West Virginia
Children's Health Insurance Program

Annual Report 2015

Georgetown University Health Policy Institute
http://ccf.georgetown.edu/wp-content/uploads/2015/11/ACS-report-2015.pdf

West Virginia
Children's Health Insurance Program

2015 Annual Report

Earl Ray Tomblin, Governor

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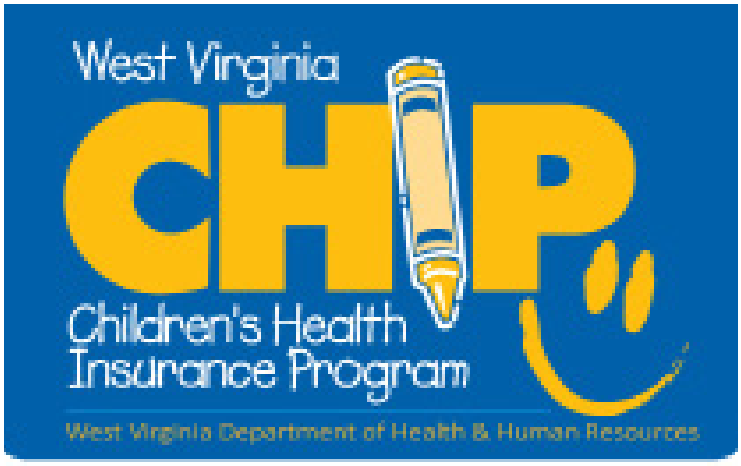
State of West Virginia

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health & Human Resources

Sharon L. Carte, MHS, Executive Director
West Virginia Children's Health Insurance Program

Prepared by:
Stacey L. Shamblin, MHA
Chief Financial Officer
West Virginia Children's Health Insurance Program



Our Mission

To provide quality health insurance to eligible children in a way that improves child population health and promotes healthy kids and healthy communities.

Our Vision

West Virginia CHIP will be a leader in value driven and innovative child health care.

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Introductory Section

What A Difference CHIP Can Make -

"CHIP is a life jacket to our home. Thank you."

Parent quote from a 2001 CHIP survey.

West Virginia Children's Health Insurance Program
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Suite 101
Charleston, WV 25301

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Helpline 877-982-2447
www.chip.wv.gov

December 18, 2015

Earl Ray Tomblin, Governor
State of West Virginia

Honorable Members of the
West Virginia Legislature

Board of Directors
West Virginia Children's Health Insurance Program

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human Resources

Jeremiah Samples, Deputy Secretary
West Virginia Department of Health and Human Resources

Sharon L. Carte, MHS, Executive Director
West Virginia Children's Health Insurance Program

Ladies and Gentlemen:

It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2015. This report was prepared by the Chief Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented and the completeness and fairness of the presentation, including all disclosures. We believe the data, as presented, are accurate in all material respects and presented in a manner that fairly reports the financial position and results of operations of WVCHIP. All disclosures necessary to enable the reader to gain an understanding of WVCHIP's financial activities have been included. It should be noted that these financial reports are unaudited and for management purposes only.

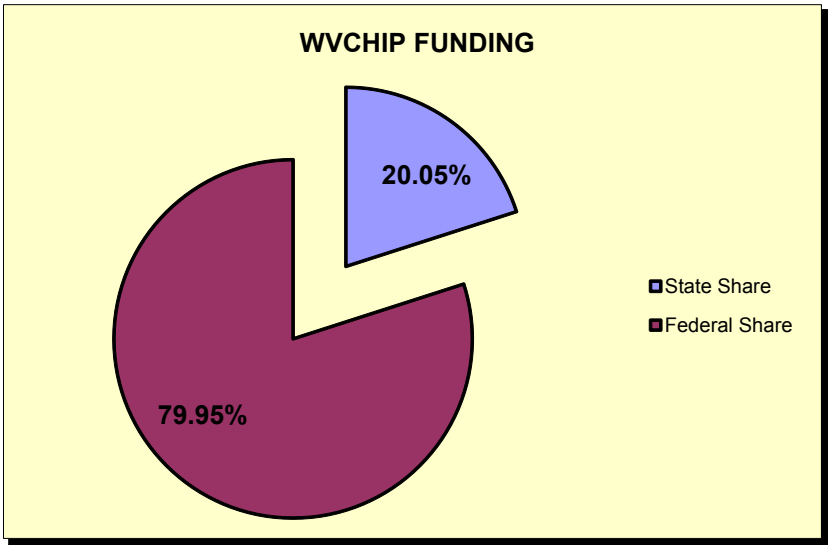
This Annual Report is presented in three sections: introductory, financial, and statistical. The introductory section contains this transmittal letter, a list of the principal officers of WVCHIP, and WVCHIP's organizational chart. The financial section includes the basic financial statements and footnotes as well as certain supplementary information as required by State Code. Also included in the financial

section is management's discussion and analysis (MD&A) which provides the reader a narrative introduction, overview and further analysis of the financial information presented. The statistical section includes selected financial and statistical data.

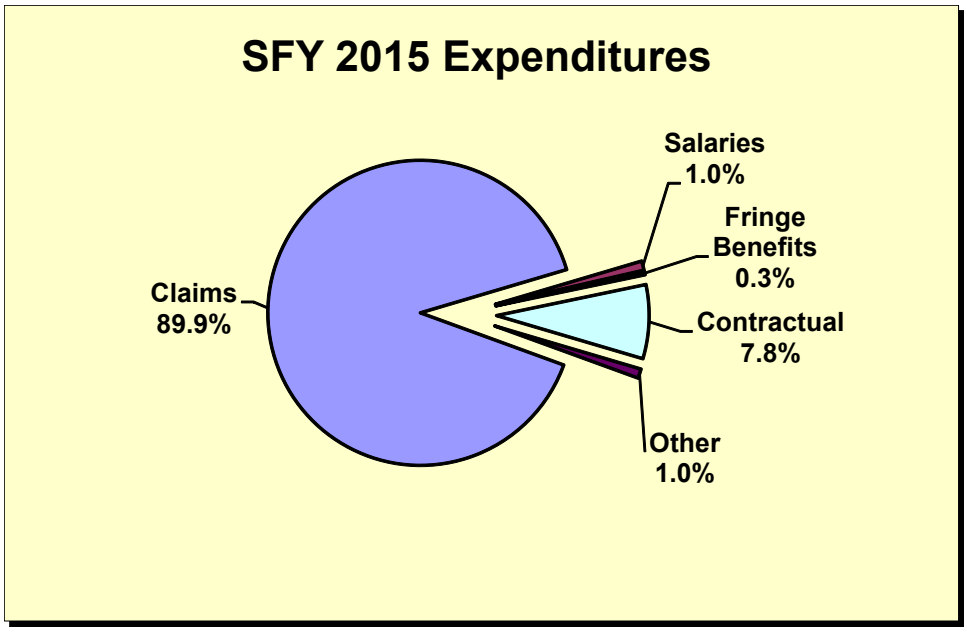
The West Virginia Legislature passed House Bill 4299 on April 19, 1998, to create WVCHIP. Since its inception, it has undergone several changes that include transfer of the program from the West Virginia Department of Health and Human Resources (DHHR), and establishing the Children's Health Insurance Agency within the Department of Administration, with the passage of Senate Bill 565 in 2000. WVCHIP is governed by a Board of Directors of up to eleven members, through approval of an annual financial plan and modifications to benefits. Day-to-day operations of WVCHIP are managed by the Executive Director who is responsible for the implementation of policies and procedures established by the Board of Directors. The West Virginia Children's Health Insurance Agency is responsible for the administration of the WVCHIP. On February 19, 2015, the West Virginia Legislature passed Senate Bill 262 moving the Children's Health Insurance Agency from the Department of Administration to the DHHR effective July 1, 2015.

FINANCIAL PERFORMANCE AND OUTLOOK

WVCHIP is funded by both federal and state monies. Each year the program receives an allotment of federal money that may be used to fund program expenditures at a set percentage. Currently, federal allotments are available for a period of two years. State money is provided through general appropriations that are approved by both the Governor and the State Legislature. State money that is not used in the current year is carried-over to the next year. The match rates at June 30, 2015, were 79.95% federal share and 20.05% state share.



West Virginia State Code requires that estimated program claims and administrative costs, including incurred but not reported claims, not exceed 90 percent of the total funding available to the program, and provides for an actuarial opinion to ensure that this requirement will be met. The Actuarial Report dated June 30, 2015, confirms this requirement will be met through State Fiscal Year (SFY) 2021, assuming that federal funding amounts remain the same as they are in 2015, and considering projected enrollment and program costs trends. It should be noted that the Affordable Care Act (ACA) added 23% to the federal matching rate starting October 1, 2015. This increase makes WVCHIP 100% federally funded through at least Federal Fiscal Year (FFY) 2017.



REAUTHORIZATION BY UNITED STATES CONGRESS

The Children's Health Insurance Program (CHIP) was reauthorized by Congress on March 26, 2015, by the Medicare Access and CHIP Reauthorization Act (MACRA) (H.R.2). MACRA extends CHIP funding through FFY 2017, but likely provides enough funding to cover some expenditures in FFY 2018. These additional CHIP costs are somewhat offset by reductions in Medicaid costs and premium tax credits and cost-sharing subsidies in the health insurance marketplaces.

HEALTH CARE REFORM

Congress passed the ACA which was signed into law on March 23, 2010. Healthcare reform will impact WVCHIP significantly. While the bill extends CHIP appropriations through 2015, it also increases the federal share for the program from 2016 through 2019. WVCHIP will be virtually 100% federally funded during this time. One major impact of healthcare reform is the increase in the income eligibility limit for children served by the state Medicaid program. Effective January 1, 2014, the upper income limit for Medicaid children aged six (6) through eighteen (18) increased to 133% Federal Poverty Level (FPL). This increase caused many children that were income eligible for WVCHIP to transfer enrollment to Medicaid. The Centers for Medicare and Medicaid Services (CMS) approved West Virginia's State Plan Amendment (SPA) to continue to utilize Title XXI funding for this population of CHIP children that moved to Medicaid also effective January 1, 2014. Prior to ACA implementation, Title XXI funds financed approximately 25,000 children monthly and now post ACA Title XXI funds finance approximately 34,000 children monthly.

INITIATIVES

This year was another one of intensive management activity for WVCHIP. Work continued under the "Tri-State Children's Health Improvement Consortium" (T-CHIC), a multi-state grant focused on improving the quality of health care provided to children. The program continued activities necessary to implement the changes brought about by the ACA. WVCHIP began the design, development, and implementation phase to move medical and dental claims processing from the current Third-Party Administrator (TPA) to

the Medicaid Management Information System (MMIS). This change is necessary to assure compliance with provider enrollment regulations and new monthly data reporting to the CMS under the Transformed Medicaid Statistical and Information System (T-MSIS). Failure of WVCHIP to comply with T-MSIS requirements would cause a freeze on Medicaid funding for this project.

OTHER

Title XXI of the Social Security Act, enacted in 1997 by the Balanced Budget Act, authorized federal grants to states for the provision of child health assistance to uninsured, low-income children. The CMS monitors the operation of WVCHIP. Financial statements are presented for the SFY ended June 30, 2015. The FFY ends September 30 and further documentation is submitted to CMS based on that period. Certain statistical information such as pediatric quality reports, by nature, is presented on a calendar year basis as required.

ACKNOWLEDGMENTS

As this year closes, we wish to especially thank and acknowledge the leadership of Governor Earl Ray Tomblin whose call for further expansion of children's coverage in 2011 further closed the gap for uninsured children when the program expanded the premium part of the plan from 250% FPL to 300% FPL. Not only did this protect more families who were losing employer group coverage during difficult economic times, it paved the way for the State's recent excellent ranking of 4th in the nation for the lowest children's uninsurance rate - 97% of all West Virginia children have health care coverage. Without his action we could not have reached this point.

Special thanks are extended to members of the Legislature for their continued support. Gratitude is also expressed to the members of WVCHIP's Board of Directors for their continued leadership and direction during this period. Our most sincere appreciation to both Cabinet Secretary Jason Pizatella, Department of Administration, for his leadership and support in the past year, and to Cabinet Secretary Karen Bowling for making our transition to the Department of Health and Human Resources in the new fiscal year 2016 a smooth one. We look forward to working under the direction of Deputy Secretary Jeremiah Samples whose leadership will guide us towards value based care for children in both the WVCHIP and Medicaid Programs. Lastly, this report would not have been possible without dedication and efforts of WVCHIP's Executive Director, Sharon L. Carte. Respectfully, we submit this Annual Report of the West Virginia Children's Health Insurance Program for the year ended June 30, 2015.

Sincerely,

Stacey L. Shamblin, MHA
Chief Financial Officer

Principal Officials

Earl Ray Tomblin, Governor
State of West Virginia

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health & Human Resources

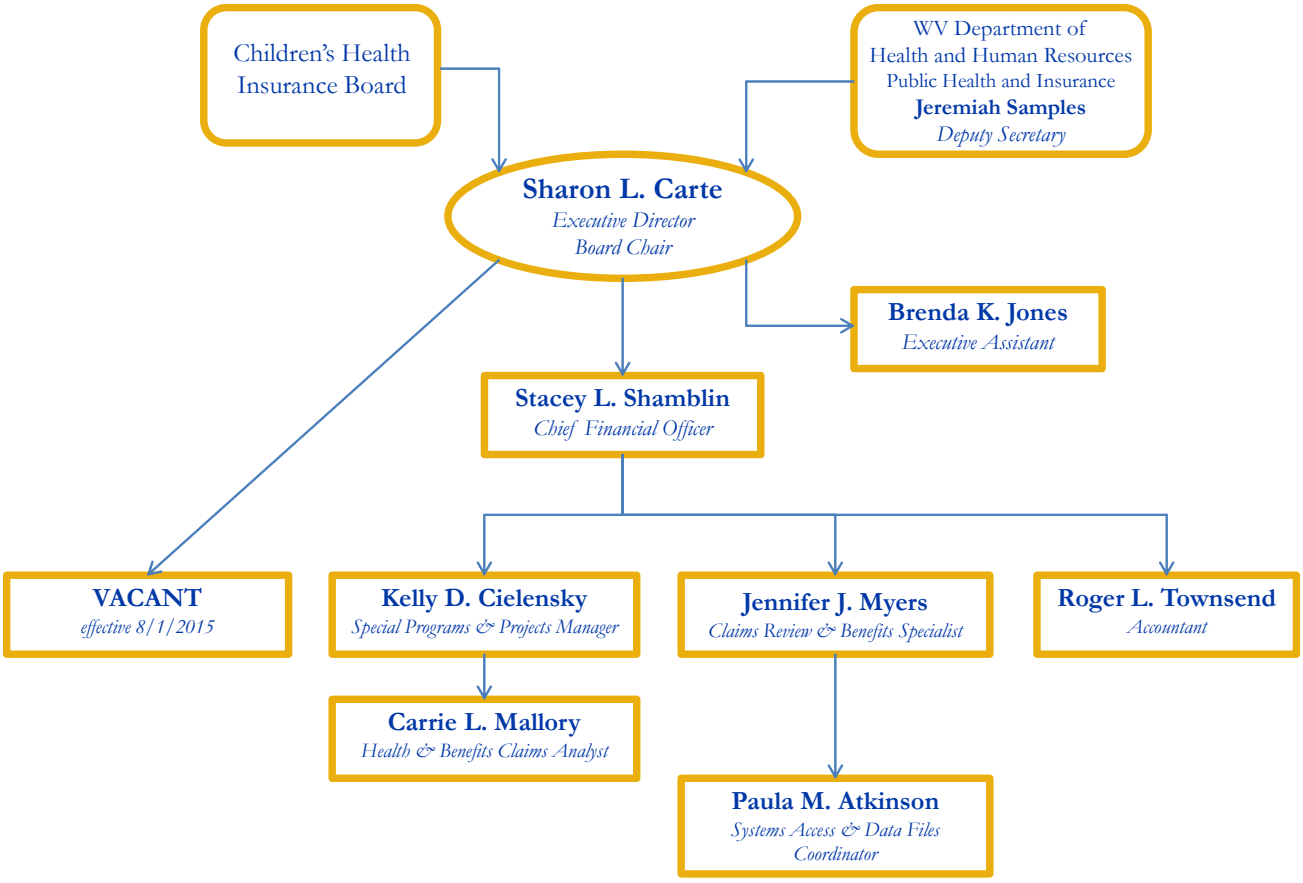
Board Members

Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Jeremiah Samples, Deputy Secretary, Designee for Karen L. Bowling, Cabinet Secretary, DHHR
The Honorable Ryan Ferns, West Virginia Senate, Ex-Officio
The Honorable Joe Ellington, West Virginia House of Delegates, Ex-Officio
Margie Hale, Citizen Member
Travis Hill, Citizen Member
Larry Hudson, Citizen Member
Kellie Wooten-Willis, Citizen Member
VACANT, Citizen Member
VACANT, Citizen Member

Staff

Sharon L. Carte, Executive Director
Paula M. Atkinson, Systems Access & Data Files Coordinator
Kelly D. Cielensky, Special Programs and Projects Manager
Brenda K. Jones, Executive Assistant
Carrie L. Mallory, Health and Benefits Claims Analyst
Jennifer J. Myers, Eligibility, Claims Review, & Benefits Specialist
Stacey L. Shamblin, Chief Financial Officer
Roger L. Townsend, Accountant
Candace A. Vance, RN, Temporary Employee

Staff Organizational Chart



Financial Section

What A Difference CHIP Can Make -

More than 166,000 *children have had the benefit of health care coverage in West Virginia since CHIP began.....*

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM
For the Year Ended June 30, 2015

Management of the WVCHIP provides this MD&A for readers of WVCHIP's financial statements. This narrative overview of the financial statements of WVCHIP is for the year ended June 30, 2015. We encourage readers to consider this information in conjunction with the additional information that is furnished in the footnotes which are found following the financial statements. Please note that these financial statements are unaudited and for management purposes only.

HISTORY AND BACKGROUND

WVCHIP's primary purpose is to provide health insurance coverage to uninsured children in families whose income disqualifies them from coverage available through the Medicaid Program, but is less than or equal to 300% of the current FPL. When Congress amended the Social Security Act in 1997 to create Title XXI "State Children's Health Insurance Program" (SCHIP), federal funding was allocated to the states for such programs over a ten year period. The West Virginia Legislature established the legal framework for this State's program in legislation enacted in April 1998. The Children's Health Insurance Program Reauthorization Act (CHIPRA), signed on February 4, 2009, reauthorized the program through 2013. On March 3, 2010, the passage of the ACA extended federal appropriations through 2015 and increased the share of the program's federal funding from 2016 through 2019. The program will be virtually 100% federally funded during this time. Congress passed the MACRA on March 26, 2015, extending federal CHIP funding through 2017.

Historically, Congress annually appropriated funds on a national level, and states received their share of this total funding based on a complex allotment formula that considered the state's population of uninsured, low-income children. This annual allotment formula changed in 2009 under reauthorization to consider each state's actual projected expenditures, demographics, and national cost trends. States use this annual Federal allotment to cover expenditures at a federal-matching percentage that is determined by the CMS, the program's federal regulatory agency, and posted in the Federal Register.

To use federal monies allotted for the CHIP program, each state is required to file a state plan with CMS that outlines the individuals responsible for program administration, where the program is housed within state government, the program's enrollment policies, how it proposes to use the federal monies, as well as other policies and processes used by the state to administer the program. Once the state plan is approved, the state may use its federal allotment, at the federal matching percentage, to finance program expenditures according to the plan.

Since inception in 1998, WVCHIP has undergone several changes of its State Plan to reach its current form. These changes include:

- Phase I: In July 1998, the Program began as a Medicaid expansion by covering children from ages 1 to 5 in households with incomes from 131% FPL to 150% FPL.

- Phase II: On April 1, 2000, coverage for children from ages 6 through 18 in households from 100% to 150% FPL was added. WVCHIP also adopted PEIA's Preferred Benefit Plan to serve as the benchmark equivalent coverage program.

- In June 2000, WVCHIP notified the federal government that it was withdrawing the Medicaid expansion program and combining it with Phase II to create a separate state program.

- Phase III: In October 2000, WVCHIP expanded coverage for all children through age 18 in families with incomes between 151% and 200% FPL.

- In June 2002, WVCHIP modified its co-payment requirements for pharmacy benefits to eliminate co-pays for generic drugs and expand co-pay requirements for brand name drugs. It also adopted an annual benefit limit of $200,000 and a lifetime benefit limit of $1,000,000.

- In January 2006, WVCHIP modified its pharmacy benefits by implementing a Preferred Drug List which encouraged utilization of generic drugs and increased the amount of drug rebates received from drug manufacturers.

- In January 2007, WVCHIP expanded its upper income limit for program eligibility to 220% FPL. This expanded program from 200-220% FPL is called WVCHIP Premium. Families enrolled in this group are required to make monthly premium payments based on the number of children enrolled in the family. Children in this group receive full medical and drug benefits, limited dental, and no vision coverage.

