Poverty Level	65,009	9.99%
Qualified Medicare Beneficiary		
Aged	279	0.04%
Blind	20	0.00%
Disabled	125	0.02%
Qualified Individuals		
Aged	0	0.00%
Blind	0	0.00%
Disabled	0	0.00%
Poverty Level		
Aged	34,068	5.24%
Disabled	28,667	4.41%
Hospice		
Aged	443	0.07%
Blind	0	0.00%
Disabled	174	0.03%
Other Medical Assitance Only		
Automatic Infants	22,918	3.52%
Specified Low Income Medicare Beneficiaries		
Aged	0	0.00%
Blind	0	0.00%
Disabled	0	0.00%
Home and Community Based Services Waivers		
Assisted Living - Aged	4	0.00%
Assisted Living - Blind	0	0.00%
Assisted Living - Disabled	3	0.00%
Elderly	497	0.08%
Disabled	242	0.04%
Independent Living	193	0.03%

Source: MAM260-A)

*Percentage column may not total 100% due to rounding

TABLE 4

Recipients of Medical Services by Type of Service for Fiscal Years 2001 and 2002

Type of Service	Recipients FY 2001	Recipients FY 2002	% of Incr. Or Decr.
Total	587,341	650,452	10.75%
Inpatient Hospital	70,266	71,910	2.34%
Outpatient Hospital	277,407	349,671	26.05%
Laboratory/X-Ray	109,155	106,892	-2.07%
Nursing Facility	19,582	19,636	0.28%
Physician	403,977	474,961	17.57%
EPSDT	129,411	112,660	-12.94%
EPSDT Dental	104,523	124,621	19.23%
EPSDT Vision	60,051	71,818	19.60%
EPSDT Hearing	4,281	5,663	32.28%
Rural Health Clinic	104,194	115,282	10.64%
Federally Qualified Health Centers	63,602	76,151	19.73%
Home Health	7,812	9,283	18.83%
Transportation	39,405	49,594	25.86%
Prescribed Drugs	521,735	589,269	12.94%
Dental	30,567	35,731	16.89%
Eyeglasses	46,063	51,955	12.79%
Intermediate Care Facility - Mentally Retarded	2,973	2,957	-0.54%
Per Capita Managed Care	676	0	-100.00%
Buy-in, Parts A & B, Medicare	289,388	319,989	10.57%
Mental Health Clinic	42,058	48,111	14.39%
Home & Community Based Waiver	9,944	13,800	38.78%
Durable Medical Equipment	22,072	27,054	22.57%
Therapy	2,983	3,911	31.11%
Inpatient Residential Psychiatric	686	656	-4.37%
Inpatient Psychiatric Hospital	2,121	1,625	-23.39%
Nurse Practitioner	84,018	109,556	30.40%
Ambulatory Surgical Center	4,099	5,635	37.47%
Personal Care	0	0	0.00%
Hospice	1,099	1,328	20.84%
Outpatient Psychiatric Hospital	1	0	-100.00%
Private Mental Health Centers	961	1,573	63.68%
Family Planning Drugs	24,081	29,315	21.73%
Dialysis	593	651	9.78%

