West Virginia Children's Health Insurance Program

Annual Report 2014

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West Virginia
Children's Health Insurance Program

2014 Annual Report

Earl Ray Tomblin, Governor

Earl Ray Tomblin, Governor
State of West Virginia

Jason Pizatella, Cabinet Secretary
West Virginia Department of Administration

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
and strive for a health care system in which all
West Virginia children have access to health care coverage.

Our Vision

All West Virginia's children have access to health care coverage.

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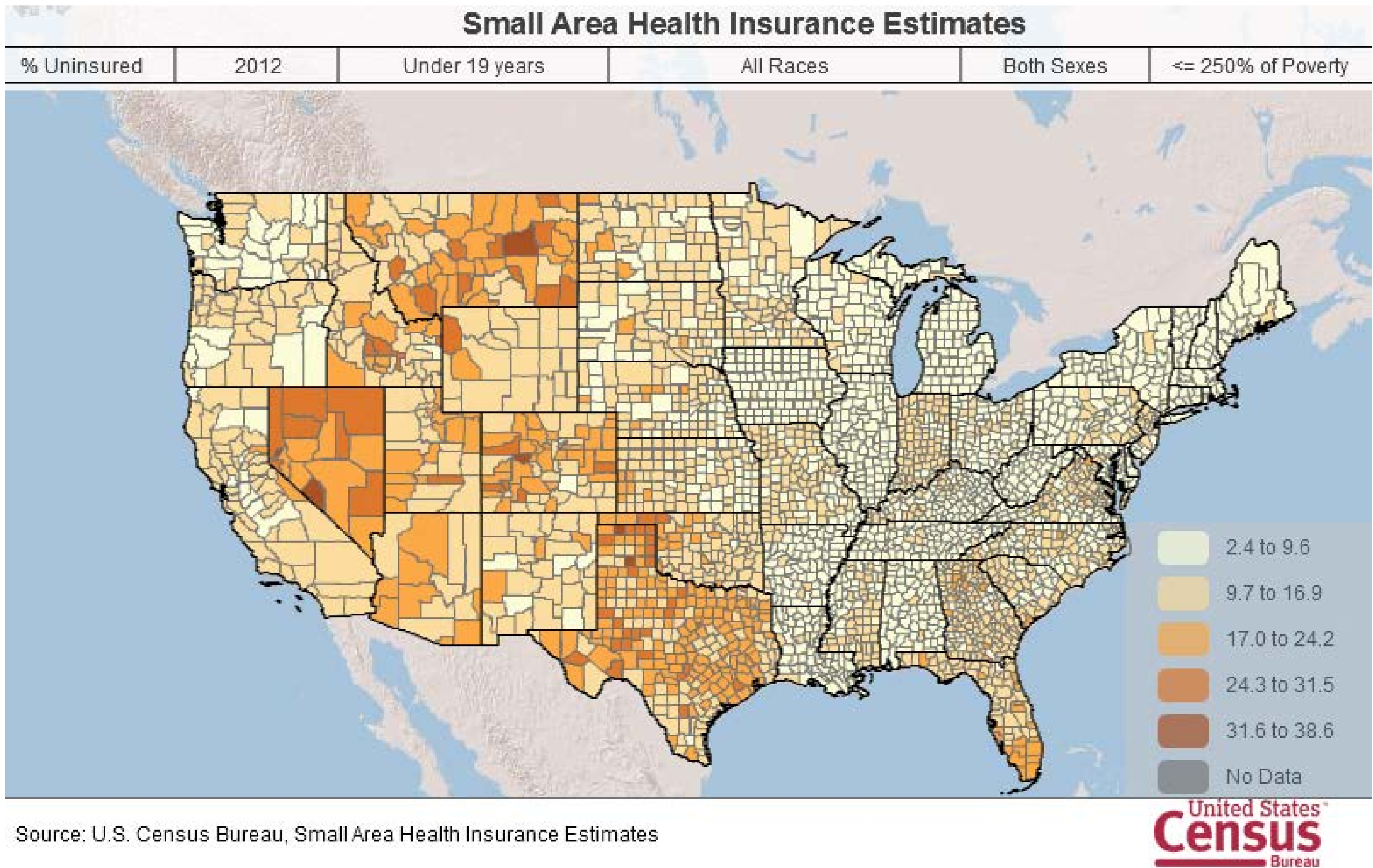


The most recent* U.S. Census data shows West Virginia is among the states with the lowest rates of uninsured children.

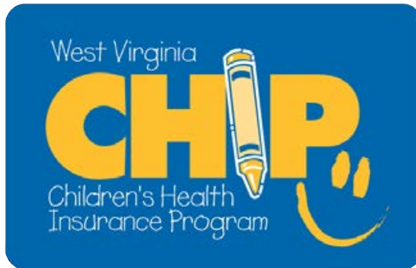
**Census data of this kind is based on updated survey data with 2012 being the most recent.*

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
304-558-2732 voice / 304-558-2741 fax
Helpline 877-982-2447
www.chip.wv.gov

December 19, 2014

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

Jason Pizatella, Cabinet Secretary
West Virginia Department of Administration

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

Ladies and Gentlemen:

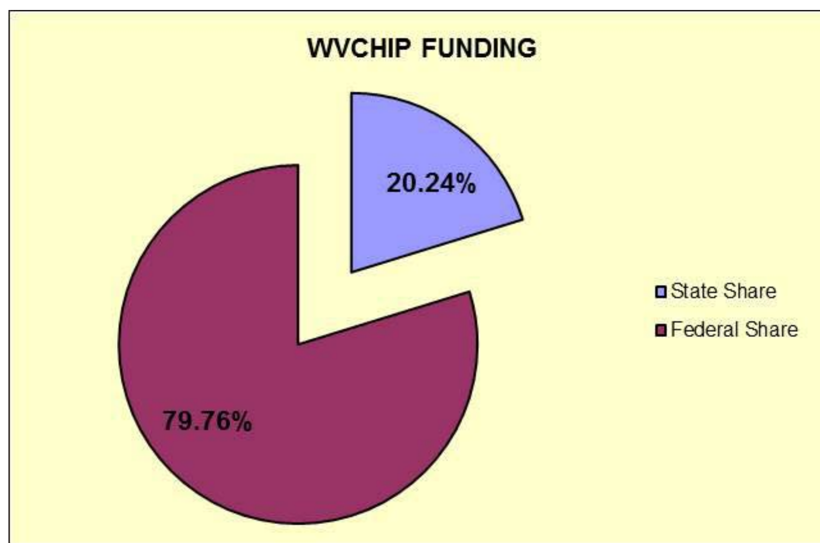
It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2014. This report was prepared by the Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented 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 WV Department of Health and Human Resources, 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 WV Children's Health Insurance Agency is responsible for the administration of the WVCHIP.

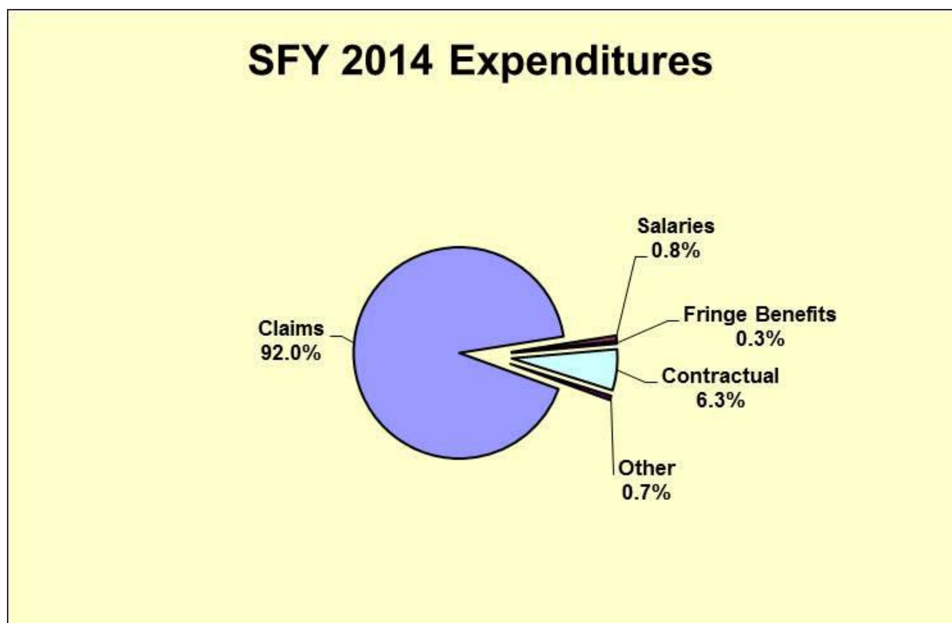
FINANCIAL PERFORMANCE AND OUTLOOK

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, 2014, were 79.76% federal share and 20.24% state share.



WV 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, 2014 confirms this requirement will be met through SFY 2021, assuming that state appropriations remain at the current level as SFY 2014, $9,987,312, and considering projected enrollment and program costs trends.

Based on estimated funding, enrollment, and costs, the June 30, 2014 Actuarial report projected no federal funding shortfalls for SFYs 2015 through 2021. All projections assume federal allotments will remain at the same level as the 2014 allotment, $51,303,242.



REAUTHORIZATION BY UNITED STATES CONGRESS

The Children's Health Insurance Program was reauthorized by Congress on February 4, 2009, extending the program through 2013. Under the new bill, states will receive annual allotments based on a revised formula that considers the state's actual projected spending and demographics, as well as national trends. Also, provisions that extend program eligibility, additional coverage options, and streamlined enrollment processes are part of the bill.

HEALTH CARE REFORM

Congress passed the Affordable Care Act (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% FPL. This increase caused many children that were income eligible for WVCHIP to transfer enrollment to Medicaid. Approximately 5,482 children moved from WVCHIP coverage to Medicaid coverage through June 30, 2014. In addition, some Medicaid children became eligible for WVCHIP, and some WVCHIP and Medicaid children became eligible for Advanced Payment Tax Credits (APTC) through the marketplace.

INITIATIVES

This year was another one of intensive management activity for WVCHIP. The program continued activities necessary to implement the changes brought about by the Affordable Care Act (ACA). Work continued under the "Tri-State Children's Health Improvement Consortium," a multi-state grant focused on improving the quality of health care provided to children - work that is drawing to a close as the grant enters its final year (see Major Initiatives for further discussion). WVCHIP started assessing work required 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 other provisions focused on program integrity as well as new monthly data reporting to the Centers for Medicare and Medicaid Services (CMS) under the Transformed Medicaid Statistical and Information System (T-MSIS). Changes in reporting these data are key to driving health quality and performance in a post-health care reform world. Failure of WVCHIP to comply with TMSIS 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 Centers for Medicare and Medicaid Services (CMS) monitors the operation of WVCHIP. Financial statements are presented for the state fiscal year ended June 30, 2014. The federal fiscal year 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 must make a special acknowledgement to one of this program's most stalwart of supporters in Congress. Ever mindful of the importance of this program to West Virginia's working families and children, Senator John D. Rockefeller IV, is not only a key author of legislation to enact CHIP, and of its 2009 reauthorization, but this year also introducing Senate Bill 2461 to allow for meaningful continued health coverage for children in lower income families who otherwise may not be able to afford it, even in a post-health care reform world. We thank him for his work on behalf of this State's and our Nation's children.

Special thanks are extended to Governor Earl Ray Tomblin and members of the Legislature for their continued support. Gratitude is expressed to the members of WVCHIP's Board of Directors for their leadership and direction. Our most sincere appreciation is extended to Secretary Ross Taylor, whose leadership and support has helped the Agency embrace this year's challenges. Finally, this report would not have been possible without the dedication and effort of WVCHIP's Executive Director, Sharon L. Carte. Respectfully, we submit this Annual Report for the West Virginia Children's Health Insurance Program for the year ended June 30, 2014.

Sincerely,

Stacey L. Shamblin, MHA
Chief Financial Officer

Principal Officials

Earl Ray Tomblin, Governor
State of West Virginia

Jason Pizatella, Cabinet Secretary
West Virginia Department of Administration

Board Members

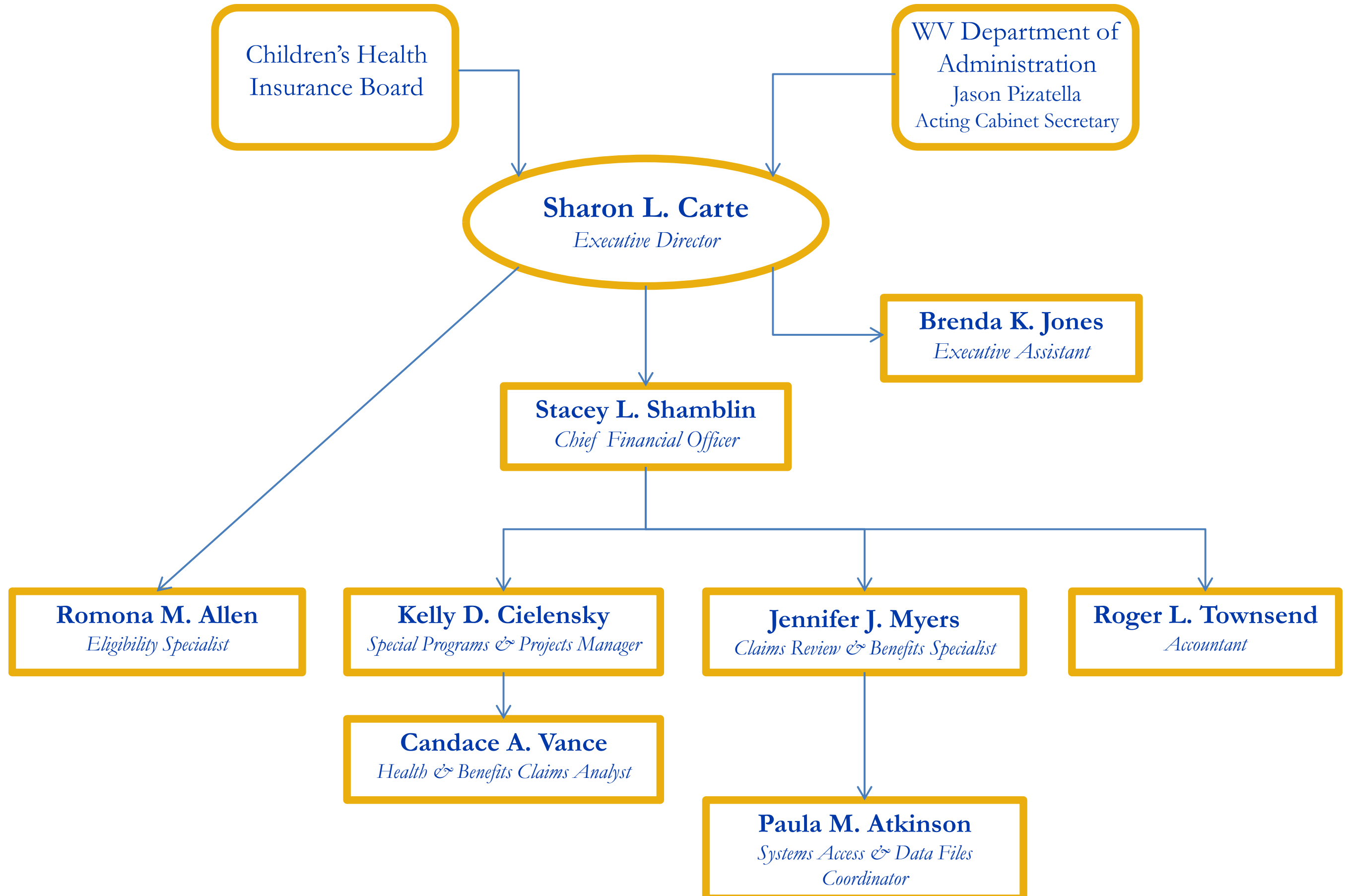
Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Karen L. Bowling, Department of Health & Human Resources, Cabinet Secretary
The Honorable Ron Stollings, West Virginia Senate, Ex-Officio
The Honorable Don Perdue, West Virginia House of Delegates, Ex-Officio
Margie Hale, 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
Romona M. Allen, Eligibility Specialist
Paula M. Atkinson, Systems Access & Data Files Coordinator
Kelly D. Cielensky, Special Programs and Projects Manager
Brenda K. Jones, Executive Assistant
Jennifer J. Myers, Claims Review & Benefits Specialist
Stacey L. Shamblin, Chief Financial Officer
Roger L. Townsend, Accountant
Candace A. Vance, Health and Benefits Claims Analyst

