ANNUAL REPORT

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

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

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

Ladies and Gentlemen:

It is my pleasure to submit to you the 24th Annual Report of the Division of Medicaid for Fiscal Year 1994. It is being submitted in accordance with the requirements of Section 43-13-127 of the Mississippi Code of 1972 as amended.

The Division gratefully acknowledges the vital contributions made by the State Department of Human Services, the State Department of Rehabilitation Services, the State Department of Health, and the Mississippi Foundation for Medical Care to the ongoing administration of Mississippi's Medicaid program. In addition we acknowledge the continued commitment of Medicaid providers throughout the state who provide the necessary health care to those who would otherwise go without.

On behalf of the more than 550,000 Mississippians who are being helped through the Medicaid program, we wish to thank the Governor and the members of the Legislature for continuing to make these services available.

Respectfully,

Helen Wetherbee

Helen Wetherbee, J.D., M.P.H.
Executive Director
Division of Medicaid
Office of the Governor

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Tables and Charts

Medicaid is a national health care program, administered by states, which provides funding to ensure the availability of medical services to qualified people. It was created in 1965 through Title XIX of the federal Social Security Act and was enacted in Mississippi by the state Legislature in December, 1969.

In Mississippi, the Medicaid program is administered by the Division of Medicaid, Office of the Governor, by authority of Section 43-13-101 *et seq.* of the Mississippi Code of 1972, as amended. The Division of Medicaid operates twenty-four regional offices throughout Mississippi (see map on page 13) to serve the public by providing local accessibility.

MISSION STATEMENT

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

PROGRAM HIGHLIGHTS FOR FY 1994

HealthMACS - Mississippi's Managed Care Program

As medical costs throughout the country have continued their explosive rate of growth, Medicaid agencies have implemented various cost containment programs. Among the most effective of these is managed care. Through this program, medical services for Medicaid recipients are coordinated by a single managed care provider to ensure appropriate referrals for care and to reduce unnecessary or duplicative services, particularly in hospital emergency rooms. States which have implemented managed care programs have realized substantial savings in the overall cost of medical services as well as improvements in health care of Medicaid recipients. This has been done by providing timely care and avoiding unnecessary hospitalization.

Recognizing the need to control the costs of the state Medicaid program while ensuring the availability of adequate quality of care for Medicaid recipients, the Mississippi Legislature (1992 Legislative Session) directed the Division of Medicaid to implement a managed care program in the state. To implement such a program, the Division was required to submit a waiver application to the Health Care Financing Administration (HCFA). The first phase of the program received final approval from HCFA in January 1993, and with that approval came the development of HealthMACS, ***Health through Medicaid Managed Access to Care and Services.***

Prior to statewide implementation, the Division is establishing managed care services in seven (7) pilot counties. The program was first launched in Washington County in October 1993, with expansion to Covington, Jefferson Davis, and Lawrence Counties in June 1994. Implementation of the HealthMACS program in the remaining pilot counties, Claiborne, Jefferson, and Warren, is expected to take place in Fiscal Year 1995. These counties are home to approximately 32,000 Medicaid recipients.

Specified categories of Medicaid recipients who currently must participate in HealthMACS are Aid to Families with Dependent Children (AFDC) and four (4) Medicaid-only programs that cover pregnant women and children. Recipients in these categories of eligibility are excluded from participation in HealthMACS if: (1) Medicaid eligibility is retroactive only; (2) the recipient resides in a nursing or intermediate care / mentally retarded facility, or a mental hospital; or (3) good cause exists because the recipient has a pre-existing relationship with a physician who is not a HealthMACS provider, or travel time from the recipient's home or work to a HealthMACS provider is prohibitive.

Some recipients are enrolled by automated means based on historical usage of participating Medicaid providers. The remaining eligible Medicaid recipients may either choose a primary care provider (PCP) that has enrolled as a HealthMACS provider or, if they have no preference, a PCP will be selected for them. Each Medicaid recipient is instructed to contact his/her PCP any time that medical assistance is needed. The doctor or clinic provides the needed medical assistance to the Medicaid recipient, or may refer the patient to another provider for specialty services. Other providers are reimbursed for services provided to a recipient *only* if the recipient is referred to them by the recipient's PCP. The PCP receives a case management fee of $3.00 per month per Medicaid recipient whose care the PCP coordinates, in addition to the usual fee for services provided.

Providers eligible to enroll as primary care providers include family or general practitioners, internists, obstetricians, gynecologists, pediatricians, federally qualified health centers, rural health clinics, State Department of Health clinics, physician group practices, and certified family, adult, and pediatric nurse practitioners. All PCPs must be Medicaid providers in good standing. Individual physician PCPs and HealthMACS physicians in a clinic/center must also have hospital admitting privileges. Certified registered nurse practitioners must be associated with a HealthMACS physician who has approved the protocol for care.

PCPs may specify the number of HealthMACS enrollees they will accept, as long as the number does not exceed the maximum number established by the Division of Medicaid. A physician provider may have no more than 1,500 enrollees; a certified nurse practitioner may have no more than 500 enrollees; and a clinic/center may have no more than 1,500 times the number of full-time equivalent participating physicians plus 500 times the number of participating certified registered nurse practitioners. The Division of Medicaid may waive the upper limit on enrollees per PCP, if the PCP agrees, in order to secure adequate coverage or when other factors necessitate such action.

The primary purpose of a managed care program is to provide quality medical assistance to eligible recipients while reducing the amount spent for this care through more appropriate use of the health care system by Medicaid recipients. The Division of Medicaid has estimated that the costs of physician, inpatient, outpatient, pharmacy, and lab/x-ray services will be reduced by $3.5 million during the first two years of Medicaid's HealthMACS program.

Case Mix in Mississippi

The Mississippi Demonstration Integrating Case-Mix Payment and Quality Monitoring Systems in Nursing Facilities is part of a six-state Health Care Financing Administration (HCFA)-sponsored demonstration project. This project was designed for the mutual benefit of providers and patients to develop a payment system and quality monitoring system for the Medicaid and Medicare programs. The Mississippi Medicaid Case-Mix System establishes a facility-specific payment rate based on a facility's case mix of residents. Quality of care is assured by equitably analyzing facility-specific payments. This allows staff to assure that residents' health care requirements are being fulfilled at the optimal level. Staff of the Division of Medicaid and the Division of Health Facilities Licensure and Certification, State Department of Health, form the core staff for planning and implementing the resident assessment, case mix, and reimbursement systems. This system was designed to produce the following:

1. a resident classification system based on the characteristics of facility residents;

2. a quality monitoring system to create resident data-specific facility profiles for detecting quality of care changes; and

3. a case mix payment system that is facility-specific based on the case mix of residents.

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

Through case mix, the Division of Medicaid has gained a system which:

1. assures quality care for all residents;

2. establishes a payment system that equitably reimburses providers for the level of care required for the individual resident and that represents the level of effort and professional supervision required to care for the individual residents in the facility; and

3. provides residents with the benefit of improved, more accessible care.

Mississippi Information for State Health Policy Project

Information is critical in the development of viable health care policies. In Mississippi, there is a need for integrated health data systems. Fragmented sets of health and related human services data are found scattered throughout many different agencies and organizations, both public and private. Traditionally, most of the current health data systems in Mississippi were originally designed as reporting systems and so are not easily integrated with other systems and yield no outcomes analysis.

Responding to the country's needs, The Robert Wood Johnson Foundation announced the *Information for State Health Policy Initiative* in January of

1991, inviting all states to apply for funds to strengthen health statistics systems to support policy development.

Answering this call, the Governor selected twenty-nine individuals, who represented the major stakeholders in planning data system enhancements, to the Interagency Working Group (IWG) which was charged with the responsibility of prioritizing the state's needs for information. This group had the benefit of participation from representatives of key health and human services agencies/organizations, judicial and legislative branches, consumer organizations, and private providers. Group deliberations led to the selection of four major policy issues: (1) health care financing, (2) access to health care, (3) cost containment, and (4) comprehensive care.

From this initial information base, the Governor selected the focus of health care access as one of the highest and most urgent priorities for Mississippians. Access was cited as an important challenge of health care, particularly to a rural state. Following the submission of the final proposal to the Foundation, on August 1, 1991, Mississippi was chosen as one of ten states to proceed with the project.

In April of 1992, the Division of Medicaid was awarded a grant to fund the *Mississippi Information for State Health Policy Project (INFOSHP) - Phase I* with the responsibility of administering the project and coordinating the efforts of more than thirty public and private organizations. The primary objectives of the IWG in Phase I of this project were to (1) conduct a comprehensive review of information needs, (2) identify and prioritize data systems enhancement strategies, and (3) select specific projects to meet high priority information needs. The interagency effort used in achieving these goals has potential long-term significance for the continued management of the state's data systems. It is hoped that the experiences of the IWG through these efforts has set a precedent for a long-standing coalition of agency directors, program managers, and analysts who will advocate accurate and timely data in health policy and program development and management.

In the spring of 1993, Mississippi competed with nine other states for an additional Robert Wood Johnson Foundation grant to proceed with Phase II. In November 1993, the Division was notified that Mississippi had been granted $924,000 to be received over a four-year period to support Phase II activities. The state is now in the process of developing strategies for data enhancement and development.

The IWG provides continuing oversight to INFOSHP staff at the Division as they implement an interagency collaborative work plan for four data projects:

Hospital Discharge Data Set: Develop a statewide database producing analytic reports profiling facility utilization and morbidity.

Ambulatory Services Data Set:

1. Community Health Centers - MS Department of Health Uniform Data Set: Modification and linkage of extracted databases from the twenty community health centers and the Mississippi State Department of Health to develop a uniform ambulatory services data set providing analytic reports on utilization patterns across the state. These reports will improve the state's ability to assess service gaps and needs for low-income populations.

2. Patient Information Management System (PIMS) at MS Department of Health Linkages and Reporting: Creation and linkage of extracted PIMS data files to change data into information that facilitates policy and decision making.

3. Vital Records Data Linkages: Linkage of vital records and Medicaid claims files to assess the relationship between maternal and newborn Medicaid services utilization, infant outcomes, and other policy issues.