- In January 2008, WVCHIP modified its state plan to allow the program to secure federal match to pay for comprehensive well-child exams for uninsured children entering Kindergarten using administrative funds.

- In January 2009, WVCHIP further expanded its upper income limit for program eligibility to 250% FPL. Children covered under this expanded group are enrolled in WVCHIP Premium.

- In July 2009, WVCHIP removed restrictions on dental and vision benefits for members in WVCHIP Premium. Members in this group now receive full dental benefits, but with copayments for some services. They also receive full vision benefits.

- In July 2011, WVCHIP once again expanded its upper income limit for program eligibility to 300% FPL. Other changes were also made to the program to come into compliance with the ACA including decreasing the waiting period for enrollment from a maximum of twelve months to three months for all income groups and eliminating the annual and lifetime limits on benefits.

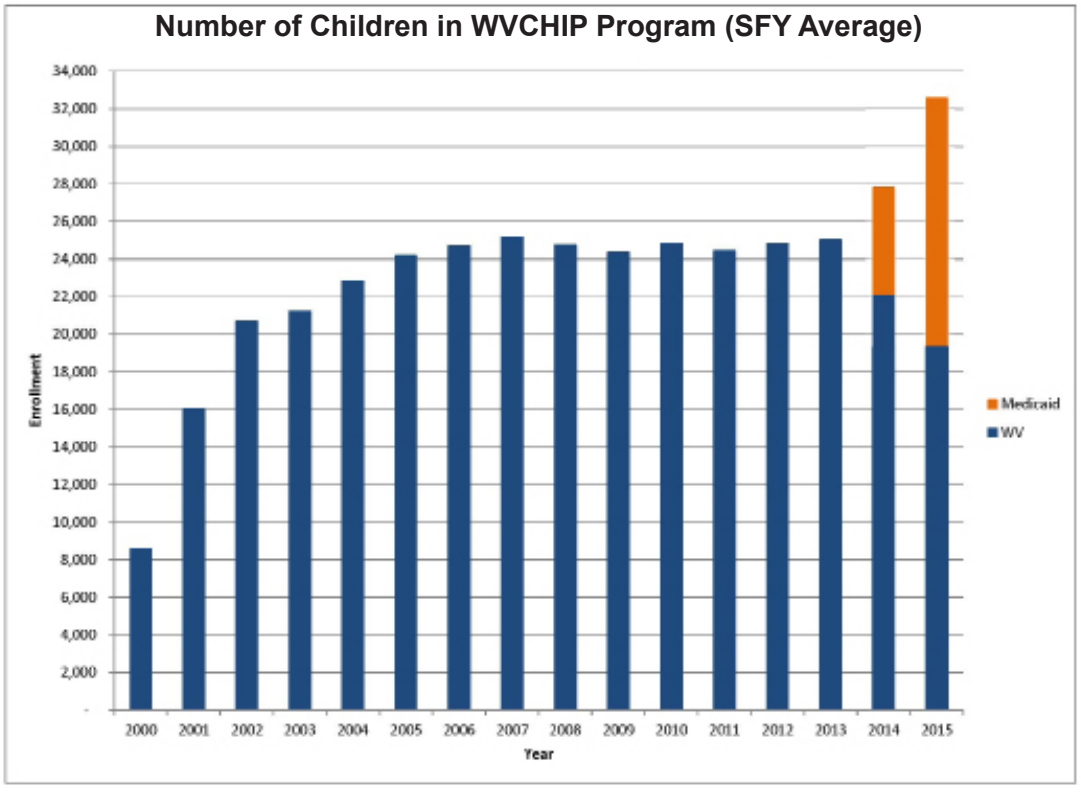
- In October 2013, WVCHIP amended its state plan to implement a combination CHIP and move children aged six (6) through eighteen (18) with incomes between 100% FPL and 133% FPL from coverage under a separate CHIP to a Medicaid-expansion CHIP. The amendment also changed the income counting methodology to determine program eligibility to a Modified Adjusted Gross Income (MAGI) methodology, eliminated the waiting period, and lifted the five-year ban on enrollment for legal residents.

FIFTEEN YEARS OF CHIP AND CHILDREN'S HEALTH CARE COVERAGE NOW

In October, we learned a new milestone had been reached in children's coverage in West Virginia. A report issued by Georgetown University Health Policy Institute that analyzed newly updated health insurance enrollment data by state concluded that children's rate of uninsurance declined significantly from 2013 to 2014 to a new historical low of 6% nationally, and that West Virginia's rate of uninsurance for children was now the 4th lowest in the nation at 3.0% (to see the full report online, please go to http://ccf.georgetown.edu/wp-content/uploads/2015/11/ACS-report-2015.pdf). In addition, West Virginia had one of greatest rates of uninsurance decrease since 2013. They conclude that nationally much of this improvement was due to parents signing up for available coverage through ACA exchanges. There was some effect seen for children even in states with no Medicaid expansion.

Although WVCHIP's inception was in 1998 (as noted in the previous History and Background section) it was in 2000 that WVCHIP expanded to 200% FPL allowing for a more full participation of those children between the ages of 6 and 18 years and this was also when it became a separate program modeled on the public employee plan. It is meaningful now in 2015 to take a long view of the relationship between WVCHIP enrollment growth and expansion since 2000 (Chart A). In **Chart A**, a decrease can be seen in WVCHIP enrollment in 2014, when WVCHIP enrollees below 133% FPL transitioned to Medicaid, and by 2015 there was an overall enrollment increase of roughly an additional 11,000 children. Although the children shown in the gold portion of the 2014 and 2015 bars are in Medicaid, they are supported by the federal WVCHIP allotment.

Chart A

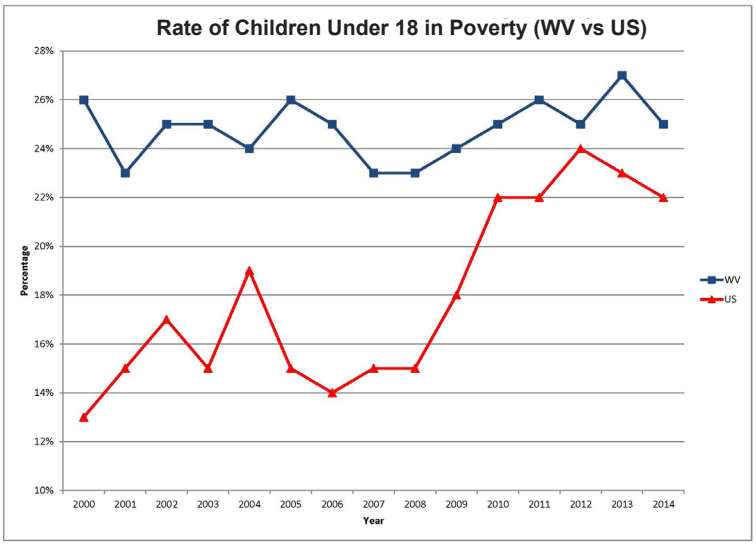


CCRC Actuaries, LLC

Chart 2

Chart B reflects changes in the rates of child poverty in West Virginia compared to the national average over this fifteen year period.

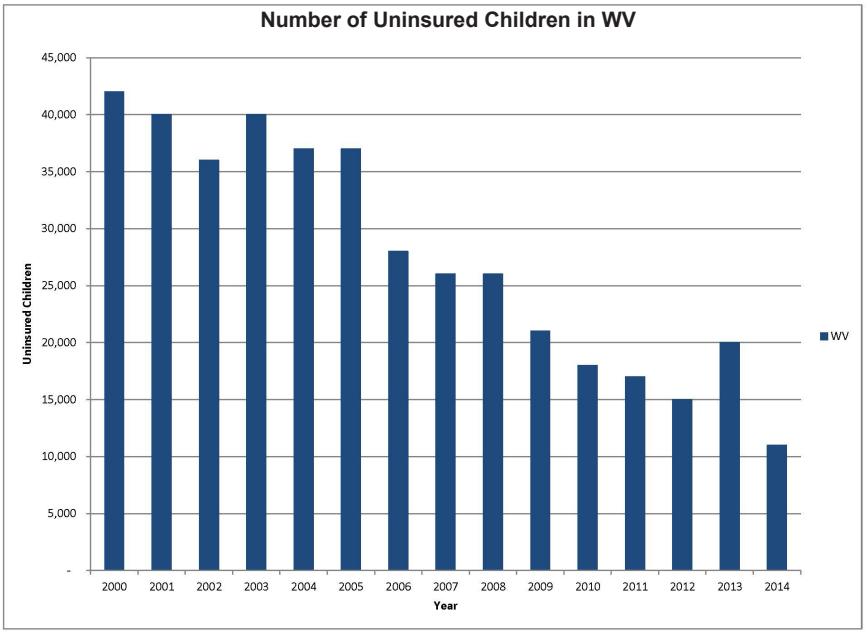
Chart B



CCRC Actuaries, LLC *Chart 3*

Chart C shows the corresponding decrease in child uninsurance rates over this fifteen year span. While this decrease cannot be attributed only to the enrollment growth in WVCHIP or WVCHIP and Medicaid during this period, the state could not have reached this historic low rate if WVCHIP had not previously expanded to 300% FPL. Also, the fact of having a child-only public insurance option with low cost sharing was certainly a factor, along with the outreach of WVCHIP and its community partners over the span.

Chart C



CCRC Actuaries, LLC *Chart 4*

OVERVIEW OF THE FINANCIAL STATEMENTS

WVCHIP's financial statements have been prepared on a modified accrual basis of accounting in conformity with generally accepted accounting principles (GAAP) as prescribed or permitted by the Governmental Accounting Standards Board. As a governmental fund, WVCHIP is required to present two basic statements in this section as follows:

Balance Sheet: This statement reflects WVCHIP's assets, liabilities and fund balance. Assets equal liabilities plus fund balances. The major line item asset consists primarily of investments and funds due from the federal government to cover WVCHIP's major liability, incurred claims.

Statement of Revenues, Expenditures and Changes in Fund Balances: This statement reflects WVCHIP's operating revenues and expenditures. The major source of revenue is federal grant awards while the major expenditure areas include medical, dental, and prescription drug claims costs.

In addition to these two basic statements and the accompanying notes, required supplementary information is presented in the MD&A section and the Budget-to-Actual Statement presented for the year. The Budget-to-Actual Statement compares the program's actual expenditures to amounts budgeted on a cash basis for the state fiscal year and is located after the notes to the financial statements.

FINANCIAL HIGHLIGHTS

The following financial statements summarize the financial position and the results of operations for the years ended June 30, 2015 and 2014. (See pages 18 and 19.)

- Total assets decreased approximately $3,254,146, or 19% in comparison to the previous year-end amount. This decrease is primarily a result of the lower ending balance of the "Cash and Cash Equivalents" line. The decrease is the result of the program spending its fund balance in lieu of new state funding throughout half the year.
- Total liabilities decreased by approximately $1,062,716, or 25%, from last year. The majority of the decrease is attributable to the decreases in Deferred Revenues and in the estimate of Unpaid Insurance Claims Liability. In this section, Deferred Revenues reflect state general appropriations that have been "drawn-down" but not yet used to match with federal funds to pay program expenses. Since the program has not "drawn-down" any new state funding since October 2014, this amount is negative on this statement.
- Total fund equity decreased approximately $2,191,431, or 17%, in comparison to the previous year end amount. The decrease is reflective of the Program using its fund balance in lieu of any new state funding for half the year.
- Total revenues reflect an 18% decrease, around $9,875,325, when compared to the prior year. While federal and state revenues decreased, as well as investment income, premiums increased about 38%.

- Medical, dental and prescription drug expenditures comprise approximately 90% of WVCHIP's total costs. These expenditures decreased $7,957,789, or 16% compared to the prior year.

- Administrative costs accounted for 10% of overall expenditures. These expenditures increased approximately $156,331, or 3%. Expenditures under the multi-state quality grant (T-CHIC) are reflected in the outreach and health promotion line and are 100% federally funded. Program Administration reflects the highest increase, $540,027, or 19%, and is due to costs associated with the transition of the medical and dental claims processing system from the current TPA to Medicaid's claims processor. More detail on increases in administrative costs is included in the next section.

FINANCIAL ANALYSIS

Costs

A negative 16% trend in medical, dental, and prescription drug claims is much lower than the 5.4% increases in spending experienced by plans nationally. Three factors affect total claims expenditures; enrollment, utilization of services, and fees paid to providers for services they render to WVCHIP members. Each of these factors affected WVCHIP's claims costs as follows:

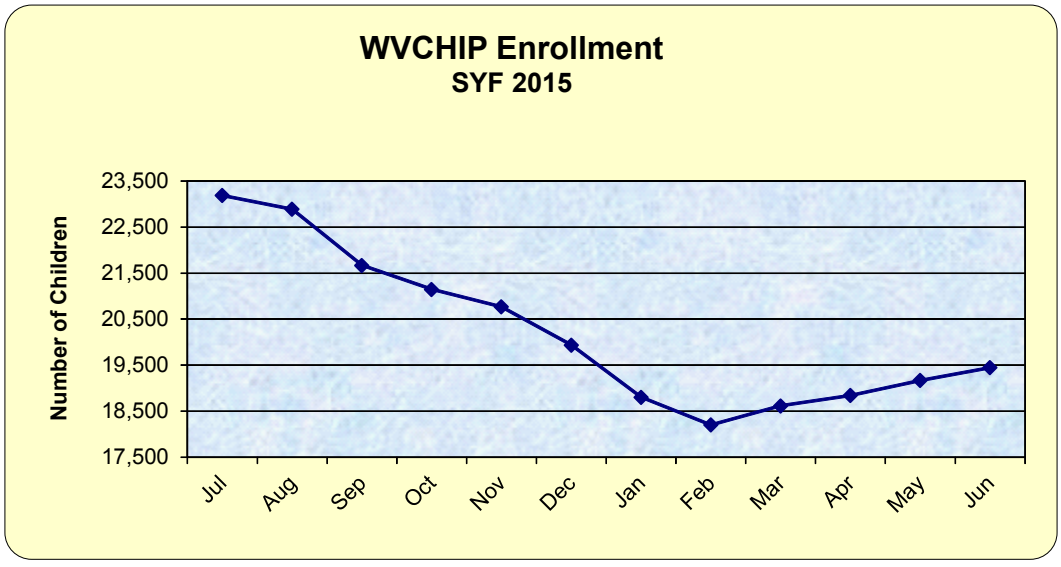
- Enrollment: -17.1%
- Service Utilization: -17.3%
- Price/Fee Increases: +18.7%

Note: These percentages are composites and not further broken down by service line item.

Enrollment

Monthly enrollment decreased steadily throughout the first eight months of the SFY, then increase steadily the next four months. However, there was an overall decrease in enrollment of 17.1% compared to last year.

WVCHIP has three enrollment groups, categorized by the differing levels of family financial participation (i.e. copayments and/or monthly premiums) based on family income levels as compared to the FPL. The following chart identifies these three groups, as well as enrollment changes in each:



GROUP	FPL	AVG MONTHLY ENROLLMENT	PERCENT INCREASE
CHIP Gold (Phases I&II)	134% - 150%	6,598	-51.3%
CHIP Blue (Phase III)	151% - 211%	9,462	+13.4%
WVCHIP Premium	212% - 300%	4,163	+67.1%

WVCHIP Premium is the newest enrollment group and includes children in families with income above 211%FPL up to and including 300%FPL. Initially, 12 children were enrolled in this group when it was "rolled-out" in February 2007. By June 2015, enrollment increased to 4,894 members, a 54.5% increase over June 2014.

It should be noted that provisions of the ACA made changes to WVCHIP eligibility and enrollment in October 2013. In addition to expanding the income limits for children under Medicaid to 133% FPL and necessitating the move of WVCHIP membership within these FPLs to Medicaid, other FPLs were converted at that time, making the lower FPL for WVCHIP Premium 211% as opposed to 200%.

Utilization

It is easy to explain that a health plan would incur lower costs consistent with enrollment decreases: fewer members = payments for fewer services = decreased costs. This is consistent with WVCHIP's experience during SFY 2015. Decreased payments due to service utilization changes are caused by factors more dynamic than simply the number of members covered by the plan. Not only do changes in plan membership cause the plan to pay for more or less services, but so do other factors including provider practices and service guidelines; services mandated or recommended by either law or professional organizations; the benefit package and utilization management strategies adopted by the plan; as well as many more factors. A combination of these many factors contributed to a decrease of 17.3% in claims expenditures for the year.

"Pent-up" demand refers to the amount of services utilized by new plan members. Children new to the program may require more medical, dental, or prescription drug services within the first three months of enrollment due to the fact they may have not been able to access these services prior to enrollment in the plan. This "pent-up" demand is illustrated in Table 12 on page 56.

Prices/Fees

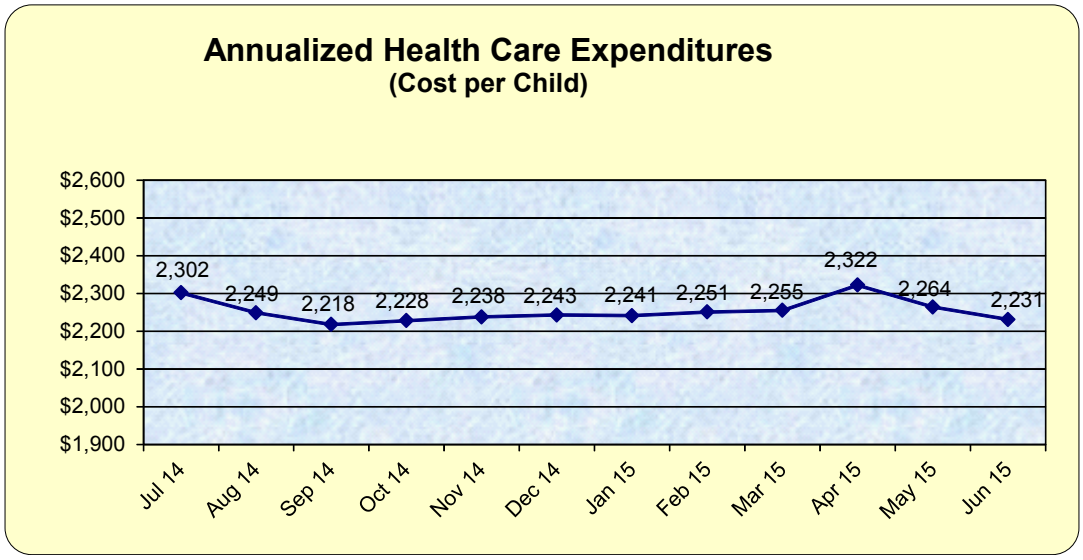
The amount WVCHIP pays providers for particular services is also determined by a number of factors: fee schedules adopted by the plan or rates negotiated with providers; whether the service is provided in West Virginia or outside the state; and service availability, among others. A combination of all these factors contributed to higher plan prices in SFY 2015. During SFY 2015, prices increased around 18.7%. The increase in prices is a result of many factors, such as inflationary updates to fee schedules, and the number of services provided out-of-state and increase in drug prices. Services provided out-of-state are typically more than double the cost of service provided in-state.

The average cost per claim for all medical and dental providers decreased 1.7%, from $177 in SFY 2014 to $174 in SFY 2015. Costs to in-state service providers decreased 0.6% during this time, from an average $161 in SFY 2014 to $160 in SFY 2015. For out-of-state providers, the average cost per claim decreased 12.1%, from $488 in SFY 2014 to $429 in SFY 2015. Utilization of out-of-state service providers stayed about the same this fiscal year – approximately 5.0% of all claims paid by WVCHIP were to out-of-state providers. The portion of WVCHIP dollars going out-of-state decreased from 13.8% in SFY 2014 to 12.4% in SFY 2015.

Prescribed Drugs appear to be the major impact of price increases that WVCHIP experienced throughout the year. WVCHIP has a very high generic drug utilization rate, 87.0% in SFY 2015, up from 85.6% in SFY 2014. While generic drugs cost much less than brand name drugs, the price for generic drugs increased 4.0% during this time, from $33.71 in SFY 2014 to $35.12 in SFY 2015, resulting in increased costs to the plan. It should be noted that during this same time brand drug costs increased 23.8%, from $252.71 in SFY 2014 to $313.51 in SFY 2015. WVCHIP is one of the only CHIP plans in the nation to operate a closed formulary.

Average Cost Per Child

WVCHIP's average cost per child for SFY 2015 was $2,231. This amount represents the average cost per child based on a "rolling enrollment" calculation and is not adjusted for the total unduplicated enrollment in the program for the year. This average decreased 0.3% from the prior year and resulted from all factors discussed above. The fluctuation in the average cost per child during the year is illustrated in the following chart.



