West Virginia
Children's Health Insurance Program

Annual Report 2012

West Virginia
Children's Health Insurance Program

2012 Annual Report

Earl Ray Tomblin, Governor

Earl Ray Tomblin, Governor
State of West Virginia

Ross A. Taylor, Acting 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
Financial Officer
West Virginia Children's Health Insurance Program

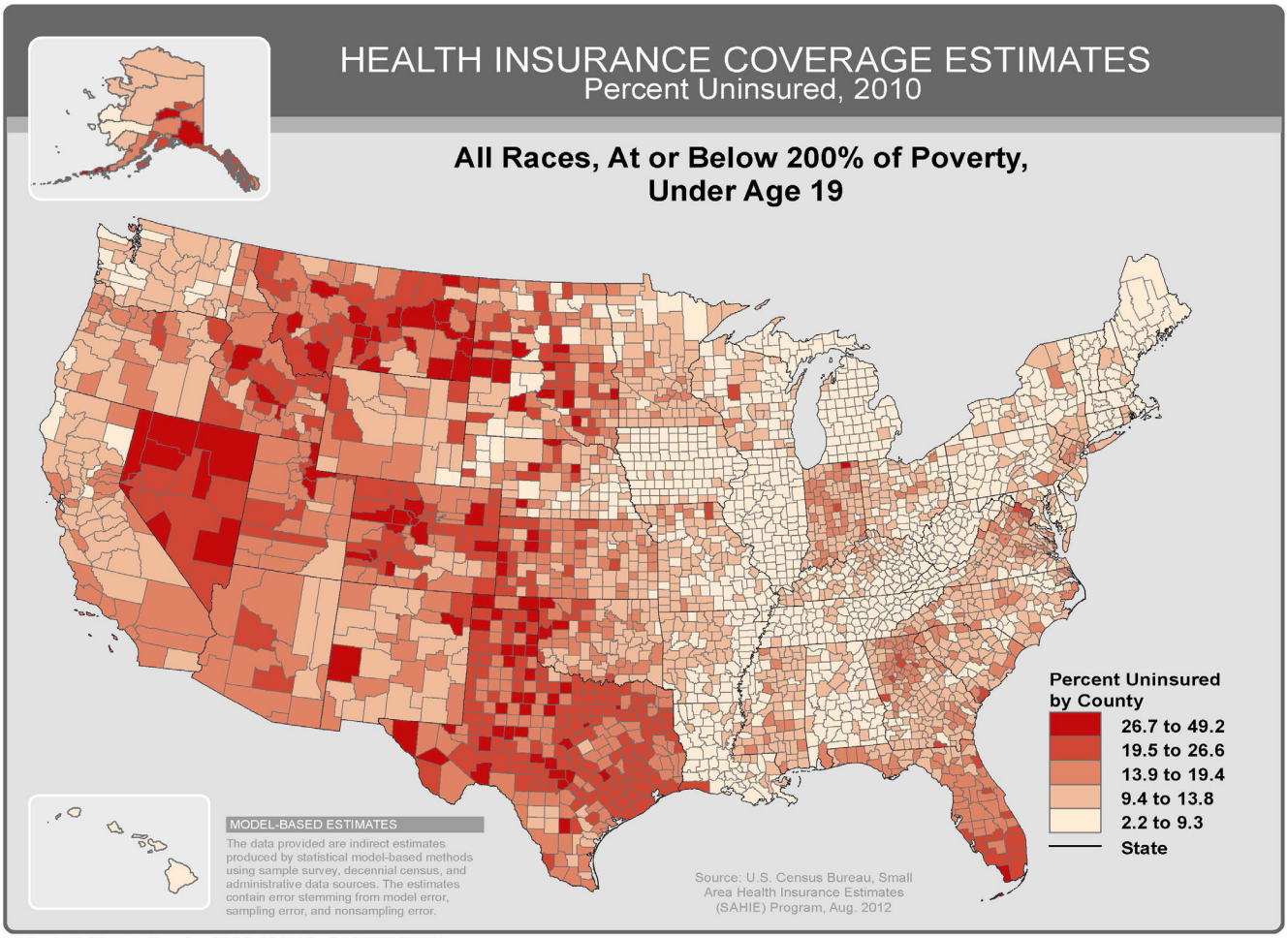
Our Mission

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.

Table of Contents



In 2012, the most recent U.S. Census data shows West Virginia is among the states with the lowest rates of uninsured children.

Introductory Section

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

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

December 17, 2012

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

Ross A. Taylor., Acting Cabinet Secretary
West Virginia Department of Administration

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

Ladies and Gentlemen:

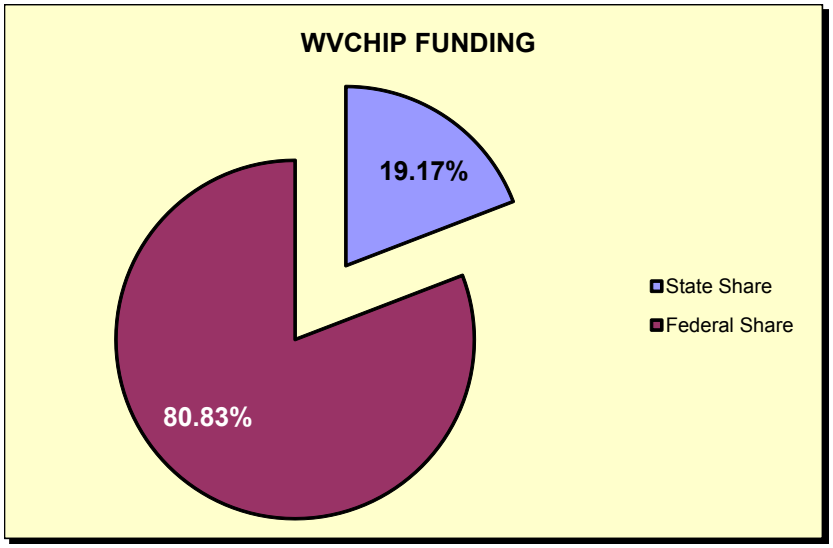
It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2012. This report was prepared by the Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented 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.

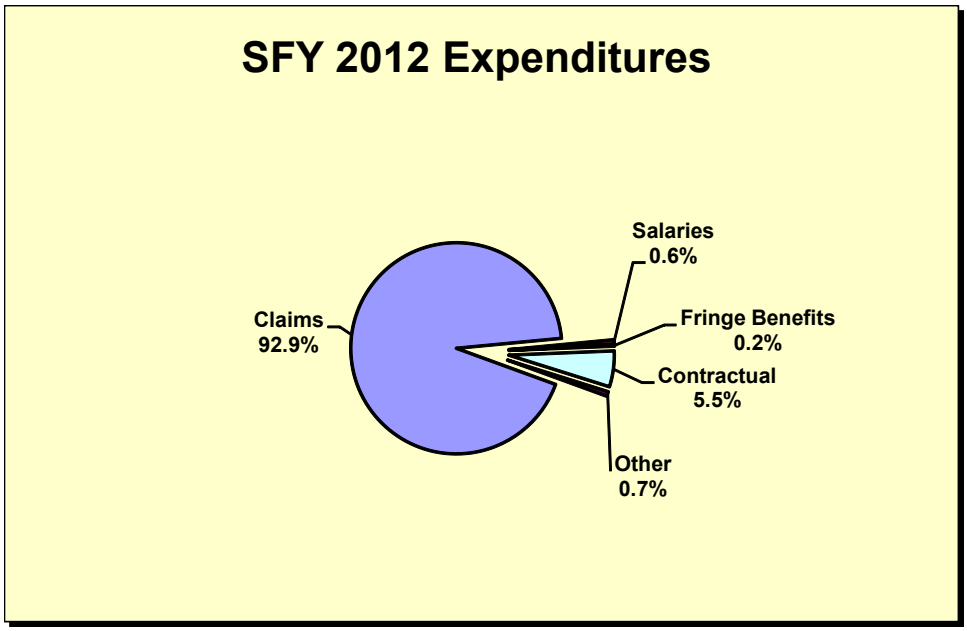
FINANCIAL PERFORMANCE AND OUTLOOK

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, 2012 were 80.83% federal share and 19.17% 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, 2012 confirms this requirement will be met through SFY 2019, assuming that state appropriations remain at the current level as SFY 2012, $10,925,514, and considering projected enrollment and program costs trends.

Based on estimated funding, enrollment, and costs, the June 30, 2012 Actuarial report projected no federal funding shortfalls for SFYs 2013 through 2018. All projections assume federal allotments will remain at the same level as the 2012 allotment, $43,068,980.



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 will increase to 133% FPL (regardless of the state's decision to expand Medicaid eligibility to the adult population). This increase means many children that are now income eligible for WVCHIP will transfer enrollment to Medicaid (currently estimated at 11,900), some Medicaid children will become eligible for WVCHIP, and some WVCHIP and Medicaid children will become eligible for Advanced Payment Tax Credits (APTC) through the exchange. Other impacts of the ACA are still being determined.

INITIATIVES

This year was one of intensive activity for WVCHIP with implementing a Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC), supporting work under the "Tri-State Children's Health Improvement Consortium", a multi-state grant focused on improving the quality of health care provided to children, and ongoing activities necessary to implement healthcare reform under the Affordable Care Act (ACA).

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, 2012. 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

Special thanks are extended to Governor Earl Ray Tomblin, at whose request the Board took up the issue of further expansion to 300% FPL, 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 Acting Secretary Ross A. Taylor., for his leadership and support. 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, 2012.

Sincerely,

Stacey L. Shamblin, MHA
Financial Officer

Principal Officials

Earl Ray Tomblin, Governor
State of West Virginia

Ross A. Taylor, Acting Cabinet Secretary
West Virginia Department of Administration