Medicaid Utilization Reporting: Facilitate rapid dissemination of reports on Mississippi Medicaid utilization, explore alternate analytic options and report formats for the variety of users among the IWG, and study the feasibility of Medicaid claims file linkages to other databases.

The Information Center:
Institutionalize INFOSHP grant activities so that, when Phase II is completed, an independent state and/or privately supported entity remains whose charge will be to process, integrate, and disseminate information for Mississippi's health and human services providers.

The Governor's Commission on Health Care

Recognizing the potential changes in health care on the national level and the existing concerns about the cost and delivery of health care in Mississippi, Governor Kirk Fordice signed an Executive Order on May 12, 1993, creating the Governor's Commission on Health Care. The thirty-one members the Governor appointed to the Commission included State legislators, public health officials, hospital administrators, insurance representatives, nurses, doctors, and private sector experts from across the state.

The Commission, which served as an official advisory group to the Governor, was given full authority under the Executive Order to review existing programs data, research, and other information as it deemed necessary. The Governor's charge to the Commission was that they had the responsibility of recommending to him, no later than October 1, 1993, strategies for addressing the cost, financing, access, and delivery of health care in Mississippi. He stated his objective for the Commission as finding solutions to address the unique needs of the state with the ultimate goal of achieving a healthier population in the most cost efficient manner. The Governor asked the Commission to consider the rural nature of the state and emphasized the importance of prevention. He urged Commission members to consider alternatives based on a free market approach and to carefully identify the problems before recommending solutions.

From the beginning, the Commission adopted a policy of public involvement. Public hearings were held in four locations in the state with individuals, consumers, and providers testifying to the broad range of issues relating to the cost, financing, and availability of health care services. Commission members listened to comments on issues ranging from the recruitment and retention of physicians and nurses in rural areas to the exclusion of basic health care coverage for individuals too sick to work.

On September 23, 1993, the Commission formally adopted six (6) guiding principles for health care reform in Mississippi:

1. Mississippians, regardless of health or financial status, should have access to quality, affordable and appropriate basic health care.

2. The health care system should be restructured to emphasize primary and preventive care, managed care principles and efficient delivery networks in rural and urban areas.

3. Mississippi's health care system should respond to the needs of individuals and communities, promote competition and consumer choice, and build on the positive values of the current system.

4. Individuals should assume greater responsibility for their health by minimizing unhealthy behaviors, taking appropriate measures, and making cost-effective decisions about the use of health services.

5. State government should streamline bureaucratic regulations and other administrative functions; reduce system costs, including cost of professional malpractice litigation; and promote private sector flexibility innovation.

6. For financing, we should look first at the reallocation of existing resources and at savings realized from a more efficient system.

The final report of the Commission was presented to the Governor on September 30, 1993, and included recommendations to the Governor in the areas of health education, tort reform, and health finance.

The Commission recommended the establishment of a new agency, The Mississippi Health Finance Authority, to be charged with responsibility for research and analysis of the state and the state's health care system, and the development of a proposal to provide a basic package of benefits to state employees.

teachers, local government employees, Medicaid recipients, and as many uninsured as possible. The Authority would be governed by a seven-member board, and guided by a Legislative Oversight Committee and five (5) advisory committees. If established upon legislative enactment, the Authority could have nine (9) months to prepare such a proposal for approval and appropriation in the next legislative session. When the plan is implemented, it is expected that this agency will replace the Governor's Division of Medicaid and the Office of Insurance in the Department of Finance and Administration.

The Commission strongly recommended detailed proposals in both health education and tort reform as essential elements to a comprehensive strategy for Mississippi. The education proposal emphasizes the importance of health and physical education in schools, as well as the need for health manpower in our state. The Commission identified high risk behaviors, such as smoking and poor physical condition, as major factors causing preventable diseases. Health and physical education are critical to reducing many of these, such as AIDS, heart disease, and many forms of cancer. Not only could millions of dollars be saved from unnecessary medical expenses, but health and physical education would be an investment in healthy, fit Mississippians.

The tort reform proposals address the impact that malpractice liability has on health care costs in the form of high malpractice insurance premiums and defensive medicine. Medical malpractice, the fear of malpractice, and the large awards sometimes associated with medical malpractice have resulted in escalating insurance premiums for malpractice liability insurance. In order to avert lawsuits and as a preparation of a good legal defense in the event of a lawsuit, physicians have more frequently been practicing "defensive medicine," which further drives up the cost of medical care. In an effort to address these factors, the Commission recommended a 4-point plan for reducing costs associated with malpractice liability: (1) place a cap on non-economic damage awards, (2) restrict use of the collateral source rule, (3) add a statute of repose to the statute of limitations, and (4) limit plaintiff attorneys' fees.

ELIGIBILITY

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

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

- Persons who are eligible for Aid to Families with Dependent Children (AFDC).
- Pregnant women who would be eligible for AFDC if the child were born and living with the mother.
- Children in licensed foster homes or private child care institutions for whom public agencies in Mississippi are assuming financial responsibility.
- Children receiving subsidized adoption payments.
- Children under age 18 and pregnant women, including those from intact families, whose family incomes and resources do not exceed the allowable limits for the AFDC need standards.
- Pregnant women and children under age six whose family income is equal to or below 133 percent of the federal poverty level.
- Pregnant women and children under age one whose family income is between 133 percent and 185 percent of the federal poverty level.
- Pregnant women and children born after 9/30/83 whose family income is equal to or below 100 percent of the federal poverty level.
- Infants, up to age one, born to Medicaid eligible mothers provided the mother was eligible during pregnancy and the child lives with her.

Offices of the Social Security Administration determine eligibility for:

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

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

- Persons in medical facilities who, if they left such facilities, would qualify for SSI except for their institutional status.
- Persons in institutions who are eligible under a special income level who remain institutionalized for thirty (30) consecutive days or longer.
- Persons who would qualify for SSI except for certain Social Security cost-of-living increases.
- Persons who are age 65 or over or disabled and whose income is below 100 percent of the federal poverty level and whose resources are at SSI levels.
- Qualified Medicare beneficiaries (QMBs) who are entitled to Medicare Part A, whose income is below 100 percent of the federal poverty level and whose resources are no more than double the SSI resource limits. *(This group is only eligible for Medicare cost-sharing.)*
- Certain former SSI eligibles who are "deemed" Medicaid eligible because of specified circumstances.
- Certain qualified working disabled persons who are only eligible for Medicaid to pay their Part A Medicare premiums.
- Certain disabled children under age 18 who live at home but who would be eligible if they lived in a medical institution as certified by DOM.
- Specified Low-Income Medicare Beneficiaries (SLMBs), a category originating January 1, 1993, which includes individuals/couples whose income does not exceed 120 percent of the federal poverty level and whose resources do not exceed twice the SSI limits. The only benefit paid by Medicaid for this group is the Medicare Part B premium. (These individuals must be entitled to Part A Medicare benefits under their own coverage as Medicaid does not pay the Part A premium.)
- Individuals receiving hospice services who would be eligible for Medicaid if they were living in a Medicaid certified institution as certified by DOM.

During Fiscal Year 1994, 555,573 persons were eligible for Medicaid benefits. The length of eligibility periods for these individuals ranged from one month to the entire year. Information on eligibility numbers by specific categories can be found in Tables 1 and 2 of this report. *(In reviewing information throughout this report, it is important to note the difference between the terms "eligible" and "recipient". A person who has met the basic eligibility requirements for income and resources is referred to as an "eligible".*

Although a person may have been determined to be eligible for Medicaid, that person may not have actually received any service. A "recipient" is a person who has received Medicaid benefits.)

Throughout Fiscal Year 1994, 504,427 Mississippians benefited from one or more of the health care services covered by Medicaid. This figure represents an increase of 0.83 percent, or 4,159 more individuals who received benefits than in Fiscal Year 1993. Tables 3 and 4 show recipient distribution by program category and the comparison of recipients by types of service.

TABLE 1

Certified Eligibles by Eligibility Categories for Fiscal Years 1993 and 1994

Program Category	Total Number of Cert. Eligibles FY 1993	Total Number of Cert. Eligibles FY 1994	Percent of Total (FY 1994)	Percent of Increase/ Decrease
Total	550,174	555,573	100.00%*	0.98%
Money Payment Eligibles				
Aged	53,386	52,343	9.42	-1.95
Blind	1,769	1,726	0.31	-2.43
Disabled	100,911	111,134	20.00	10.13
Aid to Families with Dependent Children (AFDC)	232,799	222,165	39.99	-4.57
CWS Foster Care	2,428	1,192	0.21	-50.91
Poverty Level Pregnant Women & Children				
At 100% Federal Poverty Level	20,310	16,132	2.90	-20.57
At 133% Federal Poverty Level	46,570	44,839	8.07	-3.72
At 185% Federal Poverty Level	18,387	19,842	3.57	7.91
Optional & Mandatory Phased-In Children Under Age 18	24,200	35,261	6.35	45.71
Qualified Medicare Beneficiaries				
Aged	119	95	0.02	-20.17
Blind	9	9	<0.01	0.00
Disabled	17	17	<0.01	0.00
Poverty Level				
Aged	12,060	13,349	2.40	10.69
Disabled	6,481	7,563	1.36	16.69
Katie Beckett	659	694	0.12	5.31
Other Medical Assistance Only				
"K" Babies	30,069	29,212	5.26	-2.85

*Percentage column may not total 100% due to rounding

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

TABLE 2

Bureau of Census Population for Mississippi Counties and Number of Medicaid Eligibles by County for Fiscal Year 1994