**New citizen member added and expected to be confirmed by Senate in January 2015.*

Staff Organizational Chart



Financial Section

What A Difference CHIP Can Make -

***Over 150,000** children have now 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, 2014

Management of the West Virginia Children's Health Insurance Program (WVCHIP) provides this Management Discussion and Analysis for readers of WVCHIP's financial statements. This narrative overview of the financial statements of WVCHIP is for the year ended June 30, 2014. 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 Federal Poverty Level (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 Affordable Care Act (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.

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 Centers for Medicare & Medicaid Services (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.

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 (GASB). 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 Management Discussion and Analysis 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, 2014 and 2013. (See pages 16 and 17.)

- Total assets decreased $2,397,327, or 12%, in comparison to the previous year-end amount. This decrease is primarily a result of lower ending balances of "Cash and Cash Equivalents," "Due from Federal Government," and the "Due From Other Funds" lines. The "Due from Federal Government" line represents the federal share of costs to cover unpaid insurance claims liability and accounts payable. The "Due From Other Funds" line represents the state share of costs to cover unpaid insurance claims liability and accounts payable. All decreases result from lower monthly enrollment and total program costs.

- Total liabilities decreased by $2,304,115, or 35%, from last year. The majority of the decrease is attributable to the decrease 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, and also reflects the decrease in state general appropriation to the program.

- Total fund equity decreased $75,212, or 1%, in comparison to the previous year end amount. The decrease is reflective of the reduction in general appropriation of state revenues to CHIP coupled with increases in the state share required to fund the program compared to the prior year.

- Total revenues reflect a $3,930,239 decrease, or 7%, when compared to the prior year. While federal and state revenues decreased, investment income and premiums increased about 1%.

- Medical, dental and prescription drug expenditures comprise approximately 92% of WVCHIP's total costs. These expenditures decreased $4,137,657, or 8%, compared to the prior year.
- Administrative costs accounted for approximately 8% of overall expenditures. These expenditures decreased $104,849, or 12%. Expenditures under the multi-state quality grant (T-CHIC) are reflected in the outreach and health promotion line and are 100% federally funded. More detail on increases in administrative costs is included in the next section.

FINANCIAL ANALYSIS

Costs

A negative 8% trend in medical, dental, and prescription drug claims is much lower than the 3.6% 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:

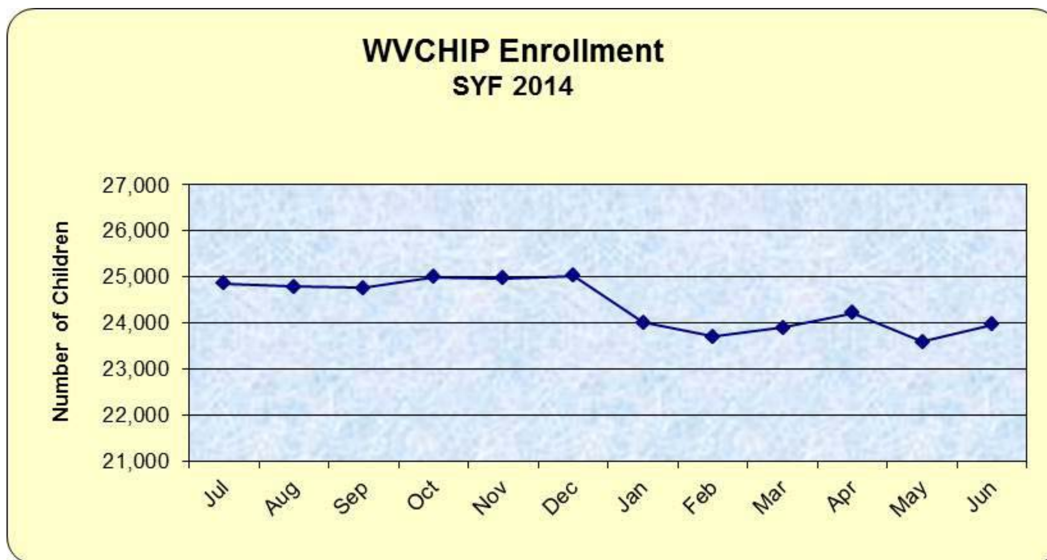
- Enrollment: -2.6%
- Service Utilization: -9.7%
- Price/Fee Increases: +10.7%

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

Enrollment

Monthly enrollment decreased steadily throughout the year, with an overall decrease in enrollment of 2.6% 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 Federal Poverty Level (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%	13,555	-0.7%
CHIP Blue (Phase III)	151% - 211%	8,343	0.0%
WVCHIP Premium	212% - 300%	2,492	+17.4%

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 2014, enrollment increased to 3,168 members, a 46.1% increase over June 2013.

It should be noted that provisions of the Affordable Care Act (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: less members = payments for less services = decreased costs. This is consistent with WVCHIP's experience during SFY 2014. 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 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 a decrease of 9.7% 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 54.

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 2014. During State Fiscal Year 2014, prices increased around 10.7%. The increase in prices is a result of many factors, such as inflationary updates to fee schedules, and a slight shift in services provided out-of-state. 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 increased 5.4%, from $168 in SFY 2013 to $177 in SFY 2014. Costs to in-state service providers increased 3.9% during this time, from an average $155 in SFY 2013 to $161 in SFY 2014. For out-of-state providers, the average cost per claim increased 12.9%, from $432 in SFY 2013 to $488 in SFY 2014. Utilization of out-of-state service providers stayed

about the same this fiscal year - 5.0% of all claims paid by WVCHIP were to out-of-state providers. The increase in prices is evidenced by the increased portion of WVCHIP dollars going out-of-state from 12.7% in SFY 2013 to 13.8% in SFY 2014.

WVCHIP has a very high generic drug utilization rate, 85.6% in SFY 2014, up from 83.7% in SFY 2013. While generic drugs cost much less than brand name drugs, the price for generic drugs increased 3.3% during this time, from $32.59 in SFY 2013 to $33.71 in SFY 2014, resulting in increased costs to the plan. It should be noted that during this same time brand drug costs increased 18.2%, from $213.86 in SFY 2013 to $252.71 in SFY 2014. 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 State Fiscal Year 2014 was $2,237. 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 2.3% 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 decreased 12% from the prior year. Three categories of administrative costs show slight increases: Salaries and Benefits – 11%; Program Administration - 10%; and, Current Expenses – 29%. The increase in Program Administration was mainly due to activities necessary to implement the ACA. Most of the increase in Current Expenses is attributable to amounts paid to the Office of Technology for computer technical assistance. It should be noted that the activities under WVCHIP's participation in a multi-state quality initiative with Oregon and Alaska (T-CHIC) are 100% federally funded and reflected in the Outreach & Health Promotion line. Activities under this grant are winding down as we enter the final year. WVCHIP spent $622,824 on T-CHIC activities in SFY 2014, down 30.3% compared to the prior year.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2014 and 2013
(Accrual Basis)

	June 30, 2014	June 30, 2013	Variance	
Assets:				
Cash & Cash Equivalents	$13,182,762	$14,321,126	$(1,138,364)	-8%
Due From Federal Government	3,108,563	4,132,444	(1,023,881)	-25%
Due From Other Funds	788,833	1,005,495	(216,662)	-22%
Accrued Interest Receivable	8,760	6,823	1,937	28%
Fixed Assets, at Historical Cost	93,386	95,744	(2,357)	-2%
Total Assets	$17,182,305	$19,561,632	$(2,379,327)	-12%
Liabilities:				
Accounts Payable	$ 227,532	$ 186,160	$ 41,372	22%
Deferred Revenue	418,797	1,482,369	(1,063,572)	-72%
Unpaid Insurance Claims Liability	3,669,864	4,951,779	(1,281,915)	-26%
Total Liabilities	$ 4,316,193	$ 6,620,308	$(2,304,115)	-35%
Fund Equity	$12,866,112	$12,941,324	$ (75,212)	-1%
Total Liabilities and Fund Equity	$17,182,305	$19,561,632	$(2,379,327)	-12%

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, 2014 and June 30, 2013
(Modified Accrual Basis)

	June 30, 2014	June 30, 2013	Variance	
Revenues:				
Federal Grants	$44,250,164	$47,256,492	$(3,006,328)	-6%
State Appropriations	9,987,748	10,925,578	(937,830)	-9%
Premium Revenues	874,070	862,043	12,027	1%
Investment Income:				
Investment Earnings	80,324	78,432	1,892	2%
Total Revenues	**$55,192,306**	**$59,122,545**	**$(3,930,239)**	**-7%**
Expenditures:				
Claims:				
Outpatient Services	$13,670,001	$15,078,062	$(1,408,061)	-9%
Physicians and Surgical	10,307,517	12,238,690	(1,931,173)	-16%
Prescribed Drugs	9,583,481	9,554,564	28,917	0%
Dental	7,685,042	8,262,262	(577,220)	-7%
Inpatient Hospital Services	4,350,580	4,181,422	169,158	4%
Outpatient Mental Health	1,560,955	1,637,170	(76,215)	-5%
Inpatient Mental Hospital	1,469,760	1,008,706	461,054	46%
Durable & Disposable Equipment	1,190,283	1,198,865	(8,582)	-1%
Vision	796,349	834,924	(38,575)	-5%
Therapy	682,149	752,243	(70,094)	-9%
Medical Transportation	376,399	431,872	(55,473)	-13%
Other Services	132,254	145,148	(12,894)	-9%
Less Collections*	(1,058,276)	(439,783)	(618,493)	141%
Total Claims	50,746,494	54,884,145	(4,137,651)	-8%
General and Admin Expenses:				
Salaries and Benefits	622,481	562,452	60,029	11%
Program Administration	2,807,330	2,562,568	244,762	10%
Eligibility	206,135	392,340	(186,205)	-47%
Outreach & Health Promotion	712,697	982,223	(269,526)	-27%
Current	206,104	160,013	46,091	29%
Total Administrative	4,554,747	4,659,596	(104,849)	-2%
Total Expenditures	**55,301,241**	**59,543,741**	**(4,242,500)**	**-7%**
Excess of Revenues Over (Under) Expenditures	**(108,935)**	**(421,196)**	**312,261**	**-74%**
Unrealized Gain (loss) On Investments**	**33,724**	**16,081**	**17,642**	**110%**
Fund Equity, Beginning	**12,941,324**	**13,346,439**	**(405,115)**	**-3%**
Fund Equity, Ending	**$12,866,112**	**$12,941,324**	**$ (75,212)**	**-1%**

* 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, 2014

Note 1

Summary of Significant Accounting Policies

Basis of Presentation

The accompanying general purpose financial statements of the West Virginia Children's Health Insurance Program (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 West Virginia Children's Health Insurance Program (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.

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, 2014, 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	$ 574,107	———	———

Investments

	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$ 2,028,550	$2,028,550	Cash Liquidity
	$10,580,105	$10,580,105	Short Term Bond Pool
Total	$12,608,655		

Note 3

Accounts Payable:

Joint PEIA/CHIP Contracts for Third Party Administration & Pharmacy Benefit Management	$ 178,936
CCRC Actuaries	16,066
JCDC Call Center	13,689
Other	18,841
Total Accounts Payable	$ 227,532

Note 4

Risk Management Unpaid Claims Liabilities

Claims Payable, Beginning of Year	$ 4,951,779
Incurred Claims Expense	51,804,770
Payments:	
Claim Payments for Current Year	46,376,087
Claim Payments for Prior Year	6,710,598
Claims payable, year to date	$ 3,669,864

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 2014
For the Twelve Months Ended June 30, 2014

	Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Actual Amt Jun-14	Actual Amt May-14	Actual Amt Apr-14
Projected Cost	$47,897,012	$47,897,012	$54,064,849	($6,167,837)	-13%	$3,991,418	$4,961,788	$5,029,684	$3,418,467
Premiums	969,397	969,397	$909,555	($59,842)	-6%	$80,783	74,773	83,146	30,405
Subrogation & Rebates	457,374	457,374	$1,058,276	600,902	131%	$38,115	153,468	38,092	0
Net Benefit Cost	46,470,241	46,470,241	$52,097,018	($5,626,777)	-12%	$3,907,458	4,733,547	4,908,446	3,388,062
Salaries & Benefits	$710,522	$710,522	$622,484	$88,038	12%	$59,210	$51,037	$51,442	$51,037
Program Administration	3,024,544	3,024,544	$2,733,054	291,490	10%	$252,045	266,144	241,805	310,474
Eligibility	400,000	400,000	$237,137	162,863	41%	$33,333	510	3,825	4,378
Outreach & Health Prom.	1,000,000	1,000,000	$754,046	245,954	25%	$83,333	159,723	0	14,387
Current Expense	170,000	170,000	$202,140	(32,140)	-19%	$14,167	25,348	19,730	12,149
Total Admin Cost	$5,305,066	$5,305,066	$4,548,861	$756,205	14%	$442,089	$502,762	$316,802	$392,425
Total Program Cost	$51,775,307	$51,775,307	$56,645,879	($4,870,572)	-9%	$4,349,547	$5,236,309	$5,225,248	$3,780,487
Federal Share 79.76%	41,642,879	41,642,879	$45,270,769	(3,627,890)	-9%	3,469,199	4,176,480	4,167,658	3,015,316
State Share 20.24%	10,132,428	10,132,428	$11,375,109	(1,242,682)	-12%	880,348	1,059,829	1,057,590	765,171
Total Program Cost *	$51,775,307	$51,775,307	$56,645,879	($4,870,572)	-9%	$4,349,547	$5,236,309	$5,225,248	$3,780,487

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2013 Report.

Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES

Affordable Care Act (ACA)

WVCHIP has implemented a number of changes this past year in order to comply with the ACA. Many activities took place this year, most notably:

- Transitioning income eligibility determination to one based on Modified Adjusted Gross Income – effective October 1, 2013.
- Dropping the waiting period required before a child becomes eligible for CHIP.
- Redesigning the premium program to comply with regulations regarding premium collections and program enrollment.
- Transitioning WVCHIP kids in families with incomes up to 133% FPL to the Medicaid program.

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 pediatric quality demonstration grant project known as the Tri-State Children's Health Improvement Consortium (T-CHIC). The final year of the T-CHIC grant is devoted to developing the final tri-state report as well as to driving improvement in pediatric quality measures being reported by 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.

The West Virginia project team joined the other state team members (Oregon and Alaska) for the Annual Learning Session. The focus for the two-day session was to distill and synthesize what has been learned from the four and a half years by individual grant categories; patient centered medical home characteristics, using data and measurement to improve quality outcomes and the incorporation of Health Information Technology.

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.

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
- A "no cost extension" has been filed for an extension of the project
- The Advisory Council continued to meet and provide guidance for the effort
- Each of the sites has shown improvement in the CMS Proposed Core Measures

Transition to Medicaid Management Information System (MMIS)

WVCHIP began the transition of medical and dental claims processing from the current Third-Party Administrator (TPA) to the MMIS this last year. This project is necessary to comply with more stringent provider enrollment requirements and data reporting for purposes of enhanced program integrity as mandated by the ACA. The move will allow the WVCHIP to gain efficiencies from the Medicaid processes in place for these activities. WVCHIP staff has devoted many hours planning and designing this move over the course of this period. These efforts continue into a new phase of design, implementation, and testing in the next annual cycle.

The state's Medicaid program has been working to upgrade to its current MMIS to also comply with these same ACA mandates. CMS has agreed to additional funding so the system can be designed to also process claims for CHIP. Funding to develop MMIS is awarded to the state's Medicaid program. The total funding is equal to 90% of the total cost of designing, developing, and implementing the system. WVCHIP will provide the 10% state match for its share of costs to make the MMIS compatible with processing CHIP medical and dental claims, become compliant with provider enrollment mandates, in order to meet enhanced data reporting mandates.

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, 2014 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 2014 ("FY 2014") 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. State funding is assumed to be $9,987,312 in FY 2014 and in future years. At the Federal level, the Federal funding for West Virginia is assumed to be $48,275,692 in FY 2014 and $51,303,242 in FY 2015, and we have assumed that this funding remains constant in the future. The Federal funding numbers are not yet finalized due to the uncertainty of when and how many eligible CHIP children would move to Medicaid.

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 1,000 children will ultimately transfer to CHIP and 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 Baseline Scenario, the projected cost of the CHIP Program in FY 2014 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. And we are not projecting any deficit in the Federal funding 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 also 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 2013 in this projection. The Federal share of program expenditure is currently at 79.76% for Federal Fiscal Year 2014 and 79.95% for Federal Fiscal Year 2015 and it remains unchanged through December 31, 2015. While there is uncertainty of Federal funding availability after 2015, we have assumed that the Federal funding will remain constant after 2015.

CHIP Program management has requested CCRC Actuaries to produce two alternative scenarios which assume that (1) CHIP Program will pay the Medicaid Children Transfer Cost, and (2) CHIP Program Federal funding will end starting in 2016.

Under the Medicaid Children Transfer Cost 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 $12.2 million in FY 2014. This estimate has not been reviewed by CHIP management team nor by CCRC Actuaries.

Under the Federal Funding Ending Scenario, including the assumption of Medicaid Children Transfer Cost Scenario, the Federal funding will terminate at the end of the Federal Fiscal Year 2016. Effectively, this will allow the CHIP Program to operate midway through State Fiscal Year 2017, depending on enrollment and costs.

Enrollment for the program as of June 2014 has slightly increased since March 2014. The current program enrollment as of June 2014 consists of 23,955 children total: 11,637 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"), 9,150 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 3,168 children as part of WVCHIP Premium. WVCHIP Blue children are required to make co-payments as part of the benefit structure of the program. Since the March 31, 2014 Quarterly Report with March 2014 enrollment data, overall enrollment has increased by 68 children. WVCHIP Gold has decreased enrollment by 1,116 children, WVCHIP Blue has increased enrollment by 700 children and WVCHIP Premium has increased enrollment by 484 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 increased 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 2014 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 $4,548,859 in FY 2014, representing a 9% decrease over FY 2013 administrative expenses of $4,992,918. West Virginia CHIP management team assumes a 5% administrative expense trend in future years. In Fiscal Year 2014, reimbursement from subrogation was $134,132 and prescription drug rebates totaled $924,144. West Virginia CHIP management team assumes a 4% trend on drugs rebates and subrogation in future years.

Under the State fiscal year basis, we have calculated that the incurred claim costs under the Baseline Scenario assumptions for FY 2014 to be $53,155,294. The updated projection for FY 2015 claims is $44,028,228.

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 CHIP eligibility rules through 9/30/2019.

While this forecast assumes Federal funding levels based on the FY 2014 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 2014, there are 3,168 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 two years extension to CHIPRA reauthorization through December 31, 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. Through May, 2014, 1,613 children have moved from the CHIP Program to Medicaid, in addition this projection assumes that 9,397 children in WVCHIP Gold will ultimately move to Medicaid under the HCR Bill between June 2014 and December 2014. At the same time, the projection assumes that approximately 2,500 children will transfer coverage to the CHIP Program from Medicaid due to the MAGI conversion change.

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.

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 2014 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 is 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 using federally contracted rates. This amount is 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 2014 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 will 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 WV CHIP Premium members, and include coverage for Orthodontic services.

- Addition of the vision benefit for WV CHIP 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 2014. WVCHIP Gold enrollment has decreased in recent months. The program had enrollment at the end of FY 2013 of 24,950 children, with 14,769 under WVCHIP Gold, 8,013 under WVCHIP Blue, and 2,168 under WVCHIP Premium. Current enrollment as of June 2014 is 23,955 children, with 11,637 under WVCHIP Gold, 9,150 under WVCHIP Blue, and 3,168 under WVCHIP Premium.

It is noteworthy that WVCHIP Premium enrollment has been higher than our projected levels made at the implementation of this component of the Program. Based on our observation of the historical WVCHIP Premium enrollment increase, we have changed the original growth assumptions from 38 to 60 new enrollees per month, combined with actual WVCHIP Premium enrollment through June 2014, and we will continue to monitor the projected enrollment by actual results and make adjustments as necessary.

The following table summarizes the FY 2014 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%
Jul-13	14,742	7,979	2,128	24,849	-0.8%
Aug-13	14,753	7,940	2,093	24,786	-1.8%
Sep-13	14,710	7,931	2,116	24,757	-1.6%
Oct-13	14,302	8,577	2,111	24,990	-0.5%
Nov-13	14,572	8,060	2,323	24,955	-0.3%
Dec-13	14,518	8,095	2,398	25,011	-0.1%
Jan-14	13,421	8,144	2,435	24,000	-3.5%
Feb-14	12,863	8,292	2,535	23,690	-5.1%
Mar-14	12,753	8,450	2,684	23,887	-4.5%
Apr-14	12,575	8,711	2,924	24,210	-3.4%
May-14	11,812	8,787	2,986	23,585	-5.9%
Jun-14	11,637	9,150	3,168	23,955	-4.0%

The table below summarizes the projected fiscal year June 30th ending enrollment assumptions for Baseline Scenario by WVCHIP Gold & Blue, WVCHIP Premium and PEIA Children. We have assumed that a net of approximately 8,510 children in WVCHIP Gold will move to Medicaid under the HCR Bill after the approximately 2,500 children from MAGI conversion and the migration assumptions that are consistent with The Marketplace report.

Baseline Scenario (300% FPL)

Ending Enrollment	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
WVCHIP Gold & Blue	20,787	11,650	11,650	11,650	11,650	11,650	11,650	11,650
WVCHIP Premium	3,168	3,528	3,528	3,528	3,528	3,528	3,528	3,528
PEIA Children	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000
Total	23,955	16,178	16,178	16,178	16,178	16,178	16,178	16,178

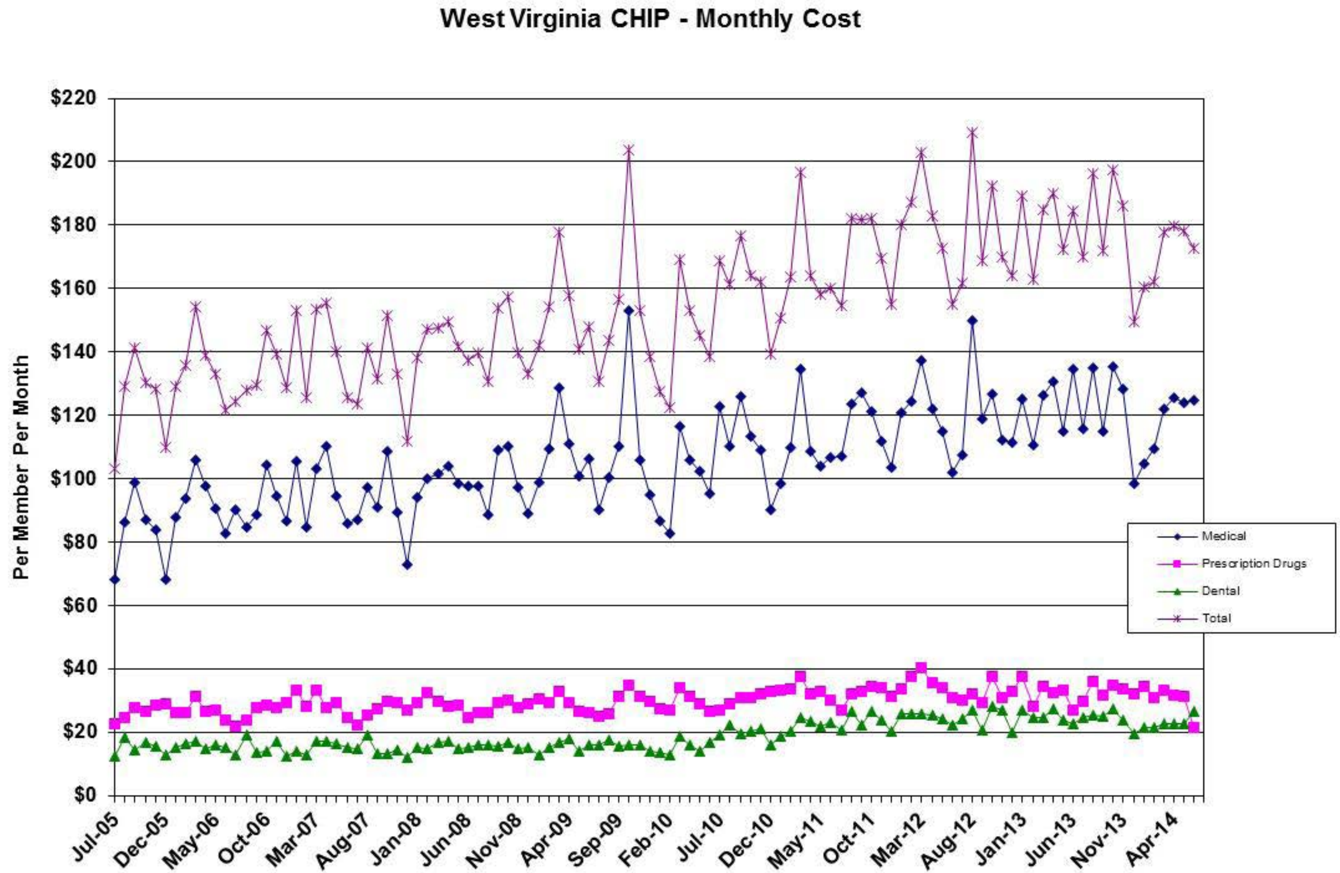
CLAIM COST AND TREND ANALYSIS

The plan has experienced favorable claim experience with overall 12-month trend of -2.2%. We have maintained the medical, dental and prescription drugs trend assumptions from the March 31, 2014 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 WV CHIP experience over the last six months, nine months and twelve months as of June 30, 2014. Overall trend experience has been favorable, with a composite trend of -2.2% 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	-4.2%	-1.8%	-2.0%
Dental	-8.0%	-7.3%	-4.6%
Prescription Drugs	-5.2%	-3.5%	-1.2%
Composite	-4.9%	-2.9%	-2.2%

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 2014. 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 2014-2021

Under the Baseline Scenario, we have assumed that State funding to be $9,987,312 in FY 2014 and in future years. At the Federal level, the Federal funding for West Virginia is assumed to be $48,275,692 in FY 2014 and $51,303,242 in FY 2015, and we have assumed that this funding remains constant in the future. The Federal funding numbers are not yet finalized due to the uncertainty of when and how many eligible CHIP children would move to Medicaid.

The updated incurred claims for FY 2014 is $53,155,294 based on the fiscal year 2014 average enrollment of 24,390 children and the incurred claim per member per month cost data assumption of $181.62, as summarized in the following table.

Category	Current Report FY2014 Baseline Incurred Claims	Current Report FY2014 Baseline Per Member Per Month	3/31/14 Report FY2014 Baseline Per Member Per Month	12/31/13 Report FY2014 Baseline Per Member Per Month
Medical	$36,380,395	$124.30	$122.93	$128.92
Prescription Drugs	9,628,889	32.90	32.80	33.48
Dental	7,146,010	24.42	23.85	25.45
Total	$53,155,294	$181.62	$179.58	$187.85

The Baseline Scenario financial forecast for the Federal and State fiscal years 2014 through 2021 can be found in Appendix A. 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 not projecting the Federal funding shortfall through 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 Federal Government has not provided projections of expected Federal funding in the final years of the projection and these estimates are subject to change.