Source: MAM260-A0

TABLE 5

Claims by Type of Service for Fiscal Years 2001 and 2002

Type of Service	Claims FY 2001	Claims FY 2002	% of Incr. Or Decr.
Total	32,117,417	35,160,882	9.48%
Inpatient Hospital	454,735	253,524	-44.25%
Outpatient Hospital	2,169,133	1,917,810	-11.59%
Laboratory/X-Ray	1,088,302	859,488	-21.02%
Nursing Facility	477,812	238,166	-50.15%
Physician	5,027,115	5,590,294	11.20%
EPSDT	776,845	517,578	-33.37%
EPSDT Dental	796,621	1,025,986	28.79%
EPSDT Vision	432,031	569,171	31.74%
EPSDT Hearing	11,823	16,378	38.53%
Rural Health Clinic	863,595	904,909	4.78%
Federally Qualified Health Centers	568,842	681,404	19.79%
Home Health	90,359	81,292	-10.03%
Transportation	319,512	386,265	20.89%
Prescribed Drugs	10,456,747	11,925,651	14.05%
Dental	192,780	248,219	28.76%
Eyeglasses	345,189	376,041	8.94%
Intermediate Care Facility - Mentally Retarded	129,491	49,755	-61.58%
Per Capita Managed Care	1,634	0	0.00%
Buy-in, Parts A & B, Medicare	5,744,866	6,795,387	18.29%
Mental Health Clinic	1,100,781	1,304,887	18.54%
Home & Community Based Waiver	261,429	364,059	39.26%
Durable Medical Equipment	167,469	206,966	23.58%
Therapy	103,436	156,632	51.43%
Inpatient Residential Psychiatric	9,716	6,968	-28.28%
Inpatient Psychiatric Hospital	6,804	3,990	-41.36%
Nurse Practitioner	404,483	520,285	28.63%
Ambulatory Surgical Center	11,262	16,854	49.65%
Personal Care	0	0	0.00%
Hospice	9,016	13,202	46.43%
Outpatient Psychiatric Hospital	6	11	83.33%
Private Mental Health Centers	17,868	33,230	85.97%
Family Planning Drugs	68,280	86,569	26.79%
Dialysis	9,435	9,911	5.05%

Source: MRO-08

TABLE 6

Total Expenditures for Medical Services, Total Number of Recipients, Average Expenditure per Recipient and Percentage by Program Category for Fiscal Year 2002

Program Category	Amount of Expenditures	Percent of Total	Recipients	Percent of Total	Average per Recipient
Total	$2,445,523,630	100.00%	650,452	100.00%	$3,760
Money Payment Eligibles					
Aged	105,196,436	4.30%	23,501	3.61%	4,476
Blind	8,463,864	0.35%	1,297	0.20%	6,526
Disabled	804,703,827	32.91%	119,338	18.35%	6,743
Low Income Families	11,267,283	0.46%	10,328	1.59%	1,091
IV-E Foster Care	5,939,153	0.24%	1,561	0.24%	3,805
CWS Foster Care	7,375,262	0.30%	1,200	0.18%	6,146
Medicaid Only					
Aged	386,699,620	15.81%	13,832	3.00%	27,957
Blind	161,954	0.01%	8	0.00%	20,244
Disabled	133,874,565	5.47%	3,003	0.65%	44,580
Disabled Children at home	7,080,179	0.29%	832	0.18%	8,510
Working Disabled	1,442,995	0.06%	246	0.05%	5,866
Low Income Families	174,042,702	7.12%	717	0.16%	242,737
Breast/Cervical Cancer	230,604	0.01%	24		9,609
Poverty Level Pregnant Women & Children		0.00%		0.00%	#DIV/0!
At 100% Federal Poverty Level	202,358,257	8.27%	286,442	62.07%	706
At 133% Federal Poverty Level	39,765,315	1.63%	35,481	7.69%	1,121
At 185% Federal Poverty Level	191,793,256	7.84%	65,009	14.09%	2,950
Qualified Medicare Beneficiary					
Aged	178,466	0.01%	279	0.06%	640
Blind	8,709	0.00%	20	0.00%	435
Disabled	77,138	0.00%	125	0.02%	617
Qualified Individuals					
Aged	0	0.00%	0	0.00%	0
Blind	0	0.00%	0	0.00%	0
Disabled	0	0.00%	0	0.00%	0
Poverty Level					
Aged	114,731,409	4.69%	34,068	5.24%	3,368
Disabled	163,618,524	6.69%	28,667	4.41%	5,708
Hospice					
Aged	4,481,994	0.18%	443	0.07%	10,117
Blind	0	0.00%	0	0.00%	0
Disabled	1,623,836	0.07%	174	0.03%	9,332
Other Medical Assitance Only					
Automatic Infants	58,748,638	2.40%	22,918	3.52%	2,563
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
Home and Community Based Services Waivers					
Assisted Living - Aged	82,263	0.00%	4	0.00%	20,566
Assisted Living - Blind	0	0.00%	0	0.00%	#DIV/0!
Assisted Living - Disabled	58,014	0.00%	3	0.00%	19,338
Elderly	11,555,162	0.47%	497	0.08%	23,250
Disabled	6,746,471	0.28%	242	0.04%	27,878
Independent Living	3,217,734	0.13%	193	0.03%	16,672