County	County Population	Number of Medicaid Eligibles	Percent of Population	County	County Population	Number of Medicaid Eligibles	Percent of Population
Adams	35,356	9,220	26.08	Leflore	37,341	13,099	35.08
Alcorn	31,722	5,606	17.67	Lincoln	30,278	6,066	20.03
Amite	13,328	2,816	21.13	Lowndes	59,308	11,263	18.99
Attala	18,481	4,366	23.62	Madison	53,794	11,001	20.45
Benton	8,046	1,929	23.97	Marion	25,544	6,596	25.82
Bolivar	41,875	15,261	36.44	Marshall	30,361	7,683	25.31
Calhoun	14,908	3,033	20.34	Monroe	36,582	6,433	17.59
Carroll	9,237	1,758	19.03	Montgomery	12,388	3,191	25.76
Chickasaw	18,085	3,850	21.29	Neshoba	24,800	5,482	22.10
Choctaw	9,071	1,976	21.78	Newton	20,291	4,182	20.61
Claiborne	11,370	3,400	29.90	Noxubee	12,604	4,222	33.50
Clarke	17,313	3,078	17.78	Oktibbeha	38,375	6,666	17.37
Clay	21,120	5,393	25.54	Panola	29,996	8,005	26.69
Coahoma	31,665	12,906	40.76	Pearl River	38,714	8,309	21.46
Copiah	27,592	7,569	27.43	Perry	10,865	2,691	24.77
Covington	16,527	4,224	25.56	Pike	36,882	10,214	27.69
DeSoto	67,910	6,524	9.61	Pontotoc	22,237	3,124	14.05
Forrest	68,314	14,414	21.10	Prentiss	23,278	3,712	15.95
Franklin	8,377	2,127	25.39	Quitman	10,490	4,093	39.02
George	16,673	2,870	17.21	Rankin	87,161	9,560	10.97
Greene	10,220	2,269	22.20	Scott	24,137	5,518	22.86
Grenada	21,555	5,132	23.81	Sharkey	7,066	2,760	39.06
Hancock	31,760	5,581	17.57	Simpson	23,953	5,049	21.08
Harrison	165,365	28,421	17.19	Smith	14,798	2,968	20.06
Hinds	254,441	51,726	20.33	Stone	10,750	2,592	24.11
Holmes	21,604	9,723	45.01	Sunflower	32,867	11,049	33.62
Humphreys	12,134	4,497	37.06	Tallahatchie	15,210	5,129	33.72
Issaquena	1,909	598	31.33	Tate	21,432	3,981	18.58
Itawamba	20,017	2,474	12.36	Tippah	19,523	4,097	20.99
Jackson	115,243	15,986	13.87	Tishomingo	17,683	2,612	14.77
Jasper	17,114	3,851	22.50	Tunica	8,164	3,241	39.70
Jefferson	8,653	3,246	37.51	Union	22,085	3,210	14.53
Jefferson Davis	14,051	3,775	26.87	Walthall	14,352	4,475	31.18
Jones	62,031	12,724	20.51	Warren	47,880	10,618	22.18
Kemper	10,356	2,208	21.32	Washington	67,935	22,217	32.70
Lafayette	31,826	3,565	11.20	Wayne	19,517	5,378	27.56
Lamar	30,424	4,712	15.49	Webster	10,222	2,194	21.46
Lauderdale	75,555	14,613	19.34	Wilkinson	9,678	3,129	32.33
Lawrence	12,458	2,721	21.84	Winston	19,433	4,459	22.95
Leake	18,436	4,364	23.67	Yalobusha	12,033	3,206	26.64
Lee	65,581	10,089	15.38	Yazoo	25,506	8,362	32.78

TABLE 3

Recipients of Services by Program Category for Fiscal Year 1994

Program Category	Number of Recipients	Percent of Total
Total	**504,427**	**100.0%***
Money Payment Eligibles		
Aged	52,467	10.40
Blind	1,591	0.32
Disabled	104,614	20.74
Aid to Families with Dependent Children (AFDC)	194,440	38.55
CWS Foster Care	1,163	0.23
Poverty Level Pregnant Women and Children		
At 100% Federal Poverty Level	12,778	2.53
At 133% Federal Poverty Level	41,122	8.15
At 185% Federal Poverty Level	19,934	3.95
Optional & Mandatory Phased-In Children Under 18	30,923	6.13
Qualified Medicare Beneficiaries		
Aged	61	0.01
Blind	7	<0.01
Disabled	14	<0.01
Poverty Level		
Aged	13,631	2.70
Disabled	7,846	1.56
Katie Beckett	628	0.12
Other Medical Assistance Only		
"K" Babies	23,208	4.60

*Percentage column may not total 100% due to rounding

Source: MAM 260-R1

TABLE 4
Recipients of Medical Services by Type of Service for Fiscal Years 1993 and 1994

Type of Service	Recipients FY 1993	Recipients FY 1994	% of Increase or Decrease
Total	**500,268**	**504,427**	**0.83%**
Inpatient Hospital	62,907	54,468	-13.42
Outpatient Hospital	250,337	222,117	-11.27
Laboratory / X-Ray	80,641	75,802	-6.00
Nursing Facility	18,357	17,674	-3.72
Physician	401,177	361,683	-9.84
EPSDT	139,538	119,145	-14.61
EPSDT Dental	79,472	71,172	-10.44
EPSDT Vision	36,817	35,482	-3.63
EPSDT Hearing	1,255	1,241	-1.12
Rural Health Clinic	8,777	27,556	213.96
Federally Qualified Health Center	49,699	41,796	-15.90
Home Health	5,115	5,101	-0.27
Transportation	22,215	21,070	-5.15
Prescribed Drugs	473,941	434,971	-8.22
Dental	29,595	26,297	-11.14
Eyeglasses	4,390	5,034	14.67
Intermediate Care Facility - Mentally Retarded	2,224	2,214	-0.45
Family Planning	43,606	0	N/A
Family Planning Drugs	27,999	21,387	-23.62
Buy-In, Medicare (Parts A & B)	136,524	136,423	-0.07
Mental Health Clinic	29,076	30,357	4.41
Home & Community Based	531	502	-5.46
Durable Medical Equipment	9,237	8,308	-10.06
Therapy	630	1,027	63.02
Inpatient Psychiatric	102	194	90.20
Inpatient Psychiatric Hospital	808	1,014	25.50
Nurse Practitioner	21,642	21,626	-0.07
Ambulatory Surgical Center	1,542	1,378	-10.64
Hospice	106	143	34.91
Private Mental Health Center	566	545	-3.71
Outpatient Psychiatric Hospital	0	38	N/A
Dialysis	303	318	4.95

Source: MAM 250-R1 & MAM 260-R1

REGIONAL OFFICES

The Division of Medicaid operates 24 regional offices throughout Mississippi. Regions are identified by the dark lines on the map on the facing page. Listed below is the address and telephone number for each office.

Brookhaven
128 South First Street
Brookhaven, MS 39601
835-2020

Clarksdale
325 Lee Drive
Clarksdale, MS 38614
627-1493

Cleveland
201 East Sunflower, Suite 5
Cleveland, MS 38932
843-7753

Columbia
1111 Highway 98 Bypass
Suite B
Columbia, MS 39429
731-2271

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

Corinth
2907 Highway 72 West
Corinth, MS 38834
286-8091

Greenville
Village Shopping Center
1407 South Main, Suite 105
Greenville, MS 38701-7027
332-9370

Greenwood
919 Highway 49W/82 Bypass
Greenwood, MS 38930-2727
455-1053

Grenada
1321 C Sunset Plaza
Grenada, MS 38901
226-4406

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

Hattiesburg
132 Mayfair Boulevard
Hattiesburg, MS 39402
264-5386

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

Jackson
5202 Keele Street, Suite 1
Jackson, MS 39206-4398
961-4361

Kosciusko
207 North Madison
Kosciusko, MS 39090
289-4477

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

McComb
312 Kendall Street
McComb, MS 39648
249-2071

Meridian
2502 9th Street
Meridian, MS 39302
483-9944

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

Newton
102 North School Street
Newton, MS 39345
632-2581

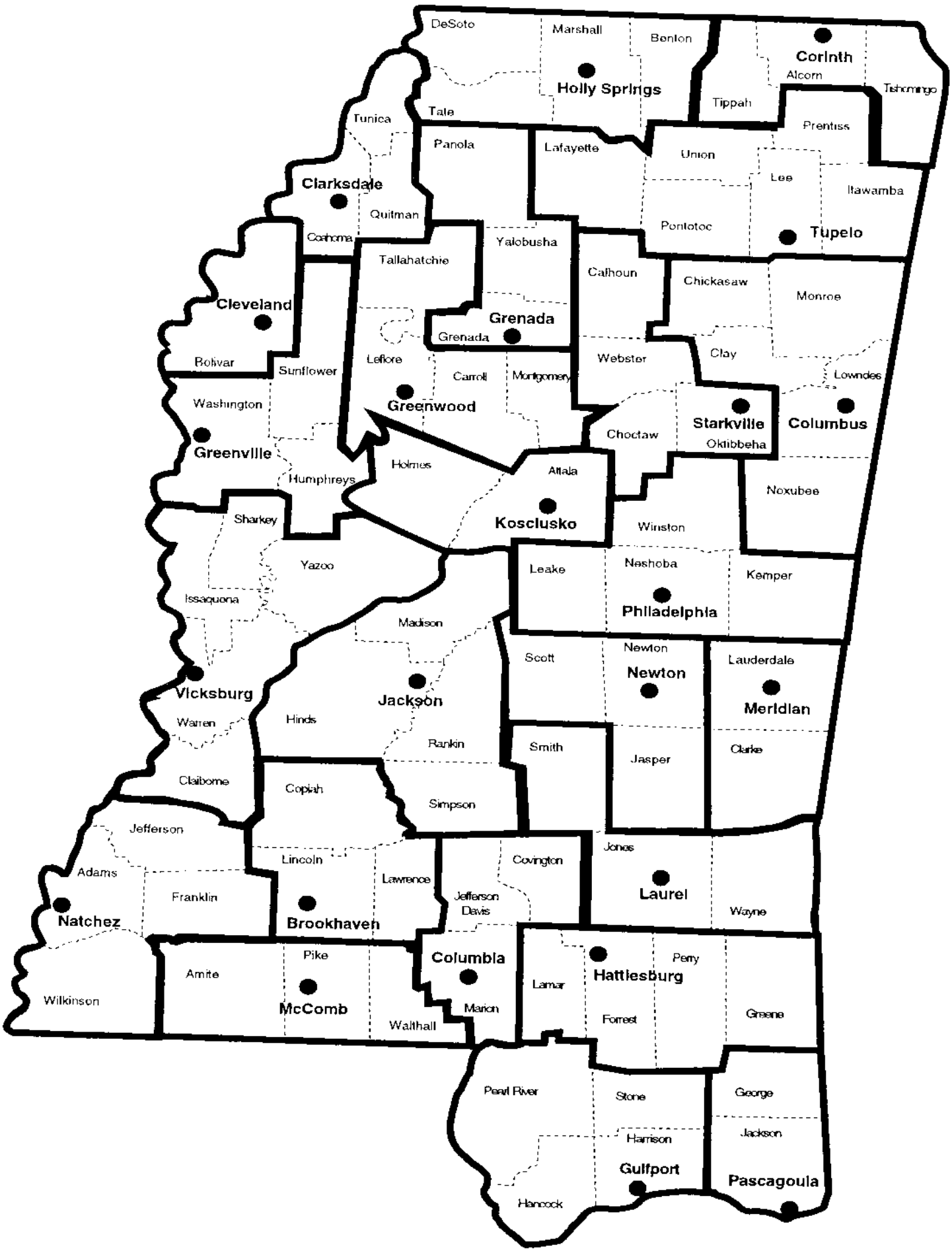
Pascagoula
3203 Pascagoula Street, Suite 202
Pascagoula, MS 39567
762-9591