Administrative Costs

Administrative costs increased 3% over the prior year. One category of administrative costs that shows a 19% increase is Program Administration. The increase in Program Administration was mainly due to activities necessary to implement the ACA, most notably the transition of the claims processing system from the current TPA to Medicaid's claims processing system. It should be noted that the activities under WVCHIP's participation in a multi-state pediatric quality initiative with Oregon and Alaska (T-CHIC) are 100% federally funded and reflected in the Outreach & Health Promotion line. Activities under this grant were winding down as we entered the final year. WVCHIP spent $357,057 on T-CHIC activities in SFY 2015, down 42.6% compared to the prior year.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2015 and 2014
(Accrual Basis)

	June 30, 2015	June 30, 2014	Variance	
Assets:				
Cash & Cash Equivalents	$ 9,953,901	$13,182,762	$(3,228,861)	-24%
Due From Federal Government	3,144,682	3,108,563	36,119	1%
Due From Other Funds	740,039	788,833	(48,794)	-6%
Accrued Interest Receivable	7,491	8,760	(1,270)	-14%
Fixed Assets, at Historical Cost	82,046	93,386	(11,341)	-12%
Total Assets	$13,928,158	$17,182,304	$(3,254,146)	-19%
Liabilities:				
Accounts Payable	$ 227,602	$ 227,532	$ 70	0%
Deferred Revenue	(402,842)	418,797	(821,639)	-196%
Unpaid Insurance Claims Liability	3,428,717	3,669,864	(241,147)	-7%
Total Liabilities	$ 3,253,477	$ 4,316,193	$(1,062,716)	-25%
Fund Equity	$10,674,682	$12,866,113	$(2,191,431)	-17%
Total Liabilities and Fund Equity	$13,928,159	$17,182,306	$(3,254,146)	-19%

Unaudited - For Management Purposes Only - Unaudited

West Virginia Children's Health Insurance Program
Comparative Statement of Revenues, Expenditures and Changes in Fund Balances
For the Twelve Months Ended June 30, 2015 and June 30, 2014
(Modified Accrual Basis)

	June 30, 2015	June 30, 2014	Variance	
Revenues:				
Federal Grants	$37,938,660	$44,250,164	$(6,311,504)	-14%
State Appropriations	6,093,437	9,987,748	(3,894,311)	-39%
Premium Revenues	1,209,744	874,070	335,674	38%
Investment Income:				
Investment Earnings	75,140	80,324	(5,184)	-6%
Total Revenues	**$45,316,981**	**$55,192,306**	**$(9,875,325)**	**-18%**
Expenditures:				
Claims:				
Outpatient Services	$12,319,675	$13,670,001	$(1,350,326)	-10%
Physicians and Surgical	9,050,279	10,307,517	(1,257,238)	-12%
Prescribed Drugs	8,453,297	9,583,481	(1,130,184)	-12%
Dental	6,088,365	7,685,042	(1,596,677)	-21%
Inpatient Hospital Services	3,034,938	4,350,580	(1,315,642)	-30%
Outpatient Mental Health	1,265,905	1,560,955	(295,050)	-19%
Durable & Disposable Equipment	987,524	1,190,283	(202,759)	-17%
Inpatient Mental Hospital	840,634	1,469,760	(629,126)	-43%
Vision	668,068	796,349	(128,281)	-16%
Therapy	613,821	682,149	(68,328)	-10%
Medical Transportation	354,895	376,399	(21,504)	-6%
Other Services	87,660	132,254	(44,594)	-34%
Less Collections*	(976,356)	(1,058,276)	81,920	-8%
Total Claims	42,788,705	50,746,494	(7,957,789)	-16%
General and Admin Expenses:				
Salaries and Benefits	609,865	622,481	(12,616)	-2%
Program Administration	3,347,357	2,807,330	540,027	19%
Eligibility	72,020	206,135	(134,115)	-65%
Outreach & Health Promotion	474,758	712,697	(237,939)	-33%
Current	207,078	206,104	974	0%
Total Administrative	4,711,078	4,554,747	156,331	3%
Total Expenditures	**47,499,783**	**55,301,241**	**(7,801,458)**	**-14%**
Excess of Revenues Over (Under) Expenditures	**(2,182,802)**	**(108,935)**	**(2,073,867)**	**1,904%**
Unrealized Gain (loss) On Investments**	**(8,629)**	**33,724**	**(42,353)**	**-126%**
Fund Equity, Beginning	**12,866,113**	**12,941,324**	**(75,211)**	**-1%**
Fund Equity, Ending	**$10,674,682**	**$12,866,113**	**$(2,191,431)**	**-17%**

* Collections are primarily drug rebates and subrogation
** Short Term Bond Fund Investment began in November 2009

Unaudited - For Management Purposes Only - Unaudited

West Virginia Children's Health Insurance Program
Notes to Financial Statements
For the Twelve Months Ended June 30, 2015

Note 1

Summary of Significant Accounting Policies

Basis of Presentation

The accompanying general purpose financial statements of the WVCHIP conform to generally accepted accounting principles (GAAP) for governments. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for governmental accounting and financial reporting.

Financial Reporting Entity

The WVCHIP expands access to health services for eligible children. Major revenue sources are federal awards and state appropriations. WVCHIP uses third party administrators to process claims, pay providers, and review utilization of health services. An eleven-member board develops plans for health insurance specific to the needs of children and annual financial plans which promote fiscal stability.

Basis of Accounting

WVCHIP follows the modified accrual basis of accounting. Revenues are recognized when they become both measurable and available. Significant revenues subject to accrual are federal awards. Expenditures are recognized when a related liability is incurred.

Assets and Liabilities

Cash and Cash Equivalents

Cash equivalents principally consist of amounts on deposit in the State Treasurer's Office (STO) that are pooled funds managed by the West Virginia Board of Treasury Investments (BTI). WVCHIP makes interest earning deposits in the WV Money Market Pool as excess cash is available. Deposit and withdrawal transactions can be completed with overnight notice. WVCHIP also has funds invested in the WV Short Term Bond Pool. This Pool is structured as a mutual fund and is limited to monthly withdrawals and deposits by Participants. Interest income from these investments is prorated to WVCHIP at rates specified by BTI based on the balance of WVCHIP's deposits maintained in relation to the total deposits of all state agencies participating in the pools. The carrying value of the deposits reflected in the financial statements approximates fair value.

Deferred Revenue

Receipts to reimburse for program expenditures to be incurred in the future periods are classified as deferred revenue. Because WVCHIP has not received any new state revenues since October 2014, this number is negative on the June 30, 2015 Balance Sheet.

Insurance Claims Payable

The liability for unpaid claims is based on an estimate of claims incurred but not yet reported as of the balance sheet date. Offsetting amounts receivable for the federal and state share of these expenditures have been recorded.

Note 2

Cash and Investments

At June 30, 2015, information concerning the amount of deposits with the State Treasurer's Office is as follows:

	Carrying Amount	Bank Balance	Collateralized Amount
Cash			
Deposits with Treasurer	$ 769,370	———	———

Investments	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$3,530,658	$3,530,658	Cash Liquidity
	$5,653,873	$5,653,873	Short Term Bond Pool
Total	$9,184,531		

Note 3

Accounts Payable:

Joint PEIA/CHIP Contracts for Third Party Administration & Pharmacy Benefit Management	$ 98,533
BerryDunn	103,505
Other	25,564
Total Accounts Payable	$ 227,602

Note 4

Risk Management Unpaid Claims Liabilities

Claims Payable, Beginning of Year	$ 3,669,864
Incurred Claims Expense	43,765,061
Payments:	
Claim Payments for Current Year	38,966,694
Claim Payments for Prior Year	5,039,514
Claims payable, year to date	$ 3,428,717

Note 5

Contingencies

WVCHIP receives significant financial assistance from the U.S. Government in the form of grants and other federal financial assistance. Entitlement to those resources is generally contingent upon compliance with the terms and conditions of the grant agreements and applicable federal regulations, including the expenditure of the resources for allowable purposes. Federal financial assistance awards are subject to financial and compliance audits under either the federal Single Audit Act or by grantor agencies of the federal government or their designees. Any obligations that may arise from cost disallowance or sanctions as a result of those audits are not expected to be material to the financial statements of WVCHIP.

West Virginia Children's Health Insurance Program
Budget to Actual Statement
State Fiscal Year 2015
For the Twelve Months Ended June 30, 2015

		Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Actual Amt Jun-15	Actual Amt May-15	Actual Amt Apr-15
Projected Cost		$44,941,229	$44,941,229	$45,215,926	($274,697)	-1%	$3,745,102	$3,636,702	$3,468,188	$3,722,149
Premiums		1,687,540	1,687,540	$1,209,744	($477,796)	-28%	$140,628	121,410	103,291	116,959
Subrogation & Rebates		1,100,607	1,100,607	$976,356	(124,251)	-11%	$91,717	186,316	132,424	39,075
Net Benefit Cost		42,153,082	42,153,082	$43,029,825	($876,743)	-2%	$3,596,831	3,328,976	3,232,473	3,566,115
Salaries & Benefits		$680,653	$680,653	$609,866	$70,787	10%	$56,721	$46,366	$46,867	$44,954
Program Administration		1,781,676	1,781,676	$3,352,699	(1,571,023)	-88%	$148,473	505,475	276,855	270,622
Eligibility		250,000	250,000	$72,020	177,980	71%	$20,833	765	18,441	510
Outreach & Health Prom.		380,900	380,900	$465,604	(84,704)	-22%	$31,742	14,361	50,187	636
Current Expense		220,000	220,000	$210,823	9,177	4%	$18,333	13,406	26,856	16,186
Total Admin Cost		$3,313,229	$3,313,229	$4,711,012	($1,397,783)	-42%	$276,102	$580,373	$419,206	$332,908
Total Program Cost		$45,466,311	$45,466,311	$47,740,837	($2,274,526)	-5%	$3,872,933	$3,909,349	$3,651,679	$3,899,023
Federal Share 79.95%		36,350,316	36,350,316	$38,144,748	(1,794,433)	-5%	3,089,052	3,125,525	2,919,518	3,117,269
State Share 20.05%		9,115,995	9,115,995	$9,596,089	(480,094)	-5%	783,882	783,824	732,162	781,754
Total Program Cost	*	$45,466,311	$45,466,311	$47,740,837	($2,274,526)	-5%	$3,872,933	$3,909,349	$3,651,679	$3,899,023

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2014 Report.

Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES

Affordable Care Act (ACA)

WVCHIP has implemented a number of changes over the past couple of years in order to comply with the ACA. The major activity that took place this year was preparing for the upcoming transition of the medical and dental claims processing system. The program's staff spent extensive amounts of time designing the system which entailed formulating rules for claims payments, developing letters that will be used for both providers and members, as well as setting up extensive test cases to be used to determine if the system will function correctly.

Tri-State Children's Health Improvement Consortium (T-CHIC)

This year completes the fifth and final year of this agency's participation with the states of Oregon and Alaska in the federally funded pediatric quality demonstration grant project known as the T-CHIC. The last year of the T-CHIC grant is devoted to developing and summarizing the final tri-state report as well as another annual period in which to drive improvement in pediatric quality measures in the participating practices. Although practices still experience significant challenges in obtaining necessary data from their respective electronic health records, all six practices able to continue through to the end have shown improvement in some of the measures. This is an important step for practices to show as a medical home they can manage a certain result for their pediatric population or a specific pediatric subpopulation.

Our agency sponsored this state's Final Learning Summit at the Clay Center on November 19, 2014, for the intent of sharing lessons learned and challenges of the project with policy makers, payers, providers, and other participants. There was a robust discussion of the need to further define the role of care coordination at the practice level and whether it should be supported through a PCMH payment model.

Project milestones to note for year five are:

- The second and final Consumer Assessment Health Plan Survey (CAHPS) was fielded for eight sites.
- The last Medical Home Office Report Tool (MHORT) Survey was completed by nine sites.
- Five sites have permanently employed their care coordinators previously supported with grant funding.
- A "no cost extension" has been filed for an extension of the project through 2015 to allow sufficient time for the summary report to CMS.
- The Advisory Council continued to meet and provide guidance for the effort.
- Each of the practice sites has shown some improvement in the CMS proposed Pediatric Core Measures set.

CONTACTING WVCHIP's MANAGEMENT

This report is designed to provide our member families, citizens, governing officials and legislators with a general overview of WVCHIP's finances and accountability. If you have questions about this report or need additional information, please contact WVCHIP's Financial Officer at 304-558-2732. General information can also be obtained through our website at www.chip.wv.gov. Electronic application to the program is available on the web at www.wvinroads.org.

Required Supplementary Information

What A Difference CHIP Can Make -

"[We are a] one income family - thankful for peace of mind knowing kids can be treated when ill."

Parent quote from a 2001 CHIP survey.

West Virginia Children's Health Insurance Program
Report of Independent Actuary
June 30, 2015 Quarterly Report

OVERVIEW

CCRC Actuaries, LLC ("CCRC Actuaries") was engaged by the West Virginia Children's Health Insurance Program ("CHIP Program") to assist the West Virginia CHIP Board in the analysis of actual and projected plan experience in the current State Fiscal Year 2015 ("FY 2015") through Fiscal Year 2021 ("FY 2021"). West Virginia enabling legislation of the CHIP Program requires that an actuary provide a written opinion that all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the fiscal year for which the plan is proposed.

CHIP Program management has requested CCRC Actuaries to produce the Baseline Scenario which includes the current WVCHIP Premium expansion to 300% of the Federal Poverty Level ("FPL") and the PEIA children and the Medicaid children transfer cost. State funding is assumed to be $9,989,262 in FY 2015 before the reductions for the State funding share to be used for CHIP children that transferred to Medicaid, and no State funding afterward. At the Federal level, the Federal funding for West Virginia is assumed to be $55,249,339 in FY 2015 before the reductions for the Federal funding share to be used for CHIP children that transferred to Medicaid. Appendix A-Baseline Scenario shows CHIP Program Federal funding continues after 2015 paying for the Medicaid Children Transfer Cost. The net Federal and State funding after the reductions for CHIP children that have transferred to Medicaid are assumed to be $38,418,019 and $5,762,111, respectively.

The Board has approved the expansion of coverage to 300% of the FPL and we have included the financial projection based on CMS' approval effective July 1, 2011. Under this scenario, participants' premiums are assumed to remain the same as of March 23, 2010 for children in the 250% to 300% FPL group under the Affordable Care Act's Maintenance of Effort provision.

PEIA children became eligible in the CHIP Program starting July 1, 2014. Enrollment issues will result in some children returning to PEIA, but for the purposes of this report, we have assumed that the enrollment will remain constant in future years. We have assumed that the claims cost of PEIA children will replicate WVCHIP claim costs.

Under the Medicaid Children Transfer Cost Baseline Scenario, the State of West Virginia has elected to use the Title XXI funds to help cover the CHIP kids that moved to Medicaid because family income was between 100% and 133% of the Federal Poverty Level ("FPL"). Based on West Virginia Department of Health and Human Resources ("WVDHHR") preliminary estimate of kids now covered by Medicaid, the expected amount that the State of West Virginia will pay to transfer the CHIP kids to Medicaid is approximately $21.1 million in FY 2015 and $21.1 million in FY 2016, with adjustments for inflation in the yearly projection thereafter.

Under the Baseline Scenario, the projected cost of the CHIP Program in FY 2015 will meet the 90% State funding requirement. Based on the Baseline Scenario and the 90% expenditure limitation on State funding of the program, we are not projecting a shortfall in State funding based on funding levels provided by CHIP management through FY 2021. However, we are projecting the Federal funding shortfall in FY 2021 based on current approved funding levels under the assumption of Medicaid eligibility and an increase in Federal participation of the Patient Protection and Affordable Care Act ("PPACA").

It should be noted that this projection reflects the current information on the availability of Federal funding. We have not assumed any future Federal redistributions for Fiscal Years 2003 through 2014 in this projection. The Federal share of program expenditure is currently at 79.95% for Federal Fiscal Year 2015 and it remains unchanged through September 30, 2015. While there is uncertainty of Federal funding availability after 2017, the state plans to apply for an increase in the allotment under MACRA. We have assumed that, due to MACRA, the Federal funding will increase to $70,867,161 in FY2016 and remain constant thereafter. Note that if we assume no Federal funding after 2017, there wil be a Federal shortfall in FY 2018 and the future years would result in a significant negative impact to the CHIP Program.

The Affordable Care Act of 2010 maintains the CHIP eligibility standards in place as of enactment through 2019. The law extends CHIP funding until October 1, 2015, when the already enhanced CHIP federal matching rate will be increased by 23 percentage points, bringing the average federal matching rate for CHIP to 93%. Under most likely scenarios, this would mean that WVCHIP will be 100% federally funded. The Affordable Care Act also provided an additional $40 million in federal funding to continue efforts to promote enrollment in Medicaid and CHIP. It should be noted that this projection reflects the 23% bump to the CHIP match rate starting October 1, 2015, through September 30, 2019.

Medicare Access and CHIP Reauthorization Act (MACRA) was signed into law on April 16, 2015. MACRA allows states to carry two-thirds of any remaining FY2017 allotment funds into 2018. MACRA contains a 2-year extension of the CHIP Program through 2017. As of the issue date of this report, the exact funding level for 2016 and 2017 is unknown.

Enrollment for the program as of June 2015 has increased since March 2015. The current program enrollment as of June 2015 consists of 19,447 children total: 4,588 children as part of Phase I and Phase II that consists of children whose families are below 150% of the federal poverty level ("WVCHIP Gold"), 9,965 children as part of Phase III that consists of children whose families are between 150% and 200% of the federal poverty level ("WVCHIP Blue"), and 4,894 children as part of WVCHIP Premium. Since the March 31, 2015 Quarterly Report with March 2015 enrollment of 18,614 children, overall enrollment has increased by 833 children. WVCHIP Gold has increased enrollment by 440 children, WVCHIP Blue has increased enrollment by 266 children and WVCHIP Premium has increased enrollment by 127 children.

The monitoring and analysis of claim trends is critical to the accurate forecast of future costs of the program. While the program's enrollment has decreased in recent months, there has been continual moderation of cost trends. Current claim trend experience has been financially favorable over the past several years. We have maintained the FY 2015 medical claim trend assumption at 6%, dental claim trend assumption at 5%, and prescription drugs claim trend assumption at 4%, based on trend experience that has been consistent with these assumptions.

Under the Baseline Scenario, administrative expenses for West Virginia CHIP are $4,711,006 in FY 2015, representing a 4% increase from FY 2014 administrative expenses of $4,548,859. West Virginia CHIP management team assumes a 5% administrative expense trend in future years. In Fiscal Year 2015, reimbursement from subrogation and prescription drug rebates are projected to be totaled $976,356. West Virginia CHIP management team assumes a 4% trend on drugs rebates and subrogation in future years.

Included in FY 2015 are the funding reductions for CHIP kids covered under Medicaid of $2,068,972 for the Federal share and $525,021 for the State share in the first quarter of 2015; $3,898,966 for the Federal share and $977,792 for the State share in the second quarter of 2015; $6,233,426.90 for the Federal share and $1,563,229.64 for the State share in the third quarter of 2015; and the projected $4,629,954.94 for the Federal share and $1,161,108.14 for the State share in the fourth quarter of 2015. We assume the expected amount that the State of West Virginia will pay to transfer the CHIP kids to Medicaid is approximately $21.1 million in FY 2015 and $21.1 million in FY 2016, and we have reduced the total Federal and State funding by these amounts to estimate the total funding available to West Virginia CHIP.

Under the State fiscal year basis, we have calculated that the incurred claim costs under the Baseline Scenario assumptions for FY 2015 to be $45,856,820. The updated projection for FY 2016 claims is $46,514,413.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") and PPACA that resulted in $69 billion in funding for the national program, the following is the result of the passing of PPACA:

- Protects CHIP through 2019, with funding through 2015;
- Provides states with additional funding to ensure children have access to the program. Between FY 2016 and 2019, states would receive a 23 percentage point increase in the CHIP federal match rate, subject to a 100 percent cap;
- Increases outreach and enrollment grants to help reach more eligible children;
- States are required to maintain current eligibility levels through 9/30/2019.

While this forecast assumes Federal funding levels based on the FY 2015 allotment level, CHIPRA has several mechanisms to adjust Federal expenditures to levels required by the State programs. The Federal funds formula allows for re-basing of the allotment every two years, and there is a contingency fund established separate from the funds allotted to the State of West Virginia that will be used to offset any shortfalls it might experience in Federal funding.

There are several significant changes in the law that are designed to improve the health care that children receive in CHIP and impact the current benefit structure for WVCHIP. Under dental benefits, there are two provisions in the legislation that are designed to improve access to dental care for children.

CHIPRA requires states to include dental coverage in their CHIP benefit packages. States must offer a dental benefit that is equivalent to one of the following: the children's coverage that is provided in the Federal Employees Health Benefits Program ("FEHBP"), state employee dependent dental coverage, or dental coverage that is offered through the commercial dental plan in the State with the highest non-Medicaid enrollment. WVCHIP is required to cover Orthodontic, Prosthodontic, and Periodontic services under CHIPRA.