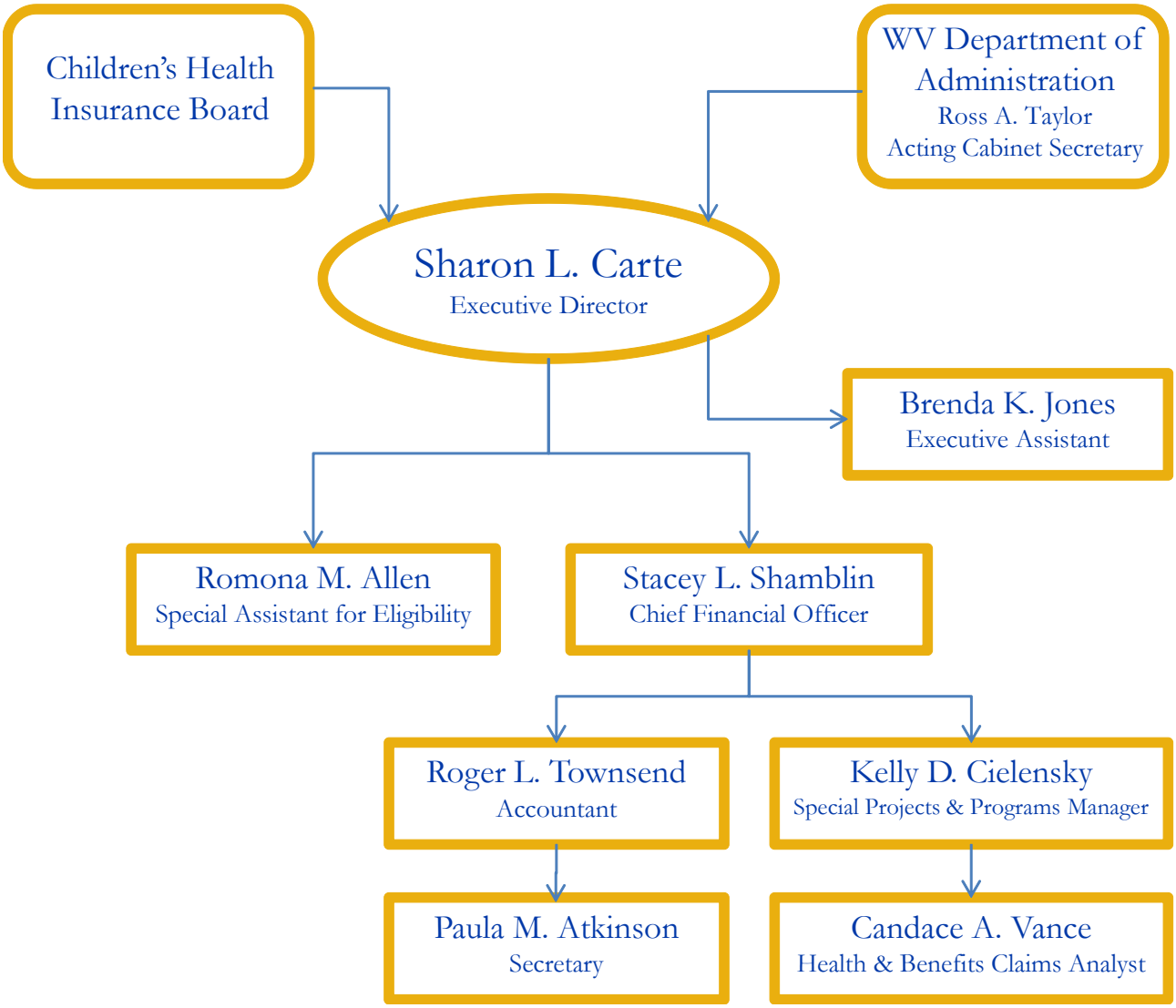
Board Members

Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Rocco S. Fucillo, 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
Lynn Gunnoe, Citizen Member
Margie Hale, Citizen Member
Travis Hill, Citizen Member
Larry Hudson, Citizen Member
VACANT, Citizen Member
VACANT, Citizen Member

Staff

Sharon L. Carte, Executive Director
Romona M. Allen, Special Assistant for Eligibility
Paula M. Atkinson, Secretary
Kelly D. Cielensky, Special Projects and Programs Manager
Brenda K. Jones, Executive Assistant
Stacey L. Shamblin, Financial Officer
Roger L. Townsend, Accountant
Candace A. Vance, Health and Benefits Claims Analyst

Staff Organizational Chart



Financial Section

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM
For the Year Ended June 30, 2012

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, 2012. 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 program was reauthorized through 2013 on February 4, 2009. On March 3, 2010, the passage of the Affordable Care Act (ACA) extended federal appropriations through 2015 and increased the share of the programs' 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.

OVERVIEW OF THE FINANCIAL STATEMENTS

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

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

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

In addition to these two basic statements and the accompanying notes; required supplementary information is presented in the 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 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, 2012 and 2011. (See pages 16 and 17.)

- Total assets increased approximately $1,229,725, or 7% in comparison to the previous year-end amount. This increase is primarily a result of higher ending balances of funds due from the federal government and funds due from other funds, and reflects federal and state monies that had been requested but not yet received as of the last day of the year.
- Total liabilities increased by approximately $1,821,430, or 55%, over last year. The majority of the increase is attributable to increases in deferred revenues and the estimate of Unpaid Insurance Claims Liability. Deferred Revenues reflect state general appropriations that have been "drawn-down" but not yet used to match with federal funds to pay program expenses.
- Total fund equity decreased approximately $591,705, or 4%, in comparison to the previous year end amount.
- Total revenues reflect an 8% increase, around $4,442,791, when compared to the prior year. While the state and federal revenues increased, as well as premium revenues, investment income decreased about 49%.
- Medical, dental and prescription drug expenditures comprise approximately 93% of WVCHIP's total costs. These expenditures increased $6,564,821, or 14% compared to the prior year.
- Administrative costs accounted for 7% of overall expenditures. These expenditures decreased approximately $152,303, or 4%. Decreases occurred in all administrative cost lines except salaries and benefits, outreach and health promotion, and current expenses. Expenditures under the multi-state quality grant are reflected in the outreach and health promotion line and are 100% federally funded.

FINANCIAL ANALYSIS

Costs

A 14% trend in medical, dental, and prescription drug claims is much higher than the 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 contributed to the following increases in WVCHIP's claims costs:

- Enrollment: +1.5%
- Service Utilization: +5.3%
- Price/Fee Increases: +7.2%

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

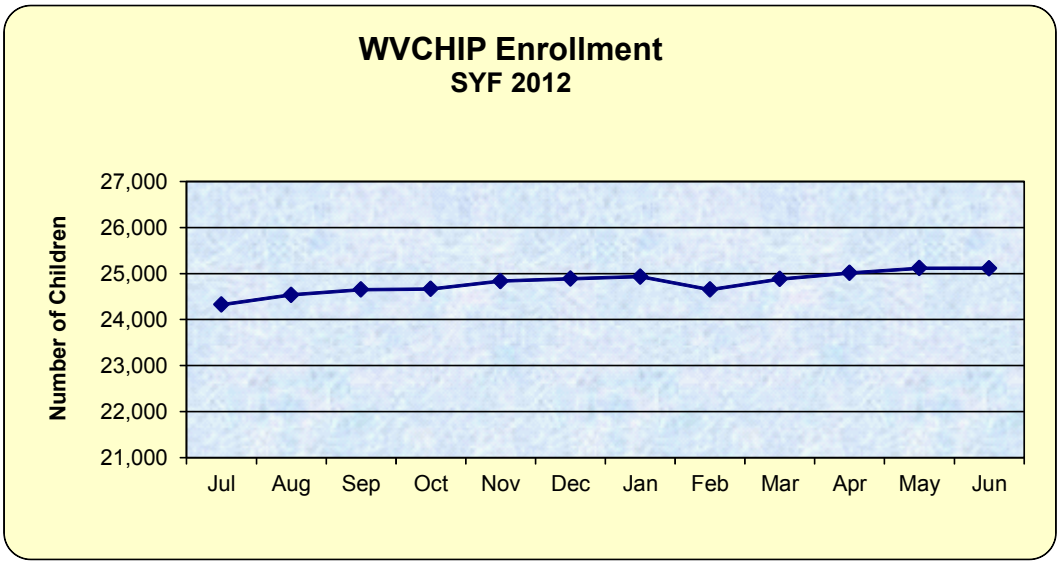
Enrollment

Monthly enrollment increased steadily during the year, with an overall increase in enrollment of 1.5% 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)	100% - 150%	14,504	-2.6%
CHIP Blue (Phase III)	151% - 200%	8,435	+1.3%
WVCHIP Premium	201% - 250%	1,843	+5.2%

WVCHIP Premium is the newest enrollment group and includes children in families with income above 200%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 2012, enrollment increased to 2,182 members, a 57.4% increase since June 2011.



Utilization

It is easy to assume that a health plan would incur higher costs consistent with enrollment increases: more members = payments for more services = increased costs. This is not a correct assumption of WVCHIP's experience during SFY 2012, however. Increased 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 an increase of 5.3% in claims expenditures for the year.

"Pent-up" demand refers to the amount of services utilized by new plan members. Children new to the program may require more medical, dental, or prescription drug services within the first three-months of enrollment due to the fact they may have not been able to access these services prior to enrollment in the plan. This "pent-up" demand is illustrated in Table 13 on page 55.

Prices/Fees

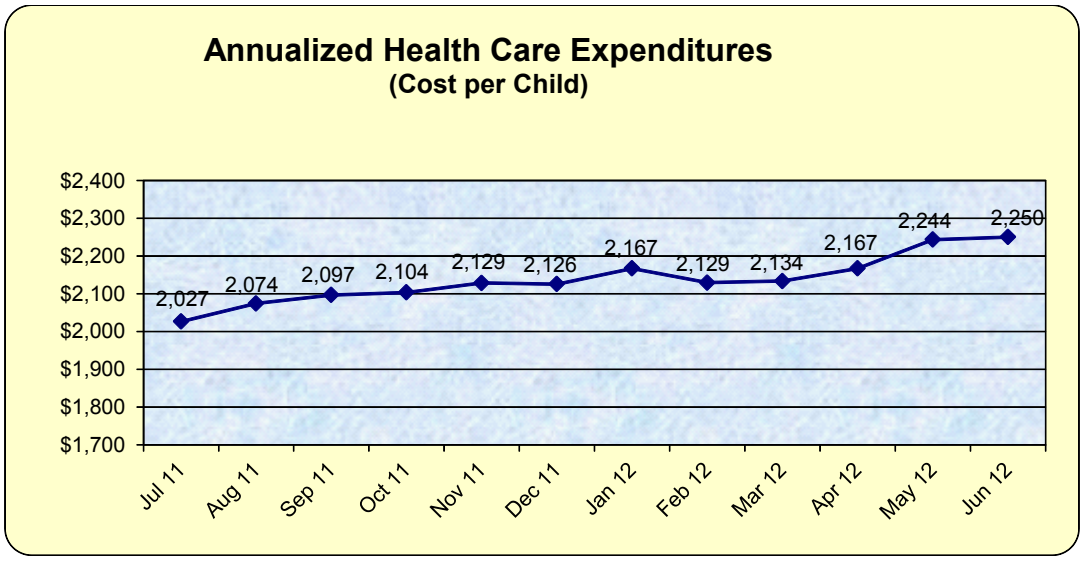
The amount WVCHIP pays providers for particular services is also determined by a number of factors; fee schedules adopted by the plan or rates negotiated with providers, whether the service is provided in West Virginia or outside the state; and service availability, among others. A combination of all these factors contributed to price inflation. During State Fiscal Year 2012, prices increased around 7.2%. The increase is a result of many factors, including 1) a change in reimbursement methodology from fee-for-service to a prospective payment based on "reasonable costs" for federally qualified health centers (FQHC) and Rural Health Centers (RHC); 2) increased costs for vaccines purchased at federally contracted rates through the Vaccines for Children (VFC) program; and 3) increases in the costs of drugs.

The average cost per claim for all medical and dental providers increased 6.4%, from $154 in SFY 2011 to $164 in SFY 2012. Costs to in-state service providers increased 7.9% during this time, from an average $139 in SFY 2011 to $150 in SFY 2012. For out-of-state providers, the average cost per claim decreased 0.4%, from $457 in SFY 2011 to $455 in SFY 2012. Utilization of out-of-state service providers remained flat across both fiscal years – 4.7% of all claims paid by WVCHIP were to out-of-state providers during both fiscal years. The decrease in prices, however, decreased the portion of WVCHIP dollars going out-of-state from 13.9% in SFY 2011 to 13.1% in SFY 2012.