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 2014 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 2014 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 30, 2014

APPENDIX A
West Virginia Children's Health Insurance Program
June 30, 2014 Quarterly Report
Baseline Scenario - 300% FPL and PEIA Children

Available Funding - Beginning of the Year	2014	2015	2016	2017	2018	2019	2020	2021
Federal 2013	$37,010,991	$0	$0	$0	$0	$0	$0	$0
Federal 2014	48,275,692	40,765,798	5,166,589	0	0	0	0	0
Federal Medicaid Children Transfer Cost	0	0	0	0	0	0	0	0
Federal 2015	0	51,303,242	51,303,242	18,791,978	0	0	0	0
Federal 2016	0	0	51,303,242	51,303,242	28,170,084	0	0	0
Federal 2017	0	0	0	51,303,242	51,303,242	35,174,368	0	0
Federal 2018	0	0	0	0	51,303,242	51,303,242	39,669,240	0
Federal 2019	0	0	0	0	0	51,303,242	51,303,242	41,511,397
Federal 2020	0	0	0	0	0	0	51,303,242	51,303,242
Federal 2021	0	0	0	0	0	0	0	51,303,242
State 2012	$2,466,810	$0	$0	$0	$0	$0	$0	$0
State 2013	10,925,578	2,309,371	0	0	0	0	0	0
State 2014	9,987,312	9,987,312	3,435,687	1,442,262	1,442,262	1,442,262	1,442,262	1,442,262
State 2015	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2016	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2017	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2018	0	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312
State 2019	0	0	0	0	0	9,987,312	9,987,312	9,987,312
State 2020	0	0	0	0	0	0	9,987,312	9,987,312
State 2021	0	0	0	0	0	0	0	9,987,312

Program Costs	2014	2015	2016	2017	2018	2019	2020	2021
WVCHIP Gold & Blue & Premium								
Medical Expenses	$36,380,395	$28,235,526	$24,760,728	$26,246,372	$27,821,154	$29,490,424	$31,259,849	$33,135,440
Prescription Drugs Expenses	9,628,889	7,332,163	6,308,515	6,560,855	6,823,290	7,096,221	7,380,070	7,675,273
Dental Expenses	7,146,010	5,493,834	4,772,286	5,010,901	5,261,446	5,524,518	5,800,744	6,090,781
Administrative Expenses	3,796,652	2,234,211	2,345,921	2,463,218	2,586,378	2,715,697	2,851,482	2,994,056
WVCHIP New Premium								
Medical Expenses	$0	$443,605	$593,964	$629,602	$667,378	$707,420	$749,865	$794,857
Prescription Drugs Expenses	0	115,195	151,330	157,383	163,678	170,225	177,034	184,115
Dental Expenses	0	86,313	114,478	120,202	126,212	132,523	139,149	146,106
Administrative Expenses	752,207	879,570	923,548	969,725	1,018,212	1,069,122	1,122,578	1,178,707
WVCHIP - PEIA Children								
Medical Expenses	$0	$1,596,419	$1,692,204	$1,793,736	$1,901,361	$2,015,442	$2,136,369	$2,264,551
Prescription Drugs Expenses	0	414,556	431,138	448,384	466,319	484,972	504,371	524,546
Dental Expenses	0	310,618	326,149	342,456	359,579	377,558	396,436	416,258
Administrative Expenses	0	199,449	209,421	219,892	230,887	242,431	254,553	267,281
Total Program Costs								
Medical Expenses	$36,380,395	$30,275,550	$27,046,896	$28,669,710	$30,389,893	$32,213,286	$34,146,083	$36,194,848
Prescription Drugs Expenses	9,628,889	7,861,914	6,890,982	7,166,622	7,453,287	7,751,418	8,061,475	8,383,934
Dental Expenses	7,146,010	5,890,765	5,212,914	5,473,559	5,747,237	6,034,599	6,336,329	6,653,145
Administrative Expenses	4,548,859	3,313,229	3,478,891	3,652,835	3,835,477	4,027,251	4,228,613	4,440,044
Premiums (WVCHIP Premium)	$944,291	$1,308,573	$1,336,995	$1,336,995	$1,336,995	$1,336,995	$1,336,995	$1,336,995
Premiums (PEIA Children)	0	378,967	378,967	378,967	378,967	378,967	378,967	378,967
Program Revenues-Interest	$97,684	$93,106	$97,812	$131,212	$172,940	$214,669	$256,397	$298,126
Program Revenues-Drugs Rebates/Subrogation	1,058,276	1,100,607	1,144,631	1,190,416	1,238,033	1,287,554	1,339,056	1,392,618
Net Incurred Program Costs Excluding Interest	$55,701,586	$44,553,311	$39,769,090	$42,056,348	$44,471,898	$47,023,038	$49,717,482	$52,563,392
Net Paid Program Costs	55,001,586	45,466,311	40,257,090	41,840,348	44,243,898	46,782,038	49,462,482	52,294,392
Federal Share	$44,520,885	$35,599,209	$37,677,852	$41,925,137	$44,298,958	$46,808,369	$49,461,085	$52,265,266
State Share of Expenses - Net of Interest	11,083,017	8,860,996	1,993,426	0	0	0	0	0
Beginning IBNR	$4,620,000	$5,320,000	$4,407,000	$3,919,000	$4,135,000	$4,363,000	$4,604,000	$4,859,000
Ending IBNR	5,320,000	4,407,000	3,919,000	4,135,000	4,363,000	4,604,000	4,859,000	5,128,000

APPENDIX A
West Virginia Children's Health Insurance Program
June 30, 2014 Quarterly Report
Baseline Scenario - 300% FPL and PEIA Children

Funding Sources - End of the Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Federal 2013	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2014	40,765,798	5,166,589	0	0	0	0	0	0
Federal 2015	0	51,303,242	18,791,978	0	0	0	0	0
Federal 2016	0	0	51,303,242	28,170,084	0	0	0	0
Federal 2017	0	0	0	51,303,242	35,174,368	0	0	0
Federal 2018	0	0	0	0	51,303,242	39,669,240	0	0
Federal 2019	0	0	0	0	0	51,303,242	41,511,397	0
Federal 2020	0	0	0	0	0	0	51,303,242	40,549,373
Federal 2021	0	0	0	0	0	0	0	51,303,242
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State 2012	$0	$0	$0	$0	$0	$0	$0	$0
State 2013	2,309,371	0	0	0	0	0	0	0
State 2014	9,987,312	3,435,687	1,442,262	1,442,262	1,442,262	1,442,262	1,442,262	1,442,262
State 2015	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2016	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2017	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2018	0	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312
State 2019	0	0	0	0	0	9,987,312	9,987,312	9,987,312
State 2020	0	0	0	0	0	0	9,987,312	9,987,312
State 2021	0	0	0	0	0	0	0	9,987,312
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State Shortfall – 90% Funding Requirement	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***

415 Main Street
Reisterstown, MD 21136

Email: info@ccrcactuaries.com

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

December 1, 2014

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 2014. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2015 based on the updated information. CHIP Program's financial projections continue to improve primarily due to a decrease in enrollment 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 2021 based on the assumption that future funding remains constant. After the September 30, 2014 Quarterly Report was issued in November 2014, several changes have occurred in the program:

- Enrollment for the CHIP Program has decreased significantly from 23,955 in June 2014 to 21,146 as of October 2014, due to the WV CHIP Gold children moving to Medicaid under the HCR Bill.

- October 2014 claim experience showed the projected incurred FY 2015 expenditures to be $45,438,688, a decrease of $26,654 from $ 45,465,342 in the September 30, 2014 Quarterly Report.

- The categories of FY 2015 medical, dental and prescription drug expenses in the current claim experience through October 2014 showed favorable experience over the September 30, 2014 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2015 is now projected to be $182.51, down from the projected $183.77 PMPM cost in the September 30, 2014 Quarterly Report.

- Medical PMPM for Fiscal Year 2015 is now projected to be $125.17, down from the projected $125.75 PMPM cost in the September 30, 2014 Quarterly Report.

- Dental PMPM for Fiscal Year 2015 is now projected to be $24.17, down from the projected $24.36 PMPM cost in the September 30, 2014 Quarterly Report.

- Prescription Drugs PMPM for Fiscal Year 2015 is now projected to be $33.18, down from the projected $33.66 PMPM cost in the September 30, 2014 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, however we believe these rates to be overstated due to census sampling methodology. Some of the enrollment changes at the county level can be seen in the Statistical Section in Tables 8 and 9 *(shown on Page 51 and 52)*.

Public Information via the Helpline, Website, and WVinRoads

WVCHIP continues to make application and program information available through its 1-877-982-2447 toll-free Helpline, which averages over 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.

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

In 2012, 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 applications 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 a monthly e-bulletin 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 CHIP 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, WVCHIP contracted with the WVHKF to field 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.

WVCHIP Premium Survey and Reaching Out to CHIP Parents

In preparation for healthcare reform, WVCHIP conducted a survey of CHIP parents in March 2013 to determine how many had an interest in obtaining health insurance coverage through the new federal/state Marketplace. About 45% of parents indicated they expected to find healthcare coverage through the online Marketplace. This survey of a representative sample of adults in households of CHIP children found that more than 2 out of 3 adults (70%) had no health coverage and the most common reason given was affordability ("Cost is Too High" at 63% with 18.7% showing "Employer Does Not Offer Coverage" as the second highest reason).

WVCHIP staff developed a guide for parents with children whose income was likely to make them eligible through tax credits to gain health coverage in the Marketplace. The guide was drafted in cooperation with the appropriate staff of WV Department of Health and Human Resources and the Offices of the Insurance Commissioner. A copy of this guide can be found online at http://www.chip.wv.gov/news/Pages/Starting-To-Shop-in-the-Marketplace-for-your-Health-Care-Coverage.aspx.

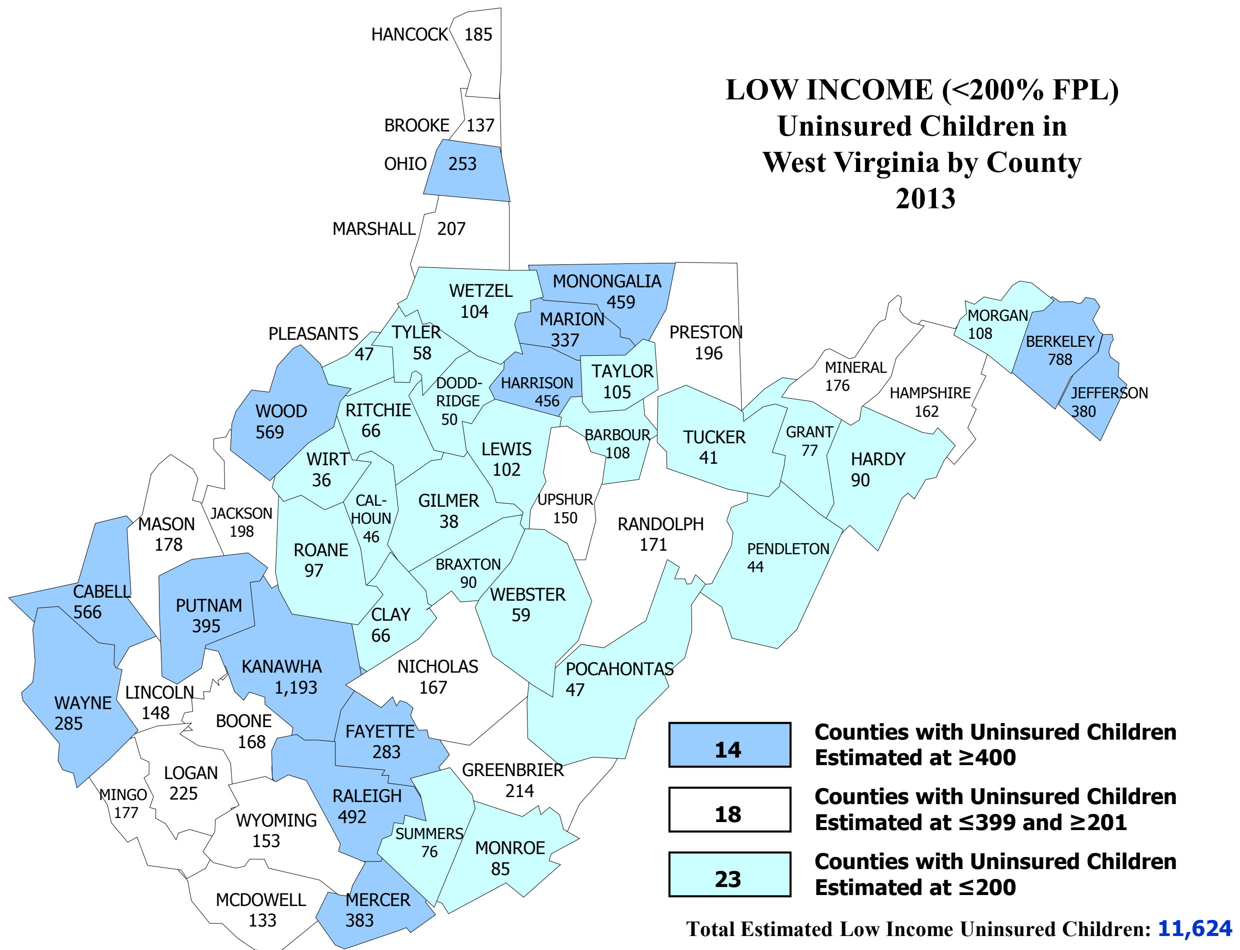
Health Collaborative Efforts

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 2010 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.
- ★ This year WVCHIP partnered 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 states of development.

Targeted Outreach For Uninsured Children



The three percent uninsured total number for children in lower income households is an estimate adapted from the US Census Current Population Survey for outreach purposes. Census data is based on three year rolling averages. While this overall percentage is a valid estimate for statewide purposes, the three percent extrapolation to the county level could vary significantly from county to county depending on the availability of employee sponsored insurance. It remains, however, our best gross estimate of remaining uninsured children to be targeted for outreach.

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 fiscal year ended June 30, 2014, unless noted otherwise.