Source: RS-O-10-2

* Percentage column may not total 100% due to rounding

TABLE 7

Expenditures for Medical Services by Type of Service for Fiscal Years 2001 and 2002

Type of Service	Expenditures FY 2001	Expenditures FY 2002	% of Incr. Or Decr.
Total	$2,089,495,383	$2,445,523,630	17.04%
Inpatient Hospital	$353,715,319	$383,241,958	8.35%
Outpatient Hospital	106,749,858	146,253,170	37.01%
Laboratory/X-Ray	8,993,901	9,453,592	5.11%
Nursing Facility	379,215,684	404,063,741	6.55%
Physician	166,098,569	197,371,563	18.83%
EPSDT	8,289,706	8,040,045	-3.01%
EPSDT Dental	26,675,648	32,138,729	20.48%
EPSDT Vision	10,081,802	12,894,708	27.90%
EPSDT Hearing	409,997	450,431	9.86%
Rural Health Clinic	20,442,020	22,679,745	10.95%
Federally Qualified Health Centers	18,834,874	23,057,191	22.42%
Home Health	10,915,766	13,005,819	19.15%
Transportation	23,523,726	32,826,287	39.55%
Prescribed Drugs	463,063,558	564,879,618	21.99%
Dental	5,792,369	6,620,412	14.30%
Eyeglasses	7,366,637	8,156,699	10.72%
Intermediate Care Facility - Mentally Retarded	164,441,513	177,293,850	7.82%
Per Capita Managed Care	-1,916,847	0	-100.00%
Buy-in, Parts A & B, Medicare	136,319,130	156,455,553	14.77%
Mental Health Clinic	69,800,366	85,154,312	22.00%
Home & Community Based Waiver	40,650,741	69,080,680	69.94%
Durable Medical Equipment	12,534,680	13,958,001	11.36%
Therapy	2,061,666	3,452,957	67.48%
Inpatient Residential Psychiatric	16,962,030	24,105,102	42.11%
Inpatient Psychiatric Hospital	7,453,010	12,066,653	61.90%
Nurse Practitioner	10,913,160	14,932,548	36.83%
Ambulatory Surgical Center	1,817,468	2,568,745	41.34%
Personal Care	0	0	0.00%
Hospice	7,149,750	9,549,776	33.57%
Outpatient Psychiatric Hospital	7	-97	-1485.71%
Private Mental Health Centers	390,500	837,465	114.46%
Family Planning Drugs	2,254,494	2,859,946	26.86%
Dialysis	8,494,281	8,074,431	-4.94%

Source: MAM250-R1

TABLE 8

Expenditures for Medical Services by Type of Service, Number of Recipients by Service, and Average Spent for Fiscal Year 2002