WVCHIP has a very high generic drug utilization rate, 78.9% in SFY 2012, up from 77.9% in SFY 2011. While generic drugs cost much less than brand name drugs, the price for generic drugs increased 11.2% during this time, from $37.33 in SFY 2011 to $30.39 in SFY 2012, resulting in increased costs to the plan. It should be noted that during this same time brand drug costs increased 11.6%, from $168.12 in SFY 2011 to $187.64 in SFY 2012. It should be noted that 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 2012 was $2,250. 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 increased 9.2% over 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 4% from the prior year. Two categories of administrative costs show significant increases, Outreach & Health Promotion and Current Expenses. The largest increase was in Outreach & Health Promotion, 40%, and was mainly due to WVCHIP's participation in its multi-state quality initiative with Oregon and Alaska. It should be noted that the activities under this initiative are 100% federally funded. The increase in the current expenses line reflects one-time costs to move the WVCHIP administrative offices and increases to the West Virginia Office of Technology (WVOT) for computer and communication services.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2012 and 2011
(Accrual Basis)

	June 30, 2012	June 30, 2011	Variance	
Assets:				
Cash & Cash Equivalents	$13,698,457	$13,672,896	$ 25,561	0%
Due From Federal Government	3,946,228	2,947,830	998,398	34%
Due From Other Funds	728,597	550,254	178,343	32%
Accrued Interest Receivable	10,149	10,463	(314)	-3%
Fixed Assets, at Historical Cost	94,332	66,595	27,737	42%
Total Assets	$18,477,763	$17,248,038	$1,229,725	7%
Liabilities:				
Due To Other Funds	$ 198,370	$ 255,639	$ (57,269)	-22%
Deferred Revenue	1,330,608	372,074	958,534	258%
Unpaid Insurance Claims Liability	3,602,347	2,682,181	920,166	34%
Total Liabilities	$ 5,131,324	$ 3,309,894	$1,821,430	55%
Fund Equity	$13,346,439	$13,938,144	$(591,705)	-4%
Total Liabilities and Fund Equity	$18,477,763	$17,248,038	$1,229,725	7%

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, 2012 and June 30, 2011
(Modified Accrual Basis)

	June 30, 2012	June 30, 2011	Variance	
Revenues:				
Federal Grants	$ 45,410,962	$41,607,772	$3,803,190	9%
State Appropriations	10,925,514	10,425,628	499,886	5%
Premium Revenues	738,516	473,193	265,323	56%
Investment Income:				
Investment Earnings	128,890	254,498	(125,608)	-49%
Total Revenues	**$57,203,882**	**$52,761,091**	**$4,442,791**	**8%**
Expenditures:				
Claims:				
Outpatient Services	$14,585,881	$12,301,604	$2,284,277	19%
Physicians and Surgical	10,738,855	9,896,684	842,171	9%
Prescribed Drugs	10,584,175	9,679,814	904,361	9%
Dental	7,825,136	6,734,483	1,090,653	16%
Inpatient Hospital Services	4,725,123	3,989,797	735,326	18%
Outpatient Mental Health	1,550,096	1,447,905	102,191	7%
Durable & Disposable Equipment	1,345,606	1,188,207	157,399	13%
Inpatient Mental Hospital	938,927	843,569	95,358	11%
Vision	806,448	798,420	8,028	1%
Therapy	650,288	538,550	111,738	21%
Medical Transportation	468,565	373,914	94,651	25%
Other Services	170,702	184,360	(13,658)	-7%
Less Collections*	(650,537)	(802,863)	152,326	-19%
Total Claims	53,739,265	47,174,444	6,564,821	14%
General and Admin Expenses:				
Salaries and Benefits	497,454	488,107	9,347	2%
Program Administration	1,872,099	2,350,337	(478,238)	-20%
Eligibility	387,310	400,688	(13,378)	-3%
Outreach & Health Promotion	1,044,839	746,912	297,927	40%
Current	228,851	196,812	32,039	16%
Total Administrative	4,030,553	4,182,856	(152,303)	-4%
Total Expenditures	**57,769,818**	**51,357,300**	**6,412,518**	**12%**
Excess of Revenues Over (Under) Expenditures	**(565,935)**	**1,403,791**	**(1,969,726)**	**-140%**
Unrealized Gain (loss) On Investments**	**(25,770)**	**(92,971)**	**67,201**	**-72%**
Fund Equity, Beginning	**13,938,145**	**12,627,325**	**1,310,820**	**10%**
Fund Equity, Ending	**$13,346,439**	**$13,938,145**	**$(591,706)**	**-4%**

* 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, 2012

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, 2012, 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	$ 202,620	———	———

Investments	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$ 2,111,409	$2,111,409	Cash Liquidity
	$11,384,427	$11,384,427	Short Term Bond Pool
Total	$13,495,836		

Note 3

Due to other funds:

PEIA Piggyback Contracts (TPA, PBM, etc.)	$ 125,522
DHHR & WVOT (Eligibility)	35,200
JCDC	7,121
Other	30,527
Total due to other funds	$ 198,370

Note 4

Risk Management Unpaid Claims Liabilities

Claims Payable, Beginning of Year	$ 2,682,181
Incurred Claims Expense	53,739,265
Payments:	
Claim Payments for Current Year	48,711,843
Claim Payments for Prior Year	4,107,256
Claims payable, year to date	$ 3,602,347

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 2012
For the Twelve Months Ended June 30, 2012

		Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Jun-12	Actual Amt May-12	Actual Amt Apr-12
Projected Cost		$54,634,844	$54,634,844	$54,685,777	($50,933)	0%	$4,552,904	$5,177,980	$5,830,625	$4,877,097
Premiums		680,592	680,592	$738,516	$57,924	9%	$56,716	66,085	72,360	69,897
Subrogation & Rebates		731,381	731,381	$650,537	(80,844)	-11%	$60,948	145,915	15,486	23,100
Net Benefit Cost		53,222,871	53,222,871	$53,296,723	($73,852)	0%	$4,435,239	4,965,980	5,742,779	4,784,100
Salaries & Benefits		$580,500	$580,500	$497,451	$83,049	14%	$48,375	$44,719	$44,074	$39,610
Program Administration		3,116,505	3,116,505	$1,889,614	1,226,891	39%	$259,709	145,698	170,500	125,094
Eligibility		420,000	420,000	$374,110	45,890	11%	$35,000	94,706	0	4,313
Outreach & Health Prom.		300,000	300,000	$1,044,197	(744,197)	-248%	$25,000	11,896	218,001	51,690
Current Expense		160,000	160,000	$244,590	(84,590)	-53%	$13,333	17,014	17,264	16,287
Total Admin Cost		$4,577,005	$4,577,005	$4,049,962	$527,043	12%	$381,417	$314,033	$449,839	$236,994
Total Program Cost		$57,799,876	$57,799,876	$57,346,685	$453,191	1%	$4,816,656	$5,280,013	$6,192,618	$5,021,094
Federal Share 80.83%		46,719,640	46,719,640	$46,410,334	309,305	1%	3,893,303	4,267,835	5,005,493	4,058,550
State Share 19.17%		11,080,236	11,080,236	$10,936,351	143,885	1%	923,353	1,012,179	1,187,125	962,544
Total Program Cost	*	$57,799,876	$57,799,876	$57,346,685	$453,191	1%	$4,816,656	$5,280,013	$6,192,618	$5,021,094

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2011 Report.

Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES

Slight Upward Enrollment Trend Returns

As noted earlier in this report, enrollment steadily increased throughout the year, by about 1.5%. Major enrollment increases are noted in the WVCHIP Premium group that expanded to 300% FPL effective July 1, 2011. Prior to expansion it was estimated that an additional 192 children monthly in the 250-300% FPL income range would be eligible for and enroll in the program. By June 30, 2012, 804 children in this expanded income range were opened and enrolled.

Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

January 1, 2012 marked the start of CHIP payment system changes for FQHC's and RHC's as their CHIP payments went from fee-for-service reimbursement to a PPS that reimburses FQHCs and RHC on a per visit rate based on each centers' reasonable costs per visit adjusted annually for using the Medicare Economic Index (MEI). This change in reimbursement methodology increased reimbursement to centers by approximately 53%. In addition WVCHIP was required to pay these new rates retroactively back to October 2009, as mandated by the CHIP Reauthorization Act passed by Congress in February 2009. This meant two years of fee-for- service claims payments had to be recalculated to make these retroactive payments adjustments for each center and clinic. This project was major undertaking involving significant amounts of time by the agency's Chief Financial Officer in addition to requiring assistance by other staff not usually assigned to financial section in order to finalize these payments by the end of the Federal Fiscal Year on September 30, 2012. The retroactive payments had been estimated at $1.9 million in one-time costs for the program and the actual total costs paid as of September 30, 2012 were $1.4 million. There are still a couple of centers that need retro-active adjustments calculated and paid.

Electronic Security Improvements

The growing use of electronic health records as well as ever increasing health data interchanges among health business associates meant starting a planning and implementation process for a number of electronic security improvements largely guided by the Department of Administration's new full time security officer Thomas Miller. All CHIP staff, including the director, has completed the minimum security training requirements for the Department as well as certifying that the agency has met minimum audit standards for risk management.

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

This year completes the agency's third year of participation as partners with the states of Oregon and Alaska in the multi-state pediatric quality demonstration grant known as the Tri- State Children's Improvement Consortium or the T-CHIC Project. This project involves 10 primary care practices which receive grant funds to fund a fulltime staff person responsible for care coordination as well technical assistance in how to change their practice model to become person-centered or family-centered medical homes. This year's activity included:

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

- Each practice assessed readiness for medical home certification review using an assessment tool standardized across practices in all three grantee states;
- Information gathering and analysis of barriers related to quality data reporting;
- Review of each practice's CHIP patient quality data for certain pediatric quality measures;
- A full day Learning Session Workshop in September this year attended by 55 staff from nine of the ten practices covering topics such as Self Management support skills; developing Quality Improvement Program, Motivational Interviewing, care coordination strategies and other medical home enhancement topics;
- Continued monthly "Virtual Practice" webinars; and
- Continued quarterly meetings with the T-CHIC Advisory Council composed mostly of primary care practice physician champions.

Health Care Reform

WVCHIP continued its active participation in coordinating health care activities and federal grant opportunities related to health care reform. Major planning initiatives are taking place to implement a healthcare exchange, as well as making major modifications to the eligibility determination process to utilize the Modified Adjusted Gross Income (MAGI) for income and household determination. Once created, the healthcare exchange will be very important since WVCHIP members and their parents who will not be covered under Medicaid will begin selecting coverage from plans offered through this exchange. Planning and work during the next year to operationalize our state's exchange promises to be very exciting and challenging as the Agency prepares to enter healthcare reform.

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

West Virginia Children's Health Insurance Program
Report of Independent Actuary
June 30, 2012 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 2012 ("FY 2012") through Fiscal Year 2019 ("FY 2019"). 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 requested CCRC Actuaries to produce the Baseline Scenario which includes the current WVCHIP Premium expansion to 300% of the Federal Poverty Level ("FPL"). State funding is assumed to be $10,925,514 in FY 2012 and in future years. At the Federal level, the Federal funding for West Virginia is assumed to be $43,068,980 in FY 2012 and we have assumed that this funding remains constant in the future.

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, participant premiums are assumed to cover 25% of the policy cost for children in the 250% to 300% FPL group.

Under the Baseline Scenario, the projected cost of the CHIP Program in FY 2012 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 2019. Note that we are projecting the Federal funding shortfall of approximately $4,346,000 in FY 2019 based on current approved funding levels under the assumption of Medicaid eligibility and an increase in Federal participation of 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 2011 in this projection. The Federal share of program expenditure is currently at 80.83% for Federal Fiscal Year 2012, and it decreases slightly to 80.43% for Federal Fiscal Year 2013 and it remains unchanged through September 30, 2015. While there is uncertainty of Federal funding availability after 2015, we have assumed that the Federal funding will remain constant after 2015.

Enrollment for the program as of June 2012 has increased since March 2012. The current program enrollment as of June 2012 consists of 25,114 children total: 14,241 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"), 8,691 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 2,182 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, 2012 Quarterly Report with March 2012 enrollment data, overall enrollment has increased by 235 children. WVCHIP Gold has decreased enrollment by 286 children, WVCHIP Blue has increased enrollment by 254 children and WVCHIP Premium has increased enrollment by 267 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 some moderation of cost trends. Current claim trend experience has been financially favorable over the past several years with the notable exception of recent medical and dental trends. It is noteworthy to comment that most recently, medical trend rates have remained above the 8% trend assumption due to higher than expected medical costs. Dental trends have increased due to higher reimbursement levels which became effective at the beginning of FY 2011. We have increased the FY 2012 medical claim trend assumption from 8% to 8.5%, and we have maintained the FY 2012 dental claim trend of 8% and prescription drugs claim trend assumption of 6% as assumed in the March 31, 2012 Quarterly Report, based on trend experience consistent with these assumptions.