Table 1: Enrollment

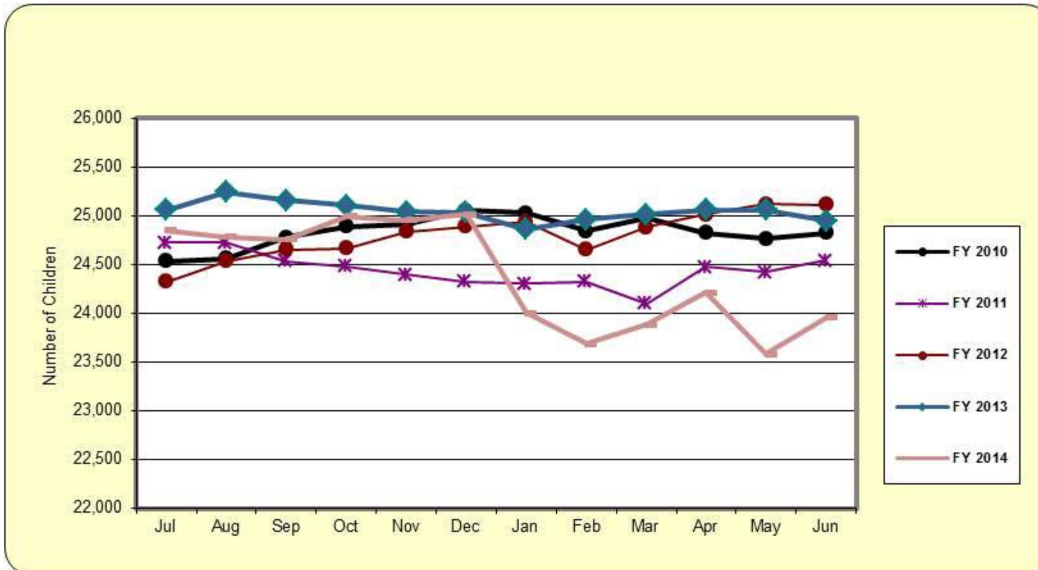
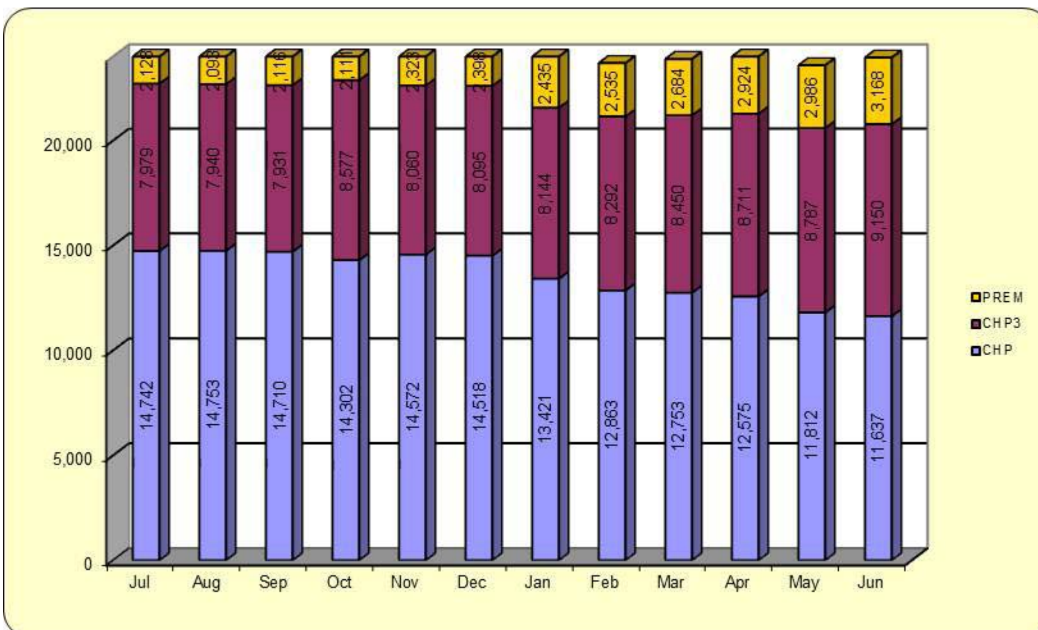
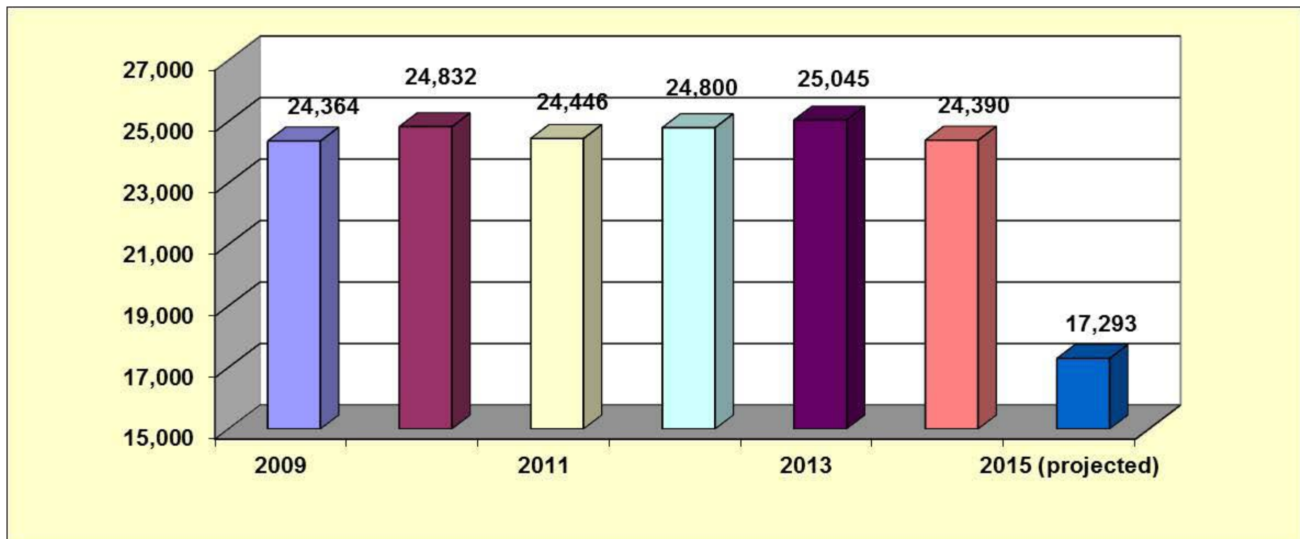


Table 2: Enrollment Detail



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

Table 3: Average Enrollment
SFY 2009 - 2015



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%

Total unduplicated number of children ever enrolled as of June 30, 2014 in WVCHIP since inception:
158,298

Table 4: Enrollment By Gender

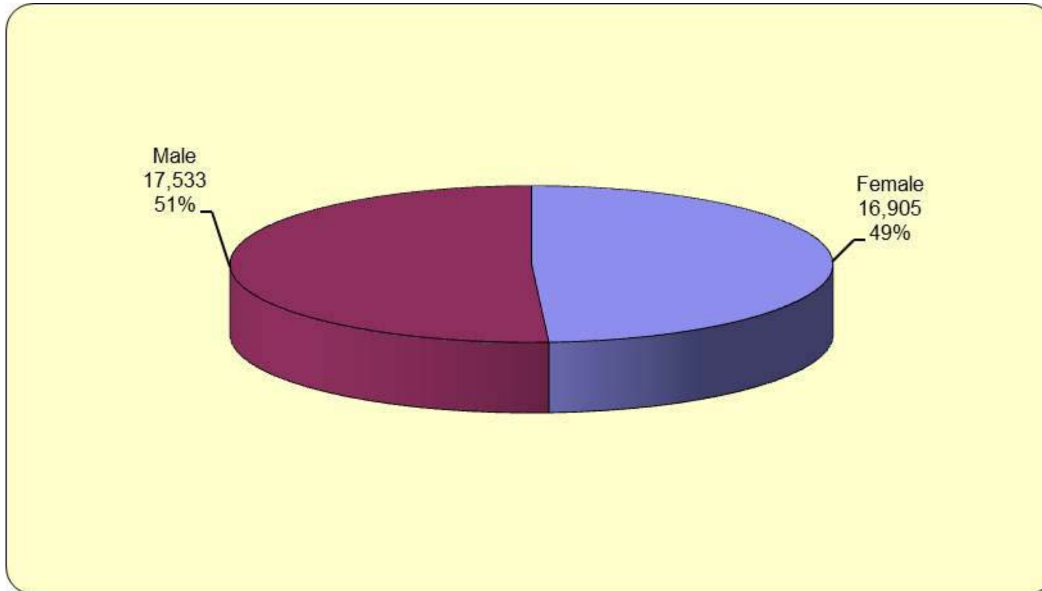


Table 5: Enrollment By Age

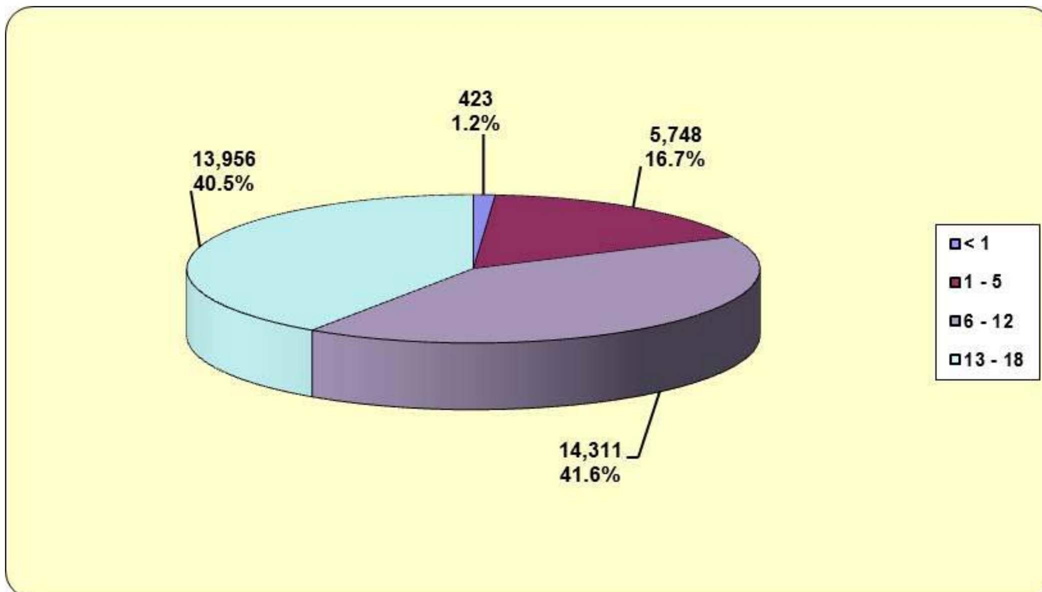
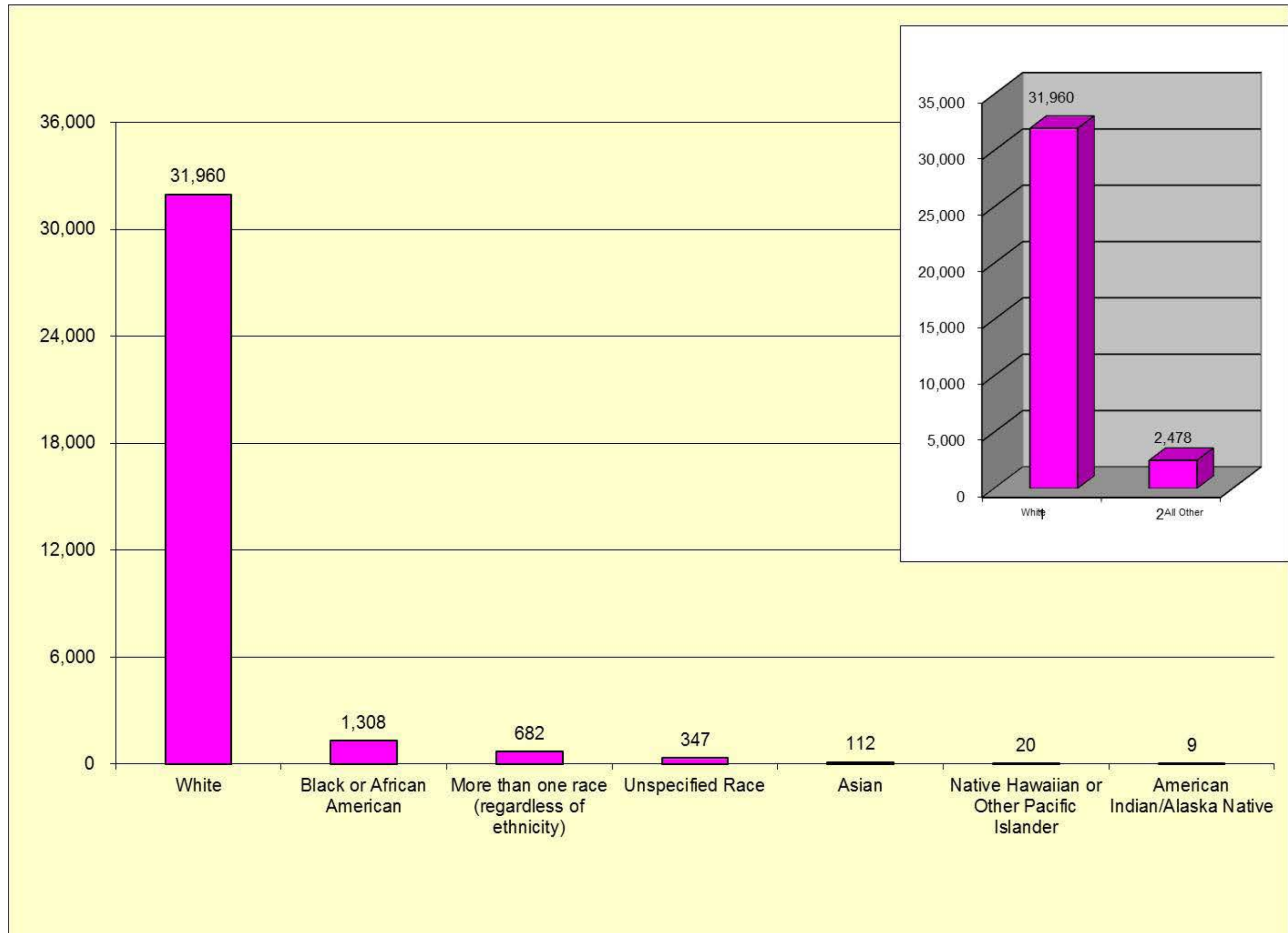
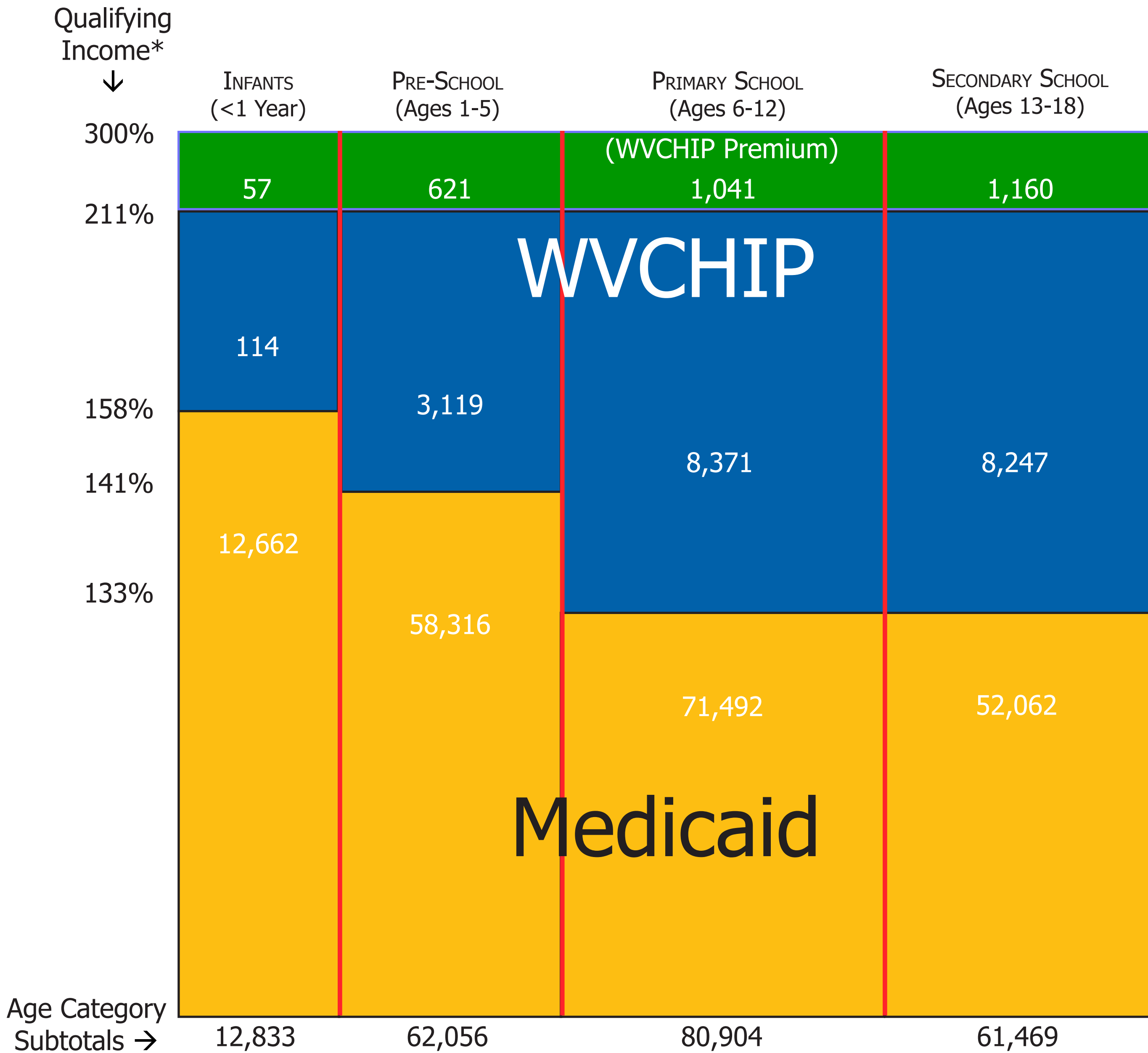