CHIPRA allows states for the first time to offer dental coverage to children who are enrolled in private or job-based plans that do not include dental coverage. As long as these children are otherwise eligible for CHIP, states can enroll them in CHIP exclusively for dental coverage. It should be noted that WV CHIP Program has not yet decided to implement this option.

In compliance with CHIPRA's requirements, the benefit design for coverages over 200% FPL changed effective July 1, 2009. Dental services for this group were limited to preventative services and subject to a maximum of $150 per year. The new dental benefit includes both preventative and restoration services. Services including all restoration, endodontics, prosthodontics, implants, dental surgeries and periodontics are subject to a co-payment of $25 per service and are capped at $100 per year.

Under mental health parity benefit, the new CHIP law also guarantees mental health parity in CHIP. This means that, as with job-based coverage, states must provide the same level of services for mental health benefits in CHIP as they provide for physical health benefits. States that operate CHIP as a Medicaid expansion and hence offer early and periodic screening, diagnosis and treatment ("EPSDT", which essentially guarantees all medically necessary health services for children) are considered to be in compliance with the mental health parity requirement.

PLAN ELIGIBILITY AND BENEFIT STRUCTURE

Under the submitted West Virginia CHIP Premium expansion plan ("WVCHIP Premium"), the CHIP expansion to 220% began enrollment effective in January 2007. Subsequently, WVCHIP Premium was expanded to 250% FPL effective in January 2009 and to 300% FPL effective in July 2011. Premiums are assumed to cover 20% of the policy cost for children in the 200% to 300% FPL eligibility group. The monthly premiums are $35 for families with one child in the program and $71 for families with more than one child in the program. We have assumed the same premium level as of March 23, 2010 in all projection years to maintain the 20% cost share threshold in the 200% to 300% FPL group. As of June 2015, there are 4,894 children enrolled in WVCHIP Premium.

It should be noted that this report incorporates some of the provisions of PPACA that includes a large number of health-related provisions to take effect over the next several years, particularly, an additional year extension to CHIP funding through September 30, 2015, the expanding Medicaid eligibility starting on January 1, 2014 and an increase in Federal funding participation in FY 2016 through 2019. At this time, the actual timetable of the PPACA remains uncertain.

Effective January 1, 2014, Medicaid eligibility expanded to individuals and families with income up to 133% FPL. The CHIP Program will continue to serve the remaining children from 133% FPL to 300% FPL, with the potential for additional members whose parents have applied for coverage through the Health Insurance Exchanges program. In addition, the Health Care Reform ("HCR") Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016, assuming the enhanced match rate does not fall below 77%.

The benefit structure for current WVCHIP Premium enrollees has significant cost sharing compared to the benefit structure for children of families under 200% FPL and currently includes the following major components:

- Medical Co-payments: $20 Office Visits
  $25 Inpatient & Outpatient Visits
  $35 Emergency Room Visits

- Prescription Drugs Co-payments: $0 Generic
  $15 Brand

- Full Dental and Vision Benefits with $25 copayments for non-preventative dental services.

Medical costs have been adjusted to reflect the expense of the "Birth to Three" program, administered by WVDHHR that work with children identified as having developmental delays. The Birth-to-Three costs have been included in the WVCHIP financial plan for FY 2015 and beyond.

It should be noted that CHIPRA requires WVCHIP to pay Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) a prospective payment for each visit based on the centers' reasonable costs. This regulation was applicable to services rendered by centers to WVCHIP members starting October 1, 2009. Retrospective payments were approximately $1,991,775 for claims with dates of services October 1, 2009, and after that were paid through June 30, 2011. Claims received after July 1, 2011 with dates of service on or after July 1, 2011 were processed under the new prospective payment methodology. Future PPS expenditures are projected as a component of medical and prescription drug per capita cost assumptions based on historical PPS payments.

This projection includes an additional $500,000 for vaccines purchased through the Vaccines for Children program (VFC) using federally contracted rates. CHIP paid $1,298,881 to VFC in FY 2015 for vaccines. This amount was the result of a review conducted by CDC on billings for these services. Furthermore, we also included in the projection an additional $20,000 to allow primary care physicians to apply fluoride varnish in connection with a well-child exam for members ages 1 through 4.

In addition, this report includes the following anticipated costs from CHIPRA requirements and the FY 2015 State Plan Amendment:

- Reduction in the length of the waiting period from 6 to 3 months for WVCHIP Gold (Below 150% FPL) and WVCHIP Blue (Between 150% and 200% FPL), and from 12 to 3 months for WV CHIP Premium (Between 200% and 300% FPL). Effective October 1, 2013, there would be no more waiting periods for new members to assure that members do not experience a gap in coverage while their eligibility transitions from CHIP to APTC eligibility or other insurance.

- Elimination of annual and lifetime benefit maximums effective July 1, 2011.

- Removal of the limit in dental coverage for WVCHIP Premium members, and include coverage for Orthodontic services.

- Addition of the vision benefit for WVCHIP Premium members.

- Addition of approximately $400,000 due to legislatively mandated coverage of autistic medical services, effective July 1, 2011.

PLAN ENROLLMENT

We have updated our projection based on the enrollment through June 2015. WVCHIP Gold enrollment has increased in recent months. The program had enrollment at the end of FY 2014 of 23,955 children, 11,637 under WVCHIP Gold, 9,150 under WVCHIP Blue, and 3,168 under WVCHIP Premium. Current enrollment as of June 2015 is 19,447 children, with 4,588 under WVCHIP Gold, 9,965 under WVCHIP Blue, and 4,894 under WVCHIP Premium.

It is noteworthy that WVCHIP Premium enrollment has been increasing gradually while the WVCHIP Gold has been decreasing. Based on our observation of the historical enrollment movement, we have assumed that all enrollments will remain constant in future years. We will continue to monitor the projected enrollment by actual results and make adjustments as necessary.

The following table summarizes the FY 2015 enrollment information using end of month enrollment information by WVCHIP Gold, WVCHIP Blue, WVCHIP Premium and in total:

Date	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium	Total	Annual % Growth
Jun-03	14,243	7,554		21,797	8.8%
Jun-04	15,015	8,417		23,432	7.5%
Jun-05	15,571	8,944		24,515	4.6%
Jun-06	15,907	8,928		24,835	1.3%
Jun-07	15,658	9,181	100	24,939	0.4%
Jun-08	15,227	8,902	289	24,418	-2.1%
Jun-09	14,727	9,164	664	24,555	0.6%
Jun-10	15,385	8,381	1,058	24,824	1.1%
Jun-11	14,649	8,505	1,386	24,540	-2.1%
Jun-12	14,241	8,691	2,182	25,114	2.3%
Jun-13	14,769	8,013	2,168	24,950	-0.7%
Jun-14	11,637	9,150	3,168	23,955	-4.0%
Jul-14	10,840	9,120	3,230	23,190	-6.7%
Aug-14	10,590	9,097	3,201	22,888	-7.7%
Sep-14	9,234	8,967	3,468	21,669	-12.5%
Oct-14	8,318	9,152	3,676	21,146	-15.4%
Nov-14	7,596	9,276	3,896	20,768	-16.8%
Dec-14	6,226	9,455	4,256	19,937	-20.3%
Jan-15	4,829	9,589	4,384	18,802	-21.7%
Feb-15	4,002	9,597	4,603	18,202	-23.2%
Mar-15	4,148	9,699	4,767	18,614	-22.1%
Apr-15	4,323	9,774	4,745	18,842	-22.2%
May-15	4,483	9,854	4,832	19,169	-18.7%
Jun-15	4,588	9,965	4,894	19,447	-18.8%

The table below summarizes the projected fiscal year June 30 ending enrollment assumptions for Baseline Scenario by WVCHIP Gold & Blue and WVCHIP Premium.

Baseline Scenario (300% FPL)

Ending Enrollment	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
WVCHIP Gold & Blue	14,553	14,553	14,553	14,553	14,553	14,553	14,553
WVCHIP Premium	4,894	4,894	4,894	4,894	4,894	4,894	4,894
Total	19,447	19,447	19,447	19,447	19,447	19,447	19,447

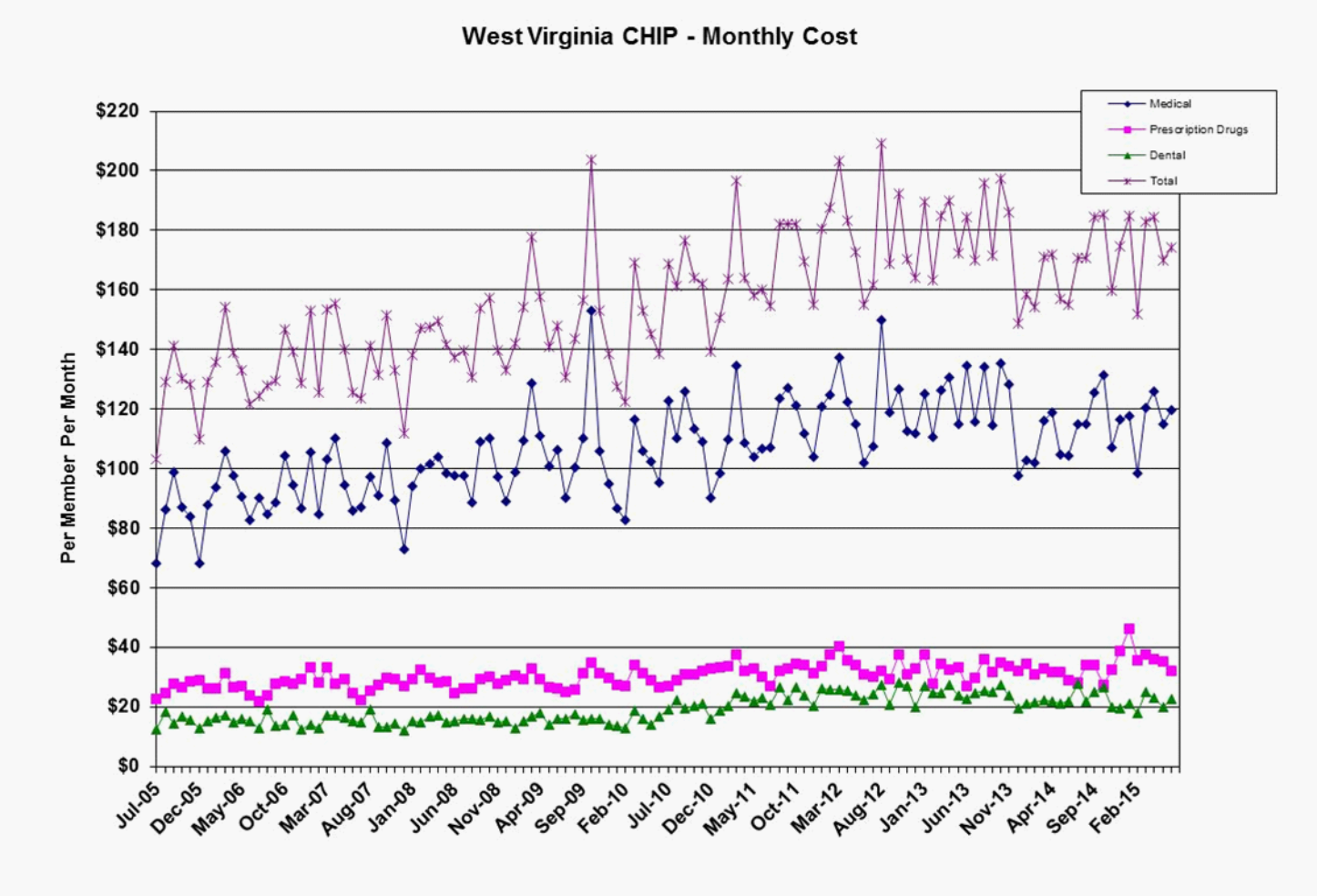
CLAIM COST AND TREND ANALYSIS

The plan has experienced favorable claim experience with overall 12-month trend of 2.8%. We have maintained the medical, dental and prescription drugs trend assumptions from the March 31, 2015 Quarterly Report. The trend assumptions have been established as 6% for medical claims, 5% for dental claims and 4% for prescription drugs claims. Detail historical claim trend analysis for medical, dental and prescription drugs are summarized in the attachments found at the end of the report.

Overall, the recent experience remains favorable compared to our trend assumptions for each trend component. The table below summarizes WVCHIP experience over the last six months, nine months and twelve months as of June 30, 2015. Overall trend experience has been favorable, with a composite trend of 2.8% over the last twelve months. Note that Prescription Drugs trends are gross of prescription drug rebates received from Express Scripts and Bayer.

Trend Period	Six Months	Nine Months	Twelve Months
Medical	7.5%	4.2%	2.4%
Dental	0.0%	-2.5%	-1.9%
Prescription Drugs	16.9%	10.5%	7.5%
Composite	8.3%	4.5%	2.8%

The following graph summarizes incurred claims on a per member per month ("PMPM") basis for the major categories of medical, dental and prescription drugs based on information received through June 2015. The attachment at the end of this report shows the trends for WVCHIP Gold & Blue and an average for the same three categories.



Detailed claim trends for medical, dental and prescription drugs are summarized in the Attachment found at the end of the report.

FINANCIAL PROJECTION – STATE FISCAL YEARS 2015-2021

Under the Baseline Scenario, we have assumed that State funding to be $5,762,111 in FY 2015 after the reductions for the State funding share to be used for CHIP children that transferred to Medicaid, and no State funding afterward. At the Federal level, the Federal funding for West Virginia is assumed to be $38,418,019 in FY 2015 after the reductions for the Federal funding share to be used for CHIP children that transferred to Medicaid, and we have assumed that the Federal funding remains constant in the future.

The updated incurred claims for FY 2015 is $45,856,820 based on the fiscal year 2015 average enrollment of 20,223 children and the incurred claim per member per month cost data assumption of $188.96, as summarized in the following table.

Category	Current Report FY2015 Baseline Incurred Claims	Current Report FY2015 Baseline Per Member Per Month	3/31/15 Report FY2015 Baseline Per Member Per Month	12/31/14 Report FY2015 Baseline Per Member Per Month
Medical	$31,018,283	$127.82	$116.86	$119.15
Prescription Drugs	8,974,987	36.98	34.77	33.76
Dental	5,863,551	24.16	22.90	23.16
Total	$45,856,820	$188.96	$174.52	$176.07

The Medicaid Children Transfer Cost Baseline Scenario financial forecast for the Federal and State fiscal years 2015 through 2021 can be found in Appendix A. This scenario is based on the assumption that Federal and State funding will be transferred to West Virginia Medicaid to cover transferred children. Based on the assumptions developed under Baseline Scenario, we are not projecting a shortfall in State funding under the 90% funding requirement based on funding levels provided by CHIP management through FY 2021.

At the Federal level, we are projecting the Federal funding shortfall in FY 2021 in the Baseline Scenario under the assumption of Medicaid eligibility of the HCR Bill. It should be noted that the HCR Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016.

Appendix A shows the Baseline Scenario with seven-year projection period as requested by CHIP management. The first section of the report is the beginning balances of both Federal and State funding sources. The middle section of the report projects and reports on incurred claim, paid claim and administrative expenses, as well as expected Interest earnings and accrued prescription drugs rebates. This section also projects Federal and State shares of paid expenses, as well as incurred but not received ("IBNR") claim liabilities. The last section of the report projects the ending balances of both Federal and State funding sources.

It should be noted that the Congress has not provided projections of expected Federal funding in the final years of the projection and these estimates are subject to change.

Appendix B summarizes the original and restated IBNR claim liabilities for the CHIP Program in Fiscal Year 2014 to 2015. IBNR projections have been lower to reflect current claim backlog experience in recent months.

STATEMENT OF ACTUARIAL OPINION

I, Dave Bond, Managing Partner of CCRC Actuaries, LLC, hereby certify that I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I meet the actuarial qualification standards to render Statements of Actuarial Opinion for Children Health Insurance Program and other self-insured entities. I have been retained by CHIP to render a Statement of Actuarial Opinion regarding the methods and underlying assumptions developed and used in this analysis.

This Statement of Actuarial Opinion was prepared in a manner consistent with the Code of Professional Conduct and Qualification Standards of the American Academy of Actuaries, and the Standards of Practice of the Actuarial Standards Board. Concerning the projection of health care expenses, I am of the opinion that the data and assumptions used are appropriate.

In my opinion, all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the future fiscal years 2015 through 2021 based on current enrollment under the Baseline Scenario.

It should be noted that this opinion is based on State funding levels as illustrated in Appendix A and FY 2015 through FY 2021 have not been appropriated by the West Virginia Legislature.

Dave Bond
Fellow of the Society of Actuaries
Member of the American Academy of Actuaries
Managing Partner
CCRC Actuaries, LLC
Reisterstown, Maryland
July 24, 2015

APPENDIX A
West Virginia Children's Health Insurance Program
June 30, 2015 Quarterly Report
Medicaid Children Transfer Cost Baseline Scenario

Available Funding - Beginning of the Year	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Federal 2014	$40,765,798	$2,477,322	$0	$0	$0	$0	$0
Federal 2015	38,418,019	38,418,019	0	0	0	0	0
Federal 2016	0	49,747,897	44,523,293	0	0	0	0
Federal 2017	0	0	49,346,631	28,363,516	0	0	0
Federal 2018	0	0	0	48,937,741	23,055,658	0	0
Federal 2019	0	0	0	0	48,521,082	14,256,133	0
Federal 2020	0	0	0	0	0	48,096,506	1,785,402
Federal 2021	0	0	0	0	0	0	47,663,864
State 2013	$2,309,371	$0	$0	$0	$0	$0	$0
State 2014	9,987,312	2,647,078	211,459	140,973	140,973	140,973	140,973
State 2015	5,762,111	5,762,111	5,762,111	3,841,407	3,841,407	3,841,407	3,841,407
State 2016	0	0	0	0	0	0	0
State 2017	0	0	0	0	0	0	0
State 2018	0	0	0	0	0	0	0
State 2019	0	0	0	0	0	0	0
State 2020	0	0	0	0	0	0	0
State 2021	0	0	0	0	0	0	0
Program Costs	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
WVCHIP Gold & Blue & Premium & PEIA Children							
Medical Expenses	$31,018,283	$31,617,988	$33,515,067	$35,525,971	$37,657,529	$39,916,981	$42,312,000
Prescription Drugs Expenses	8,974,987	8,975,895	9,334,931	9,708,328	10,096,662	10,500,528	10,920,549
Dental Expenses	5,863,551	5,920,530	6,216,557	6,527,384	6,854,754	7,196,441	7,556,263
Administrative Expenses	4,711,006	4,946,556	5,193,884	5,453,579	5,726,257	6,012,570	6,313,199
Premiums (WVCHIP Premium)	$1,577,513	$1,854,664	$1,854,664	$1,854,664	$1,854,664	$1,854,664	$1,854,664
Program Revenues-Interest	$75,876	$35,332	$25,099	$16,732	$16,732	$16,732	$16,732
Program Revenues-Drugs Rebates/Subrogation	976,356	1,015,410	1,056,026	1,098,267	1,142,198	1,187,886	1,235,401
Net Incurred Program Costs Excluding Interest	$48,013,957	$48,590,895	$51,349,749	$54,262,331	$57,337,340	$60,583,970	$64,011,946
Net Paid Program Costs	47,740,832	48,539,895	51,150,749	54,052,331	57,115,340	60,348,970	63,763,946
Federal Share of Expenses	$38,288,476	$46,119,945	$51,324,650	$54,245,599	$57,320,607	$60,567,238	$63,995,213
State Share of Expenses - Net of Interest	9,649,605	2,435,619	0	0	0	0	0
Beginning IBNR	$3,306,875	$3,580,000	$3,631,000	$3,830,000	$4,040,000	$4,262,000	$4,497,000
Ending IBNR	3,580,000	3,631,000	3,830,000	4,040,000	4,262,000	4,497,000	4,745,000

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2015 Quarterly Report

Medicaid Children Transfer Cost Baseline Scenario

Funding Sources - End of the Year	2015	2016	2017	2018	2019	2020	2021
Federal 2014	$2,477,322	$0	$0	$0	$0	$0	$0
Federal 2015	38,418,019	0	0	0	0	0	0
Federal 2016	0	44,523,293	0	0	0	0	0
Federal 2017	0	0	42,545,274	0	0	0	0
Federal 2018	0	0	0	23,055,658	0	0	0
Federal 2019	0	0	0	0	14,256,133	0	0
Federal 2020	0	0	0	0	0	1,785,402	0
Federal 2021	0	0	0	0	0	0	0
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$14,545,948***
State 2013	$0	$0	$0	$0	$0	$0	$0
State 2014	2,647,078	211,459	211,459	140,973	140,973	140,973	140,973
State 2015	5,762,111	5,762,111	5,762,111	3,841,407	3,841,407	3,841,407	3,841,407
State 2016	0	0	0	0	0	0	0
State 2017	0	0	0	0	0	0	0
State 2018	0	0	0	0	0	0	0
State 2019	0	0	0	0	0	0	0
State 2020	0	0	0	0	0	0	0
State 2021	0	0	0	0	0	0	0
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State Shortfall – 90% Funding Requirement	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***

CCRC Actuaries, LLC

415 Main Street
Reisterstown, MD 21136

Phone: 410-833-4220
Fax: 410-833-4229

Email: info@ccrcactuaries.com

November 19, 2015

Ms. Sharon Carte
Director
West Virginia Children's Health Insurance Program
2 Hale Street, Suite 101
Charleston, WV 25301

Subject: West Virginia Children's Health Insurance Program – Review of Experience

Dear Sharon:

CCRC Actuaries, LLC was engaged by the management of West Virginia Children's Health Insurance Program ("CHIP Program") to assist the West Virginia CHIP Board in the analysis of actual and projected plan experience and review the claim experience through October 2015. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2016 based on the updated information. CHIP Program's financial projections continue to improve primarily due to a steady enrollment increase and a lower overall claims trend.