Administrative expenses for West Virginia CHIP are projected to be $4,049,965 in FY 2012, representing a 5% decrease over FY 2011 administrative expenses of $4,282,309. West Virginia CHIP management team assumes a 5% administrative expense trend in future years. Drugs rebates are projected to be $553,837 in FY 2012. West Virginia CHIP management team assumes a 4% drugs rebates trend in future years.

Under the State fiscal year basis, we have calculated that the incurred claim costs under the Baseline Scenario assumptions for FY 2012 to be $55,151,897. The updated projection for FY 2013 claims is $61,211,895.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") and the Patient Protection and Affordable Care Act ("PPACA") that resulted in $69 billion in funding for the national program, CHIPRA and PPACA reauthorize CHIP through the end of September 2015. 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 2012 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, space maintainers, 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 premiums will increase with policy cost increases in the future to maintain the 20% cost share threshold in the 200% to 300% FPL group. As of June 2012, there are 2,182 children enrolled in WVCHIP Premium.

It should be noted that this report incorporates some of the provisions of PPACA, a product of the Health Care Reform ("HCR") Bill. PPACA 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 September 30, 2015, the expanding Medicaid eligibility starting on January 1, 2014 and an increase in Federal funding participation in FY 2016 through 2019. At this time, the actual timetable of the PPACA is uncertain.

Effective January 1, 2014, Medicaid eligibility will expand to individuals and families with income up to 133% FPL. We have assumed that approximately 11,433 children in WVCHIP Gold will move to Medicaid under the HCR Bill. The CHIP Program will serve the remaining children up to 300% FPL. In addition, 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.

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 West Virginia Department of Health and Human Resources ("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 2012 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. This additional retro-active adjustment will be made during State Fiscal Year 2012. Claims received after July 1, 2011 will be processed under the new prospective payment methodology regardless of the date of service included on the claim. An estimate of $2,000,000 is included in the projections of State Fiscal Years 2012 and later years.

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 thru 4.

In addition, this report includes the following anticipated costs from CHIPRA requirements and the FY 2012 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).

- 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 2012. WVCHIP Gold enrollment has decreased in recent months. The program had enrollment at the end of FY 2011 of 24,540 children, with 14,649 under WVCHIP Gold, 8,505 under WVCHIP Blue, and 1,386 under WVCHIP Premium. Current enrollment as of June 2012 is 25,114 children, with 14,241 under WVCHIP Gold, 8,691 under WVCHIP Blue, and 2,182 under WVCHIP Premium.

It is noteworthy that WVCHIP Premium enrollment has been significantly 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 are changing the original growth assumptions from 38 to 60 new enrollees per month, combined with actual WVCHIP Premium enrollment through June 2012, and we will continue to monitor the projected enrollment by actual results and make adjustments as necessary.

The following table summarizes the FY 2011 to FY 2012 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%
Jul-10	15,267	8,370	1,088	24,725	0.8%
Aug-10	15,275	8,389	1,062	24,726	0.7%
Sep-10	15,186	8,269	1,080	24,535	-1.0%
Oct-10	15,104	8,255	1,123	24,482	-1.6%
Nov-10	14,928	8,309	1,160	24,397	-2.1%
Dec-10	14,809	8,330	1,184	24,323	-2.9%
Jan-11	14,721	8,337	1,247	24,305	-2.9%
Feb-11	14,788	8,284	1,252	24,324	-2.1%
Mar-11	14,537	8,277	1,286	24,100	-3.5%
Apr-11	14,743	8,417	1,315	24,475	-1.4%
May-11	14,667	8,412	1,345	24,424	-1.4%
Jun-11	14,649	8,505	1,386	24,540	-2.1%
Jul-11	14,611	8,350	1,362	24,323	-1.6%
Aug-11	14,617	8,454	1,463	24,534	-0.8%
Sep-11	14,619	8,397	1,636	24,652	0.5%
Oct-11	14,586	8,376	1,702	24,664	0.7%
Nov-11	14,621	8,367	1,847	24,835	1.8%
Dec-11	14,589	8,410	1,889	24,888	2.3%
Jan-12	14,556	8,460	1,917	24,933	2.6%
Feb-12	14,474	8,223	1,953	24,650	1.3%
Mar-12	14,527	8,437	1,915	24,879	3.2%
Apr-12	14,323	8,582	2,107	25,012	2.2%
May-12	14,283	8,686	2,146	25,115	2.8%
Jun-12	14,241	8,691	2,182	25,114	2.3%

The tables below summarize the projected fiscal year June 30th ending enrollment assumptions for Baseline Scenario and Expansion Scenario, by WVCHIP Gold & Blue, and WVCHIP Premium. Effective January 1, 2014, we have assumed that approximately 11,433 children in WVCHIP Gold will move to Medicaid under the HCR Bill.

Baseline Scenario (300% FPL)

Ending Enrollment	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019
WVCHIP Gold & Blue	22,932	22,932	11,499	11,499	11,499	11,499	11,499	11,499
WVCHIP Premium	2,182	2,902	3,622	3,982	3,982	3,982	3,982	3,982
Total	25,114	25,834	15,121	15,481	15,481	15,481	15,481	15,481

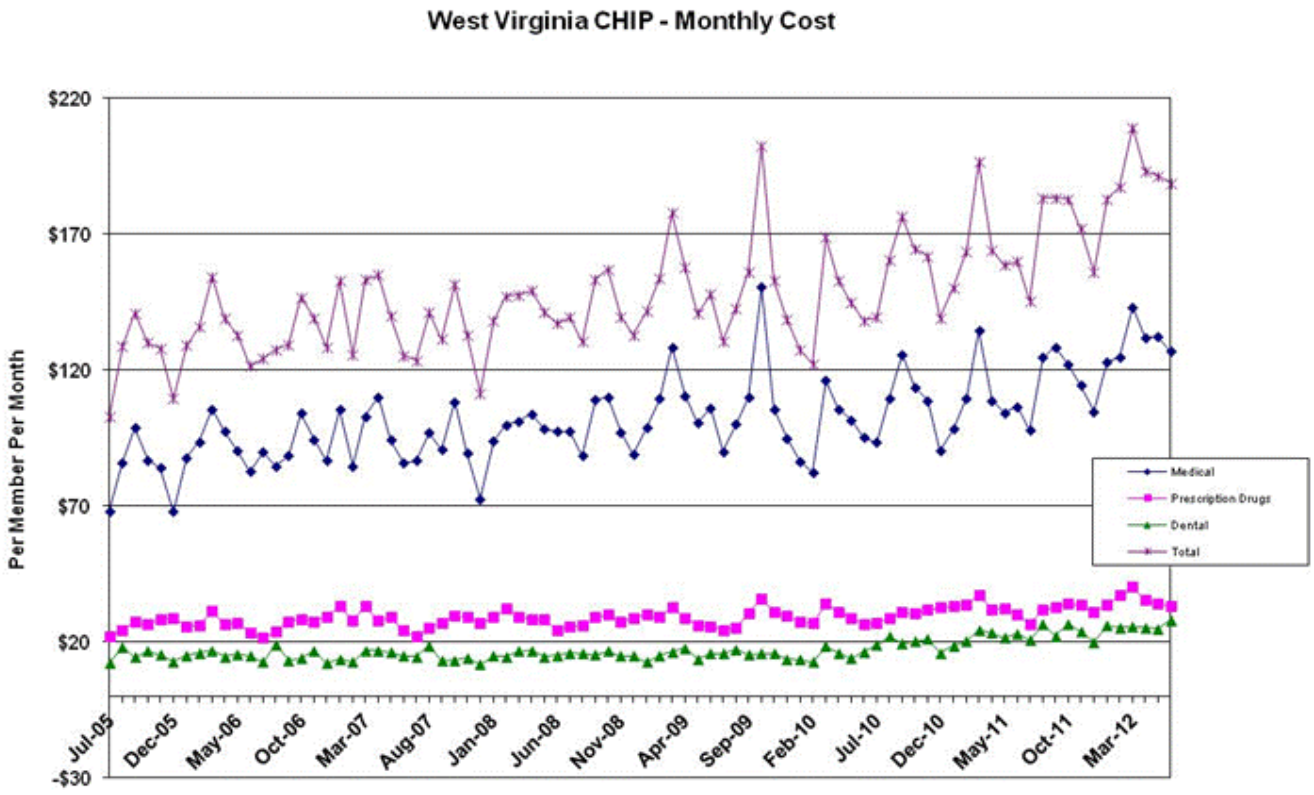
CLAIM COST AND TREND ANALYSIS

We have adjusted the trend assumptions from the March 31, 2012 Quarterly Report. The new trend assumptions are 8.5% for medical claims, 8% for dental claims and 6% 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 trend experience is higher compared to our trend assumptions. Based on the current experience, we have increased the medical trend from 8% to 8.5%. The dental and prescription drugs trends have remained the same at 8% and 6%, respectively. It is noteworthy to comment that most recently, medical trend rates have remained above the 8% trend assumption due to higher than expected medical costs. (Average medical PMPM has increased from $103.40 in FY 2010 to $108.81 in FY 2011 to $123.03 in FY 2012, an annual medical trend increase from 5.2% in FY 2011 to 13.1% in FY 2012.) The high dental trends were expected due to higher reimbursement levels and richer dental benefits. The table below summarizes WV CHIP experience over the last six months, nine months and twelve months as of June 30, 2012. 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	18.1%	15.2%	13.1%
Dental	18.0%	19.6%	18.5%
Prescription Drugs	7.9%	6.6%	6.3%
Composite	16.0%	14.0%	12.4%

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 2012. 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 2012-2019

Under the Baseline Scenario, we have assumed State funding to be $10,925,514 in FY 2012 and in future years. At the Federal level, the Federal funding for West Virginia is assumed to be $43,068,980 in FY 2012, and we have assumed that this funding remains constant in the future.

The updated incurred claims for FY 2012 is $55,151,897 based on the fiscal year 2012 average enrollment of 24,800 children and the incurred claim per member per month cost data assumption of $185.32, as summarized in the following table.

Category	Current Report FY2012 Baseline Incurred Claims	Current Report FY2012 Baseline Per Member Per Month	3/31/12 Report FY2012 Baseline Per Member Per Month	12/31/11 Report FY2012 Baseline Per Member Per Month
Medical	$38,146,408	$128.18	$122.44	$127.30
Prescription Drugs	9,821,865	33.00	33.59	33.76
Dental	7,183,624	24.14	24.22	23.80
Total	$55,151,897	$185.32	$180.25	$184.85

The Baseline Scenario financial forecast for the Federal and State fiscal years 2012 through 2019 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 2019.

At the Federal level, we are projecting the Federal funding shortfall of approximately $4,346,000 in FY 2019 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.

Appendix B summarizes the original and restated IBNR claim liabilities for the CHIP Program in Fiscal Year 2010 to 2012. IBNR projections have been recently lower to reflect current claim experience as illustrated.