TABLE 6: ENROLLMENT BY RACE/ETHNICITY



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	31,960	92.8%	349,196	91.2%
Black or African American	1,308	3.8%	12,252	3.2%
More than one race (regardless of ethnicity)	682	2.0%	16,464	4.3%
Unspecified Race	347	1.0%	1,532	0.4%
Asian	112	0.3%	2,680	0.7%
Native Hawaiian or Other Pacific Islander	20	0.1%	383	0.1%
American Indian/Alaska Native	9	0.0%	383	0.1%
Total	**34,438**	**100.0%**	**382,890**	**100.0%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2014 -



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

Total WVCHIP Enrollment 22,730 **Total WV Medicaid Enrollment 194,532**

Total # of Children Covered by WVCHIP and Medicaid - 217,262

Table 8: Enrollment Changes By County
As % Difference from July 2013 through June 2014

County	Total Enrollees July 2013	Total Enrollees June 2014	Difference	% Change
Ritchie	126	146	20	14%
Pleasants	122	134	12	9%
Harrison	934	993	59	6%
Wirt	85	89	4	4%
Pocahontas	149	156	7	4%
Barbour	268	279	11	4%
Fayette	768	792	24	3%
Cabell	990	1,015	25	2%
Berkeley	1,405	1,425	20	1%
Wetzel	232	235	3	1%
Monongalia	784	782	-2	0%
Taylor	224	223	-1	0%
Braxton	220	219	-1	0%
Ohio	494	490	-4	-1%
Jefferson	569	564	-5	-1%
Monroe	225	223	-2	-1%
Nicholas	400	394	-6	-2%
Lewis	238	234	-4	-2%
Morgan	258	253	-5	-2%
Kanawha	2,376	2,329	-47	-2%
Summers	188	184	-4	-2%
Hancock	375	365	-10	-3%
Gilmer	74	72	-2	-3%
Wood	1,138	1,095	-43	-4%
Randolph	515	495	-20	-4%
Mingo	385	369	-16	-4%
Doddridge	144	138	-6	-4%
Raleigh	1,262	1,209	-53	-4%
Mineral	288	275	-13	-5%
Hampshire	278	265	-13	-5%
Mason	279	262	-17	-6%
Putnam	802	752	-50	-7%
Brooke	273	255	-18	-7%
Mercer	1,093	1,018	-75	-7%
Logan	501	466	-35	-8%
Webster	154	143	-11	-8%
Upshur	395	366	-29	-8%
Greenbrier	594	548	-46	-8%
Wyoming	419	386	-33	-9%
Preston	457	421	-36	-9%
Jackson	441	405	-36	-9%
Tyler	103	94	-9	-10%
Marion	697	636	-61	-10%
Hardy	191	174	-17	-10%
Marshall	354	320	-34	-11%
Wayne	509	460	-49	-11%
Boone	321	289	-32	-11%
Pendleton	121	108	-13	-12%
Lincoln	371	328	-43	-13%
Roane	317	280	-37	-13%
Calhoun	132	116	-16	-14%
McDowell	279	245	-34	-14%
Clay	195	167	-28	-17%
Tucker	137	117	-20	-17%
Grant	200	157	-43	-27%
Totals	**24,849**	**23,955**	**-894**	**-4%**
12-Mo. Ave.		***24,388***	***-75***	***-5%***

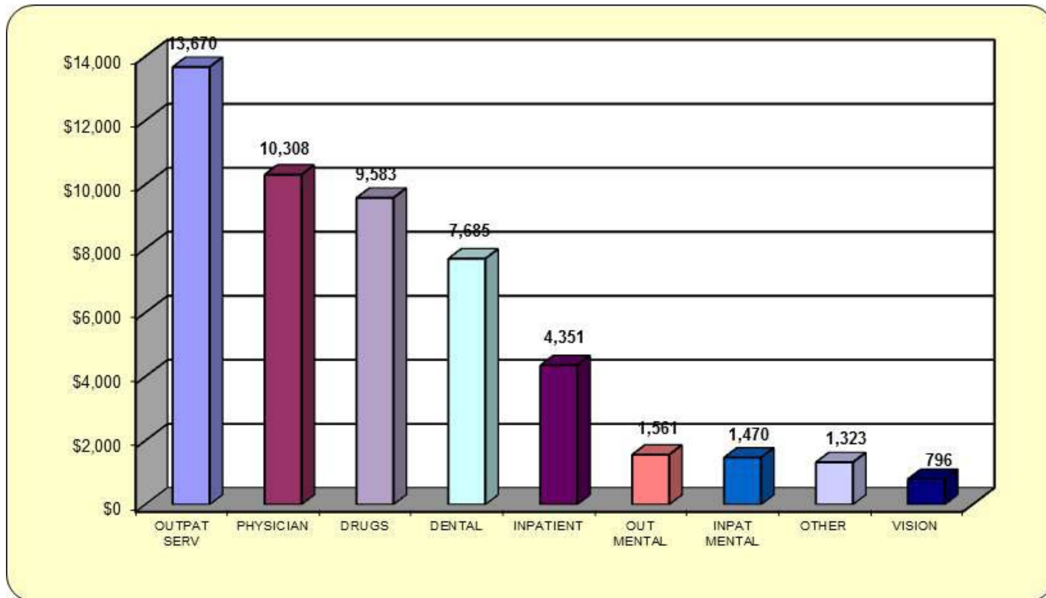
Median (line between Raleigh and Mineral)

Table 9: Enrollment Changes By County

As % of Children Never Before Enrolled from July 2013 through June 2014

County	Total Enrollees July 2013	Total Enrollees June 2014	New Enrollees Never in Program	New Enrollees As % of June 2014
Tyler	103	94	38	40%
Wetzel	232	235	91	39%
Boone	321	289	107	37%
Nicholas	400	394	141	36%
Hardy	191	174	59	34%
Gilmer	74	72	24	33%
Monongalia	784	782	257	33%
Jefferson	569	564	180	32%
Berkeley	1,405	1,425	444	31%
Mineral	288	275	85	31%
Hancock	375	365	112	31%
Pleasants	122	134	41	31%
Marshall	354	320	96	30%
Calhoun	132	116	34	29%
Monroe	225	223	65	29%
Greenbrier	594	548	158	29%
Ritchie	126	146	42	29%
Taylor	224	223	64	29%
Webster	154	143	41	29%
Cabell	990	1,015	291	29%
Summers	188	184	52	28%
Wirt	85	89	25	28%
Raleigh	1,262	1,209	337	28%
McDowell	279	245	68	28%
Wyoming	419	386	106	27%
Braxton	220	219	59	27%
Pocahontas	149	156	42	27%
Median				
Mingo	385	369	97	26%
Marion	697	636	167	26%
Kanawha	2,376	2,329	608	26%
Lewis	238	234	61	26%
Lincoln	371	328	85	26%
Putnam	802	752	192	26%
Logan	501	466	118	25%
Ohio	494	490	124	25%
Barbour	268	279	68	24%
Wood	1,138	1,095	266	24%
Harrison	934	993	240	24%
Doddridge	144	138	32	23%
Brooke	273	255	59	23%
Upshur	395	366	83	23%
Jackson	441	405	91	22%
Wayne	509	460	103	22%
Hampshire	278	265	59	22%
Mercer	1,093	1,018	226	22%
Clay	195	167	37	22%
Roane	317	280	62	22%
Fayette	768	792	175	22%
Randolph	515	495	109	22%
Mason	279	262	57	22%
Morgan	258	253	52	21%
Preston	457	421	80	19%
Pendleton	121	108	20	19%
Grant	200	157	28	18%
Tucker	137	117	14	12%
Totals	**24,849**	**23,955**	**6,372**	**27%**
12-Mo. Ave.		***24,388***	***531***	***2.2%***

Table 10: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

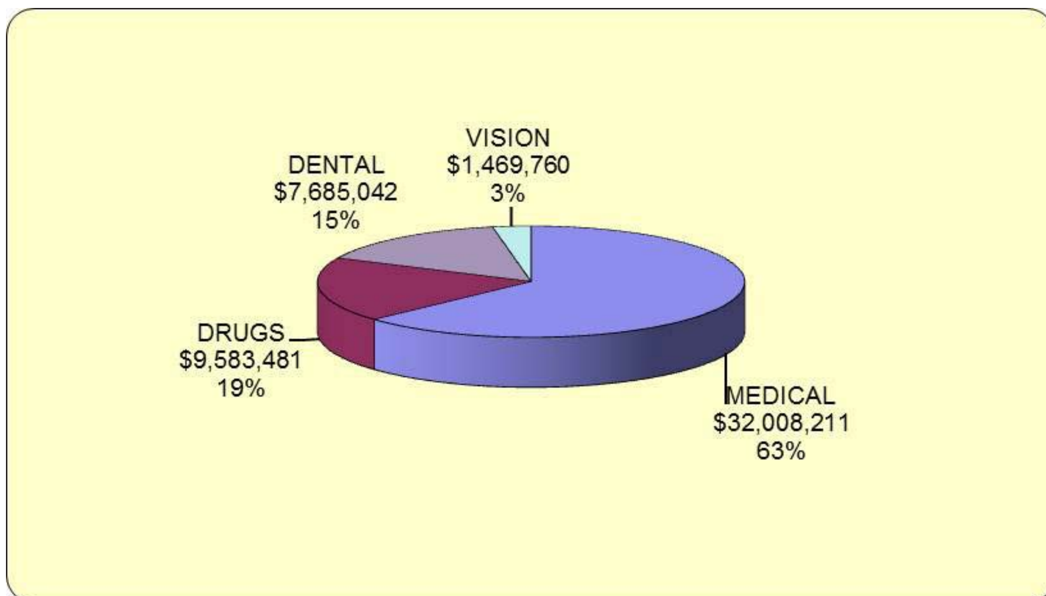


Table 11: Total Program Expenditures

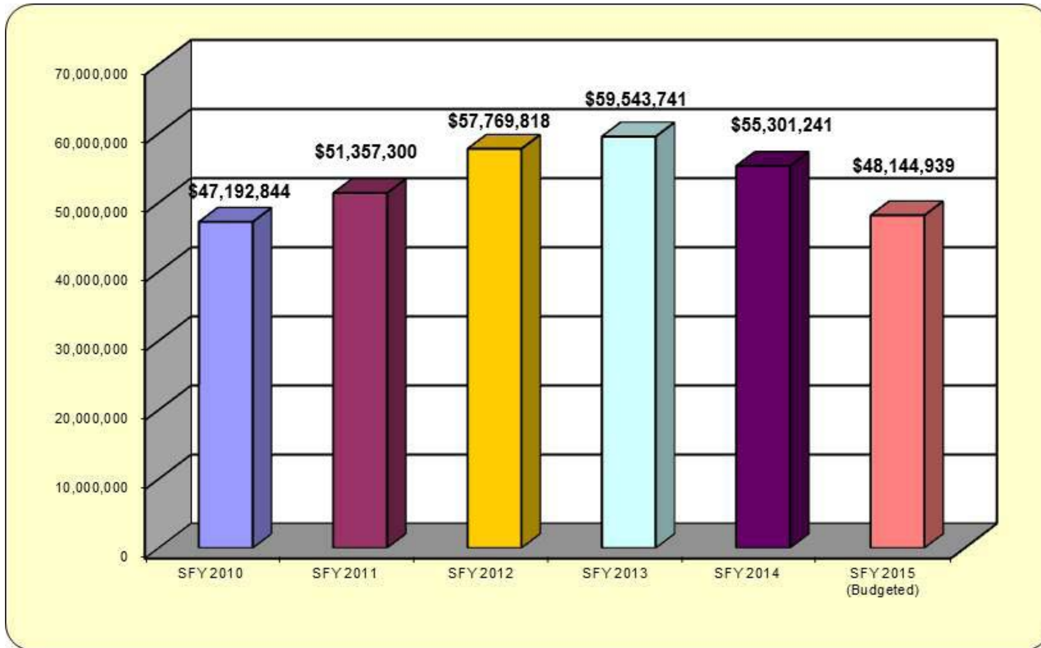
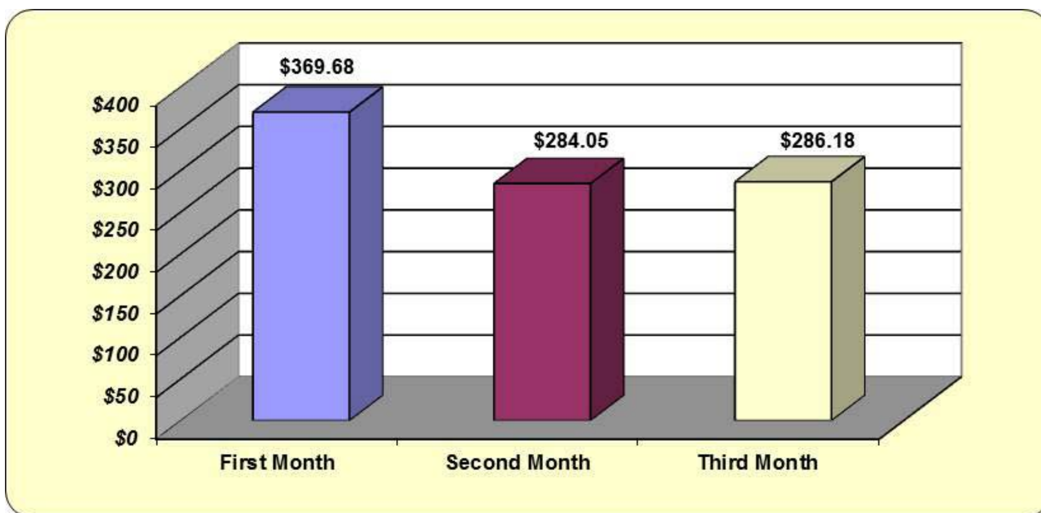