Type of Service	Expenditures FY 2002	Recipients FY 2002	Avg. per Recipient
Total	$2,445,523,630	650,452	$3,760
Inpatient Hospital	$383,241,958	71,910	5,329
Outpatient Hospital	146,253,170	349,671	418
Laboratory/X-Ray	9,453,592	106,892	88
Nursing Facility	404,063,741	19,636	20,578
Physician	197,371,563	474,961	416
EPSDT	8,040,045	112,660	71
EPSDT Dental	32,138,729	124,621	258
EPSDT Vision	12,894,708	71,818	180
EPSDT Hearing	450,431	5,663	80
Rural Health Clinic	22,679,745	115,282	197
Federally Qualified Health Centers	23,057,191	76,151	303
Home Health	13,005,819	9,283	1,401
Transportation	32,826,287	49,594	662
Prescribed Drugs	564,879,618	589,269	959
Dental	6,620,412	35,731	185
Eyeglasses	8,156,699	51,955	157
Intermediate Care Facility - Mentally Retarded	177,293,850	2,957	59,957
Per Capita Managed Care	0	0	0
Buy-in, Parts A & B, Medicare	156,455,553	319,989	489
Mental Health Clinic	85,154,312	48,111	1,770
Home & Community Based Waiver	69,080,680	13,800	5,006
Durable Medical Equipment	13,958,001	27,054	516
Therapy	3,452,957	3,911	883
Inpatient Residential Psychiatric	24,105,102	656	36,746
Inpatient Psychiatric Hospital	12,066,653	1,625	7,426
Nurse Practitioner	14,932,548	109,556	136
Ambulatory Surgical Center	2,568,745	5,635	456
Personal Care	0	0	0
Hospice	9,549,776	1,328	7,191
Outpatient Psychiatric Hospital	-97	0	0
Private Mental Health Centers	837,465	1,573	532
Family Planning Drugs	2,859,946	29,315	98
Dialysis	8,074,431	651	12,403

Source: MAM250-R1

TABLE 8-A

Expenditures for Medical Services by Type of Service, Average cost per Recipient for Fiscal Years 2001 and 2002

Type of Service	FY 2001	FY 2002	% of Incr. Or Decr.
Total	$3,558	$3,760	5.69%
Inpatient Hospital	5,034	5,329	5.86%
Outpatient Hospital	385	418	8.62%
Laboratory/X-Ray	82	88	6.80%
Nursing Facility	19,366	20,578	6.26%
Physician	411	416	1.18%
EPSDT	64	71	10.84%
EPSDT Dental	255	258	1.09%
EPSDT Vision	168	180	7.21%
EPSDT Hearing	96	80	-16.47%
Rural Health Clinic	196	197	0.41%
Federally Qualified Health Centers	296	303	2.32%
Home Health	1,397	1,401	0.26%
Transportation	597	662	10.89%
Prescribed Drugs	888	959	8.05%
Dental	189	185	-2.37%
Eyeglasses	160	157	-1.83%
Intermediate Care Facility - Mentally Retarded	55,312	59,957	8.40%
Per Capita Managed Care	-2,836	0	-100.00%
Buy-in, Parts A & B, Medicare	471	489	3.81%
Mental Health Clinic	1,660	1,770	6.65%
Home & Community Based Waiver	4,088	5,006	22.46%
Durable Medical Equipment	568	516	-9.14%
Therapy	691	883	27.76%
Inpatient Residential Psychiatric	24,726	36,746	48.61%
Inpatient Psychiatric Hospital	6,637	7,426	11.89%
Nurse Practitioner	130	136	4.70%
Ambulatory Surgical Center	443	456	2.84%
Personal Care	0	0	0.00%
Hospice	6,506	7,191	10.53%
Outpatient Psychiatric Hospital	7	0	-100.00%
Private Mental Health Centers	406	532	30.92%
Family Planning Drugs	94	98	4.68%
Dialysis	14,324	12,403	-13.41%