Philadelphia
301 Main Street
Philadelphia, MS 39350
656-3131

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

Tupelo
1830 North Gloster Street
Tupelo, MS 38801
844-5304

Vicksburg
2734 Washington Street
Vicksburg, MS 39180-4656
638-6137


DeSoto
Marshall
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Corinth
Alcorn
Tishomingo
Tippah
Tate
Tunica
Panola
Lafayette
Union
Prentiss
Lee
Itawamba
Clarksdale
Quitman
Coahoma
Pontotoc
Tupelo
Yalobusha
Tallahatchie
Calhoun
Chickasaw
Monroe
Cleveland
Grenada
Grenada
Bolivar
Sunflower
Leflore
Carroll
Montgomery
Webster
Clay
Lowndes
Greenwood
Washington
Starkville
Columbus
Choctaw
Oktibbeha
Greenville
Holmes
Attala
Noxubee
Humphreys
Kosciusko
Sharkey
Winston
Yazoo
Leake
Neshoba
Kemper
Issaquena
Philadelphia
Madison
Scott
Newton
Lauderdale
Newton
Vicksburg
Jackson
Meridian
Warren
Hinds
Rankin
Smith
Jasper
Clarke
Claiborne
Copiah
Simpson
Jefferson
Jones
Adams
Lincoln
Lawrence
Covington
Laurel
Franklin
Jefferson Davis
Wayne
Natchez
Brookhaven
Pike
Columbia
Perry
Amite
Lamar
Hattiesburg
Wilkinson
McComb
Marion
Forrest
Greene
Walthall
Pearl River
Stone
George
Harrison
Jackson
Gulfport
Pascagoula
Hancock

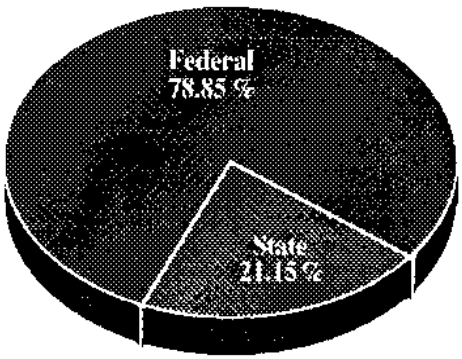
FUNDING

Throughout the nation, Medicaid is funded primarily with federal dollars that are matched by individual state contributions. In FY 1994, Mississippi's overall matching rate, which is determined by the state's per capita income, stands at 78.85 percent, the highest in the country. What this means to Mississippi is that for every single state dollar invested in the program, another $3.73 is brought into the state through federal matching funds. For FY 1994, federal contributions amounted to $833,042,292, which, when combined with state dollars, provided for total medical expenditures of $1,056,000,000. Over 97 percent of this total was paid to Mississippi providers for services to Medicaid recipients and thereby recycled into local economies throughout the state.

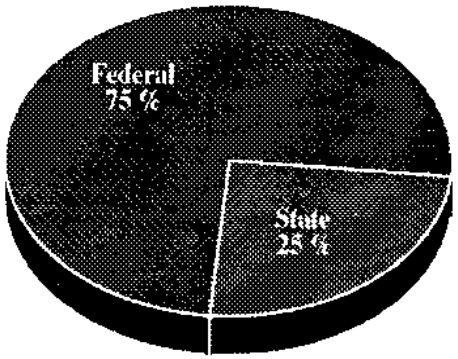
Within the Medicaid program, individual matching rates may vary depending upon the specific area in which it will be used. A breakdown of various matching rates is illustrated in Chart 1 on this page.

During FY 1994, the total administrative expenses were $31,685,048, with federal contributions of $19,796,149, or 62.48 percent. Mississippi's administrative expenses for FY 1994, which continue to be among the lowest in the Southeastern region, amounted to only 2.31 percent of the total budget.

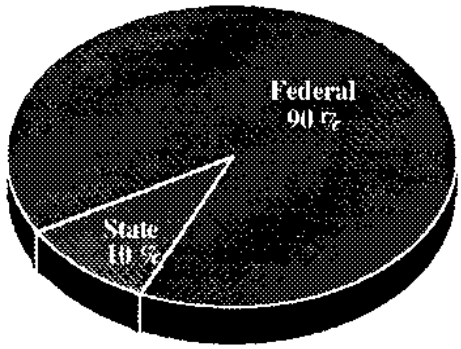
Chart 1
Source of Funds and Percentage of Distribution for FY 1994



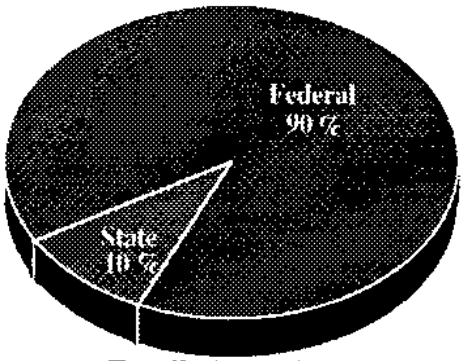
Health Care Services



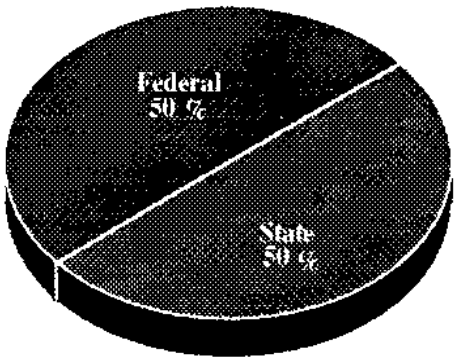
Medical Professional Staff and Related Administrative Costs



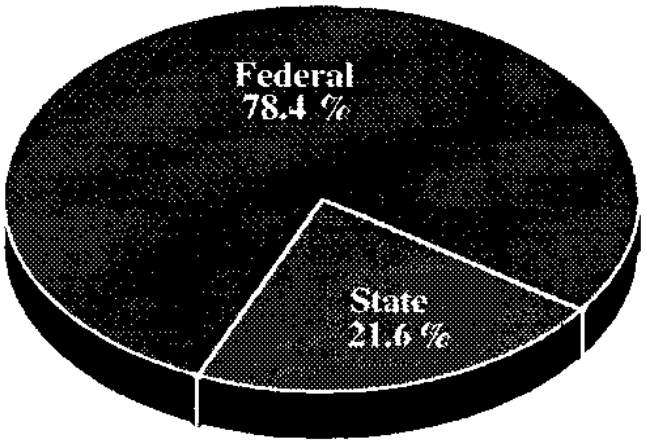
Medicaid Management Information System Development



Family Planning



Non-Medical Professional and Administrative Costs



Total Expenditures of the Medicaid Program

Source:
State Allocation Plan

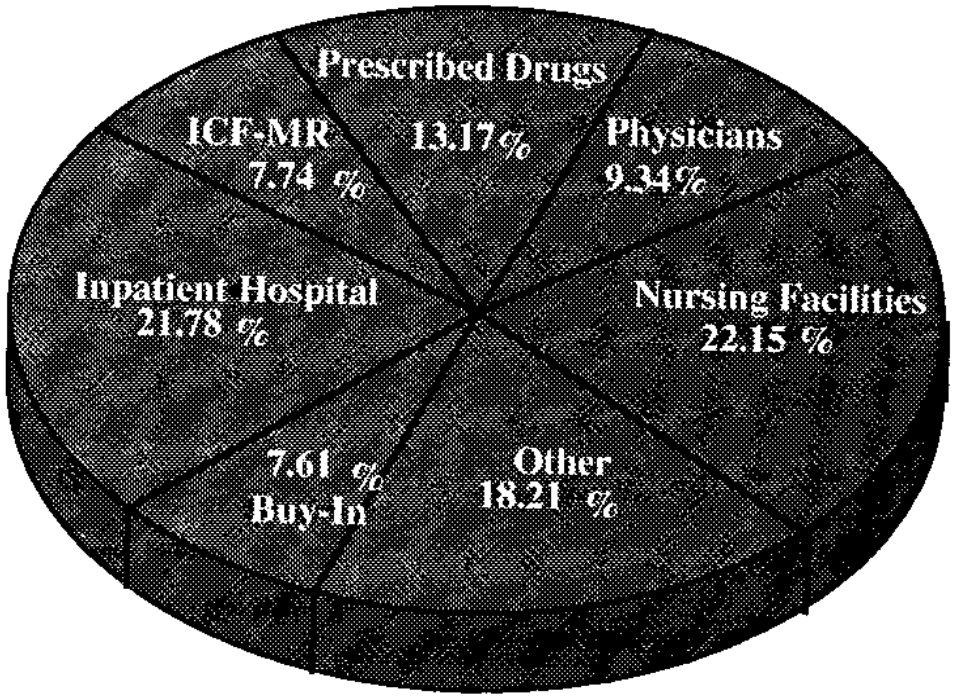
MEDICAL EXPENDITURES BY TYPE OF SERVICE

Total medical expenses for FY 1994 amount to $1,056,489,907 which represents an increase of 8.94 percent over FY 1993.