It is noteworthy that we are not projecting a shortfall in State funding based on funding levels provided by CHIP management through FY 2022 based on the assumption that future funding remains constant. After the September 30, 2015 Quarterly Report was issued in November 2015, several changes have occurred in the program:

- Enrollment for the CHIP Program has increased slightly from 19,447 in June 2015 to 20,019 in October 2015.

- October 2015 claim experience showed the projected incurred FY 2016 expenditures to be $44,955,546, a decrease of $63,135 from $ 45,018,681 in the September 30, 2015 Quarterly Report.

- The categories of FY 2016 medical and dental expenses in the current claim experience through October 2015 showed favorable experience over the September 30, 2015 Quarterly Report. Conversely, FY 2016 prescription drug expense in the current claim experience through October 2015 showed unfavorable experience over the September 30, 2015 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2016 is now projected to be $187.53, down from the projected $188.30 PMPM cost in the September 30, 2015 Quarterly Report.

- Medical PMPM for Fiscal Year 2016 is now projected to be $124.56, down from the projected $125.78 PMPM cost in the September 30, 2015 Quarterly Report.

- Dental PMPM for Fiscal Year 2016 is now projected to be $22.33, down from the projected $23.07 PMPM cost in the September 30, 2015 Quarterly Report.

- Prescription Drugs PMPM for Fiscal Year 2016 is now projected to be $40.65, up from the projected $39.46 PMPM cost in the September 30, 2015 Quarterly Report.

The management of the CHIP Program provided the medical, dental and prescription drugs claim lag data, along with the program enrollment. I had reviewed the recent projections based on the gradually increasing projected enrollment and utilized our trend assumptions with the claim lag data. Actuarial methods, considerations and analyses relied on in forming my opinion conforms to the appropriate standard of practice as promulgated by the Actuarial Standards Board.

Please review this information and if you have any questions or comments about this letter, please feel free to call me at (410) 833-4220.

Sincerely,

Dave Bond, F.S.A., M.A.A.A.
Managing Partner

Program Outreach and Health Awareness

A Continuing Community Partnership

WVCHIP continues to work with many types of community partners and entities as identified in its State Plan, however, as enrollment has stabilized, efforts to promote public awareness of the program have shifted from an enrollment focus to one of promoting child health awareness and prevention messaging on topics such as childhood health screening, child development, immunizations, quality improvement and the importance of a medical home.

A Targeted Approach

Based on health insurance survey data from the U.S. Census Bureau's "2010 Annual Social and Economic Supplement," WVCHIP continues to monitor uninsured rates for West Virginia children in its monthly reports to legislative health committees reflecting both CHIP and Medicaid enrollment data for children at the county level. Some of the enrollment changes at the county level can be seen in the Statistical Section in Tables 8 and 9 *(shown on pages 53 and 54)*.

Public Information via the Helpline, Website, WVinRoads, and healthcare.gov

WVCHIP continues to make application and program information available through its 1-877-982-2447 toll-free Helpline, which averages 1,400 calls a month and mails out about 400 applications a month. Information is also available through the agency's website at www.chip.wv.gov where program guidelines and applications can be downloaded and printed. The WVCHIP website provides a wealth of information to the public about the agency, its governance, applying and enrolling, benefits, major annual reports, program statistics, and other program and health related information.

An online electronic application process that allows people to apply from the convenience of home and print out their own applications is available by the WVDHHR Rapids Project at www.wvinroads.org. Many *INROADS* users who have evaluated the online application process have commented on its ease of use, costs avoided from travel to pick up applications, and time savings from having to wait in line at local offices. Since the implementation of the ACA in 2013, the INROADS application is also linked to the healthcare.gov website. This linkage of the federal state insurance marketplace with the INROADS online application process for both CHIP and Medicaid provides a "no wrong door" approach for any member of the public interested in health care coverage. With much of the recent enrollment growth for children seen this past year, it is clear this approach has brought the public coverage option to some families who were not aware of it and/or that they would have qualified for it.

WV Healthy Kids and Families Coalition-A Community and Faith-Based Emphasis

In the past year, WVCHIP supported those community partners interested in children's health through a three-tiered approach to outreach: tier one is promoting general awareness through information and materials; tier two is referral to partners or the Helpline to provide application information and program information; and tier three is application assistance from a local community partner who helps access electronic applications, answer questions, and actively guide an applicant through the process.

WVCHIP turns to the WV Healthy Kids and Families Coalition (WVHKF), a group of community and faith-based organizations able to conduct outreach throughout the State. WVHKF traditionally includes the WV Council of Churches, local community health centers, school nurses, child care agencies, and faith based community programs among others. Their efforts include regular online communication that goes out to all members interested in children's health issues.

Many participating coalition members keep CHIP applications at their work sites and help refer applicants to either the WVCHIP Helpline or local DHHR offices for assistance. Last year as many as 100 statewide partners ordered health informational materials from WVCHIP's website to promote children's health coverage at local events sponsored in their communities. This year as last, the WVHKF fielded a mobile team who could reach out to community groups to help with questions related to enrollment in health coverage in this state's Marketplace.

Health Collaborative Efforts

Collaborations are important to allow multiple agencies and entities inside and outside state government to integrate efforts related to a statewide mission for the health of West Virginia's children. WVCHIP prioritizes prevention efforts to support our State's Healthy People objectives for children.

The following projects and collaborative efforts were implemented in fiscal year 2013:

- Continued participation in efforts to promote healthy lifestyles with the Action for Healthy Kids Coalition and West Virginia Oral Health Coalition.
- WVCHIP continued to promote full periodic and comprehensive well-child visits recommended by pediatricians in a "HealthCheck" Campaign. WVCHIP sponsored health messages focusing on vision, dental, development, and hearing screenings that appeared in Child Care Provider Quarterly Magazine. WVCHIP supports the "HealthCheck" form as a standard form or model for provider use in all well-child exam visits.
- WVCHIP participates on the Oral Health Advisory Board to advise implementation of the State's Oral Health Plan, first reported to the Legislature in 2010.

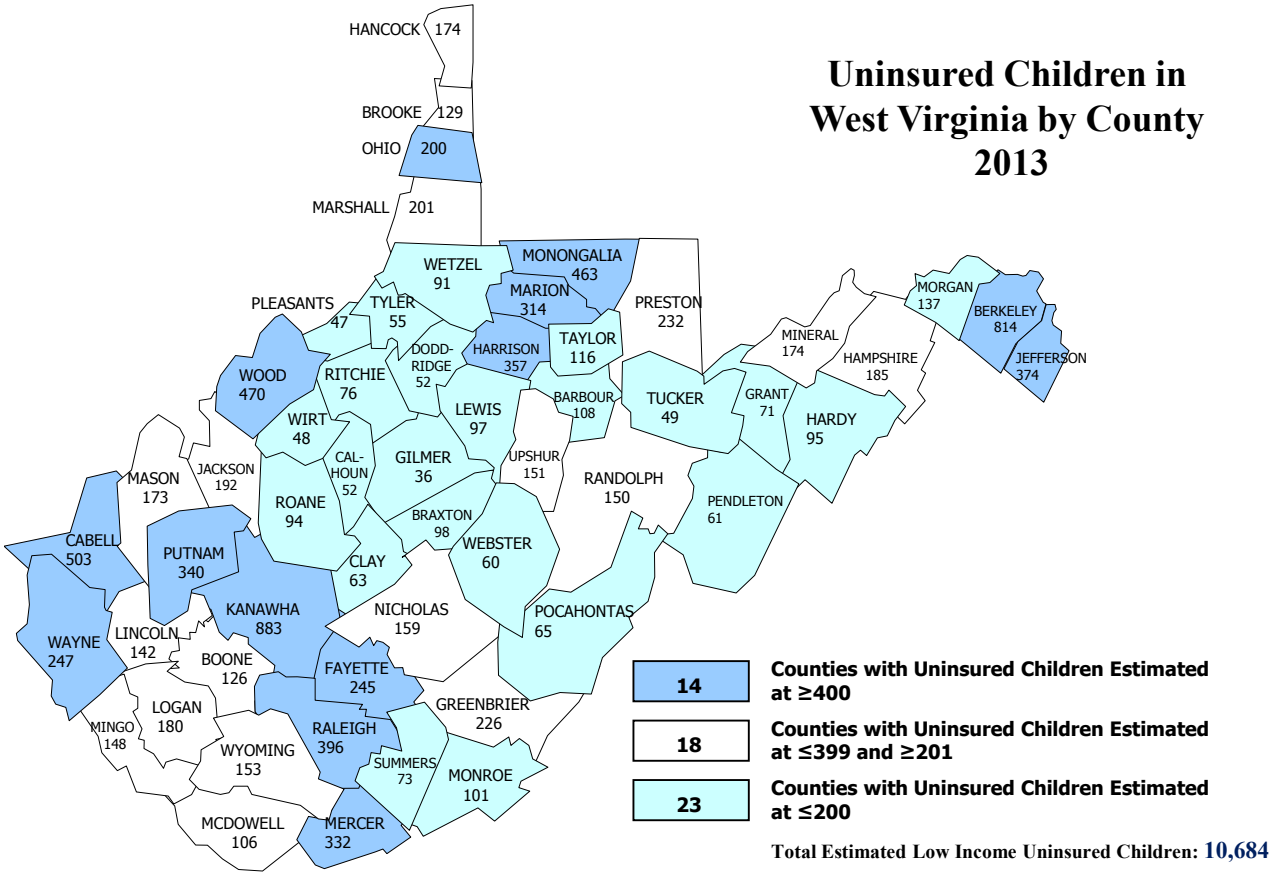
- Recognizing some children's health coverage is jeopardized when parents lose employer coverage due to workforce reductions, WVCHIP continued to support dislocated workers this year. Staff members or outreach partners were on hand as part of teams to provide CHIP information at sessions throughout the State to dislocated workers.

- WVCHIP information flyers and pocket slide guidelines on the "ABC's of Baby Care" were provided in Day One Program packets to be distributed to all new mothers at participating West Virginia hospitals.

- WVCHIP was a sponsor of the West Virginia Perinatal Partnership, a group of health care practitioners seeking to drive quality improvement for women in pregnancy and birth outcomes for newborns.

- WVCHIP continues to partner with the "Help Me Grow" program to help make health providers aware of these services which focus on developmental screening for children from birth through age 5. The program maintains a 1-800 toll-free line to assist families and providers find additional needed services and social support to address issues at these early ages and stages of development.

Targeted Outreach For Uninsured Children



The above map shows the most recent 2013 county level data provided by the U.S. Census Bureau Small Area Health Insurance Estimates (SAHIE) for children under 19 years. While the statewide average for children under 19 is now about 3%, the SAHIE data reflects more accurately the variation from county to county depending on the availability of employer sponsored insurance and should be a more accurate way to target outreach than in previous years.

Statistical Section

What A Difference CHIP Can Make -

"As small business owners, we are very grateful to the CHIP program. Purchasing medical insurance for our family was astronomically expensive, and the coverages were very limited."

Parent quote from a 2001 CHIP survey.

All statistics are for the state fiscal year ended June 30, 2015, unless noted otherwise.

Table 1: Enrollment

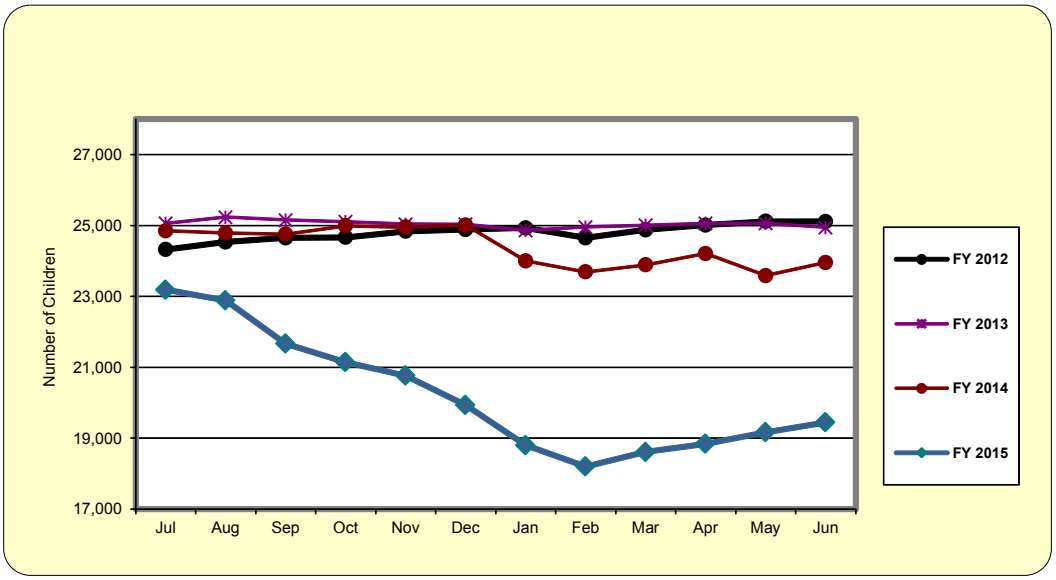
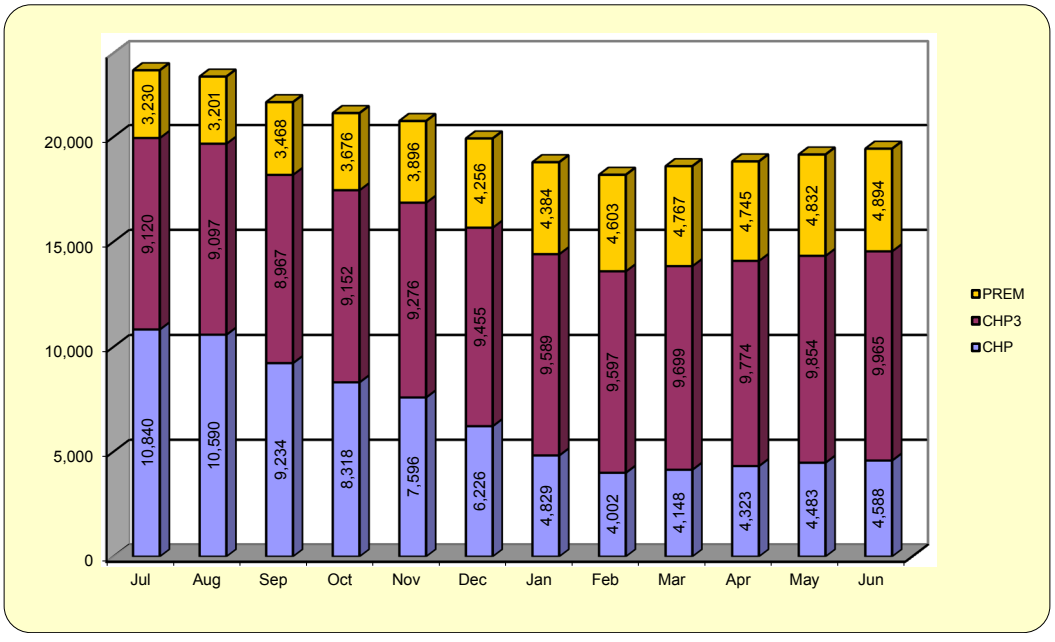
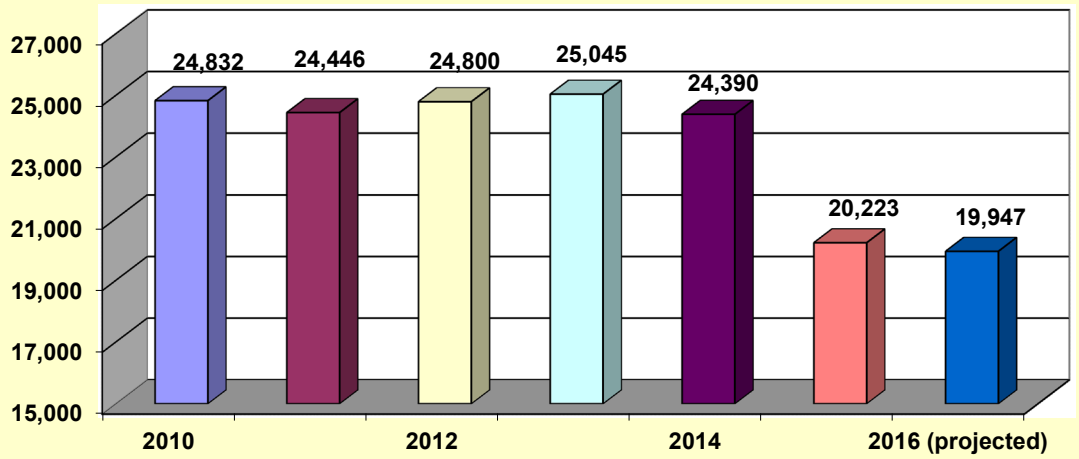


Table 2: Enrollment Detail



Note: CHIP Blue (Phase III) Effective October 2000 PREMIUM effective January 1, 2007

Table 3: Average Enrollment
SFY 2010 - 2016



Unduplicated Count of Children Served in WVCHIP Each Year on June 30

Year	Number	% Change
2001	30,006	
2002	33,569	+11.9%
2003	33,709	+0.4%
2004	35,495	+5.3%
2005	36,978	+4.2%
2006	38,064	+2.9%
2007	38,471	+1.1%
2008	37,707	-0.7%
2009	37,874	+0.4%
2010	37,758	-0.3%
2011	37,835	-0.2%
2012	37,608	-0.5%
2013	37,413	-0.5%
2014	34,438	-8.0%
2015	34,729	+0.8%

Total unduplicated number of children ever enrolled as of June 30, 2015 in WVCHIP since inception:
166,452