Source: MAM250-R1
MAM260-A0

TABLE 9

Expenditures for Major Medical Services by Program Category for Fiscal Year 2002

Program Category	Inpt. Hosp.	Outpt. Hosp.	Nursing Fac.	Physician	EPSDT	Drugs*	Dental
Total	$383,241,958	$146,253,170	$404,063,741	$197,371,563	$8,040,045	$564,879,618	$6,620,412
Money Payment Eligibles							
Aged	397,119	63,289	23,678,109	204,198	175	41,718,774	283,631
Blind	895,584	378,356	1,216,259	433,549	861	2,118,684	20,706
Disabled	135,048,977	53,068,761	43,951,047	54,537,797	355,809	221,209,289	2,583,364
Low Income Families	2,753,047	1,122,919	0	2,366,407	149,378	1,365,244	63,040
IV-E Foster Care	-62,920	290,880	0	368,335	23,251	758,567	0
CWS Foster Care	-404,194	262,843	0	403,926	19,209	846,799	68
Medicaid Only							
Aged	175,752	44,093	305,053,212	56,820	0	45,909,279	112,429
Blind	0	0	57,392	0	0	24,814	244
Disabled	3,677,182	586,052	30,029,224	828,970	1,668	9,324,605	53,719
Disabled Children at home	925,501	880,973	0	332,613	5,621	1,655,217	0
Working Disabled	212,944	102,846	0	187,863	0	733,529	9,115
Low Income Families	29,798,804	22,799,342	0	25,039,787	1,953,683	28,822,169	3,978
Breast/Cervical Cancer	23,909	96,582	0	84,696	0	16,281	226
Poverty Level Pregnant Women & Children							
At 100% Federal Poverty Level	50,975,815	30,874,279	18,925	33,220,173	1,695,949	35,130,762	1,630,941
At 133% Federal Poverty Level	8,233,886	7,440,424	43,088	7,461,698	981,741	7,348,988	7,308
At 185% Federal Poverty Level	91,138,796	17,975,463	0	49,685,825	1,956,849	9,459,641	370,492
Qualified Medicare Beneficiary							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Qualified Individuals							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Poverty Level							
Aged	178,274	170,906	3,063	387,611	383	69,912,067	495,301
Disabled	20,433,053	7,622,570	6,282	9,307,250	6,006	79,691,209	956,324
Hospice							
Aged	6,100	1,210	5,604	960	0	615,432	490
Blind	0	0	0	0	0	0	0
Disabled	206,714	38,232	1,536	36,534	0	290,495	1,800
Other Medical Assitance Only							
Automatic Infants	38,142,561	2,174,360	0	12,212,028	889,393	2,342,088	0
Specified Low Income Medicare Beneficiaries							
Aged	0	0	0	0	0	0	0
Blind	0	0	0	0	0	0	0
Disabled	0	0	0	0	0	0	0
Home and Community Based Services Waivers							
Assisted Living - Aged	0	0	0	0	0	16,341	202
Assisted Living - Blind	0	0	0	0	0	0	0
Assisted Living - Disabled	0	904	0	346	0	18,518	264
Elderly	1,598	1,258	0	10,073	0	3,429,125	11,078
Disabled	386,228	208,077	0	177,327	-	1,458,513	10,793
Independent Living	97,228	48,551	0	26,777	69	663,188	4,899

Money Payment Eligibles

Source:MAM250-R10

TABLE 10

Medical service payments to State Health Agencies and Insitutions by Source of Funds for Fiscal Years 2000-2002