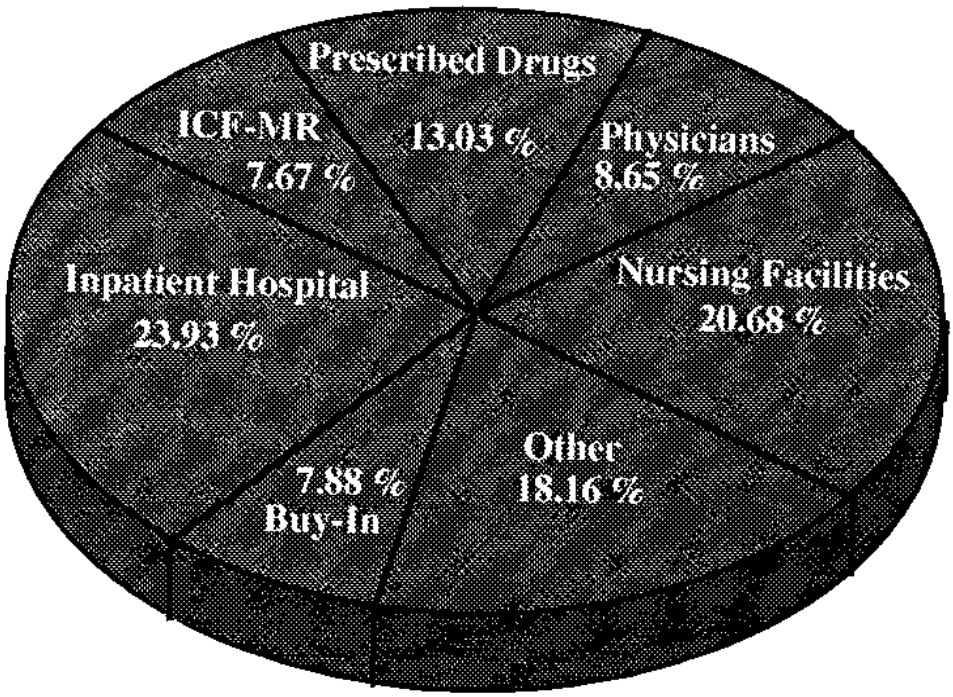
Categories having the largest expenditures included nursing facilities with $234,034,297 and inpatient hospital services totaling $230,125,811.

Chart 2

Percentage Distribution of Expenditures by Type of Service for Fiscal Years 1993 and 1994



Fiscal Year 1994



Fiscal Year 1993

Source: MAM 250-R1 Y-T-D

TABLE 5

Expenditures for Medical Services by Type of Service, Number of Recipients by Service and Average Spent Per Recipient for Fiscal Year 1994

Type of Service	Expenditures FY 1993	Expenditures FY 1994	Percent of Increase/Decrease	Number of Recipients	Average Spent Per Recipient
Total	**$969,797,743**	**1,056,489,907**	**8.94%**	**504,427**	**$2,094**
Inpatient Hospital	232,113,401	230,125,811	-0.86	54,468	4,225
Outpatient Hospital	69,027,887	73,723,780	6.80	222,117	332
Lab / X-Ray	5,097,749	5,179,891	1.61	75,802	68
Nursing Facility	200,555,038	234,034,297	16.69	17,674	13,242
Physician	83,883,681	98,748,321	17.72	361,683	273
EPSDT	7,495,405	8,428,156	12.44	119,145	71
EPSDT - Dental	8,009,851	8,983,651	12.16	71,172	126
EPSDT - Vision	3,300,831	4,282,869	29.75	35,482	121
EPSDT - Hearing	165,730	186,735	12.67	1,241	150
Rural Health Clinic	786,897	3,704,079	370.72	27,556	134
Federally Qualified Health Center	6,697,186	9,009,956	34.53	41,796	216
Home Health	7,201,145	7,875,989	9.37	5,101	1,544
Transportation	3,268,858	5,108,355	56.27	21,070	242
Prescribed Drugs	126,403,962	139,099,325	10.04	434,971	320
Dental	1,979,242	2,233,768	12.86	26,297	85
Eyeglasses	186,558	267,520	43.40	5,034	53
Intermediate Care Facility - Mentally Retarded	74,398,083	81,808,237	9.96	2,214	36,950
Family Planning	5,157,451	85,322 *	-98.35	0	N/A
Family Planning Drugs	2,711,546	2,113,539	-22.05	21,387	99
Buy-In, Medicare (Parts A & B)	76,392,374	80,394,038	5.24	136,423	589
Mental Health Clinic	25,710,578	26,393,331	2.66	30,357	869
Home & Community Based	1,175,773	1,084,963	-7.72	502	2,161
Durable Medical Equipment	7,253,326	6,720,839	-7.34	8,308	809
Therapy	259,165	474,576	83.12	1,027	462
Inpatient Residential Psychiatric	4,140,332	7,532,084	81.92	194	38,825
Inpatient Hospital Psychiatric	9,435,532	10,969,851	16.26	1,014	10,818
Nurse Practitioner	2,356,527	2,823,175	19.80	21,626	131
Ambulatory Surgical Center	647,154	691,568	6.86	1,378	502
Hospice	493,850	758,671	53.62	143	5,305
Private Mental Health Center	359,341	338,405	-5.83	545	621
Outpatient Psychiatric Hospital	0	734	N/A	38	19
Dialysis	3,133,290	3,308,071	5.58	318	10,403

Source: MAM 250-R1 & MAM 260-R1

* Decrease due to reclassification of account

EXPENDITURES BY ELIGIBILITY GROUP

Approximately 27 percent of the total expenditures for Medical Services in Fiscal Year 1994 was spent in the "Aged" category. Fewer than eleven percent of eligibles were classified as aged in 1994, but over $239 million was paid for nursing home care and drugs. Approximately $10 million was also paid for physician services for elderly Medicaid recipients.

A graphic comparison of the expenditures in each program category is presented in Chart 3 below. Tables 6 and 7, found on the following pages, provide the medical services expenditures broken out by the average cost per recipient and the major medical expenditures for the year.

Chart 3

Percentage of Total Recipients by Program Category and Percentage of Total Expenditures by Program Category For Fiscal Year 1994 (Exclusive of CWS Foster Care)

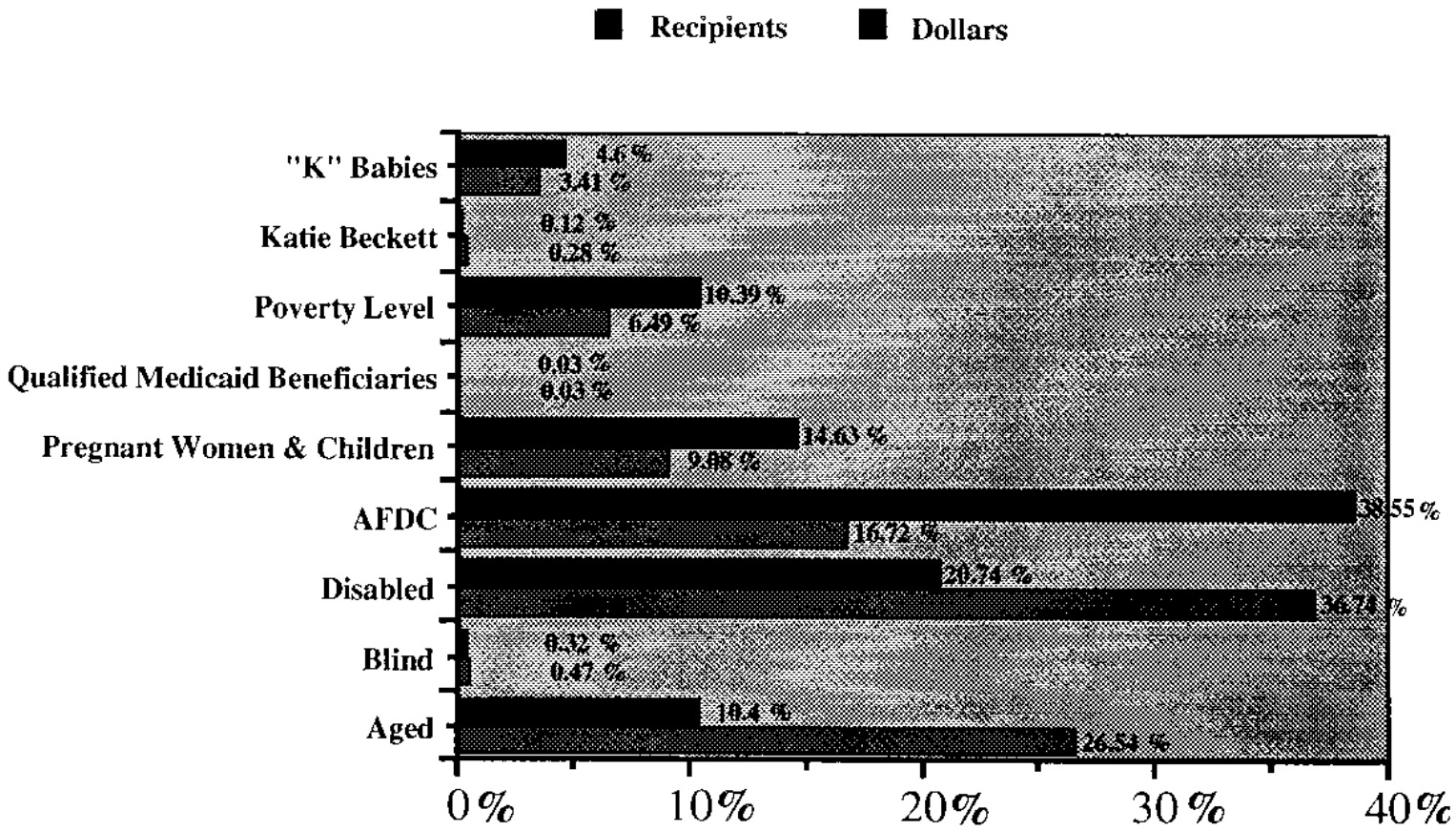


TABLE 6

Total Expenditures for Medical Services, Total Number of Recipients, Average Expenditure Per Recipient, and Percentage by Program Category for Fiscal Year 1994