Table 4: Enrollment By Gender

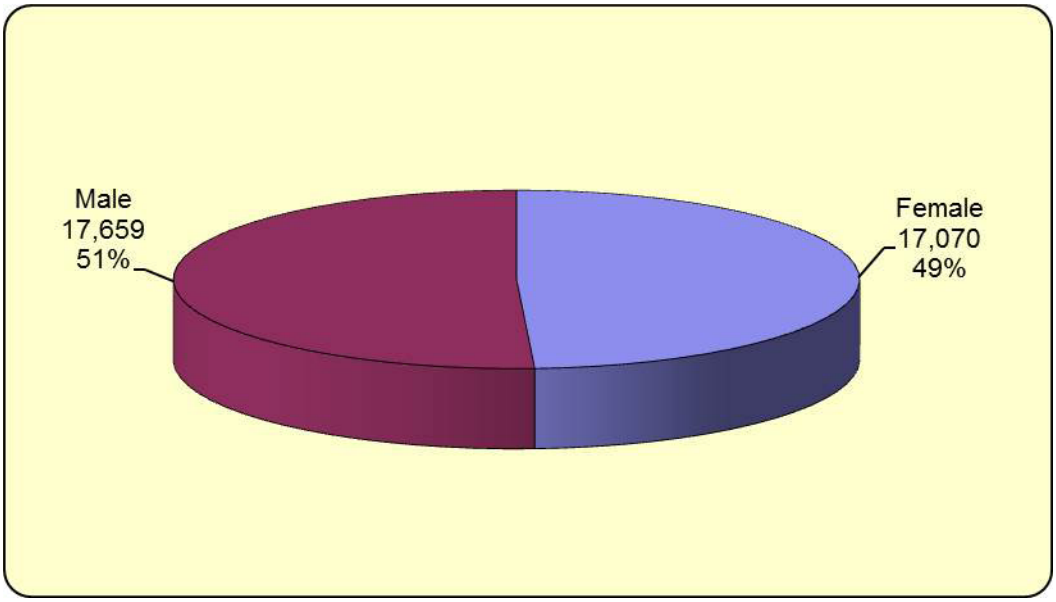


Table 5: Enrollment By Age

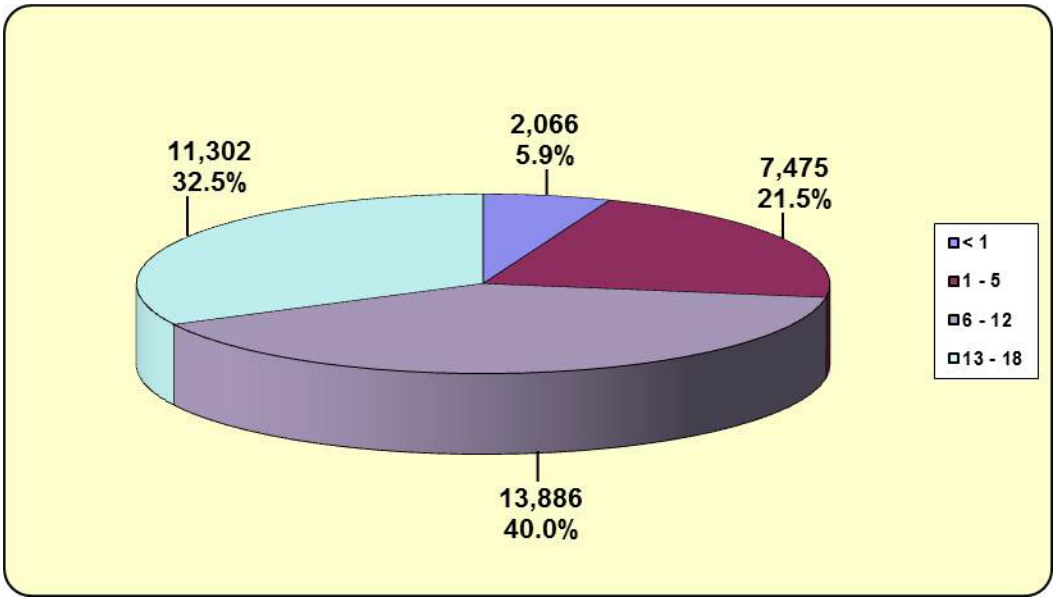
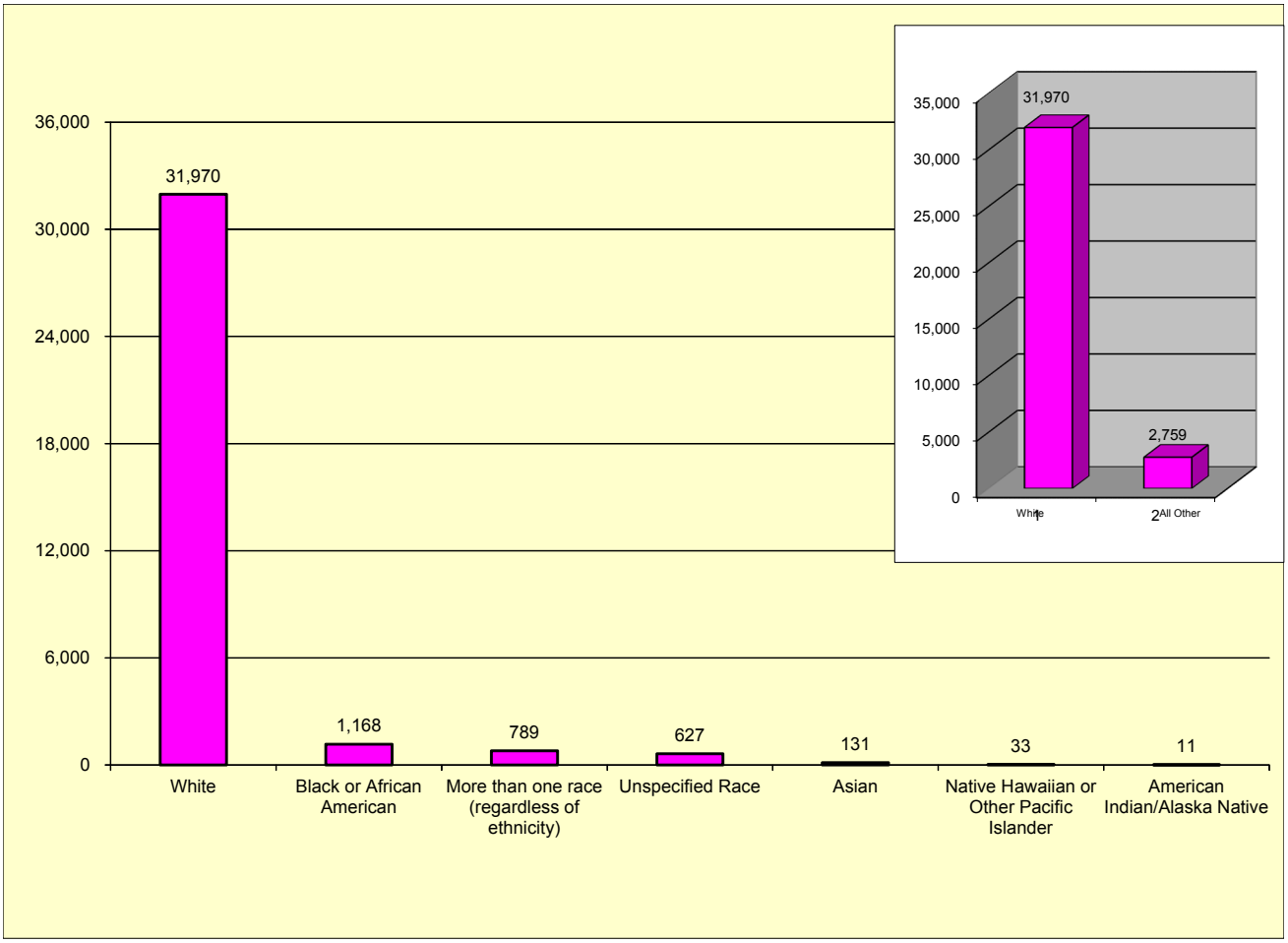
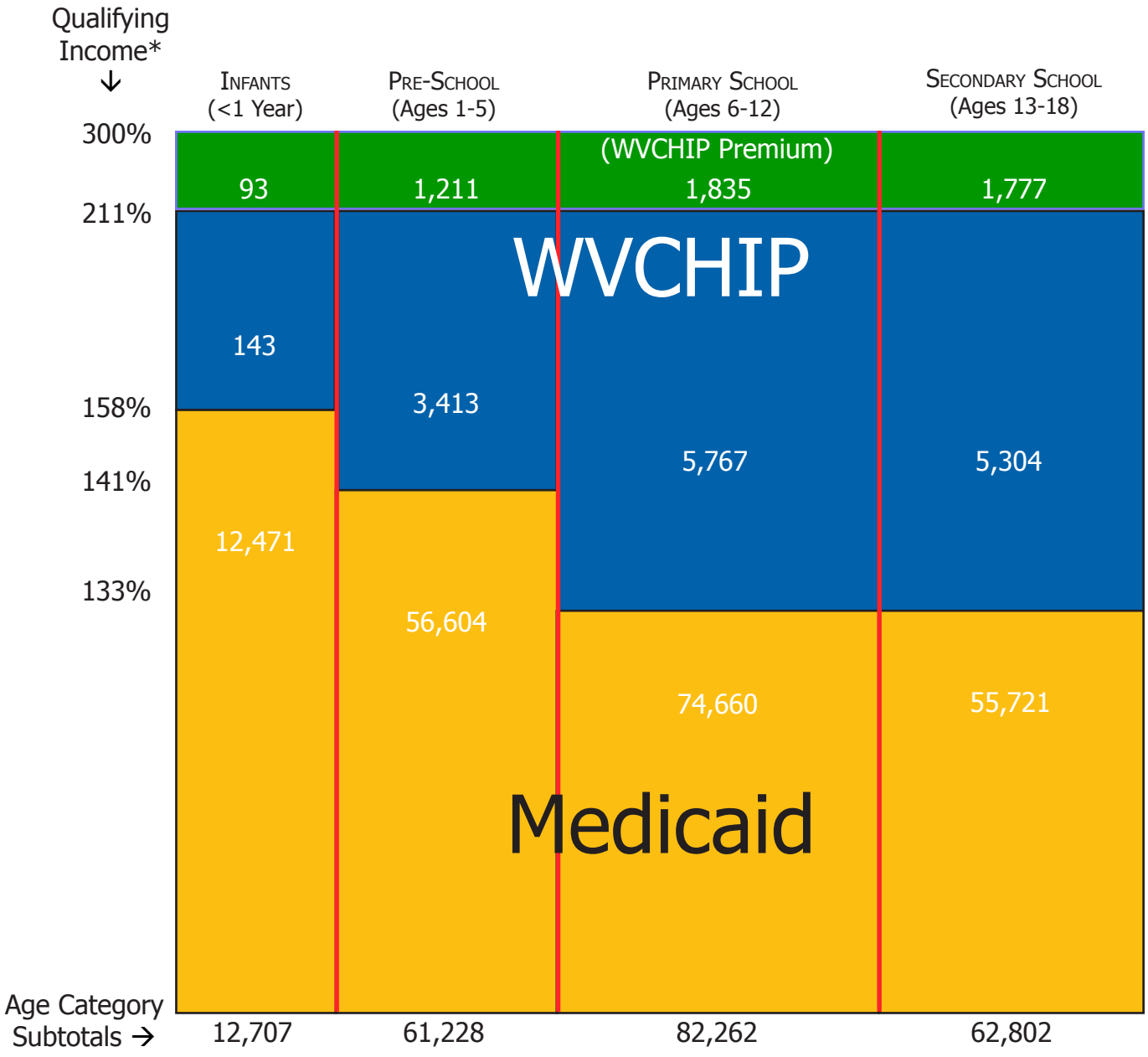


Table 6: Enrollment By Race/Ethnicity



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	31,970	92.1%	404,368	93.6%
Black or African American	1,168	3.4%	13,825	3.2%
More than one race (regardless of ethnicity)	789	2.3%	8,640	2.0%
Unspecified Race	627	1.8%	864	0.2%
Asian	131	0.4%	3,024	0.7%
Native Hawaiian or Other Pacific Islander	33	0.1%	432	0.1%
American Indian/Alaska Native	11	0.0%	864	0.2%
Total	**34,729**	**100.0%**	**432,017**	**100.0%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2015 -



*Household incomes through 300% of the Federal Poverty Level (FPL)

Total WVCHIP Enrollment **19,543** **Total WV Medicaid Enrollment** **199,456**

Total # of Children Covered by WVCHIP and Medicaid - 218,999

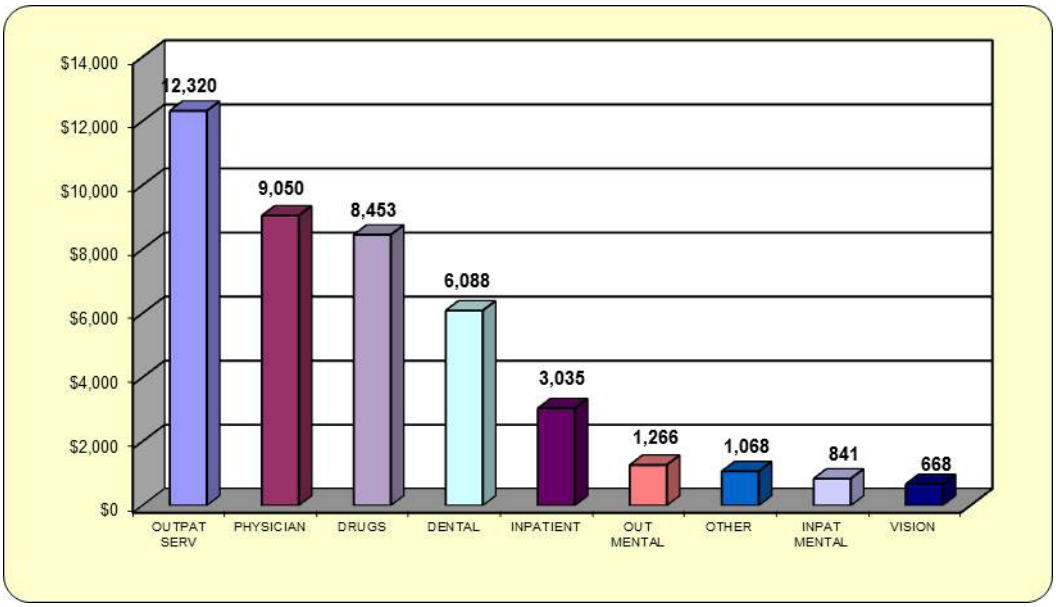
Table 8: Enrollment Changes By County
As % Difference from July 2014 through June 2015

County	Total Enrollees July 2014	Total Enrollees June 2015	Difference	% Change	
Tyler	97	116	19	16%	
Calhoun	118	120	2	2%	
Gilmer	67	68	1	1%	
Roane	271	270	-1	0%	
Monroe	211	199	-12	-6%	
Webster	133	125	-8	-6%	
Jefferson	532	499	-33	-7%	
Berkeley	1,397	1,308	-89	-7%	
Greenbrier	525	491	-34	-7%	
Wyoming	377	350	-27	-8%	
Taylor	216	199	-17	-9%	
Mason	247	225	-22	-10%	
Fayette	782	709	-73	-10%	
Lincoln	319	287	-32	-11%	
Summers	169	152	-17	-11%	
Monongalia	785	699	-86	-12%	
Pocahontas	151	133	-18	-14%	
Preston	407	357	-50	-14%	
Raleigh	1,177	1,027	-150	-15%	
Cabell	977	848	-129	-15%	
Upshur	342	296	-46	-16%	
Pleasants	126	109	-17	-16%	
Nicholas	379	327	-52	-16%	
Marshall	317	271	-46	-17%	
Ritchie	148	126	-22	-17%	
Randolph	483	410	-73	-18%	
Wetzel	224	190	-34	-18%	
Lewis	217	183	-34	-19%	**Median**
Hardy	176	147	-29	-20%	
Harrison	967	804	-163	-20%	
Hancock	354	294	-60	-20%	
Mineral	265	219	-46	-21%	
Morgan	241	198	-43	-22%	
Clay	166	136	-30	-22%	
Braxton	222	181	-41	-23%	
Mercer	971	791	-180	-23%	
Barbour	273	222	-51	-23%	
Pendleton	110	89	-21	-24%	
Marion	614	494	-120	-24%	
Tucker	116	93	-23	-25%	
Grant	141	113	-28	-25%	
Wayne	439	348	-91	-26%	
Brooke	244	193	-51	-26%	
Logan	447	353	-94	-27%	
Hampshire	260	204	-56	-27%	
Wood	1,055	826	-229	-28%	
McDowell	231	179	-52	-29%	
Jackson	399	307	-92	-30%	
Ohio	481	370	-111	-30%	
Boone	278	211	-67	-32%	
Kanawha	2,261	1,702	-559	-33%	
Wirt	83	61	-22	-36%	
Putnam	731	514	-217	-42%	
Mingo	337	225	-112	-50%	
Doddridge	134	79	-55	-70%	
Totals	**23,190**	**19,447**	**-3,743**	**-19%**	
12-Mo. Ave.		***21,319***	***-312***	***-19%***	

Table 9: Enrollment Changes By County
As % of Children Never Before Enrolled from July 2014 through June 2015

County	Total Enrollees July 2014	Total Enrollees June 2015	New Enrollees Never in Program	New Enrollees As % of June 2015	
Tyler	97	116	67	58%	
Boone	278	211	117	55%	
Hancock	354	294	161	55%	
Marshall	317	271	147	54%	
Berkeley	1,397	1,308	652	50%	
Logan	447	353	174	49%	
Lewis	217	183	90	49%	
Braxton	222	181	89	49%	
Wayne	439	348	171	49%	
Monongalia	785	699	342	49%	
Mingo	337	225	109	48%	
Nicholas	379	327	158	48%	
Mineral	265	219	105	48%	
Mason	247	225	107	48%	
Ohio	481	370	175	47%	
Jefferson	532	499	232	46%	
Hardy	176	147	68	46%	
Hampshire	260	204	93	46%	
McDowell	231	179	81	45%	
Cabell	977	848	380	45%	
Harrison	967	804	349	43%	
Calhoun	118	120	52	43%	
Marion	614	494	213	43%	
Taylor	216	199	83	42%	
Kanawha	2,261	1,702	701	41%	
Clay	166	136	56	41%	
Gilmer	67	68	28	41%	
Wirt	83	61	25	41%	**MEDIAN**
Upshur	342	296	121	41%	
Grant	141	113	46	41%	
Wyoming	377	350	142	41%	
Wetzel	224	190	77	41%	
Jackson	399	307	124	40%	
Wood	1,055	826	333	40%	
Monroe	211	199	79	40%	
Putnam	731	514	202	39%	
Fayette	782	709	278	39%	
Ritchie	148	126	49	39%	
Randolph	483	410	157	38%	
Pendleton	110	89	34	38%	
Mercer	971	791	300	38%	
Preston	407	357	135	38%	
Lincoln	319	287	108	38%	
Pleasants	126	109	41	38%	
Brooke	244	193	72	37%	
Raleigh	1,177	1,027	382	37%	
Summers	169	152	56	37%	
Roane	271	270	95	35%	
Greenbrier	525	491	171	35%	
Barbour	273	222	77	35%	
Morgan	241	198	68	34%	
Doddridge	134	79	27	34%	
Pocahontas	151	133	44	33%	
Webster	133	125	41	33%	
Tucker	116	93	25	27%	
Totals	**23,190**	**19,447**	**8,309**	**43%**	
12-Mo. Ave.		***21,319***	***692***	***2.2%***	

Table 10: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

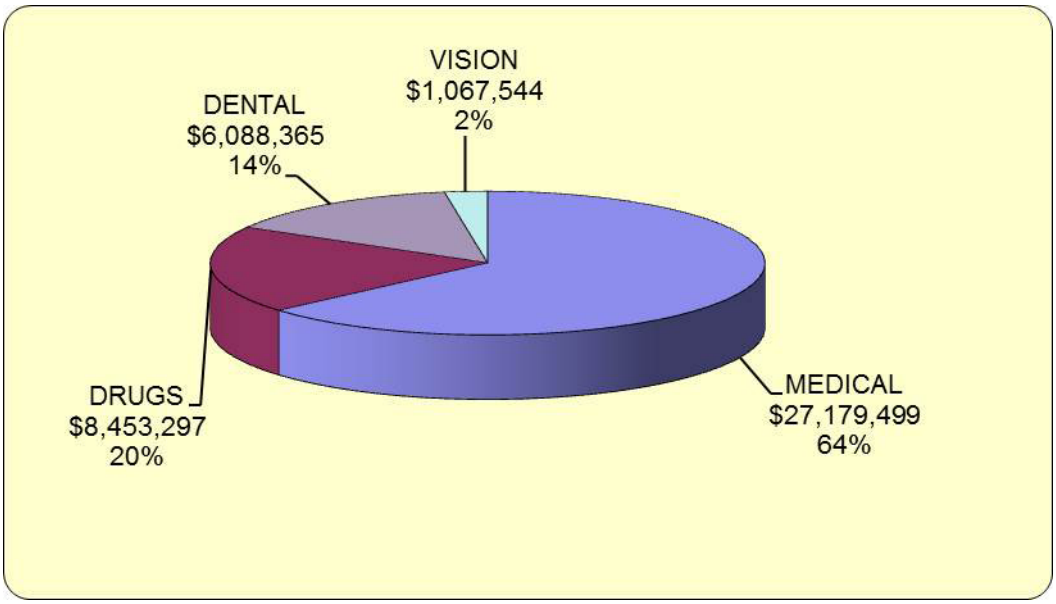


Table 11: Total Program Expenditures

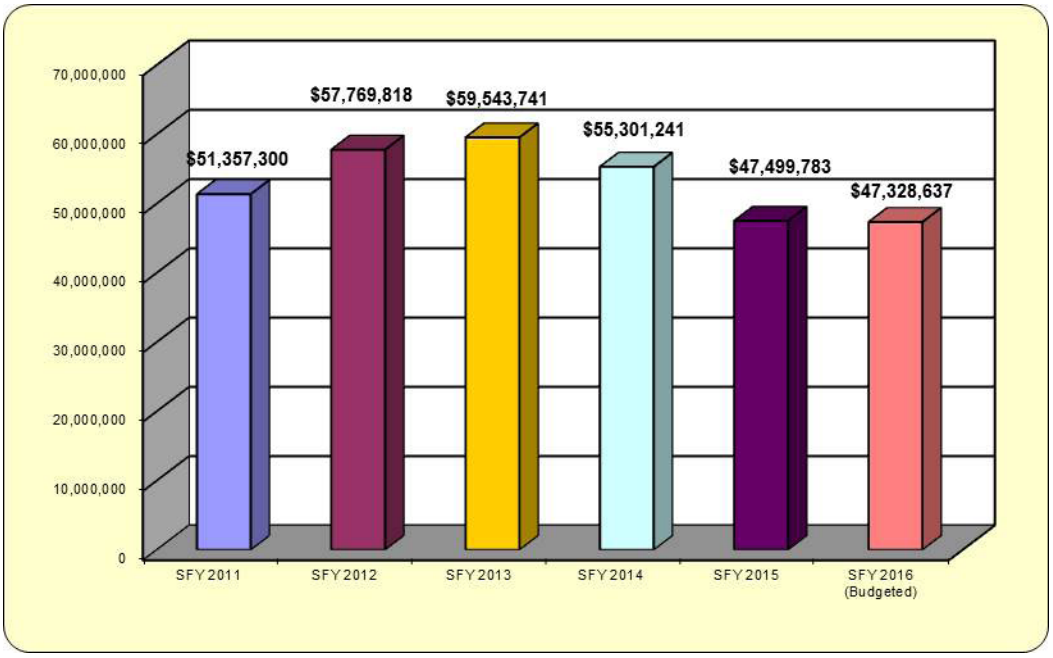
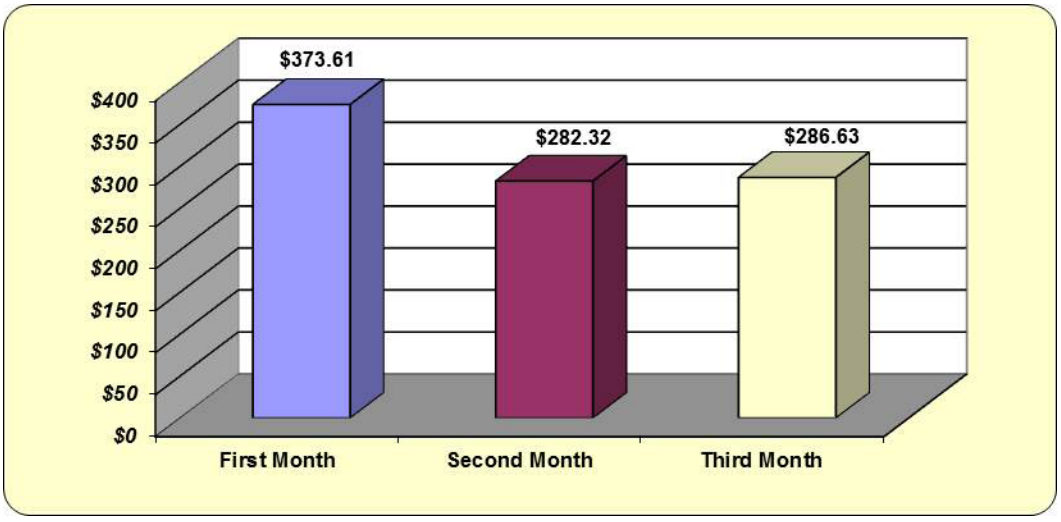