Name of Agency or Institution	Fiscal Year	Total Amount of Payment	From Federal Funds	From State Funds
Total	FY2000	399,937,083	307,151,680	92,785,403
	FY2001	405,859,938	311,781,604	94,078,334
	FY2002	492,380,792	374,652,545	117,728,247
East Miss. State Nursing Home	FY2000	8,092,241	6,214,841	1,877,400
(Meridian)	FY2001	8,610,779	6,614,800	1,995,979
	FY2002	7,727,850	5,880,121	1,847,729
Ellisville State School	FY2000	43,269,465	33,230,949	10,038,516
(Ellisville)	FY2001	43,833,712	33,673,058	10,160,654
	FY2002	48,397,702	36,825,811	11,571,891
Miss. State Dept. of Health	FY2000	15,459,232	11,872,690	3,586,542
	FY2001	19,747,641	15,170,138	4,577,503
	FY2002	21,124,633	16,073,733	5,050,900
North Miss. Regional Center	FY2000	25,702,235	19,739,316	5,962,919
(Oxford)	FY2001	29,265,947	22,482,100	6,783,847
	FY2002	31,760,563	24,166,612	7,593,951
South Miss. Regional Center	FY2000	21,373,144	16,414,575	4,958,569
(Long Beach)	FY2001	21,228,646	16,307,846	4,920,800
	FY2002	21,799,531	16,587,263	5,212,268
Hudspeth Center	FY2000	25,776,831	19,796,606	5,980,225
(Whitfield)	FY2001	27,769,602	21,332,608	6,436,994
	FY2002	28,900,374	21,990,295	6,910,079
Miss. State Hospital-Nursing Facility	FY2000	20,257,389	15,557,675	4,699,714
(Whitfield)	FY2001	20,681,322	15,887,392	4,793,930
	FY2002	2,842,950	2,163,201	679,749
Miss. State Hospital	FY2000	5,766,771	4,428,880	1,337,891
(Whitfield)	FY2001	6,188,672	4,754,138	1,434,534
	FY2002	7,239,081	5,508,217	1,730,864
Boswell Regional Center	FY2000	13,379,014	10,275,083	3,103,931
(Sanatorium)	FY2001	14,295,095	10,981,492	3,313,603
	FY2002	15,462,009	11,765,043	3,696,966
Miss. Department of Mental Health	FY2000	53,698,398	41,240,370	12,458,028
	FY2001	69,871,156	53,675,022	16,196,134
	FY2002	85,241,049	64,859,914	20,381,135
University Medical Center	FY2000	166,704,151	128,028,788	38,675,363
(Jackson)	FY2001	144,367,366	110,903,011	33,464,355
	FY2002	221,885,050	168,832,335	53,052,715
Miss. Dept of Human Services	FY2000	458,212	351,907	106,305
	FY2001	0	0	0
	FY2002	0	0	0

Source Provider History Report

TABLE 11

Total Number of Eligibles, Numbers Using Physician Services by Program Category for Fiscal Year 2002

Program Category	Total Number of Eligibles	Recipients Using Service	Percent of Total
Total	709,960	474,961	66.90%
Aged	71,004	30,751	43.31%
Blind	1,468	1,414	96.32%
Disabled	121,860	119,114	97.75%
Low Income Families - Children	221,945	137,344	61.88%
Low Income Families - Adults	139,117	107,968	77.61%
CWS Foster Care	3,712	1,561	42.05%
Optional Categorically Needy	150,854	76,809	50.92%

Source:HCFA 2082

TABLE 12

Amount of Expenditures with Percentage Distribution for Physician Services by Program Category for Fiscal Year 2002

Program Category	Expenditures	Percent of Total
Total	197,371,563	100.00%
Aged	9,192,156	4.66%
Blind	619,228	0.31%
Disabled	57,577,229	29.17%
Low Income Families - Children	27,746,935	14.06%
Low Income Families - Adults	44,062,036	22.32%
CWS Foster Care	528,127	0.27%
Optional Categorically Needy	57,645,852	29.21%

Source:HCFA 2082

TABLE 13

Amount of Expenditures with Percentage Distribution for Physician

Age in Years	Expenditures	Percent of Total*
Total	197,371,565	100.00%
Birth to age 1	12,212,028	6.19%
Ages 1 to 3	4,500,242	2.28%
Ages 3 to 5	5,705,377	2.89%
Ages 5 to 6	1,469,898	0.74%
Ages 6 to 8	3,377,272	1.71%
Ages 8 to 19	31,524,971	15.97%
Ages 19 to 21	11,575,895	5.87%
Ages 21 to 64	123,742,860	62.70%
Ages 64 and Over	3,263,022	1.65%

*Percentage columns may not total 100% due to rounding
Source:MAM250-R1

TABLE 14

Number of Physician Visits by Place of Visit for Fiscal Year 2002

Place of Visit	Number of Visits	Percent of Total
Total	6,986,087	100.00%
Physician's Office	1,499,218	21.46%
Hospital	291,343	4.17%
Nursing Home	8,222	0.12%
Emergency Room	286,168	4.10%
Consultations	236,497	3.39%
House Calls	129	0.01%
All Other	4,664,510	66.77%

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

TABLE 15

Number of Prescriptions, Number of Recipients, and Average Number of Prescriptions per Recipient by Program Category for Fiscal Year 2002