Program Category	Expenditures	Percent of Total	Total Number of Recipients	Percent of Total	Average per Recipient
Total	**$1,056,489,907**	**100.0%***	**504,427**	**100.0%***	**$2,094**
Money Payment Eligibles					
Aged	280,391,858	26.54	52,467	10.40	5,344
Blind	4,922,850	0.47	1,591	0.32	3,094
Disabled	388,162,104	36.74	104,614	20.74	3,710
AFDC	176,648,913	16.72	194,440	38.55	909
CWS Foster Care	2,829,411	0.27	1,163	0.23	2,433
Poverty Level Pregnant Women & Children					
At 100% Federal Poverty Level	10,784,367	1.02	12,778	2.53	844
At 133% Federal Poverty Level	46,710,243	4.42	41,122	8.15	1,136
At 185% Federal Poverty Level	38,501,748	3.64	19,934	3.95	1,931
Optional & Mandatory Phased-In Children Under Age 18	26,586,907	2.52	30,923	6.13	860
Qualified Medicare Beneficiaries					
Aged	35,289	<0.01	61	0.01	579
Blind	3,109	<0.01	7	<0.01	444
Disabled	6,484	<0.01	14	<0.01	463
Poverty Level					
Aged	19,592,840	1.85	13,631	2.70	1,437
Disabled	22,345,188	2.12	7,846	1.56	2,848
Katie Beckett	2,910,505	0.28	628	0.12	4,635
Other Medical Assistance Only					
"K" Babies	36,058,091	3.41	23,208	4.60	1,554

* *Percentage columns may not total 100% due to rounding*

Source: MAM 250-R1

TABLE 7

Expenditures for Major Medical Services by Program Category for Fiscal Year 1994

Program Category	Inpatient Hospital	Outpatient Hospital	Nursing Facility	Physicians	EPSDT	Drugs	Dental
Total	**$230,125,811**	**$73,723,780**	**$315,842,534**	**$98,748,321**	**$8,428,156**	**$139,099,325**	**$2,233,768**
Money Payment Eligibles							
Aged	483,719	256,796	202,170,470	96,311	601	37,604,932	238,846
Blind	711,222	324,677	1,706,800	305,683	1,779	874,784	14,955
Disabled	87,141,794	24,835,583	111,965,264	24,340,946	316,887	57,143,379	910,233
AFDC	59,350,107	29,017,532	0	35,133,507	4,124,822	17,616,005	783,994
CWS Foster Care	346,700	135,632	0	175,312	26,068	90,442	0
Poverty Level Pregnant Women & Children							
At 100% Federal Poverty Level	3,499,146	1,401,721	0	2,085,502	227,430	817,470	3,509
At 133% Federal Poverty Level	18,717,366	6,458,342	0	12,585,557	1,344,747	3,161,932	47,276
At 185% Federal Poverty Level	19,097,632	3,927,881	0	10,878,113	566,591	1,147,978	36,851
Optional & Mandatory Phased-In Children Under Age 18	9,751,468	3,706,873	0	6,052,559	753,207	2,147,494	20,063
Qualified 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
Poverty Level							
Aged	60,302	69,154	0	16,629	49	10,235,607	77,812
Disabled	5,252,959	1,470,672	0	1,247,956	844	6,651,605	100,229
Katie Beckett	936,956	227,565	0	175,487	2,389	455,378	0
Other Medical Assistance Only							
"K" Babies	24,776,440	1,891,352	0	5,654,759	1,062,742	1,152,319	0

Source: MAM 250-R1

TABLE 8

Number of Paid Claims for Fiscal Years 1993 and 1994

Type of Service	Claims for FY 1993	Claims for FY 1994	Percent of Increase/Decrease
Total	**17,306,563**	**18,513,778**	**6.98%**
Inpatient Hospital	244,217	330,833	35.47
Outpatient Hospital	739,059	748,714	1.31
Lab / X-Ray	600,166	590,517	-1.61
Nursing Facility	334,144	250,351	-25.08
Physician	4,277,253	4,278,339	0.03
EPSDT	368,471	586,125	59.07
EPSDT - Dental	520,090	500,794	-3.71
EPSDT - Vision	223,708	240,441	7.48
EPSDT - Hearing	2,751	2,562	-6.87
Rural Health Clinic	45,852	299,252	552.65
Federally Qualified Health Center	305,541	663,800	117.25
Home Health	27,028	26,178	-3.14
Transportation	456,305	337,090	-26.13
Prescribed Drugs	6,035,060	6,289,598	4.22
Dental	154,585	142,079	-8.09
Eyeglasses	11,888	13,099	10.19
Intermediate Care Facility - Mentally Retarded	108,119	29,410	-72.80
Family Planning	175,121	134,523	-23.18
Family Planning Drugs	75,098	58,592	-21.98
Buy-In, Medicare (Parts A & B)	1,957,369	2,372,528	21.21
Mental Health Clinic	423,795	427,212	0.81
Home & Community Based	13,012	13,953	7.23
Durable Medical Equipment	76,491	62,048	-18.88
Therapy	15,911	21,683	36.28
Inpatient Residential Psychiatric	4,381	2,448	-44.12
Inpatient Hospital Psychiatric	4,745	5,790	22.02
Nurse Practitioner	88,548	69,130	-21.93
Ambulatory Surgical Center	4,099	3,246	-20.81
Hospice	771	827	7.26
Dialysis	3,787	3,309	-12.62
Outpatient Psychiatric Hospital	1	233	23200.00
Private Mental Health Center	9,197	9,074	-1.34

Source: MR-0-08

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

While the Division of Medicaid (DOM) is responsible for the administration of the Medicaid program, DOM contracts with a fiscal agent for operation of the Medicaid Management Information System (MMIS) which maintains provider and recipient eligibility records, processes claims, and maintains reporting systems which enable DOM to monitor the program and enforce its policies and procedures as well as aid in agency decision-making. From July 1, 1993 through May 2, 1994, First Health Services Corporation was the fiscal agent for Mississippi Medicaid. From May 3, 1994 through June 30, 1994, EDS was the fiscal agent for Mississippi Medicaid. During FY 1994, 18,513,778 claims were processed through the MMIS. Approximately 70 percent of all claims were filed electronically.

Within the agency, the Systems Information Division (SID) is responsible for the MMIS. These responsibilities include:

- Managing the fiscal agent contract in order to ensure that the state and federal requirements for operation of an MMIS are met;

- Serving as liaison responsible for coordinating information between DOM and the fiscal agent. This involves coordinating and resolving processing problems and managing computer system requests (CSRs), which modify the MMIS to accurately reflect Medicaid policy through software changes;

- Verifying and coordinating system performance to ensure that Medicaid policy is mirrored in the MMIS through the federally mandated System Performance Review (SPR);

- Producing specialty reports and data files for in-house informational needs;

- Tracking reports to and from the fiscal agent;

- Providing for database management;

- Directing the acquisition of *ad hoc* reports.

In addition, the Systems Information Director serves as the agency security chief as it relates to confidentiality and control of users of the system.

Chart 4

Percentages of Claims Processed by Type of Service for Fiscal Year 1994

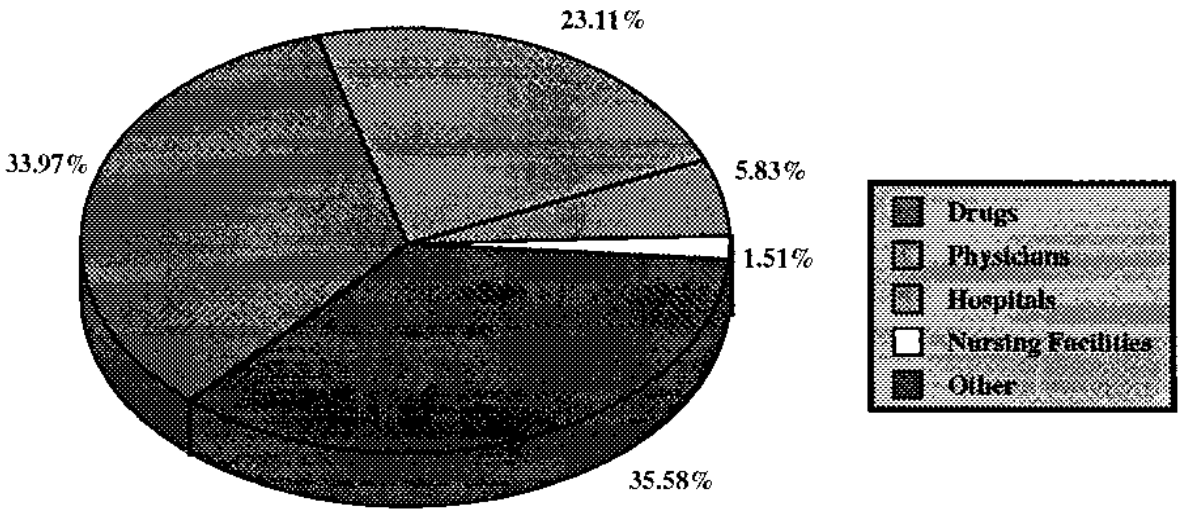


TABLE 9

Payments Made to Providers by County for Fiscal Year 1994

It is important to note that providers in one county may serve recipients living in a different county. For information on Medicaid payments for recipients by county refer to Table 10.

County	Total Payments
Adams	$ 15,272,798
Alcorn	11,110,502
Amite	488,921
Attala	5,095,911
Benton	1,318,545
Bolivar	18,969,967
Calhoun	4,486,205
Carroll	235,768
Chickasaw	5,407,213
Choctaw	1,633,002
Claiborne	3,365,917
Clarke	3,512,443
Clay	5,393,549
Coahoma	26,087,053
Copiah	5,526,238
Covington	3,663,329
DeSoto	8,253,026
Forrest	48,405,948
Franklin	2,427,108
George	3,300,245
Greene	2,406,724
Grenada	7,283,615
Hancock	5,068,215
Harrison	59,562,090
Hinds	135,870,285
Holmes	8,427,155
Humphreys	4,214,281
Issaquena	0
Itawamba	2,835,843
Jackson	20,474,948
Jasper	1,455,250
Jefferson	2,331,251
Jefferson Davis	2, 520, 199
Jones	41,410,589
Kemper	1,711,049
Lafayette	21,333,899
Lamar	7,719,430
Lauderdale	35,142,679
Lawrence	2,329,133
Leake	4,853,952
Lee	18,509,921
Leflore	$ 22,102,412
Lincoln	15,123,594
Lowndes	14,842,344
Madison	13,426,040
Marion	7,285,014
Marshall	4,548,651
Monroe	9,207,912
Montgomery	4,142,648
Neshoba	5,781,921
Newton	5,983,488
Noxubee	3,079,898
Oktibbeha	19,531,077
Panola	6,835,837
Pearl River	9,310,439
Perry	2,179,423
Pike	17,198,193
Pontotoc	4,518,943
Prentiss	3,387,450
Quitman	4,040,096
Rankin	36,577,356
Scott	5,497,142
Sharkey	2,732,906
Simpson	17,755,577
Smith	2,766,638
Stone	2,473,880
Sunflower	12,283,366
Tallahatchie	2,727,508
Tate	5,730,352
Tippah	6,540,764
Tishomingo	4,269,228
Tunica	687,527
Union	9,249,719
Walthall	5,016,297
Warren	19,974,435
Washington	25,756,555
Wayne	5,202,831
Webster	3,005,728
Wilkinson	4,665,335
Winston	4,905,557
Yalobusha	2,185,748
Yazoo	7,150,012

 Source: HMCP990M-R2

TABLE 10

Payments Made for Recipients by County for Fiscal Year 1994

It is important to note that recipients in one county may receive services from a provider in a different county. For information on Medicaid payments to providers by county refer to Table 9.