Table 12: Average Claimant Costs in First Three Months

Showing Pent Up Demand For Services Upon Enrollment



WVCHIP Set of Pediatric Core Measures 2014

In early 2010 the Secretary of the U.S. Department of Health and Human Services identified 24 pediatric core measures on which state CHIP and Medicaid programs could begin voluntary reporting. Since WVCHIP currently has no contracts with managed care plans who might already be reporting some of these measures, it must extract this information to the extent possible from claims data. Most of the data is extracted according to specifications developed for the Health Plan Effectiveness Data and Information Set (HEDIS®). Some core measures were developed by other states and for which they are the steward and were included into the core set by national panels of experts. One such example is the Emergency Department Utilization measure developed by the State of Maine. In this year's report, WVCHIP has expanded to report 18 measures in the national measure set. Reflected in this report are 16 of the 22 core data set that is being submitted to the Centers for Medicare and Medicaid Services (CMS). There are four measures which relate to perinatal health for which we hope to receive data gathered by the WV Department of Health and Human Resources in the coming years to expand further our set of reported measures. 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 years later.

HEDIS® is a 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. 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.

Table 13
Childhood Immunization Status (CIS-CH)

Measure Steward: NCQA/HEDIS: The percentage of children 2 years of age during calendar year 2013 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), two 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 2013	Number Receiving Immunizations - 2013	% Year 2013	Number of Continuously Enrolled 2012	Number Receiving Immunizations - 2012.	% Year 2012	Number of Continuously Enrolled 2011	Number Receiving Immunizations - 2011	% Year 2011
2 years old	DTaP (four immunizations)	70	53	75.7%	63	49	77.8	42	31	73.8
	IPV (three immunizations)	70	57	81.4%	63	60	95.2	42	39	92.9
	MMR (one immunization)	70	70	100.0%	63	63	100.0	42	42	100.0
	Hib (two immunizations)	70	70	100.0%	63	61	96.8	42	40	95.2
	Hepatitis B (three immunizations	70	41	58.6%	63	39	61.9	42	25	59.5
	VZV (one immunization)	70	70	100.0%	63	63	100.0	42	42	100.0
	PCV (four immunizations)	70	65	92.9%	63	53	84.1	42	23	54.7
	Hep A (two immunizations)	70	70	100.0%	63	63	100.0	42	40	95.2
	RV (two or three immunizations	70	68	97.1%	63	62	98.4	42	40	95.2
	Influenza two immunizations)	70	62	88.6%	63	60	95.2	42	41	97.6
	Total continuously enrolled	**70**	**70**	**89.4**	**63**	**63**	**90.9**	**42**	**42**	**86.4**

Table 14
Immunization Status for Adolescents (IMA-CH)

Measure Steward: NCQA/HEDIS: The percentage of adolescents who turned 13 years of age during calendar year 2013 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 2013	% Year 2012	% Year 2011
Adolescents	**Administration**					
13 Years old	**Combination (Meningococcal, Tdap/TD)**	**1844**	**1,354**	**73.4**	**71.5**	**71.3**
	Meningococcal		1,354	**73.4**	**71.5**	**71.3**
	Tdap/TD		1,357	**73.5**	**79.1**	**77.9**
Total continuously enrolled		**1,844**		**73.5**	**75.3**	**74.6**

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 2013 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 2013	% with Measure for Year 2012	% with Measure for Year2011
Age 3	284	0	0.00	0.00	0.41
Age 4	309	0	0.00	0.36	0.36
Age 5	335	0	0.00	0.34	0.00
Age 6	377	0	0.00	0.00	0.23
Age 7-11	3778	5	0.13	0.15	0.26
Age 12 and up	5530	12	0.22	0.21	0.47
Total	**10,613**	**17**	**0.16**	**0.18**	**0.44**

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 2013	% with Measure for Year 2012	% with Measure for Year 2011
Age 1	64	33	51.6	37.3	31.6
Age 2	334	158	47.3	40.9	41.3
Age 3	284	102	35.9	32.2	27.7
TOTAL:	**682**	**293**	**42.9**	**36.6**	**34.0**

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 2013 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

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2013
22	0	1	4.55
22	1	1	4.55
22	2	0	0.00
22	3	0	0.00
22	4	1	4.55
22	5	1	4.55
22	6 or more	18	81.82
Total		**22**	

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2012
11	0	0	0.00
11	1	0	0.00
11	2	0	0.00
11	3	0	0.00
11	4	0	0.00
11	5	0	0.00
11	6 or more	11	100.00
Total		**11**	

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2011
21	0	1	4.50
21	1	0	0.00
21	2	1	4.50
21	3	0	0.00
21	4	0	0.00
21	5	0	0.00
21	6 or more	19	90.50
Total		**21**	

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

Measure Steward for Measure Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life: NCQA/HEDIS: The number of children ages three to six years enrolled for calendar year 2012 who had one or more well-child visit with a PCP as defined by CPT Codes: 99382, 99383, 99392, and 99393

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Year 2013	% Prior Year 2012	% Prior Year 2011
Well Child					
Less Than Or Equal To 15 Months	22	21	95.5	100.0	95.2
Third Year Of Life	284	219	77.1	81.1	77.9
Fourth Year Of Life	309	244	79.0	82.3	80.1
Fifth Year Of Life	335	250	74.6	82.4	79.4
Sixth Year Of Life	377	237	62.9	64	68.6
Total	1,327	971	73.2	77.4	76.4

Table 19
Adolescent Well Child Visits (AWC-CH)

Measure Steward for Measure Adolescent Well-Child Visit: NCQA/HEDIS: The number of adolescents from ages 12 to 19 years old enrolled during calendar year 2012 who had at least one comprehensive well-care visit with a PCP or OB/GYN as defined by CPT Codes: 99383-99385, 99393, and 99395

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Year 2013	% Prior Year 2012	% Prior Year 2011
Adolescents					
12 To 19 Years of Age	5,530	2,390	43.2	36.0	38.2
Total	**5,530**	**2,390**	**43.2**	**36.0**	**38.2**

Table 20
Percentage of Eligibles that Received Preventive Dental Services

Measure Steward: EPSDT 416 Measure: Unduplicated number of children enrolled for the calendar year 2013 receiving a preventive dental service as a percentage of the total number of unduplicated enrollees in the program defined by HCPC Codes D1000-D1999 (ADA Codes D1000-D1999) as reported on CMS Form 416, Line 12B

Unduplicated Number of Children	Number of Children with Preventive Dental Visits	% Year 2013	% Year 2012	% Year 2011
36,526	16,490	45.1	44.5	43.2

Table 21
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 that had a visit with a PCP including four separate percentages for children ages 12 to 24 months, ages 25 months to 6 years, 7 to 11 years, and 12 to 19 years who had a visit during calendar year 2013 or the previous calendar year 2011, as defined by CPT Codes 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429

Age Group	Number of Continuously Enrolled Children	Number Having Primary Care Visit	%Prior Year 2013	% Prior Year 2012	%Prior Year 2011
12 to 24 Months	80	78	97.5	97.4	95.0
25 Months to 6 Years	1,617	1,531	94.7	97.3	96.3
7 to 11 Years	3,778	3,345	88.5	90.5	90.9
12 to 19 Years	5,330	4,849	91.0	89.4	87.1
Total	**10,805**	**9,803**	**90.7**	**90.7**	**89.8**

Table 22
Percentage of Eligibles that Received Dental Treatment Services

Measure Steward: **EPSDT 416 Measure:** Unduplicated number of children enrolled for calendar year 2013 receiving dental treatment services as a percentage of the total number of unduplicated enrollees in the program defined by HCPC Codes D1000-D1999 (ADA Codes D1000-D1999) as reported on CMS Form 416, Line 12C

Unduplicated Number of Children	Number of Children with Treatment Dental Visits	% Year 2013	% Year 2012	% Year 2011
36,526	14,234	39.0	38.1	37.4

Table 23
Ambulatory Care-Emergency Department (ED) Visits (AMB-CH)

Measure Steward: **NCQA/HEDIS:** Rate of ED visits per 1,000 member months among children up to age 19, continuously enrolled and eligible during the calendar year 2013. CPT Codes: 99281-99288

	Number of Members	Member Months	Number of ER Encounters	Rate per 1,000 members
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**
For Year 2011:				
Ages:				
<1		72	0	0.00
1 through 9		28,200	1,132	39.31
10 to 19		78,468	3,008	38.33
TOTAL:		**107,340**	**4,140**	**38.57**

Table 24
Annual Percentage of Asthma Patients 2-19 Years Old with One or More Asthma-Related ED Visits

No longer a Core measure; however, WVCHIP continues to collect this data for Quality Assurance purposes.

Age Group	Continuously Enrolled 2013	Asthma Patients 2013	ED Encounters for Asthma 2013	Asthma ED Encounters per Person 2013	Asthma Encounters Per User 2013	Asthma ED Encounters per Person 2012	Asthma Encounters Per User 2012	Asthma Encounters Per User 2011	Asthma ED Encounters Per User 2011
Under Age 2	70	0	0	0.00	0.00	0.00	0.00	0.00	0.00
Age 2	328	4	0	0.00	0.00	0.03	1.50	0.00	0.25
Age 3	284	6	2	0.01	0.33	0.01	0.33	0.01	0.40
Age 4	309	6	2	0.01	0.33	0.01	0.57	0.01	0.43
Age 5	335	8	3	0.01	0.38	0.00	0.13	0.03	0.55
Age 6	377	4	1	0.00	0.25	0.01	0.33	0.00	0.11
Ages 7-12	3778	93	23	0.01	0.25	0.01	0.18	0.01	0.31
Ages 12 and Up	5530	86	18	0.00	0.21	0.00	**0.22**	0.00	0.13
Total	**11011**	**198**	**49**	**0.00**	**0.25**	**0.01**	**0.24**	**0.01**	**0.25**

Table 25
Annual Pediatric Hemoglobin (HbA1c) Testing

No longer a Core measure; however, WVCHIP continues to collect this data for Quality Assurance purposes.

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	**1**	1	**1**	0	**0**
6 to 11 Years	9	8	**89.9**	7	**77.800**	2	**22.2**
12 to 18 Years	73	70	**95.9**	71	**97.3**	32	**43.8**
Total % Year 13	**83**	**79**	**95.2**	**79**	**95.2**	**21**	**25.3**
Total % Prior Year 12	**82**	**77**	**94.0**	**81**	**97.6**	**33**	**39.8**
Total % Prior Year 11	**75**	**65**	**86.7**	**72**	**96.0**	**21**	**28.0**

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

Measure Steward: NCQA/HEDIS: The percentage of children 6 to 12 years of age with attention-deficit/hyperactivity disorder (ADHD) medication newly prescribed who have at least three follow-up care visits within a 10-month period, one of which occurs within 30 days of when the first ADHD medication was dispensed. Two rates are reported, the initiation phase and the 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, 99383, 99384, 99393, 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

Age Group	#Members Receiving ADHD Medications	# Members on Medication with follow-up visits	% Compliance for 2013 Year	% Compliance for 2012 Year	% Compliance for 2011 Year
6 years	3	3	100	100	100
7 years	22	22	100	100	100
8 years	56	56	100	100	100
9 years	90	90	100	100	100
10 years	88	88	100	100	100
11 years	112	112	100	100	100
12 years	118	118	100	100	100
Total	**489**	**489**	**100**	**100**	100

100% compliance because this service is by precertification.