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 2012 through 2019 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 2012 through FY 2019 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 20, 2012

Chris Borcik
Associate of the Society of Actuaries
Member of the American Academy of Actuaries
Senior Actuarial Consultant
CCRC Actuaries, LLC
Reisterstown, Maryland
July 20, 2012

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2012 Quarterly Report

Baseline Scenario - 300% FPL

Available Funding - Beginning of the Year	2012	2013	2014	2015	2016	2017	2018	2019
Federal 2011	$35,590,228	$0	$0	$0	$0	$0	$0	$0
Federal 2012	43,068,980	31,816,245	0	0	0	0	0	0
Federal 2013	0	43,068,980	23,445,695	0	0	0	0	0
Federal 2014	0	0	43,068,980	23,347,164	0	0	0	0
Federal 2015	0	0	0	43,068,980	31,583,684	0	0	0
Federal 2016	0	0	0	0	43,068,980	30,128,989	0	0
Federal 2017	0	0	0	0	0	43,068,980	22,712,173	0
Federal 2018	0	0	0	0	0	0	43,068,980	11,337,060
Federal 2019	0	0	0	0	0	0	0	43,068,980
State 2010	$3,110,073	$0	$0	$0	$0	$0	$0	$0
State 2011	10,425,628	2,570,427	0	0	0	0	0	0
State 2012	10,925,514	10,925,514	1,124,583	0	0	0	0	0
State 2013	0	10,925,514	10,925,514	1,608,177	0	0	0	0
State 2014	0	0	10,925,514	10,925,514	4,121,125	1,827,173	1,827,173	1,827,173
State 2015	0	0	0	10,925,514	10,925,514	10,925,514	10,925,514	10,925,514
State 2016	0	0	0	0	10,925,514	10,925,514	10,925,514	10,925,514
State 2017	0	0	0	0	0	10,925,514	10,925,514	10,925,514
State 2018	0	0	0	0	0	0	10,925,514	10,925,514
State 2019	0	0	0	0	0	0	0	10,925,514

Program Costs	2012	2013	2014	2015	2016	2017	2018	2019
WVCHIP Gold & Blue & Premium								
Medical Expenses	$36,146,408	$39,715,548	$33,282,824	$25,469,592	$27,634,507	$29,983,440	$32,532,033	$35,297,256
Prescription Drugs Expenses	9,821,865	10,543,031	8,631,797	6,453,260	6,840,456	7,250,883	7,685,936	8,147,092
Dental Expenses	7,183,624	7,856,570	6,553,701	4,992,091	5,391,458	5,822,775	6,288,597	6,791,684
Administrative Expenses	4,049,965	3,784,353	1,992,504	2,092,129	2,196,735	2,306,572	2,421,901	2,542,996
WVCHIP New Premium								
Medical Expenses	$0	$594,217	$1,834,988	$3,094,062	$3,503,017	$3,800,773	$4,123,839	$4,474,365
Prescription Drugs Expenses	0	160,892	485,399	799,597	884,423	937,489	993,738	1,053,363
Dental Expenses	0	110,029	338,211	567,647	639,713	690,890	746,161	$805,854
Administrative Expenses	0	622,573	815,889	941,831	988,922	1,038,369	1,090,287	$1,144,801
Total Program Costs								
Medical Expenses	$36,146,408	$40,309,765	$35,117,812	$28,563,654	$31,137,524	$33,784,214	$36,655,872	$39,771,621
Prescription Drugs Expenses	9,821,865	10,703,923	9,117,196	7,252,857	7,724,879	8,188,372	8,679,674	9,200,455
Dental Expenses	7,183,624	7,966,599	6,891,913	5,559,738	6,031,171	6,513,665	7,034,758	7,597,539
Administrative Expenses	4,049,965	4,406,927	2,808,392	3,033,960	3,185,658	3,344,941	3,512,188	3,687,797
FQHC/RHC Payment	2,000,000	2,231,607	1,946,937	1,586,934	1,730,206	1,877,273	2,036,841	2,209,973
Premiums (WVCHIP Premium)	$774,337	$1,166,599	$1,612,313	$2,066,355	$2,274,405	$2,456,252	$2,652,638	$2,864,725
Program Revenues - Interest	$65,451	$65,345	$61,476	$62,770	$69,494	$92,589	$121,823	$121,823
Program Revenues - Drugs Rebates	553,837	575,990	599,030	622,991	647,911	673,827	700,780	728,811
Net Incurred Program Costs Excluding Interest	$57,873,688	$63,876,232	$53,670,907	$43,307,796	$46,887,121	$50,578,385	$54,565,915	$58,873,848
Net Paid Program Costs	57,346,688	63,351,232	54,377,907	44,185,796	46,570,121	50,255,385	54,215,915	58,495,848
Federal Share	$46,842,963	$51,439,530	$43,167,511	$34,832,461	$44,523,675	$50,485,796	$54,444,092	$58,752,025
State Share of Expenses - Net of Interest	10,965,274	12,371,358	10,441,921	8,412,566	2,293,952	0	0	0
Beginning IBNR	$4,257,000	$4,784,000	$5,309,000	$4,602,000	$3,724,000	$4,041,000	$4,364,000	$4,714,000
Ending IBNR	4,784,000	5,309,000	4,602,000	3,724,000	4,041,000	4,364,000	4,714,000	5,092,000

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2012 Quarterly Report

Baseline Scenario - 300% FPL

Funding Sources - End of the Year	2012	2013	2014	2015	2016	2017	2018	2019
Federal 2011	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2012	31,816,245	0	0	0	0	0	0	0
Federal 2013	0	23,445,695	0	0	0	0	0	0
Federal 2014	0	0	23,347,164	0	0	0	0	0
Federal 2015	0	0	0	31,583,684	0	0	0	0
Federal 2016	0	0	0	0	30,128,989	0	0	0
Federal 2017	0	0	0	0	0	22,712,173	0	0
Federal 2018	0	0	0	0	0	0	11,337,060	0
Federal 2019	0	0	0	0	0	0	0	0
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$4,345,985***
State 2010	$0	$0	$0	$0	$0	$0	$0	$0
State 2011	2,570,427	0	0	0	0	0	0	0
State 2012	10,925,514	1,124,583	0	0	0	0	0	0
State 2013	0	10,925,514	1,608,177	0	0	0	0	0
State 2014	0	0	10,925,514	4,121,125	1,827,173	1,827,173	1,827,173	1,827,173
State 2015	0	0	0	10,925,514	10,925,514	10,925,514	10,925,514	10,925,514
State 2016	0	0	0	0	10,925,514	10,925,514	10,925,514	10,925,514
State 2017	0	0	0	0	0	10,925,514	10,925,514	10,925,514
State 2018	0	0	0	0	0	0	10,925,514	10,925,514
State 2019	0	0	0	0	0	0	0	10,925,514
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State Shortfall – 90% Funding Requirement	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***

CCRC Actuaries, LLC

415 Main Street
Reisterstown, MD 21136

Email: info@ccrcactuaries.com

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

November 16, 2012

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 2012. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2013 based on the updated information. CHIP Program's financial projections continue to improve primarily due to a steady enrollment increase and a lower overall claims trend.

It is noteworthy that we are not projecting a shortfall in State funding based on funding levels provided by CHIP management through FY 2019 based on the assumption that future funding remains constant. After the September 30, 2012 Quarterly Report was issued in October 2012, several changes have occurred in the program:

- Enrollment for the CHIP Program has slightly decreased from 25,114 in June 2012 to 25,108 as of October 2012.

- October 2012 claim experience showed the projected incurred FY 2013 expenditures to be $59,108,637, a decrease of $1,059,368 from $ 60,168,005 in the September 30, 2012 Quarterly Report.

- The categories of FY 2013 medical, dental and prescription drug expenses in the current claim experience through October 2012 showed favorable experience over the September 30, 2012 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2013 is now projected to be $194.70, down from the projected $197.54 PMPM cost in the September 30, 2012 Quarterly Report. Medical PMPM for Fiscal Year 2013 is now projected to be $134.06, down from the projected $135.81 PMPM cost in the September 30, 2012 Quarterly Report. Dental PMPM for Fiscal Year 2013 is now projected to be $25.54, down from the projected $26.21 PMPM cost in the September 30, 2012 Quarterly Report. Prescription Drugs PMPM for Fiscal Year 2013 is now projected to be $35.10, slightly down from the projected $35.51 PMPM cost in the September 30, 2012 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, 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 prioritize outreach efforts to the top fifth of our counties *(shown on page 44)* in the State with either higher estimated numbers or percentages of uninsured children. Some potential impact of these efforts at the county level can be seen in the Statistical Section in Tables 9 and 10 *(shown on Page 52 and 53)*.

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 1,700 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 help access electronic application, answer questions, and actively guide an applicant through the process. With the expiration of CHIPRA outreach funds in 2012, support for active application guidance was discontinued.

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. The WV Council of Churches serves as the fiscal agent for this group which also includes 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 as well as organizing statewide "Growing Healthy Kids" conferences. Past conferences have included nationally recognized speakers for key topics such as oral health, prenatal care, as well as workshops for preventive health and mental health.

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, WVCHIP continued working with a group of faith-based partners throughout the state to actively assist in the electronic application process available through the wvInroads Community Partner system. Since West Virginians are inclined to turn to those they know and trust in their local communities, this can help the public learn more about the value of electronic applications and make it more widely available to those without online access in the home.

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 2011:

- ★ Continued participation in efforts to promote healthy lifestyles with the West Virginia Immunization Network, 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. In 2011, WVCHIP took a lead role in collaboration with the WVU School of Dentistry to help establish an oral health program for infants and toddlers that could be delivered in primary care physician offices.

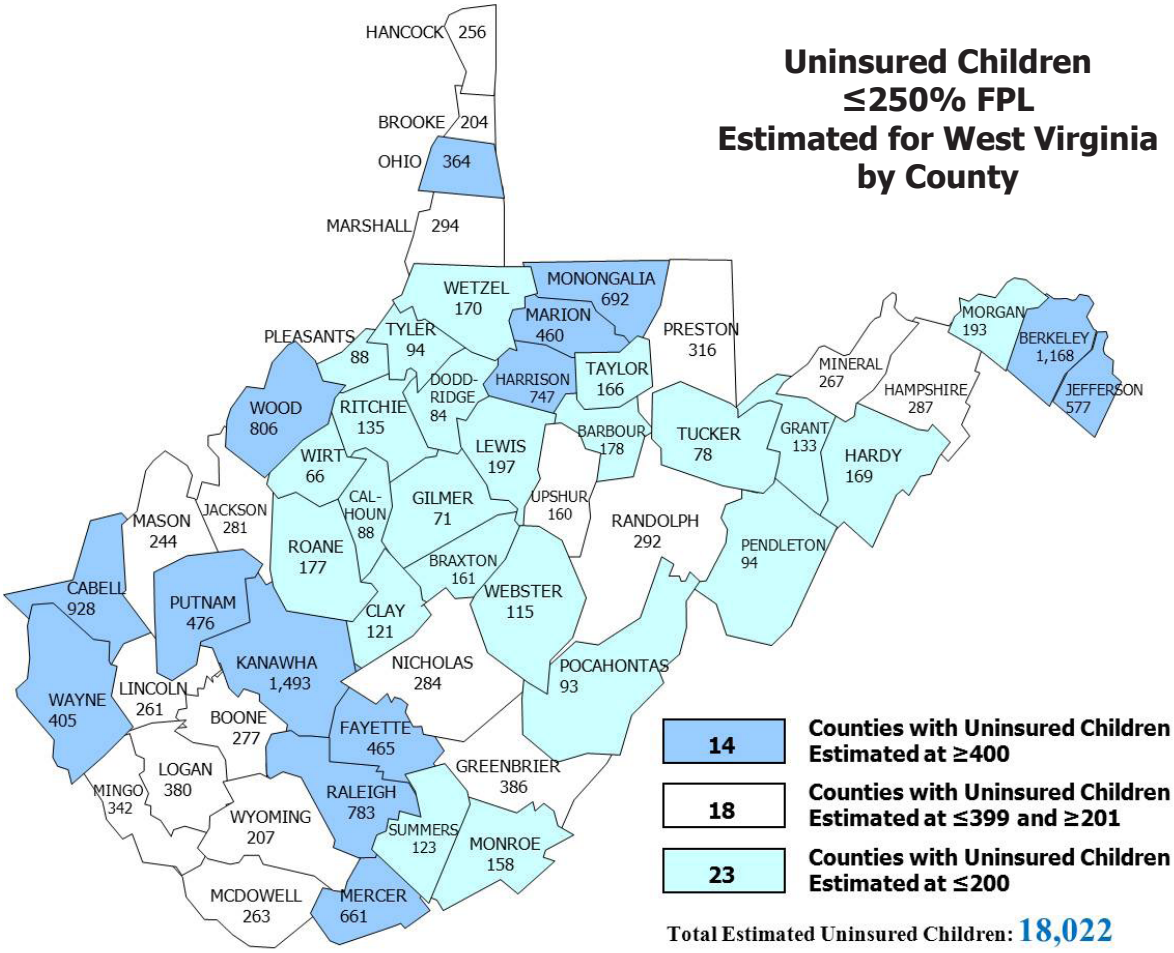
- ★ Recognizing some children's health coverage was jeopardized when parents lost employer coverage due to workforce reductions, WVCHIP continued to support dislocated workers this year. Staff members or outreach partners were on hand as part of the teams to provide CHIP information at sessions throughout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

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

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

- ★ WVCHIP was a sponsor of the state high school basketball tournament that provided information about the CHIP program as part of signing up for participation in the tournament. The tournament culminated in June 2011 with the State Championship in which the top three competitors were awarded monetary prizes.