County	Total Payments	County	Total Payments
Adams	$15,981,296	Leflore	$21,935,797
Alcorn	12,620,247	Lincoln	17,885,644
Amite	3,534,349	Lowndes	15,962,543
Attala	7,962,978	Madison	20,757,861
Benton	3,088,519	Marion	12,438,608
Bolivar	23,367,447	Marshall	10,428,458
Calhoun	6,142,160	Monroe	11,980,462
Carroll	2,209,742	Montgomery	5,298,621
Chickasaw	6,449,944	Neshoba	14,459,263
Choctaw	4,631,778	Newton	8,146,802
Claiborne	5,217,107	Noxubee	5,689,319
Clarke	5,928,266	Oktibbeha	15,656,880
Clay	8,838,172	Panola	12,852,135
Coahoma	24,083,209	Pearl River	13,817,252
Copiah	10,526,047	Perry	4,529,808
Covington	6,264,640	Pike	17,451,406
DeSoto	9,790,801	Pontotoc	7,827,498
Forrest	31,617,071	Prentiss	6,213,608
Franklin	3,704,442	Quitman	6,422,817
George	5,321,117	Rankin	40,500,123
Greene	5,226,038	Scott	9,966,570
Grenada	7,259,418	Sharkey	4,314,871
Hancock	9,572,824	Simpson	22,369,531
Harrison	61,541,410	Smith	6,439,192
Hinds	90,438,748	Stone	4,704,846
Holmes	14,311,112	Sunflower	16,564,728
Humphreys	6,442,886	Tallahatchie	6,215,290
Issaquena	465,778	Tate	6,768,856
Itawamba	5,273,130	Tippah	9,615,939
Jackson	26,261,156	Tishomingo	6,324,833
Jasper	7,032,910	Tunica	3,803,831
Jefferson	5,248,716	Union	6,384,787
Jefferson Davis	5,606,554	Walthall	7,840,978
Jones	45,284,568	Warren	18,812,802
Kemper	4,146,016	Washington	28,042,089
Lafayette	17,512,300	Wayne	7,890,603
Lamar	8,797,298	Webster	5,272,132
Lauderdale	30,762,165	Wilkinson	5,557,803
Lawrence	4,958,341	Winston	8,266,118
Leake	8,365,251	Yalobusha	4,378,897
Lee	21,687,405	Yazoo	13,314,261

Source: HMCP990M-R1

THIRD PARTY LIABILITY

In accordance with Title XIX of the Social Security Act as well as state law, Medicaid program liability is secondary to any third party benefits to which a recipient is entitled. Third party resources are any entities, individuals or programs who are legally responsible for paying the medical expenses of Medicaid recipients. Mississippi's Medicaid Third Party (TPL) Unit is responsible for identifying any third party resources and for incorporating this information into the Medicaid Management Information System (MMIS) so that when a claim is filed, payment is avoided. This third party information is also directed to the medical provider.

Mississippi's Medicaid TPL Unit operates a successful program which has saved Mississippi taxpayers millions of dollars through cost avoidance and post payment recovery of private health and casualty insurance resources. Mississippi Medicaid also pays Medicare premiums for qualified Medicare eligibles enabling avoided costs of Medicare covered services. Further, as a result of the requirements of OBRA 93, the state enacted legislation requiring the pursuit of medical support in the form of cash or insurance from absent parents. This new law eliminates many of the barriers which have restricted the coverage of children of non-custodial parents by employer-related health insurance. Through this enforcement of medical support orders, Medicaid expects increased savings to the program due to an increase in the number of children which will be enrolled in group health insurance plans.

In FY 1994, third party savings in the form of cost avoided or recovered payments from both public and private resources totaled $347.8 million. As a graphic example of the effectiveness of the TPL Unit, $12.89 was recovered for every one dollar invested in the salaries of the Medicaid auditors responsible for in-house recoveries.

Medicare Buy-In

Because some Medicaid eligibles are also eligible for Medicare, it is necessary to have some means by which this group may be identified. The Mississippi Medicaid claims payment system includes edits for Medicare coverage to ensure that claims which are submitted to Medicaid as primary payer are returned to the providers to file Medicare. The MMIS also contains segments that allow for the monitoring of payment of Medicare premiums for qualified individuals. In FY 1994, 20 percent of the Mississippi population also had Medicare coverage. The claims payment edits and buy-in program yielded $318.6 million in Medicare cost avoidance.

Private Health Insurance Resources

Approximately four (4) percent of the Mississippi Medicaid population was covered by some form of private health insurance in FY 1994. Through cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment), the Medicaid agency saved $22.8 million. Through post payment recovery (the Medicaid agency bills the third party for reimbursement), the TPL Unit collected $2.8 million.

Casualty/Tort Resources

A significant number of Medicaid recipients receive medical care each month as the result of injuries or accidents. Medicaid is responsible for identifying those recipients whose injury was caused by another party or liability and then pursue recovery from the liable third party. These resources are identified through MMIS claims processing edits and referrals from outside entities such as insurance companies, providers, and attorneys. In FY 1994, the TPL Unit collected over $1 million from casualty/tort resources.

Prescribed Drug Recovery Program

In 1985, the Mississippi Division of Medicaid obtained a federal waiver which allows Medicaid to reimburse pharmacists participating in the program even if the MMIS contains a record of third party liability. Medicaid then pursues recovery from the third party resources. The TPL Unit reported a recoupment of nearly $1 million in the drug program in FY 1994.

PROGRAM INTEGRITY

The Division of Medicaid is responsible for monitoring both provider and recipient utilization of Medicaid services. State and federal laws require periodic checks of provider records in order to verify actual receipt of services for which payment has been made and to investigate any cases suggestive of program abuse, misuse or fraud. This is accomplished through the Program Integrity Investigative Unit. Medical personnel conduct physician reviews to determine the medical necessity and appropriateness of procedures performed and to ensure that quality health care is being provided to Mississippi Medicaid recipients. Recipient management reviews are also conducted to make certain that recipients are receiving only health care services which are medically necessary as well as to control misutilization of Medicaid services.

With the assistance of a computerized surveillance and utilization reporting system (SURS), Mississippi's Program Integrity Unit is able to maintain practice and service profiles on all Medicaid providers and on recipients who receive services through the Medicaid program. These profiles provide indicators of possible fraudulent activities or abuse of program benefits and are an important source of information upon which the Program Integrity Unit bases its investigations. Examples of the types of profile information used are frequency of physician visits for a given recipient, ratio of laboratory procedures to medical visits for a physician, and extractions per recipient for a dentist. Exception reports are used by Medicaid investigators to identify unusual or exceptional profiles.

Investigations of providers by the Program Integrity Unit may result in monetary recovery, termination as a provider of Medicaid services, or referral to the Medicaid Fraud Control Unit of the Office of Attorney General. Medical review findings may be referred to the local peer review organization for their recommendation or to the State Board of Medical Licensure for corrective action.

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

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

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

CONTRACTS MONITORING

In the administration of the State Medicaid program, the Division of Medicaid enters into contractual affiliation with certain individuals and organizations which provide expertise and knowledge when such arrangements are advantageous and cost efficient to the program.

The Contracts Monitoring Division conducts financial and program reviews through desk audits and on-site evaluations to determine if contractual obligations have been met. These reviews have resulted in the recoupment of funds for inappropriately claimed contractual expenditures as well as revised project schedules for contractual work. The Division of Medicaid has realized substantial savings in contractual expenditures through the activities of the Contracts Monitoring Division.

SERVICES

Nationwide, Medicaid services fall into three main categories -- those that are mandated by federal law, optional services that states may elect to provide, and certain waivered projects which offer additional enhanced services. Based on the availability of funds, the Legislature determines each year the services that will be provided and the reimbursement schedule for providers. During Fiscal Year 1994, the Mississippi Division of Medicaid provided the following services:

Mandated Services

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

Optional Services

- Prescribed drugs
- Dental services
- Eyeglasses services
- Intermediate care facilities for the mentally retarded
- Mental health services
- EPSDT Expanded Services
- Durable medical equipment & supplies
- Birthing center services
- Hospice services
- Christian Science Sanatoria services
- Podiatry services
- Nurse practitioner services, including nurse anesthetist services
- Inpatient psychiatric services for under 21 years of age

Waivered Services

- Managed care
- Home- and community-based services for the aged & disabled

TABLE 11

Total Number of Eligibles, Number Using Physician Services by Program Category for Fiscal Year 1994

Program Category	Total Number of Eligibles	Recipients Using Service	Percent of Total
Total	**555,573**	**361,683**	**65.10%**
Aged	52,343	52,239	99.80
Blind	1,726	1,214	70.34
Disabled	111,134	76,383	68.73
AFDC Children	252,200	144,800	57.41
AFDC Adults	111,296	70,728	63.55
CWS Foster Care	1,192	1,164	97.65
Optional Categorically Needy	25,682	15,155	59.01

Source: HCFA 2082

TABLE 12

Amount of Expenditures with Percentage Distribution for Physician Services by Program Category for Fiscal Year 1994