Table 12: Average Claimant Costs in First Three Months
Showing Pent Up Demand For Services Upon Enrollment



WVCHIP Set of Pediatric Core Measures 2015

In early 2010 the Secretary of the U.S. Department of Health and Human Services identified 24 pediatric core measures for which state CHIP and Medicaid programs could begin voluntary reporting. WVCHIP extracts this information to the extent possible from administrative and claims data. Most of the data is extracted according to specifications developed for the Healthcare Effectiveness Data and Information Set (HEDIS®). Some core measures were developed by other states who are the measure steward (the expert group setting the measure specifications) and were recommended for inclusion in the core set by national panels of experts. The most common measure steward is the National Committee of Quality Assurance (NCQA). The NCQA oversees and revises its HEDIS set as recommended. Since 2010, WVCHIP has expanded the number of reported measures to include 17 measures of the national measure set which is reported annually to the Centers for Medicare and Medicaid Services (CMS). This set of measures is expected to be studied and evaluated and to become a mandatory reporting set for all states' CHIP and Medicaid child health programs in the near future. In addition, West Virginia's Medicaid program has now begun to require reporting of specified pediatric measures through its managed care contracts to begin to drive measurement and improvement in child population health.

HEDIS® is the registered trademark set of standardized health performance measures that identifies only those individuals with a continuous 12 month enrollment period before the treatment or visit data can be included in calculating the measure. This helps to assure that the population measured is comparable from one health plan to another. It also means that it only captures a subset of the child enrollees in the CHIP program each year as the denominator. For this reason WVCHIP also tracks and maintains utilization rates for many of the same HEDIS® measures reported here in order to have a health indicator for the entire unduplicated enrolled CHIP population each year. This data also can be shared upon request to CHIP management. HEDIS® specifications are annually reviewed and their sponsorship, support, and maintenance is under the aegis of the National Committee of Quality Assurance. HEDIS®-type data are usually those that meet the continuous 12 month enrollment definition for the denominator and which meet additional HEDIS® specifications in the numerator of the measure. West Virginia CHIP has maintained a number of these HEDIS-Type measures as measures important to the child population for prevention (vision care) and chronic care (diabetes and asthma).

Table 13
Childhood Immunization Status (CIS-CH)

Measure Steward: NCQA/HEDIS: The percentage of children 2 years of age during calendar year 2014 who were continuously enrolled 12 months prior to the child's second birthday, and who had four diphtheria, tetanus, and acellular pertussis (DTAP), three polio (IPV), one measles mumps and rubella (MMR), three H influenza type B (Hib), three hepatitis B (HepB), one chicken pox (VZV), four pneumococcal conjugate vaccines (PCV), one Hepatitis A (HepA), two or three rotavirus (RV), and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine (9 combination rates).

Age Group	Immunization Type	Number of Continuously Enrolled 2014	Number Receiving Each Immunization	% Year 2014	2013 Number of Continuously Enrolled	Number Receiving Each Immunization 2013	% Year 2013	2012 Number of Continuously Enrolled	2012 Number Receiving Each Immunization	% Year 2012
2 years old	DTaP (four immunizations)	57	42	73.7	70	53	75.7	63	49	77.8
	IPV (three immunizations)	57	47	82.5	70	57	81.4	63	60	95.2
	MMR (one immunization)	57	57	100.0	70	70	100.0	63	63	100.0
	Hib (two immunizations)	57	48	84.2	70	70	100.0	63	61	96.8
	Hepatitis B (three immunizations)	57	29	50.9	70	41	58.6	63	39	61.9
	VZV (one immunization)	57	54	94.7	70	70	100.0	63	63	100.0
	PCV (four immunizations)	57	51	89.5	70	65	92.9	63	53	84.1
	Hep A (two immunizations)	57	52	91.2	70	70	100.0	63	63	100.0
	RV (two or three immunizations)	57	55	96.5	70	68	97.1	63	62	98.4
	Influenza two immunizations)	57	49	86.0	70	62	88.6	63	60	95.2
	Total continuously enrolled	**57**	**57**	**84.9%**	**70**	**63**	**89.4%**	**63**	**57**	**90.9%**

Table 14
Immunizations for Adolescents (IMA-CH)

Measure Steward: NCQA/HEDIS: The percentage of adolescents who turned 13 years of age during calendar year 2014 and who were continuously enrolled 12 months prior to the adolescent's 13th birthday, and who had one dose of meningococcal vaccine (MCV4) and one tetanus, diphtheria toxoid and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoid vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Age Group	Immunization Type	Number of Continuously Enrolled	Number Receiving Immunizations	% Year 2014	% Year 2013	% Year 2012
Adolescents	**Administration**					
13 Years old	**Combination (Meningococcal, Tdap/TD)**	**1,831**	**1,356**	**74.1**	**73.4**	**71.5**
	Meningococcal	1,831	1,356	**74.1**	**73.4**	**71.5**
	Tdap/TD	1,831	1,371	**74.9**	**73.6**	**79.1**
	Total continuously enrolled	**1,831**		**74.5%**	**73.5%**	**75.3%**

NOTE: Immunization rates for all combination sets are available in WVCHIP's Annual Framework Report.

Table 15
Weight Assessment and Counseling for Nutrition and Physical Activity: BMI Assessment for Children/Adolescents (WCC-CH)

Measure Steward: NCQA/HEDIS: The percentage of members 3 to 17 years of age continuously enrolled for calendar year 2014 who had an outpatient visit with a PCP or OB/GYN and whose weight is classified based on body mass index (BMI) percentile for age and gender during the measurement year, defined by CPT Codes 99201-99205, 99211-99215, 99217, 99220,99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456

Age Group	Continuously Enrolled	BMI/Nutrition & Counseling	% with Measure for Year 2014	% with Measure for Year 2013	% with Measure for Year 2012
Age 3	268	0	0.00	0.00	0.00
Age 4	264	2	0.76	0.00	0.36
Age 5	308	1	0.32	0.00	0.34
Age 6	297	1	0.34	0.00	0.00
Age 7-11	2,286	2	0.09	0.13	0.15
Age 12 and up	3,235	10	0.31	0.22	0.21
Total	**6,658**	**16**	**24.0%**	**16.0%**	**18.0%**

Table 16
Developmental Screening in the First 3 Years of Life (DEV-CH)

Measure Steward: Oregon Health and Science University: The percentage of children screened for risk of developmental, behavioral, and social delays using an age appropriate, standardized screening tool in the 12 months preceding their first, second, or third birthday. CPT Code 96110 (Developmental screening, with interpretation and report)

Age Group	Continuously Enrolled	Developmental Screening	% with measure for Year 2014	% with measure for Year 2013	% with Measure for Year 2012
Age 1	58	34	58.6	51.6	37.3
Age 2	210	105	50.0	47.3	40.9
Age 3	268	85	31.7	35.9	32.2
TOTAL:	**536**	**224**	**41.8%**	**42.9%**	**36.6%**

Table 17
Well Child Visits in the First 15 months of Life (W15-CH)

Measure Steward: NCQA/HEDIS: The percentage of members who turned 15 months old during calendar year 2014 and had zero, one, two, three, four, five, or six or more well-child visits with a PCP during their first 15 months of life as defined by CPT Codes: 99381, 99382, 99301, 99392, 99432, 99461

2014 Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of Children for Year 2014
15	0	0	0.0
15	1	0	0.0
15	2	0	0.0
15	3	0	0.0
15	4	0	0.0
15	5	0	0.0
15	6 or more	15	100.0
2014 Total		**15**	**100.0%**

2013 Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of Children for Year 2013
22	0	1	4.5
22	1	1	4.5
22	2	0	0.0
22	3	0	0.0
22	4	1	4.5
22	5	1	4.5
22	6 or more	18	81.8
2013 Total		**22**	**100.0%**

2012 Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of Children for Year 2012
11	0	0	0.0
11	1	0	0.0
11	2	0	0.0
11	3	0	0.0
11	4	0	0.0
11	5	0	0.0
11	6 or more	11	100.0
2012 Total		**11**	**100%**

Table 18
Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (W34-CH)

Measure Steward: NCQA/HEDIS: The number of children ages three to six years enrolled for calendar year 2014 who had one or more well-child visits with a PCP as defined by CPT Codes: 99382, 99383, 99392, and 99393

Age Group	2014 Number of Continuously Enrolled Children	2014 Number Having Well Visit	% Year 2014	% Year 2013	% Prior Year 2012
Well Child					
Less Than Or Equal To 15 Month	15	15	100.0	95.5	100.0
Third Year Of Life	268	199	74.3	77.1	81.1
Fourth Year Of Life	264	204	77.3	79.0	82.3
Fifth Year Of Life	308	232	75.3	74.6	82.4
Sixth Year Of Life	297	198	66.7	62.9	64.0
Total	1,152	848	**73.6%**	**73.2%**	**77.4%**
Adolescents					
12 To 19 Years of Age	3,235	1,437	44.4	43.2	36.0
Total	4,387	2,285	**52.1%**	**49.0%**	**36.0%**

Table 19
Adolescent Well Child Visits (AWC-CH)

Measure Steward: NCQA/HEDIS: Percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP including an OB/GYN) practitioner during the measurement year as defined by CPT Codes: 99383-99385, 99393, and 99395

Age Group	2014 Number of Continuously Enrolled Children	2014 Number Having Well Visit	% Year 2014	% Year 2013	% Prior Year 2012
Adolescents					
12 To 19 Years of Age	3,235	1,437	44.4	43.2	36.0
Total	3,235	1,437	**44.4%**	**43.3%**	**36.0%**

Table 20
Child and Adolescent Access to Primary Care Practitioners (CAP-CH)

Measure Steward: NCQA/HEDIS: Percentage of children and adolescents ages 12 months to 19 years who had a visit with a primary care practitioner (PCP), including four separate percentages: children ages 12 to 24 months; and 25 months to 6 years; and 7 to 11 years; and adolescents ages 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year.

Age Group	Number of Continuously Enrolled Children	Number Having Primary Care Visit	% Year 2014	% Prior Year 2013	% Prior Year 2012
12 to 24 Months	57	56	98.2	97.5	97.4
25 Months to 6 Years	1,334	1,232	92.4	94.7	97.3
7 to 11 Years	2,286	1,992	87.1	88.5	90.5
12 to 19 Years	3,235	2,803	86.6	91.0	89.4
Total	**6,912**	**6,083**	**88.0%**	**90.7%**	**90.7%**

Table 21
Ambulatory Care-Emergency Department (ED) Visits (AMB-CH)

Measure Steward: NCQA/HEDIS: Rates per 1,000 member months for ambulatory visits to an ED (not resulting in an inpatient encounter) among children ages 0 to 19 who were continuously enrolled during the calendar year 2014. CPT Codes: 99281-99288

	Number of Members	Member Months	Number of ED Encounters	Rate per 1,000 Members
For Year 2014				
Ages:				
<1	24	2	83.3	
1 through 9	27,168	914	33.6	
10 to 19	55,776	1,782	31.9	
TOTAL:	**82,968**	**2,698**	**32.5**	
For Year 2013:				
Ages:				
<1	72	4	55.6	
1 through 9	36,912	1,316	35.7	
10 to 19	95,148	3,352	35.2	
TOTAL:	**132,132**	**4,672**	**35.4**	
For Year 2012:				
Ages:				
<1	12	0	0	
1 through 9	31,188	1,255	40.2	
10 to 19	83,100	3,260	39.2	
TOTAL:	**114,300**	**4,515**	**39.5**	

Table 22
Percentage of Eligibles that Received Preventive Dental Services

Measure Steward: CMS 416 Measure: Percentage of individuals ages 1 to 20 who are enrolled in WVCHIP program for a least 90 continuous days, are eligibile for Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services, who received at least one preventive dental service during the reporting year. Defined by HCPC Codes D1000-D1999 as reported on CMS Form 416, Line 12B

Age Group	Number of Continuously Enrolled Children	Number Having Preventive Dental Visit	% Year 2014	% Year 2013	% Year 2012
2 to 3 Years	472	237	50.2	47.2	51.2
4 to 6 Years	869	661	76.1	80.0	79.4
7 to 10 Years	1,840	1,380	75.0	77.5	79.4
11 to 14 Years	2,017	1,478	73.3	75.1	75.2
15 to 18 Years	1,664	1,153	69.3	71.8	71.5
Total	**6,862**	**4,909**	**71.5%**	**73.8%**	**74.6%**

Table 23
Percentage of Eligibles that Received Dental Treatment Services

Measure Steward: CMS 416 Measure: Percentage of individuals ages 1 to 20 who are enrolled in WVCHIP program for a least 90 continuous days, are eligibile for Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) services, who received at least one treatment dental service during the reporting year. Defined by CPT Codes 40300, 70310, 70320, 73020, 70355, (ADA Codes D0120-0999; D1110-D2999, D4210-D499, D5110-D5899, D6010-D6010-D6205, D7000-D7999, D8010-D8999, D9110-D9999).

Age Group	Number of Continuously Enrolled Children	Number Having Dental Treatment Visit	% Year 2014	% Year 2013	% Year 2012
2 to 3 Years	472	447	94.7	95.6	97.5
4 to 6 Years	869	837	96.3	98.2	98.7
7 to 10 Years	1,840	1,746	94.9	96.5	97.8
11 to 14 Years	2,017	1,931	95.7	97.4	97.5
15 to 18 Years	1,664	1,580	95.0	96.4	96.5
Total	**6,862**	**6,541**	**95.3%**	**96.8%**	**97.4%**

Table 24
West Virginia Measure - Vision Visits

Measure Steward: HEDIS-Type: The number of children continuously enrolled for calendar year 2014 who received a vision visit for CPT Codes: 92012-92014, 92002-92004, 99172-99173, 92081-92083, 99174

Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year 2014	Per Member Per Year 2013	Per Member Per Year 2012
0 to 364 Days	243	3	0.01	193.76	0.80	5.63	2.33
1 to 2 Years	1,631	100	0.06	9,346.86	5.73	6.15	5.64
3 Years	889	58	0.07	5,475.12	6.16	8.05	8.06
4 to 5 Years	1,809	299	0.17	28,695.73	15.86	19.78	18.98
6 to 11 Years	6,791	2,458	0.36	249,042.96	36.67	33.27	33.61
12 to 18 Years	8,922	3,675	0.41	358,383.97	40.17	35.17	34.77
Overall	20,285	6,593	0.33	651,138.40	**32.10**	**30.78**	**30.39**

Table 25
West Virginia Measure - Annual Pediatric Hemoglobin (HbA1c) Testing for Children with Type 1 and 2 Diabetes

Measure Steward: West Virginia: The percentage of children ages 5 to 17 years with diabetes (Type 1 and 2) that had a Hemoglobin A1c (HbA1c) test during calendar year 2014. NCQA measure with added HEDIS adult measure criteria applied to children also. The core measure shows percentage of pediatric patients with Type 1 and 2 diabetes with a hemoglobin A1c (HbA1c) test in a twelve-month measurement period. The adult criteria also includes the number of children enrolled for calendar year 2014 with Type 1 and 2 diabetes who also had - serum cholesterol level (LDL-C) screening, an eye exam, and a screen for kidney disease. The CPT codes specified for this measure are too numerous and have been omitted from this description, but can be obtained by contacting the WVCHIP office.

Age Group	Diabetic Patients	HB1C Test	Rate of HbA1c Test	Eye Examinations	Rate of Eye Exams	LDLC Test	Rate of LDLC Test
4 to 5 Years	1	1	100.0	1	100.0	0	0.0
6 to 11 Years	8	8	100.0	8	100.0	2	25.0
12 to 18 Years	51	46	90.2	48	94.1	23	45.1
Total % Year 2014	60	55	**91.7**	57	**95.0**	21	**35.0**
Total % Year 2013	83	79	**95.2**	79	**95.2**	21	**25.3**
Total % Year 2012	82	77	**94.0**	81	**97.6**	33	**39.8**

Table 26
Follow-Up Care for Children Prescribed ADHD Medication (ADD-CH)

Measure Steward: NCQA/HEDIS: The percentage of children newly prescribed attention-deficit/hyperactivity medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days from the time the first ADHD medication was dispersed, including two rates; A) Initial Phase and, B) Continuation - Maintenance Phase as defined by CPT Codes: 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245,99341-99345,99347-99350,99381-99383,99384,99391-99394,99401,99404,99411, 99412,99150,90801,90802,90816-90819,90821-90824,90826-90829,90845,90847,90849,90853,90857, 90862,90875,90876,99221-99223,99231-99233,99238,99239,99251-99255, G0463, T1015

Age Group	# Members Receiving ADHD Medications	# Members on New RX Medication with a follow-up visit within 30 days	% Compliance for 2014 Year	% Compliance for 2013 Year	% Compliance for 2012 Year
6 years	5	3	60	100	100
7 years	8	8	100	100	100
8 years	31	31	100	100	100
9 years	42	42	100	100	100
10 years	52	52	100	100	100
11 years	49	49	100	100	100
12 years	47	47	100	100	100
Total	**234**	**232**	**99.1%**	**100.0%**	**100.0%**

I) Initiation Phase Follow-up*

***The near 100% compliance rates achieved are partly due to a required precertification process for this type of medication.**

Age Group	# Continuation & Maintenance Members	# Members on Medication with follow-up visits	% Compliance for 2014 Year	% Compliance for 2013 Year	% Compliance for 2012 Year
6 years	1	1	100	100	100
7 years	3	3	100	100	100
8 years	20	20	100	100	100
9 years	10	10	100	100	100
10 years	37	37	100	100	100
11 years	31	31	100	100	100
12 years	38	38	100	100	100
Total	**140**	**140**	**100.0%**	**100.0%**	**100.0%**

II) Continuation Phase Follow-up*

***The 100% compliance rates achieved are partly due to a required precertification process for this type of medication.**

Table 27
Follow-Up After Hospitalization for Mental Illness (FUH-CH)

Measure Steward: NCQA/HEDIS: The percentage of discharges for members 6 years of age, 10-19, who were enrolled on the date of discharge and 30 days after discharge, who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge, and within 30 days of discharge. Two rates are reported. Due to the numerous CPT codes that are included in this measure, they have been omitted for purposes of this report. These codes are available for your review by contacting the WVCHIP office.