Targeted Outreach For Uninsured Children



The 4.65% uninsured total number for children in lower income (≤250% FPL) households is an estimate from the most current (2009) US Census Current Population Survey. This data is based on two year rolling averages.

Statistical Section

All statistics are for the fiscal year ended June 30, 2010, unless noted otherwise.

Table 1: Enrollment

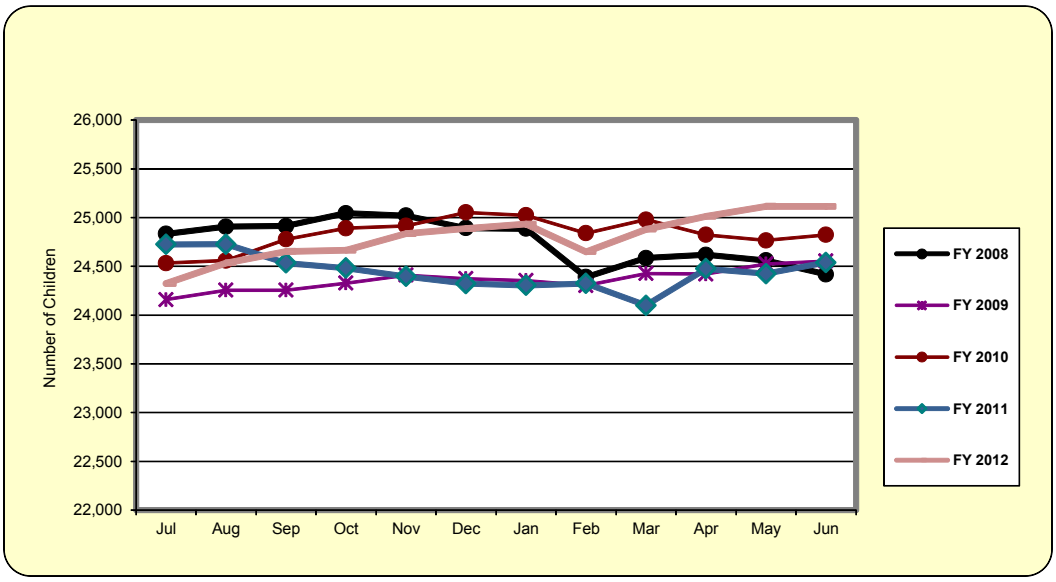
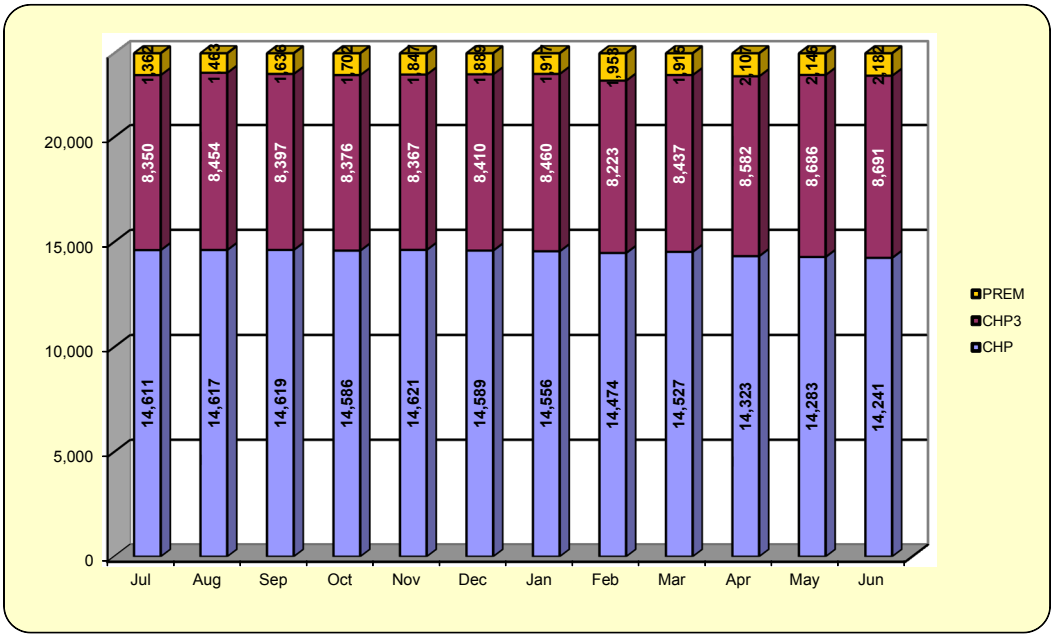
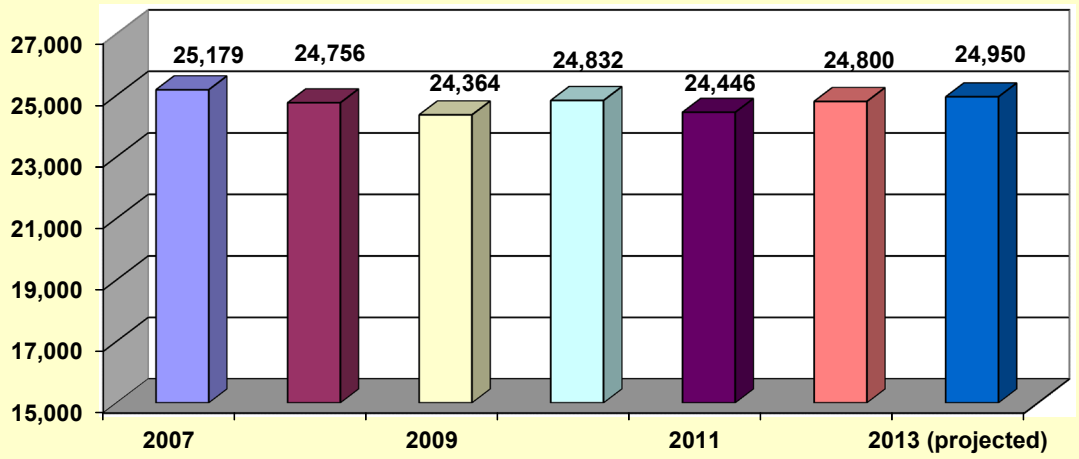


Table 2: Enrollment Detail



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

Table 3: Average Enrollment
SFY 2007 - 2013



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%

Total unduplicated number of children ever enrolled as of June 30, 2012 in WVCHIP since inception:
143,539