Program Category	Prescriptions	Percent of Total	Number of Recipients*	Percent of Total	Average Number of Prescriptions Per Recipient
Total	10,266,324	100.00%	589,269	100.00%	17.4
Aged	837,125	8.15%	24,705	4.19%	33.9
Blind	39,061	0.38%	1,311	0.22%	29.8
Disabled	3,459,305	33.70%	119,222	20.23%	29.0
Low Income Families - Children	867,591	8.45%	155,159	26.33%	5.6
Low Income Families - Adults	856,730	8.35%	121,918	20.69%	7.0
CWS Foster Care	34,574	0.34%	1,974	0.33%	17.5
Optional Categorically Needy	4,171,938	40.64%	164,980	28.00%	25.3

Source:HCFA 2082, MAM 260

* - Does not include Family Planning Drugs

TABLE 16

Number of Recipients and Number of Days of Care for Nursing Facilities by Program Category for Fiscal Year 2002

	Nursing Facility		Intermediate Care Facilities - MR		Psychiatric Residential Treatment Facility	
Program Category	Recipients	Days of Care	Recipients	Days of Care	Recipients	Days of Care
Total	19,636	4,786,506	2,957	936,043	1,625	134,002
Aged	15,997	3,947,053	125	40,457	0	0
Blind	60	15,188	19	6,133	0	0
Disabled	3,579	824,265	2,791	883,334	548	61,380
AFDC Children	0	0	2	3,212	645	48,071
AFDC Adults	0	0	0	0	132	9,164
*CWS Foster Care - Not Available	0	0	14	1,930	300	15,387
Optional Categorically Needy	0	0	6	977	0	0

Source:HCFA 2082, MAM 260

TABLE 17

Number of Children Receiving Treatment by Category of Service for Fiscal Year 2002

Place of Visit	Number of Children	
Total	117,069	100.00%
Dental	97,435	83.23%
Corrective Treatment Referrals which includes Vision and Hearing	19,634	16.77%

Source:MRO 416 Y-T-D

TABLE 18

Number of Recipients, Number of Discharges, and Total Days of Hospital Care and Average Length of Hospital Stay by Program Category for Fiscal Year 2002

Program Category	Number of Recipients	Number of Discharges	Days of Care	Average Length of Hospital Stay
Total	71,910	178,218	414,634	2.3
Aged	3,780	291	991	3.4
Blind	179	329	1,034	3.1
Disabled	17,700	55,968	148,911	2.7
Low Income Families - Children	8,471	26,715	73,852	2.8
Low Income Families - Adults	20,404	67,949	123,710	1.8
CWS Foster Care	219	1,098	1,044	1.0
Optional Categorically Needy	21,157	25,868	65,092	2.5

Source:HCFA 2082

Implementation Status of Legislation Passed During the 2002 Legislative Session

Status as of

December 30, 2002

Rica Lewis-Payton
EXECUTIVE DIRECTOR

Legislation Implementation Status: 2002 Session

House Bill 1200 (Cost Containment)

Status Summary

- All claims for dually eligible Medicare/Medicaid beneficiaries that are paid for by Medicare must be submitted to Medicare for payment before they may be processed by Medicaid's on-line payment system. **STATUS: Fully Implemented with effective date of April 1, 2003.**

- DOM shall develop a pharmacy policy in accordance with the guidelines of the State Board of Pharmacy in which drugs in tamper-resistant packaging that are prescribed for residents in a nursing home but are not dispensed to the resident shall be returned to the pharmacy and not billed to the DOM. **STATUS: Policy has been drafted and filed in accordance with the Administrative Procedures Act for public input.**

- Eliminate the HealthMACS program. **STATUS: Fully Implemented**

- DOM shall allow seven (7) prescriptions per month for each Medicaid recipient; however, after a recipient has received five (5) prescriptions in any month, each additional prescription during that month must have the prior approval of DOM. **STATUS: Fully Implemented**