Program Category	Expenditures	Percent of Total
Total	**$98,748,321**	**100.0%***
Aged	17,024,211	17.24
Blind	473,992	0.48
Disabled	28,215,520	28.57
AFDC Children	19,928,236	20.18
AFDC Adults	27,837,152	28.19
CWS Foster Care	262,670	0.27
Optional Categorically Needy	5,006,540	5.07

** Percentage columns may not total 100% due to rounding*

Source: HCFA 2082

TABLE 13

Amount of Expenditures with Percentage Distribution for Physician Services by Age Groups for Fiscal Year 1994

Age in Years	Expenditures	Percent of Total
Total	**$98,748,321**	**100.0%***
Birth to age 1	11,408,877	11.55
Ages 1 to 3	5,562,926	5.63
Ages 3 to 5	3,354,318	3.40
Ages 5 to 6	1,375,341	1.39
Ages 6 to 8	2,256,420	2.29
Ages 8 to 19	18,043,480	18.27
Ages 19 to 21	7,744,680	7.84
Ages 21 to 64	47,851,216	48.46
Age 64 and Over	1,151,063	1.17

** Percentage columns may not total 100% due to rounding*

Source: MAM 250-R1

TABLE 14

Number of Physician Visits by Place of Visit for Fiscal Year 1994

Place of Visit	Number of Visits	Percent of Total
Total	**2,016,635**	**100.0%***
Physician's Office	1,221,665	58.14
Hospital	477,138	25.44
Nursing Home	8,990	0.47
Emergency Room	277,456	14.70
Consultations	31,266	1.24
House Calls	120	<0.01

* *Percentage columns may not total 100% due to rounding*

Source: SU-0-1-10

Prescribed Drugs

The number of recipients who received prescribed drugs during FY 1994 totaled 434,971. The average number of prescriptions per recipient for the same period was 12.2.

TABLE 15

Number of Prescriptions, Number of Recipients, and Average Number Prescriptions Per Recipient by Program Category for Fiscal Year 1994

Program Category	Prescriptions	Percent of Total	Number of Recipients	Percent of Total	Avg. Number Prescriptions Per Recipient
Total	**5,326,337**	**100.00***	**434,971**	**100.00***	**12.2**
Aged	1,735,064	32.58	64,555	14.84	26.9
Blind	30,582	0.57	1,524	0.35	20.1
Disabled	1,826,479	34.29	97,528	22.42	18.7
AFDC Children	892,715	16.76	171,390	39.40	5.2
AFDC Adults	330,533	9.96	80,567	18.52	6.6
CWS Foster Care	6,397**	0.12	1,257	0.29	5.1
Optional Categorically Needy	304,567	5.72	18,150	4.17	16.8

* *Percentage columns may not total 100% due to rounding*

** *Prescriptions for CWS Foster Care children were estimated as data was unavailable.*

Source: HCFA 2082

Long-Term Care Facilities

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

TABLE 16

Number of Recipients and Number of Days of Care for Nursing Facilities by Program Category for Fiscal Year 1994

Program Category	Nursing Facilities		Intermediate Care Facilities - MR	
	Recipients	*Days of Care*	*Recipients*	*Days of Care*
Total	***17,674**	**4,289,093**	**2,214**	**634,286**
Aged	15,318	3,730,423	71	20,194
Blind	48	12,847	23	6,622
Disabled	1,399	310,771	1,120	314,272
AFDC Children	0	0	0	0
AFDC Adults	6	155	0	0
CWS Foster Care	0	0	0	0
Optional Categorically Needy	903	234,897	1,000	293,198

** These data are incomplete but are presented to show distribution of NF residents by category to the extent possible.*

Source: HCFA 2082

Family Planning Services

Expenditures for the planning services program amounted to $85,322 in Fiscal Year 1994 with the federal government paying 90 percent and Mississippi paying the remaining 10 percent. Payments were made to private physicians, pharmacies and family planning clinics located throughout the state.

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

During Fiscal Year 1994, a total of 119,145 of Mississippi's children and youth under age 21 received a comprehensive physical evaluation through EPSDT screenings. The number of treatments, by program category, received as a result of problems diagnosed during the screenings are found in Table 17.

TABLE 17

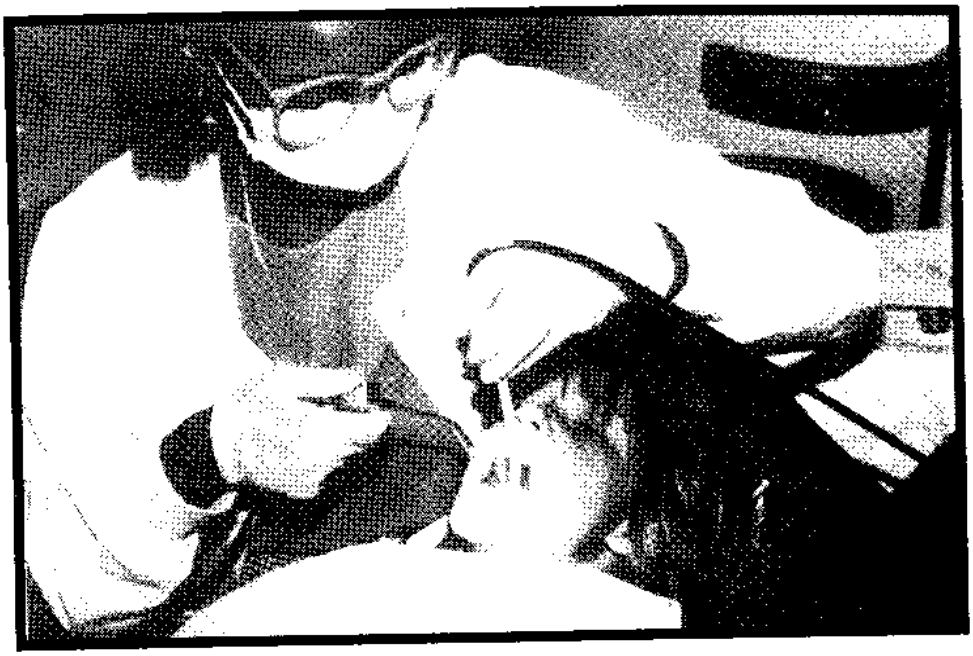
Number of Children Receiving Treatment by Category of Service

Program Category	Number of Children
Dental	58,282
Vision	30,695
Hearing	15,367
Medical Referrals	238,432

Source: HCFA 416 Y-T-D

Dental Services

Limited dental care was provided to 26,297 recipients during Fiscal Year 1994 with expenditures amounting to $2,233,768.



Inpatient Hospital Services

During Fiscal Year 1994, Medicaid provided for 337,863 days of inpatient hospital care. The average length of hospital stay was 3.5 days. Table 18 shows the number of Medicaid recipients who received inpatient hospital service benefits, the number of discharges, the total days of care and the average length of stay per recipient by program during Fiscal Year 1994.

Outpatient Hospital Services

A total of 520,454 outpatient visits were provided to 222,117 Medicaid recipients during Fiscal Year 1994 with an average of 2.5 visits per outpatient recipient.

TABLE 18

Number of Recipients, Number of Discharges, Total Days of Hospital Care, and Average Length of Hospital Stay by Program Category for Fiscal Year 1994

Program Category	Number of Recipients*	Number of Discharges	Days of Care	Average Length of Hospital Stay
Total	**88,741**	**96,998**	**337,863**	**3.5**
Aged	10,207	365	1,638	4.5
Blind	323	290	1,215	4.2
Disabled	23,315	30,335	128,526	4.2
AFDC Children	15,637	23,126	88,731	3.8
AFDC Adults	26,793	38,783	99,518	2.6
CWS Foster Care	120	**	**	**
Optional Categorically Needy	12,346	4,099	18,235	4.4

* *Does not include Medicaid recipients who are covered under Medicare Part A*
** *Data not available*

Source: HCFA 2082

TABLE 19

Amount Paid to State Health Agencies and Institutions by Source of Funds for Fiscal Years 1993 and 1994

Name of Agency or Institution	Fiscal Year	Total Amount of Payment	From Federal Funds	From State Funds
Total	**FY 1993**	**$201,985,831**	**$159,589,006**	**$42,396,825**
	FY 1994	**216,548,115**	**170,748,189**	**45,799,926**
Miss. State Dept. of Health	FY 1993	20,155,057	15,924,511	4,230,546
	FY 1994	17,262,520	13,611,497	3,651,023
Miss. Dept. of Human Services	FY 1993	2,119,732	1,674,800	444,932
	FY 1994	2,476,024	1,952,345	523,679
Miss. Department of Mental Health	FY 1993	25,726,932	20,326,849	5,400,083
	FY 1994	26,424,712	20,835,885	5,588,827
East Miss. State Nursing Home (Meridian)	FY 1993	3,447,820	2,724,123	723,697
	FY 1994	4,142,938	3,266,707	876,231
Ellisville State School (Ellisville)	FY 1993	21,943,416	17,337,493	4,605,923
	FY 1994	23,644,322	18,643,548	5,000,774
North Miss. Regional Center (Oxford)	FY 1993	172,918	136,623	36,295
	FY 1994	141,040	111,210	29,830
South Miss. Regional Center (Long Beach)	FY 1993	10,798,685	8,532,041	2,266,644
	FY 1994	12,134,897	9,568,366	2,566,531
Hudspeth Retardation Center (Whitfield)	FY 1993	13,306,742	10,513,657	2,793,085
	FY 1994	14,066,742	11,091,626	2,975,116
Miss. State Hospital-Nursing Facilities (Whitfield)	FY 1993	9,286,644	7,337,377	1,949,267
	FY 1994	8,456,098	6,667,633	1,788,465
Miss. State Hospital (Whitfield)	FY 1993	791,454	625,328	166,126
	FY 1994	623,026	491,256	131,770
Boswell Retardation Center (Sanatorium)	FY 1993	3,615,115	2,856,302	758,813
	FY 1994	4,163,685	3,283,066	880,619
University Medical Center * (Jackson)	FY 1993	90,621,316	71,599,902	19,021,414
	FY 1994	103,012,111	81,225,050	21,787,061

Source: Provider History Report

*** - FY 1993 amount includes Disproportionate Share Hospital Payments**