Age Group	# Continuation & Maintenance Members	# Members on Medication with follow-up visits	% Compliance for 2013 Year	% Compliance for 2012 Year	% Compliance for 2011 Year
6 years	2	2	100	100	100
7 years	10	10	100	100	100
8 years	39	39	100	100	100
9 years	70	70	100	100	100
10 years	70	70	100	100	100
11 years	94	94	100	100	100
12 years	89	89	100	100	100
Total	**374**	**374**	100	**100**	**100**

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 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 30 days of Discharge Year 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
129	26	20.2	67	51.9

#6 years & older Hospitalized with Mental Health DX Year 2011	# of follow-up visits within 7 days of Discharge Year 2011	% of follow-up visits within 7 days of Discharge Year 2011	# of follow-up visits within 30 days of Discharge Year 2011	% of follow-up visits within 30 days of Discharge Year 2011
118	31	26.3	65	55.1

Table 28
West Virginia Measure - Vision Visits

Not a reportable HEDIS measure. However, WVCHIP collects data for Quality Assurance purposes

Measure Steward: **HEDIS-Type Data:** The number of children continuously enrolled for calendar year 2013 who received a vision visit for CPT Codes: 92012-92014, 92002-92004, 99172-99173, 92081-92083, 99174

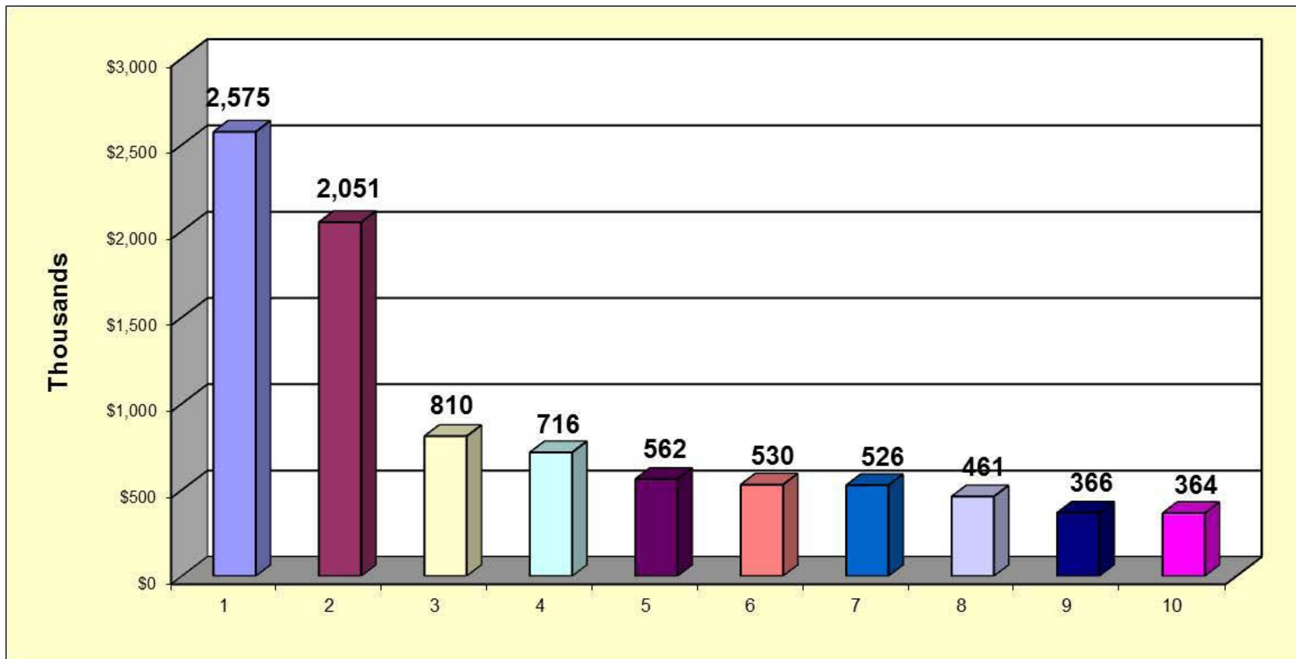
Age Group	Enrollment	Services	Utilization Rate	CHIP Expenditures	Per Member Per Year 2013	Per Member Per Year 2012	Per Member Per Year 2011
0 to 364 Days	145	8	0.06	816.50	5.63	2.33	1.54
1 to 2 Years	1,490	109	0.07	9,164.44	6.15	5.64	3.46
3 Years	740	65	0.09	5,957.57	8.05	8.06	8.92
4 to 5 Years	1,657	336	0.20	32,777.32	19.78	18.98	15.76
6 to 11 Years	9,231	3,050	0.33	307,103.41	33.27	33.61	31.13
12 to 18 Years	11,927	4,209	0.35	419,499.00	35.17	34.77	34.84
Overall	**25,190**	**7,777**	**0.31**	**775,318**	**30.78**	**30.39**	**29.19**

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 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	477	94.7	94.5	88.6	84.5
12-18 years	326	93.5	93.5	81.5	78.7
Total	803				

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	Psychotherapy, 60 Minutes with Patient	(90837)
4	Therapeutic Activities, 15 Minutes	(97530)
5	ER Exam - Extended - New Patient	(99284)
6	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
7	Office Visit - Intermediate - New Patient	(99203)
8	ER Exam - Intermediate - New Patient	(99283)
9	Psychotherapy, 45 Minutes with Patient	(90834)
10	ER Exam - Comprehensive - New Patient	(99285)

**As described in Current Procedure Terminology 2012 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 **Psychotherapy, 60 Minutes with Patient:** Psychotherapy, 60 minutes with patient and/or family member *(90837)*

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

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 **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)*

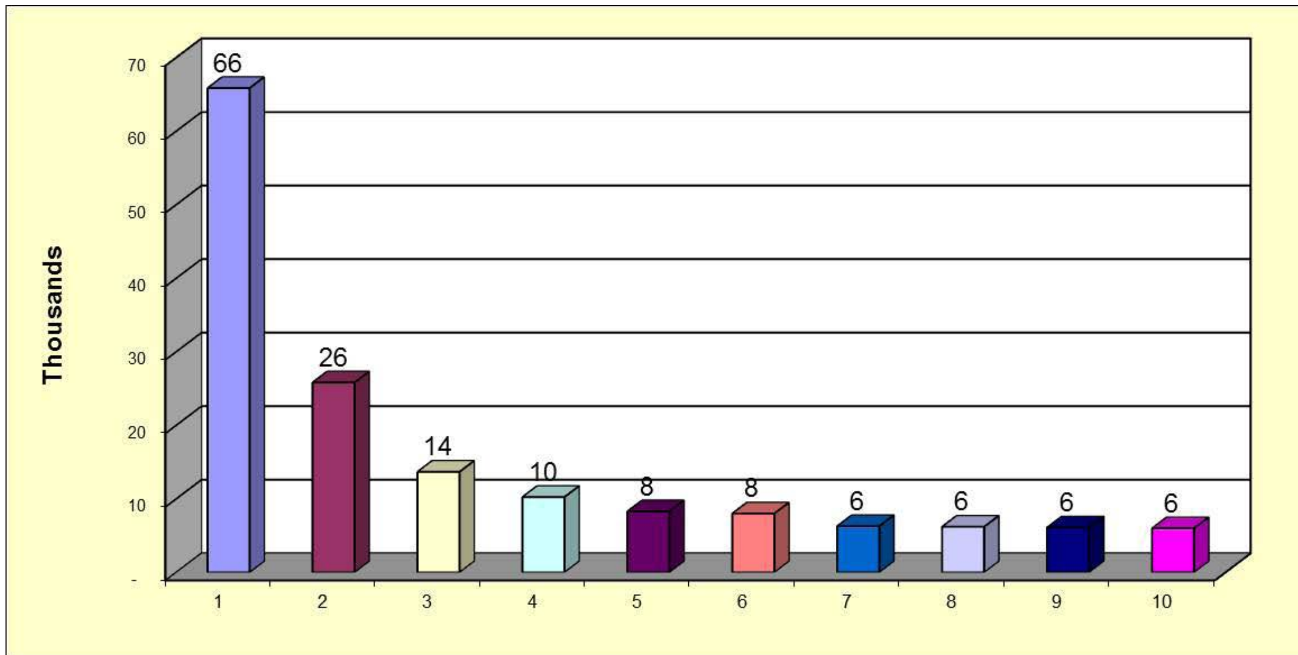
7 **Office Visit - Intermediate - New Patient:** for a new patient taking about 30 minutes of face-to-face time with the patient and/or family for problems of moderate severity; requires three key components including a detailed history, an exam, and medical decision making of low complexity (*CPT 99203)*

8 **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)*

9 **Psychotherapy, 45 Minutes with Patient:** Psychotherapy, 45 minutes with patient and/or family member *(CPT 90834)*

10 **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 signifiicant 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)*

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	Office Visit - Brief - Est. Patient	(99212)
5	Psychotherapy, 60 Minutes with Patient	(90837)
6	Blood Count	(85025)
7	Test for Streptococus	(87880)
8	Immunization Administration - Each Add. Vaccine	(90472)
9	Therapeutic Procedure - Each 15 Minutes	(97110)
10	ER Exam - Intermediate - New Patient	(99283)

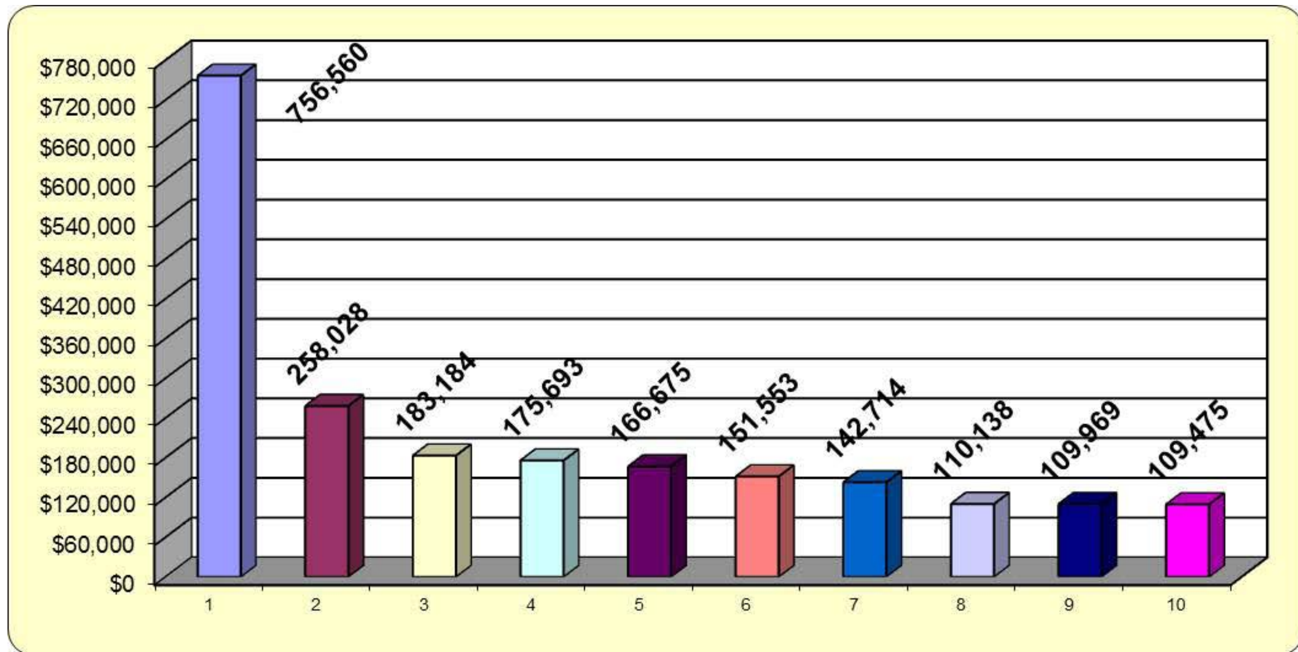
**As described in Current Procedure Terminology 2012 by the American Medical Association.*

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. **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)*
5. **Psychotherapy, 60 Minutes with Patient:** Psychotherapy, 60 minutes with patient and/or family member *(CPT 90837)*
6. **Blood Count:** automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count *(CPT 85025)*
7. **Test for Streptococcus:** infectious agent antigen detection by immunoassay with direct optical observation; streptococcus, group A *(CPT 87880)*
8. **Immunization Administration - Each Add. Vaccine:** injection of each additional vaccine (over one) whether percutaneous, intradermal, subcutaneous, or intramuscular *(CPT 90472)*
9. **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)*
10. **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)*

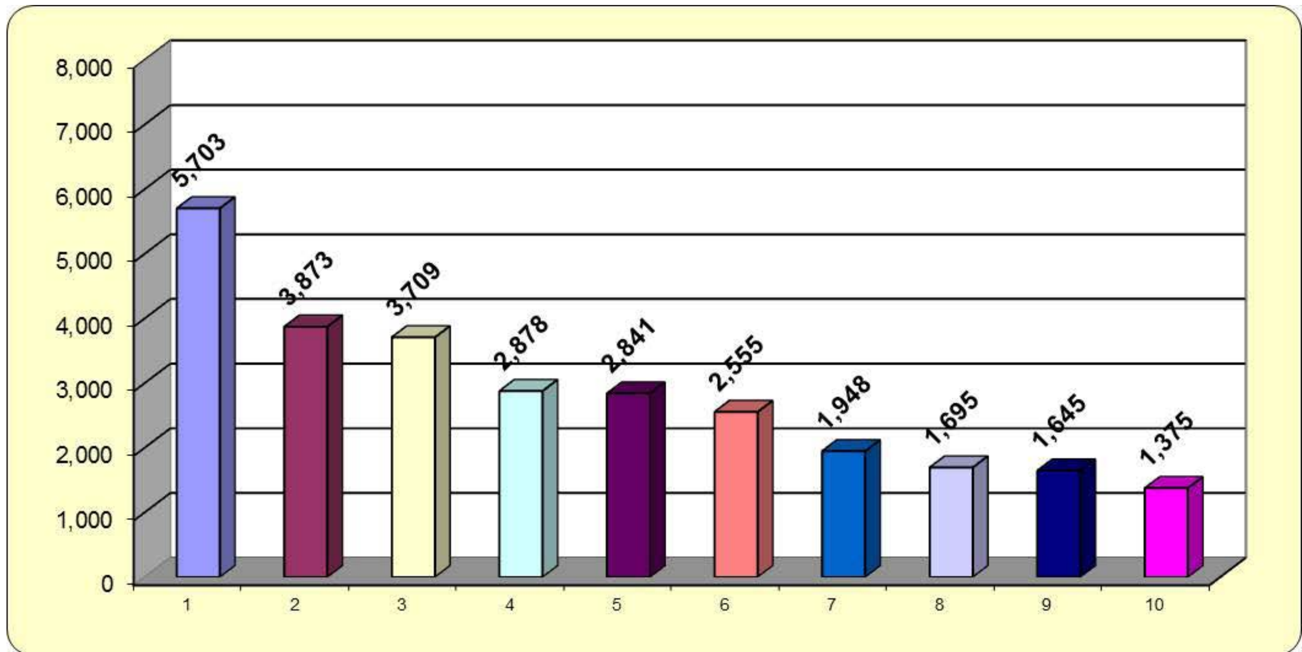
Table 32: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Vyvanse	-	Attention Deficit Hyperactivity Disorder (ADHD)
2	Kalydeco	-	Cystic Fibrosis
3	Proair HFA	-	Asthma
4	Abilify	-	Autistic Disorder
5	Humira	-	Arthritis
6	Tev-Tropin	-	Growth Hormone
7	Humalog	-	Diabetes
8	Novolog	-	Diabetes
9	Norditropin Flexpro	-	Growth Hormone
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	Proair	-	Asthma
3	Fluticasone Propionate	-	Allergies
4	Montelukast Sodium	-	Asthma
5	Loratadine	-	Allergies
6	Vyvanse	-	Attention Deficit Hyperactivity Disorder (ADHD)
7	Cefdinir	-	Antibiotic
8	Promethazine	-	Allergies
9	Azithromycin	-	Antibiotic
10	Tri-Sprintec	-	Contraception