	# 6 years & older Hospitalized with Mental Health Dx Year 2014	# of follow-up visits within 7 days of Discharge Year 2014	% of follow-up visits within 7 days of Discharge Year 2014	# of follow-up visits within 30 days of Discharge Year 2014	% of follow-up visits within 7 days of Discharge Year 2014
2014	126	27	21.4	76	60.0%

	# 6 years & older Hospitalized with Mental Health Dx Year 2013	# of follow-up visits within 7 days of Discharge Year 2013	% of follow-up visits within 7 days of Discharge Year 2013	# of follow-up visits within 30 days of Discharge Year 2013	% of follow-up visits within 7 days of Discharge Year 2013
2013	144	31	21.5	77	53.5%

	#6 years & older Hospitalized with Mental Health DX Year 2012	# of follow-up visits within 7 days of Discharge Year 2012	% of follow-up visits within 7 days of Discharge Year 2012	# of follow-up visits within 30 days of Discharge Year 2012	% of follow-up visits within 30 days of Discharge Year 2012
2012	129	26	20.2	67	51.9%

Table 28
West Virginia Measure - Annual Percentage of Asthma Patients with One or More Asthma-Related ED Visits

Measure Steward: HEDIS-Type: Percentage of children continuously enrolled during calendar year 2014 diagnosed with asthma during the measurement year with one or more asthma-related ED visits.

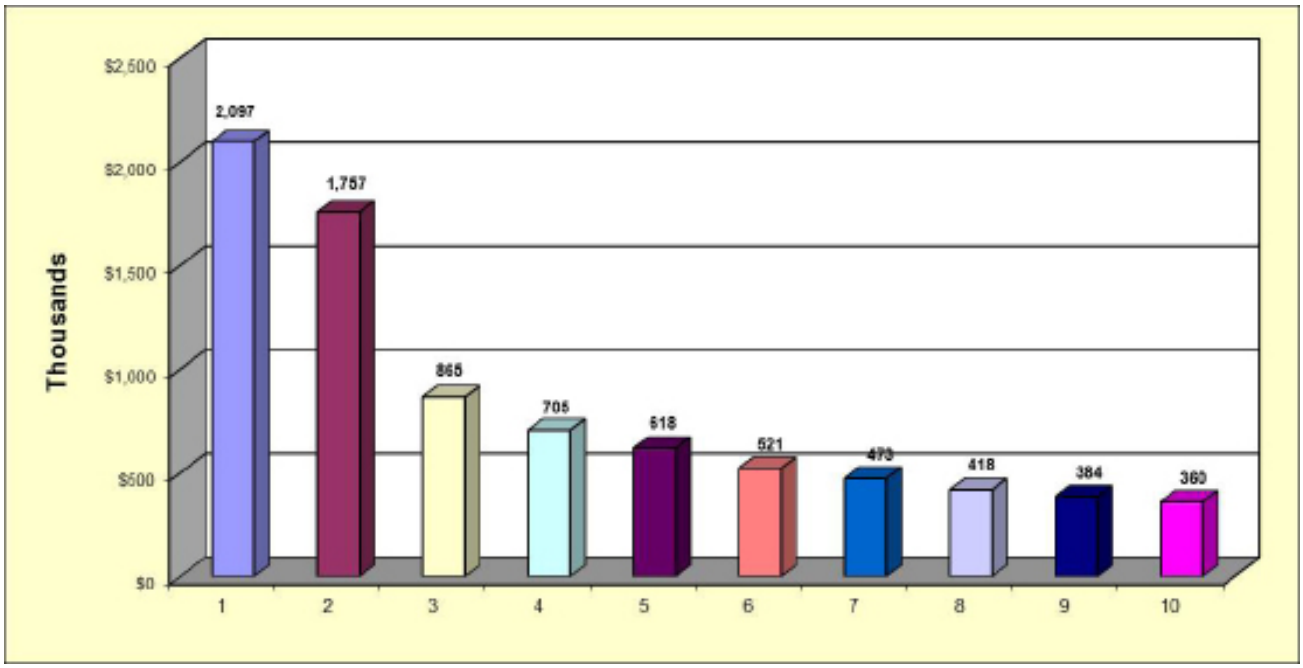
	with One or More Asthma-Related ED Visits	Continuously Enrolled 2014	Asthma Patients 2014	ED Encounters for Asthma 2014	Asthma ED Encounters per Person 2014	Asthma Encounters Per User 2014	Asthma ED Encounters per Person 2013	Asthma Encounters Per User 2013	Asthma ED Encounters per Person 2012	Asthma Encounters Per User 201-
Under Age 2	52	1	1	0.02	0.00	0.00	0.00	0.00	0.00	0.00
Age 2	204	4	0	0.00	0.00	0.00	0.00	0.03	1.50	
Age 3	268	3	1	0.00	0.33	0.01	0.33	0.01	0.33	
Age 4	264	7	2	0.01	0.29	0.01	0.33	0.01	0.57	
Age 5	308	7	0	0.00	0.00	0.01	0.38	0.00	0.13	
Age 6	297	10	2	0.01	0.20	0.00	0.25	0.01	0.33	
Ages 7-12	2,286	47	13	0.01	0.28	0.01	0.25	0.01	0.18	
Ages 12 and Up	3,235	41	5	0.00	0.12	0.00	0.21	0.00	0.22	
Total	**6,914**	**120**	**24**	0.00	0.20	0.00	0.25	0.01	0.24	

Table 29
West Virginia Measure - Medication Management for Children with Asthma (MMA-CH)

Measure Steward: NCQA/HEDIS: Percentage of children ages 5 to 19 years that were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates reported: percentage of children who remained on an asthma controller medication for at least 50% of treatment period, and, percentage of children who remained on an asthma controller medication for at least 75% of treatment period, as defined by CPT Codes: 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291, 99281-99285

Age Group	Asthma Patients	% who remained on an asthma controller medication 50% Year 2014	% who remained on an asthma controller medication 75% Year 2014	% who remained on an asthma controller medication 50% Year 2013	% who remained on an asthma controller medication 75% Year 2013	% who remained on an asthma controller medication 50% Year 2012	% who remained on an asthma controller medication 75% Year 2012
5 - 11 years	310	90.6%	90.6%	94.7	94.5	88.6	84.5
12-18 years	213	91.1%	90.1%	93.5	93.5	81.5	78.7
Total		**90.9%**	**90.4%**			**85.3%**	**81.5%**

Table 30: Top Ten Physician Services
By Amounts Paid
(in thousands)



Key

		CPT Code*
1	Office Visit - Limited - Est. Patient	(99213)
2	Office Visit - Intermediate - Est. Patient	(99214)
3	Therapeutic Activities, 15 Minutes	(97530)
4	Psychotherapy, 60 Minutes with Patient	(90837)
5	ER Exam - Extended - New Patient	(99284)
6	ER Exam - Intermediate - New Patient	(99283)
7	Office Visit - Intermediate - New Patient	(99203)
8	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
9	ER Exam - Comprehensive - New Patient	(99285)
10	Office Visit - Extended - New Patient	(99204)

**As described in Current Procedure Terminology 2015 by the American Medical Association.*

Table 30: Top Ten Physician Services
By Amounts Paid

CPT Code Description

1 Office Visit - Limited - Est. Patient: for an established patient taking about 15 minutes or less of face-to-face time with patient and/or family for problems with low to moderate severity; requires 2 of 3 key components: an expanded problem focused history and examination and medical decision making of low complexity *(CPT 99213*)

2 Office Visit - Intermediate - Est. Patient: for an established patient taking about 25 minutes of face-to-face time with the patient and/or family for problem(s) of moderate to high severity; 2 of 3 required visit components are a detailed history and examination and medical decision making of moderate complexity *(CPT 99214)*

3 Therapeutic Activities, 15 Minutes: direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes *(CPT 97530)*

4 Psychotherapy, 60 Minutes with Patient: Psychotherapy, 60 minutes with patient and/or family member *(90837)*

5 ER Exam - Extended - New Patient: requiring 1) a detailed history; 2) a detailed examination; and 3) medical decision making of moderate complexity - usually when urgent evaluation is needed for a problem of high severity *(CPT 99284)*

6 ER Exam - Intermediate - New Patient: requiring 1) an expanded problem-focused history; 2) an expanded problem focused examination; and 3) medical decision making of moderate complexity - usually for a problem of moderate severity *(CPT 99283)*

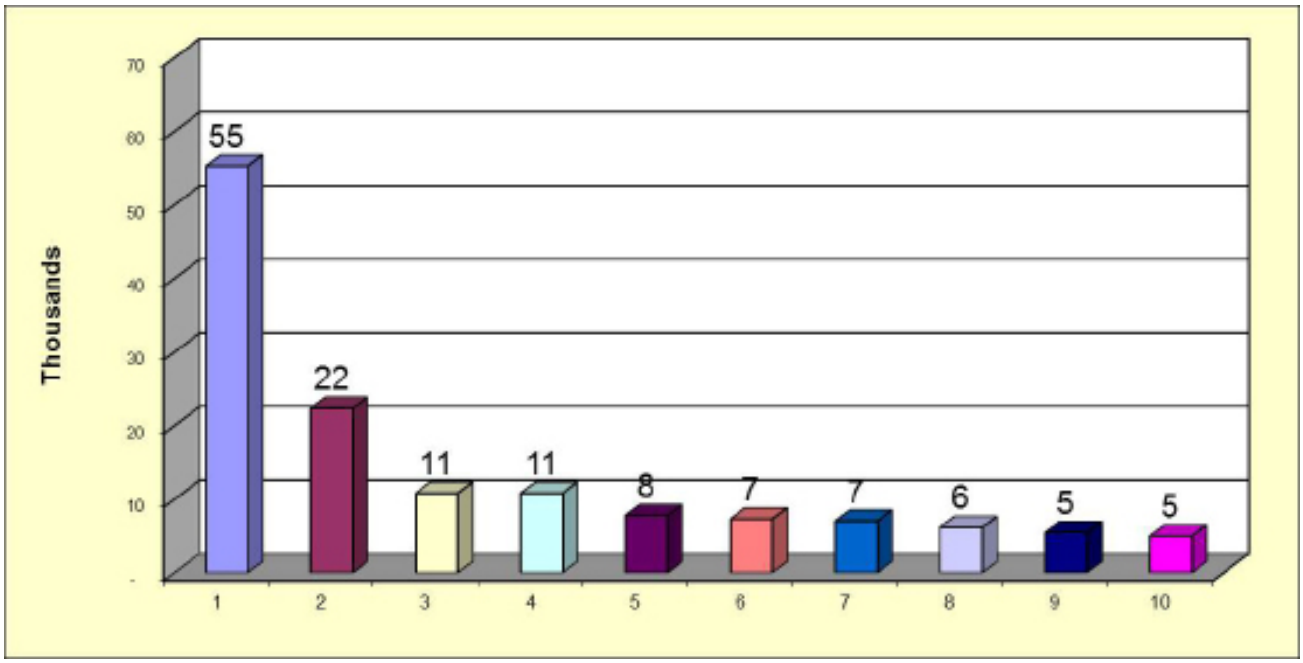
7 Office Visit - Intermediate - New Patient: for a new patient taking about 30 minutes of face-to-face time with the patient and/or family for problems of moderate severity; requires three key components including a detailed history, an exam, and medical decision making of low complexity (*CPT 99203)*

8 Ophthalmological Exam - Comprehensive - Est. Patient: for an established patient at an intermediate level in a face-to-face encounter by the physician for a general evaluation of the complete visual system including history, general medical observation, external and ophthalmological examinations, gross visual fields and basic sensorimotor examination and does not need to be performed all in one session *(CPT 92014)*

9 ER Exam - Comprehensive - New Patient: emergency department visit for a new or established patient where the presenting problem(s) are of high severity and pose an immediate or significant threat to life or physiologic function; requires three key components including a comprehensive history, an exam, and a medical decision making of high complexity (*CPT 99285)*

10 Office Visit - Extended - New Patient: For a new patient taking about 45 minutes of face-to-face time with patient and/or family for problems with moderate to high severity; requires three key components: a comprehensive history and exam and medical decision making of moderate complexity *(CPT 99204)*

Table 31: Top Ten Physician Services
By Number of Transactions
(in thousands)



Key

		CPT Code*
1	Office Visit - Limited - Est. Patient	(99213)
2	Office Visit - Intermediate - Est. Patient	(99214)
3	Immunization Administration	(90471)
4	Test for Streptococus	(87880)
5	Office Visit - Brief - Est. Patient	(99212)
6	Therapeutic Activities, 15 Minutes	(97530)
7	Psychotherapy, 60 Minutes with Patient	(90837)
8	Blood Count	(85025)
9	Immunization Administration - Each Add. Vaccine	(90472)
10	Therapeutic Procedure - Each 15 Minutes	(97110)

**As described in Current Procedure Terminology 2015 by the American Medical Association.*

Table 31: Top Ten Physician Services
By Number of Transactions

CPT Code Description

1 Office Visit - Limited - Est. Patient: for an established patient taking about 15 minutes or less of face-to-face time with patient and/or family for problems with low to moderate severity; requires 2 of 3 key components: an expanded problem focused history and examination and medical decision making of low complexity *(CPT 99213*)

2 Office Visit - Intermediate - Est. Patient: for an established patient taking about 25 minutes of face-to-face time with the patient and/or family for problem(s) of moderate to high severity; 2 of 3 required visit components are a detailed history and examination and medical decision making of moderate complexity *(CPT 99214)*

3 Immunization Administration: injection of a vaccine (single or combination toxoid) whether percutaneous, intradermal, subcutaneous, or intramuscular *(CPT 90471)*

4 Test for Streptococcus: infectious agent antigen detection by immunoassay with direct optical observation; streptococcus, group A *(CPT 87880)*

5 Office Visit - Brief - Est. Patient: for an established patient taking about ten minutes or less of face-to-face time with patient and/or family for self limiting or minor problems; 2 of 3 required visit components are a problem focused history and examination and straightforward medical decision making *(CPT 99212)*

6 Therapeutic Activities, 15 Minutes: direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes *(CPT 97530)*

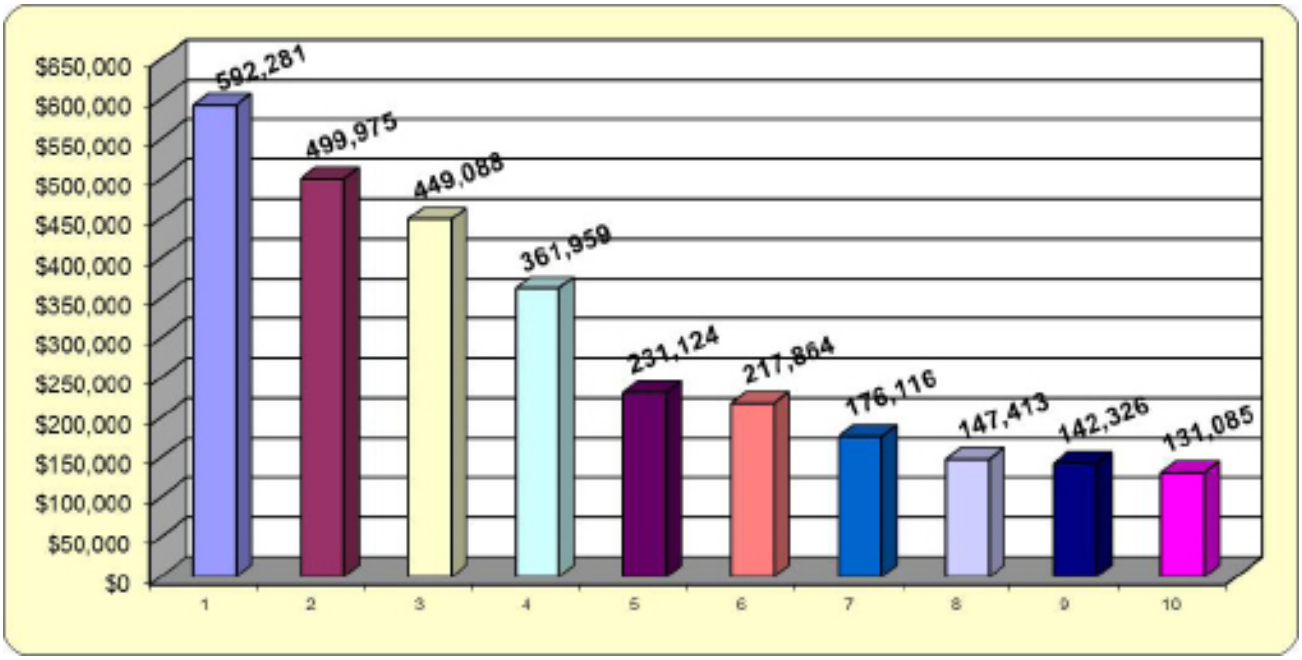
7 Psychotherapy, 60 Minutes with Patient: Psychotherapy, 60 minutes with patient and/or family member *(CPT 90837)*

8 Blood Count: automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count *(CPT 85025)*

9 Immunization Administration - Each Add. Vaccine: injection of each additional vaccine (over one) whether percutaneous, intradermal, subcutaneous, or intramuscular *(CPT 90472)*

10 Therapeutic Procedure - Each 15 Minutes: 1 or more areas, each 15 minutes; therapeutic exercise to develop strength and endurance, range of motion, and flexibility *(CPT 97110)*

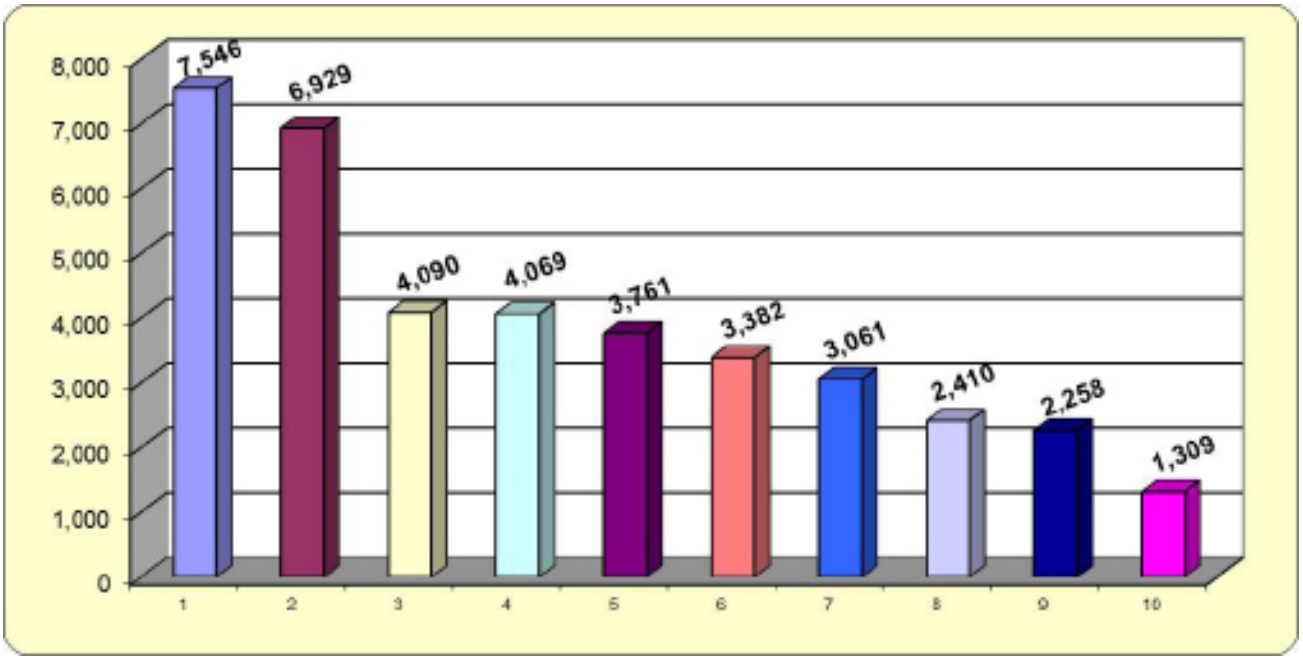
Table 32: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Vyvanse	-	Attention Deficit Hyperactivity Disorder (ADHD)
2	Kalydeco	-	Cystic Fibrosis
3	Norditropin Flexpro	-	Growth Hormone
4	Humalog	-	Diabetes
5	Tamiflu	-	Influenza
6	Abilify	-	Autistic Disorder
7	Proair HFA	-	Asthma
8	Budesonide	-	Crohn's Disease
9	Pulmozyme	-	Cystic Fibrosis
10	Epipen 2-pak	-	Allergies

Table 33: Top Ten Prescription Drugs
By Number of Rx



Key

	Drug Brand Name		Major Use Indication
1	Amoxicillin	-	Antibiotic
2	Montelukast Sodium	-	Asthma
3	Azithromycin	-	Antibiotic
4	Cefdinir	-	Antibiotic
5	Fluticasone Propionate	-	Allergies
6	Loratadine	-	Allergies
7	Proair	-	Asthma
8	Prednisolone Sodium Phosphate	-	Asthma & Allergies
9	Promethazine	-	Allergies
10	Tamiflu	-	Influenza