Table 4: Enrollment By Gender

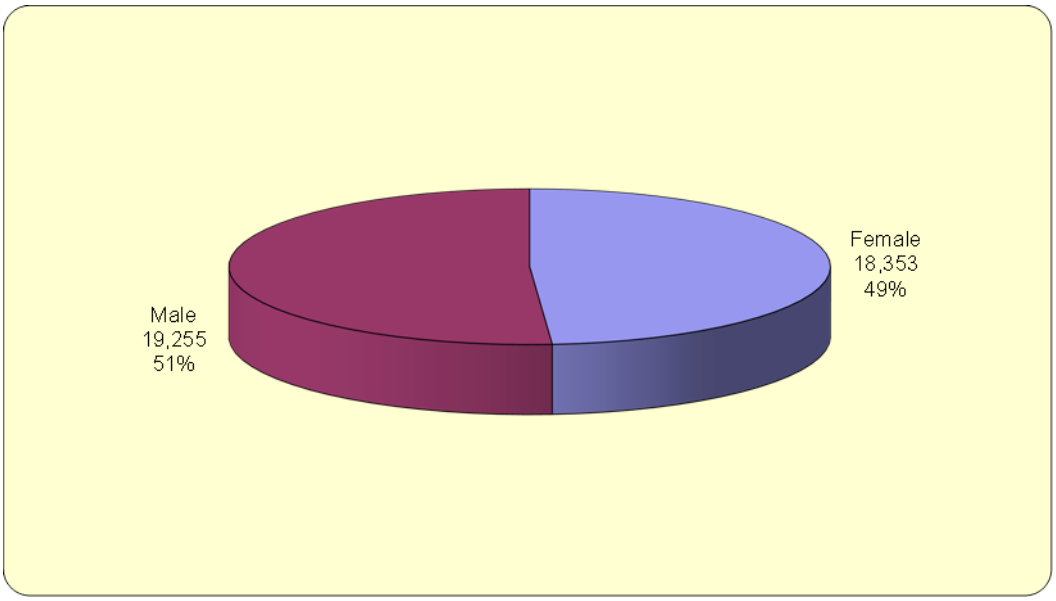


Table 5: Enrollment By Age

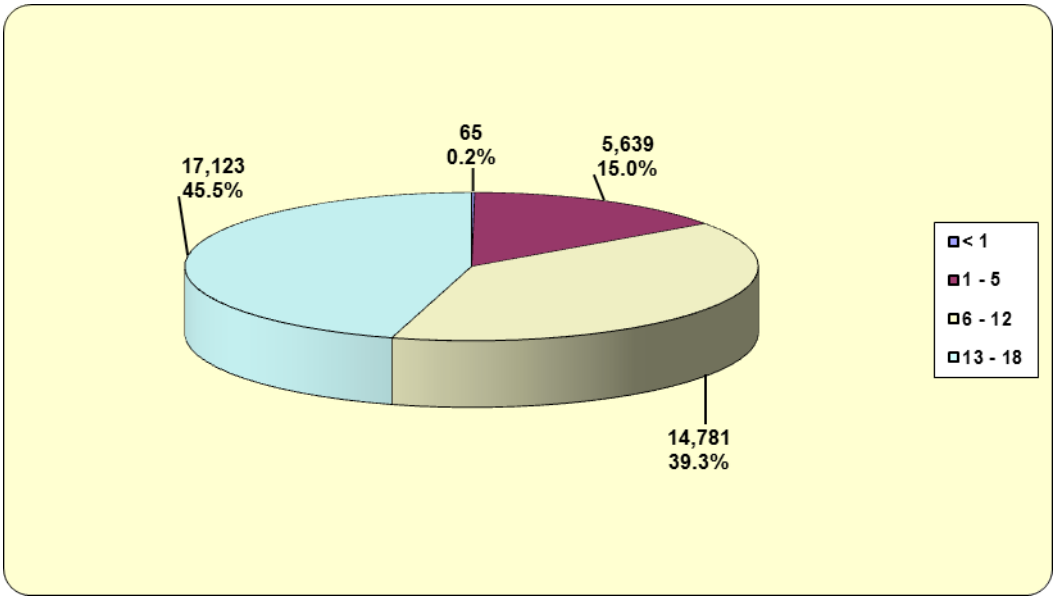
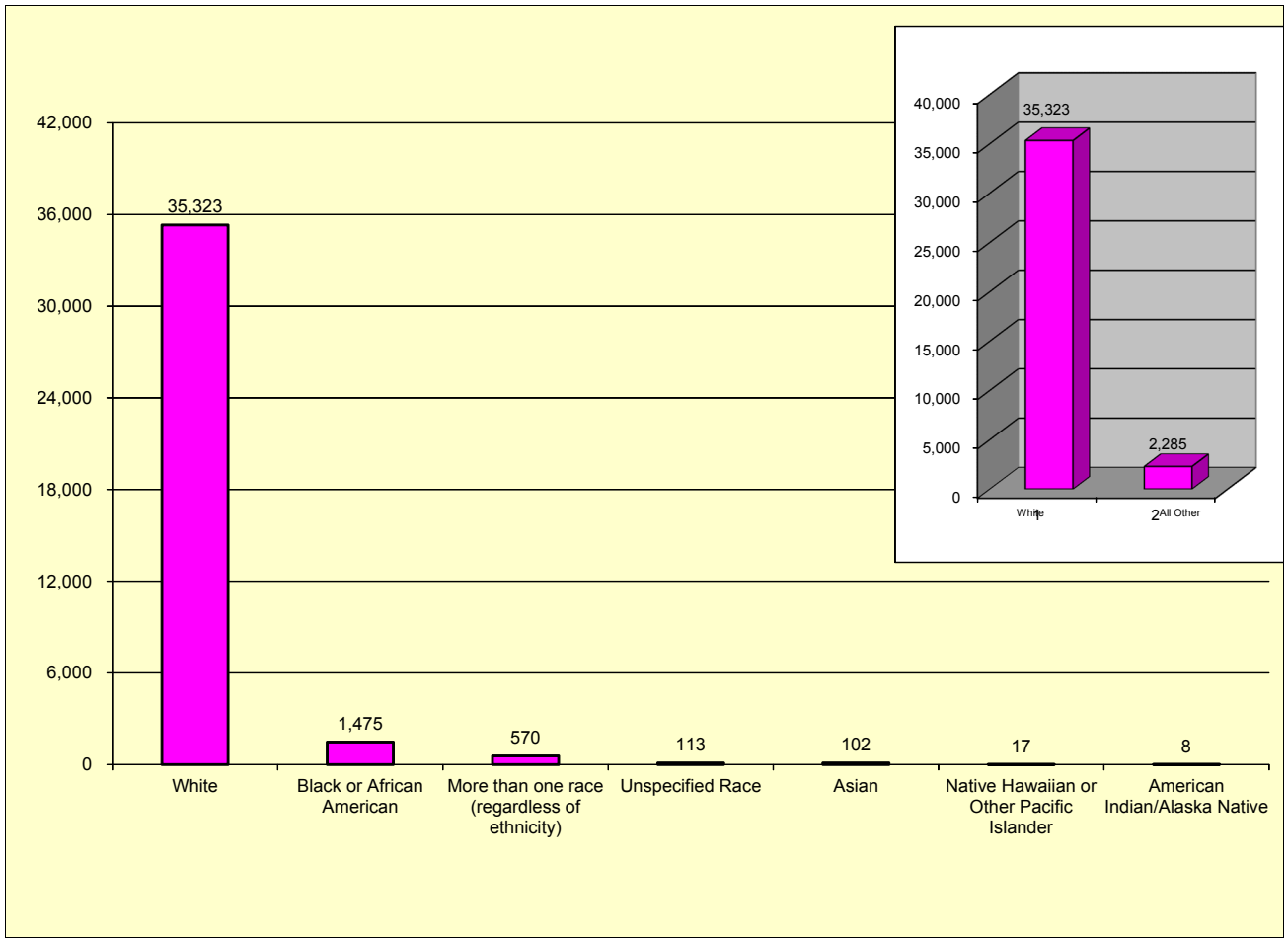
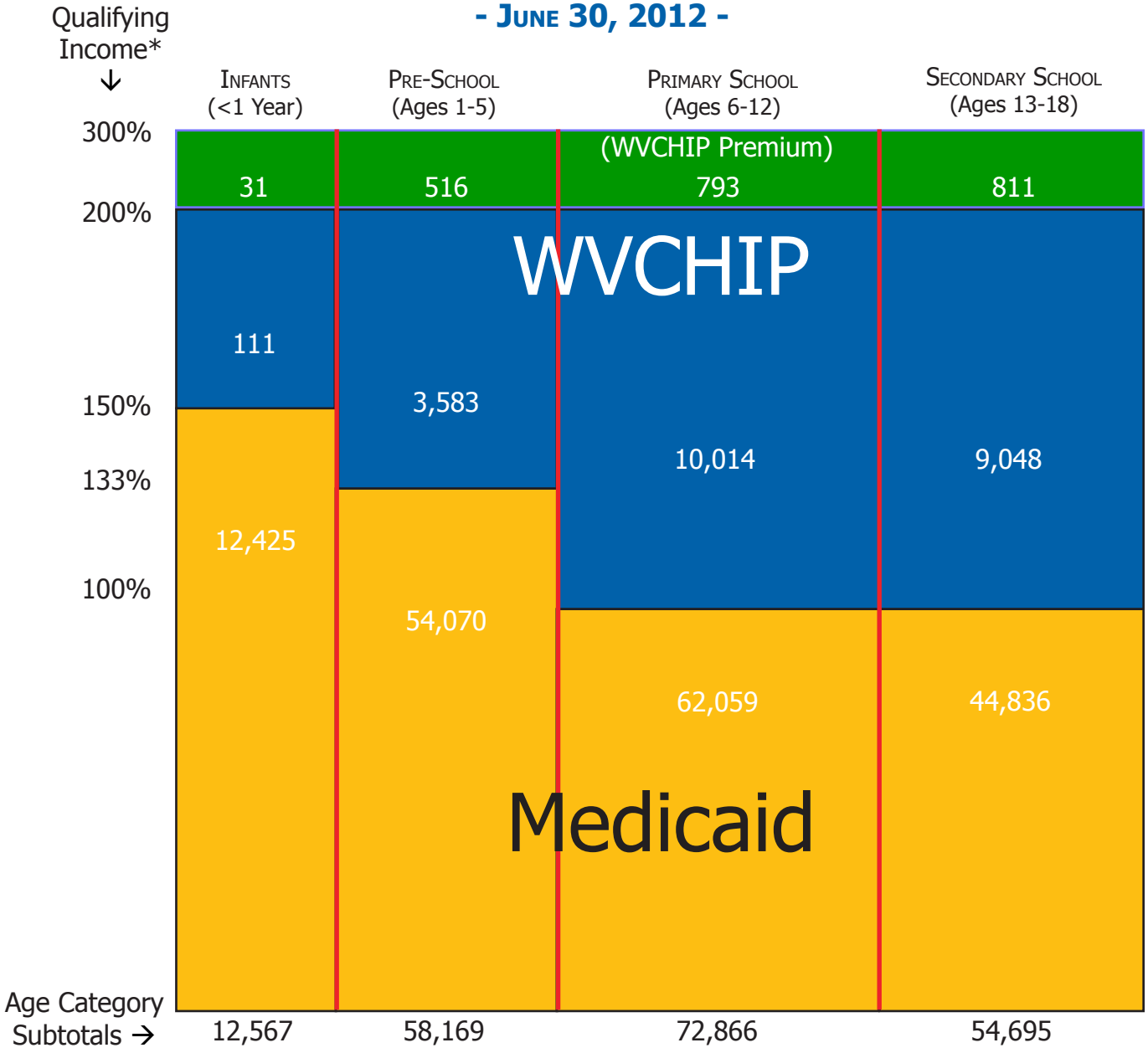


Table 6: Enrollment By Race/Ethnicity



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	35,323	93.9%	414,260	94.0%
Black or African American	1,475	3.9%	14,102	3.2%
More than one race (regardless of ethnicity)	570	1.5%	7,492	1.7%
Unspecified Race	113	0.3%	1,322	0.3%
Asian	102	0.3%	2,644	0.6%
Native Hawaiian or Other Pacific Islander	17	0.0%	88	0.0%
American Indian/Alaska Native	8	0.0%	881	0.2%
Total	**37,608**	**100.0%**	**416,100**	**100.0%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2012 -



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

Total WVCHIP Enrollment **24,907** **Total WV Medicaid Enrollment** **173,390**

Total # of Children Covered by WVCHIP and Medicaid - 198,297

Table 8: Annual Re-Enrollment and Non-Responses Upon Renewal
July 2011 through June 2012

County	# of Renewal Forms Mailed Monthly To CHIP Households	# of Closure Notices Mailed For Non-Returned Forms	# of Households Re-Opened as CHIP	% of Households Re-Opened After Closure	# of Households Closed with No Response	% of Households Closed
Pendleton	98	18	3	16.7%	12	12.2%
Grant	144	34	13	38.2%	18	12.5%
Hardy	138	45	14	31.1%	22	15.9%
Webster	116	43	11	25.6%	21	18.1%
Doddridge	113	34	10	29.4%	21	18.6%
Pocahontas	133	36	10	27.8%	25	18.8%
Upshur	318	93	22	23.7%	61	19.2%
Roane	252	70	11	15.7%	49	19.4%
Preston	416	112	15	13.4%	81	19.5%
Monroe	218	68	13	19.1%	44	20.2%
Ohio	402	129	25	19.4%	82	20.4%
Wyoming	307	94	24	25.5%	63	20.5%
Mercer	258	81	19	23.5%	53	20.5%
Raleigh	1,058	330	60	18.2%	223	21.1%
Tucker	104	31	5	16.1%	22	21.2%
Braxton	188	67	20	29.9%	40	21.3%
Mason	219	71	15	21.1%	47	21.5%
Tyler	93	32	7	21.9%	20	21.5%
Wetzel	189	67	14	20.9%	41	21.7%
Marshall	288	87	12	13.8%	64	22.2%
Mineral	298	102	24	23.5%	69	23.2%
Wood	972	359	83	23.1%	226	23.3%
Mingo	609	201	42	20.9%	144	23.6%
Lewis	236	75	12	16.0%	56	23.7%
Calhoun	105	50	23	46.0%	25	23.8%
Nicholas	314	106	18	17.0%	75	23.9%
Putnam	621	219	40	18.3%	149	24.0%
Randolph	353	122	29	23.8%	85	24.1%
Hampshire	274	93	14	15.1%	66	24.1%
Pleasants	92	32	9	28.1%	23	25.0%
Summers	172	65	18	27.7%	43	25.0%
Harrison	773	297	70	23.6%	195	25.2%
Monongalia	193	72	18	25.0%	49	25.4%
Jefferson	408	139	22	15.8%	104	25.5%
Clay	125	42	6	14.3%	33	26.4%
Jackson	367	139	24	17.3%	98	26.7%
Wirt	71	24	3	12.5%	19	26.8%
Ritchie	136	71	20	28.2%	37	27.2%
Barbour	219	87	23	26.4%	60	27.4%
Hancock	317	121	23	19.0%	87	27.4%
Greenbrier	474	191	40	20.9%	131	27.6%
Kanawha	1,894	819	198	24.2%	536	28.3%
Taylor	187	87	20	23.0%	53	28.3%
Brooke	234	92	16	17.4%	67	28.6%
Berkeley	1,096	516	115	22.3%	315	28.7%
Lincoln	305	126	28	22.2%	88	28.9%
Boone	238	95	17	17.9%	69	29.0%
Logan	438	184	34	18.5%	129	29.5%
McDowell	941	428	104	24.3%	285	30.3%
Fayette	680	292	59	20.2%	208	30.6%
Gilmer	71	30	3	10.0%	22	31.0%
Marion	529	208	26	12.5%	165	31.2%
Cabell	830	360	64	17.8%	260	31.3%
Morgan	265	119	25	21.0%	84	31.7%
Wayne	438	192	33	17.2%	140	32.0%
Totals	**20,327**	**7,697**	**1,626**	**21.1%**	**5,204**	**25.6%**
12-Mo. Ave.		***641***	***136***	***21.1%***	***434***	***25.6%***