- DOM shall establish co-payments for all Medicaid services (excluding NET) for which co-payments are allowable under federal law or regulation, and shall set the amount of co-payment for each of those services at the maximum amount allowable under federal law or regulation (the maximum co-pay is $3.00). **STATUS: Fully Implemented**

- DOM in conjunction with the Health Department shall develop and implement disease management programs statewide for individuals with asthma, diabetes, or hypertension, including the use of grants, waivers, demonstrations, or other projects as necessary. **STATUS: Contract awarded to Disease Management contractor effective 1/01/03. Enrollment of beneficiaries began on April 15, 2003.**

- As used in this paragraph (9), "estimated acquisition cost" means twelve percent (12%) less than the average wholesale price (AWP) for a drug. **STATUS: Fully Implemented**

- Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, or one (1) pair every five (5) years as prescribed by a physician or an optometrists. **STATUS: Fully Implemented**

- The Medicaid provider shall not prescribe, the Medicaid pharmacy shall not bill, and DOM shall not reimburse for name brand drugs if there are equally effective generic equivalents available and if the generic equivalents are the least expensive. **STATUS: Fully Implemented**

- DOM shall not reimburse for any portion of a prescriptions that exceeds a thirty four (34) day supply of the drug based on the daily dosage. **STATUS: Fully Implemented**

- DOM shall reduce the rate of reimbursement to providers for any service provided under this section by five percent (5%) of the allowed amount for that service. However, the reduction in the reimbursement rates required by this paragraph shall not apply to any service provided by the University of Mississippi Medical Center, a state agency, a state facility, or a public agency that either provides its own state match through intergovernmental transfer or certification of funds to DOM, or a service for which the federal government sets the reimbursement methodology and rates. **STATUS: Fully Implemented**

- The dispensing fee for each new refill prescription shall be Three Dollars and Ninety-one Cents ($3.91). **STATUS: Fully Implemented**

- There is established a Drug Use Review Board (DUR), which shall be the board that is required by federal law. The board shall consist of not less than twelve (12) members appointed by the Governor or his designee. The board shall meet quarterly and shall furnish written notice of the meetings at least ten (10) days before the date of the meeting. The board meeting shall be open to the public, members of the press, legislators, and consumers. **STATUS: Fully Implemented**

- There is established a Pharmacy and Therapeutic Committee which shall be appointed by the Governor or his designee. The board shall meet quarterly and shall furnish written notice of the meetings at least ten (10) days before the date of the meeting. The board meeting shall be open to the public, members of the press, legislators, and consumers. **STATUS: Fully Implemented**

Senate Bill 2189 (DOM Technical Amendments)

Status Summary

- DOM shall opt out of the federal drug rebate program and shall create a closed drug formulary. Drugs included on the formulary will be those with the lowest and best price as determined through a bidding process. DOM may implement a program of prior approval for dugs to extent permitted by law. **STATUS: CMS ruled that we cannot opt out of the drug rebate program and receive Federal Financial Participation (FFP) for prescription drugs. DOM has developed a Preferred Drug List (PDL) in conjunction with our Pharmacy Benefits Manager contractor and the Pharmacy and Therapeutics Committee.**

- DOM may apply for a waiver to conduct a population management program for pregnant women and infants through age one (1), as there will be no expansion of coverage. **STATUS: Fully Implemented**

- Creates a separate reimbursement category for pediatric long-term acute care hospital services for chronic or long term care for children under age 21. **STATUS: Fully Implemented**

- Exempts Non Emergency Transportation (NET) from co-payments. **STATUS: Fully Implemented**

- Exempts NFs, ICF/MRs, PRTFs, hospitals and pharmacy services from the 5% cut contained in HB 1200. Also exempts CM services and home delivered meals in the E&D wavier program from the 5% cut. **STATUS: Fully Implemented**

- Provides for an assessment of $3.00 per day for each licensed or certified bed in NFs, ICF/MRs, PRTFs and an assessment of 1.50 for each acute care hospital bed. Facilities are exempt from the assessment if they provide their own state match through IGTs or certifies funds to DOM. **STATUS: Fully Implemented**