MEDIAN

Table 9: Enrollment Changes By County
As % Difference from July 2011 through June 2012

County	Total Enrollees July 2011	Total Enrollees June 2012	Difference	% Change
Grant	172	206	34	17%
Tucker	120	141	21	15%
Barbour	247	286	39	14%
Mason	265	303	38	13%
Randolph	430	486	56	12%
Mingo	339	383	44	11%
Berkeley	1,240	1,399	159	11%
Clay	172	187	15	8%
Greenbrier	568	615	47	8%
Roane	293	317	24	8%
Boone	288	310	22	7%
Ohio	470	504	34	7%
Wood	1,141	1,221	80	7%
Jefferson	473	505	32	6%
Monongalia	758	805	47	6%
Marion	647	687	40	6%
Putnam	745	788	43	5%
Fayette	789	834	45	5%
Summers	209	220	11	5%
Morgan	267	280	13	5%
Logan	513	531	18	3%
Hancock	368	379	11	3%
Lewis	281	288	7	2%
Marshall	331	338	7	2%
Cabell	993	1,009	16	2%
Mineral	311	316	5	2%
Nicholas	384	390	6	2%
Brooke	268	272	4	1%
Upshur	377	382	5	1%
Pocahontas	155	157	2	1%
Mercer	1,142	1,154	12	1%
Taylor	228	230	2	1%
Kanawha	2,299	2,319	20	1%
Wyoming	398	400	2	1%
Hampshire	327	328	1	0%
Raleigh	1,276	1,271	-5	0%
Harrison	929	923	-6	-1%
Webster	153	152	-1	-1%
Ritchie	150	149	-1	-1%
Doddridge	135	134	-1	-1%
Calhoun	123	122	-1	-1%
Pendleton	123	122	-1	-1%
Pleasants	113	112	-1	-1%
Hardy	163	161	-2	-1%
Wayne	537	527	-10	-2%
Jackson	429	420	-9	-2%
Preston	501	488	-13	-3%
Braxton	211	202	-9	-4%
Tyler	130	123	-7	-6%
Monroe	241	228	-13	-6%
McDowell	324	305	-19	-6%
Wetzel	233	219	-14	-6%
Wirt	100	93	-7	-8%
Gilmer	83	77	-6	-8%
Lincoln	361	316	-45	-14%
Totals	**24,323**	**25,114**	**791**	**3%**
12-Mo. Ave.		***24,800***	***66***	***2%***

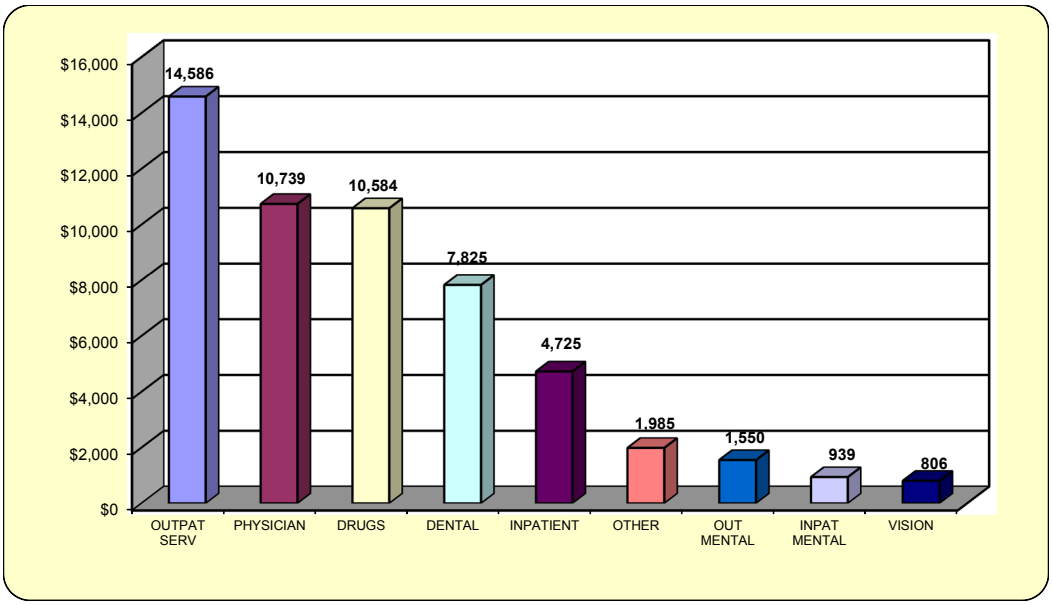
Median

Table 10: Enrollment Changes By County
As % of Children Never Before Enrolled from July 2011 through June 2012

County	Total Enrollees July 2011	Total Enrollees June 2012	New Enrollees Never in Program	New Enrollees As % of June 2012
Marshall	331	338	152	45%
Jefferson	473	505	220	44%
Hardy	163	161	69	43%
Mason	265	303	112	37%
Morgan	267	280	102	36%
Tyler	130	123	44	36%
Berkeley	1,240	1,399	498	36%
Webster	153	152	54	36%
Cabell	993	1,009	343	34%
Grant	172	206	69	33%
Wetzel	233	219	73	33%
Mineral	311	316	104	33%
Tucker	120	141	46	33%
Gilmer	83	77	25	32%
Wood	1,141	1,221	391	32%
Pendleton	123	122	39	32%
Marion	647	687	219	32%
Clay	172	187	59	32%
Barbour	247	286	90	31%
Hampshire	327	328	103	31%
Boone	288	310	96	31%
Monroe	241	228	70	31%
Nicholas	384	390	119	31%
Randolph	430	486	147	30%
Hancock	368	379	114	30%
Harrison	929	923	277	30%
Wayne	537	527	158	30%
Monongalia	758	805	241	30%
Greenbrier	568	615	184	30%
Lewis	281	288	86	30%
Mercer	1,142	1,154	343	30%
Kanawha	2,299	2,319	687	30%
Ohio	470	504	149	30%
Putnam	745	788	229	29%
Wirt	100	93	27	29%
Ritchie	150	149	43	29%
McDowell	324	305	86	28%
Roane	293	317	88	28%
Preston	501	488	134	27%
Brooke	268	272	73	27%
Summers	209	220	59	27%
Raleigh	1,276	1,271	340	27%
Upshur	377	382	102	27%
Taylor	228	230	61	27%
Fayette	789	834	221	26%
Wyoming	398	400	105	26%
Braxton	211	202	53	26%
Jackson	429	420	107	25%
Mingo	339	383	96	25%
Lincoln	361	316	79	25%
Pleasants	113	112	28	25%
Doddridge	135	134	32	24%
Logan	513	531	125	24%
Calhoun	123	122	24	20%
Pocahontas	155	157	30	19%
Totals	**24,323**	**25,114**	**7,625**	**30%**
12-Mo. Ave.		***24,800***	***635***	***2.6%***

Median

Table 11: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

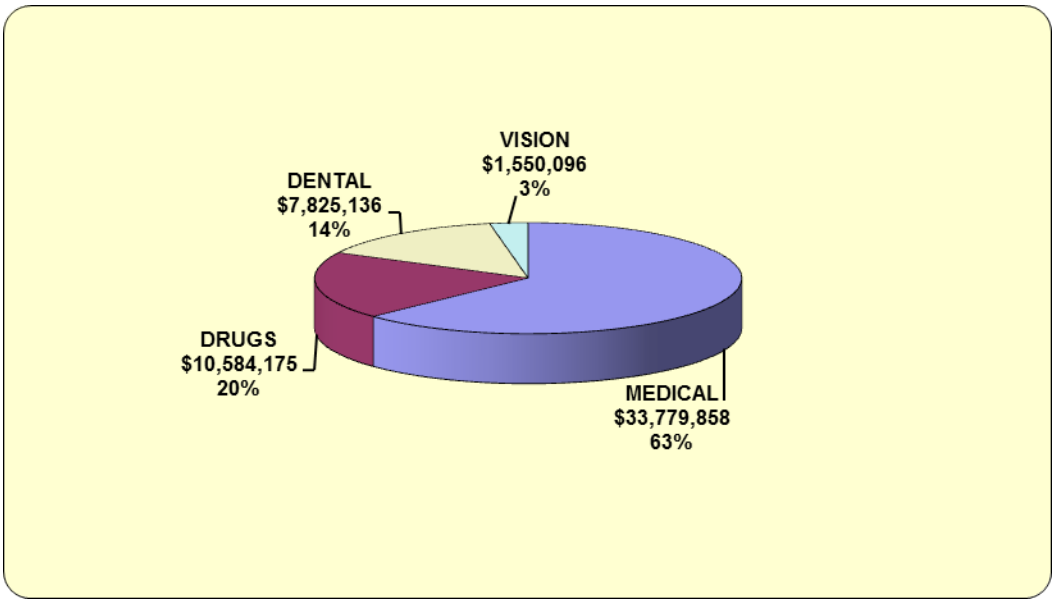


Table 12: Total Program Expenditures

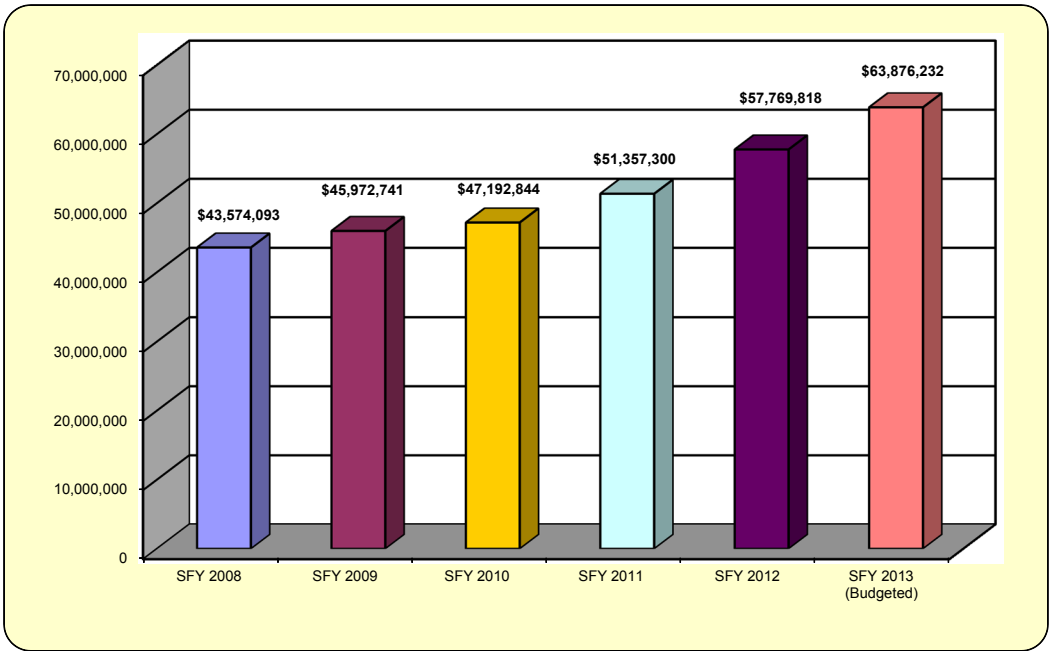
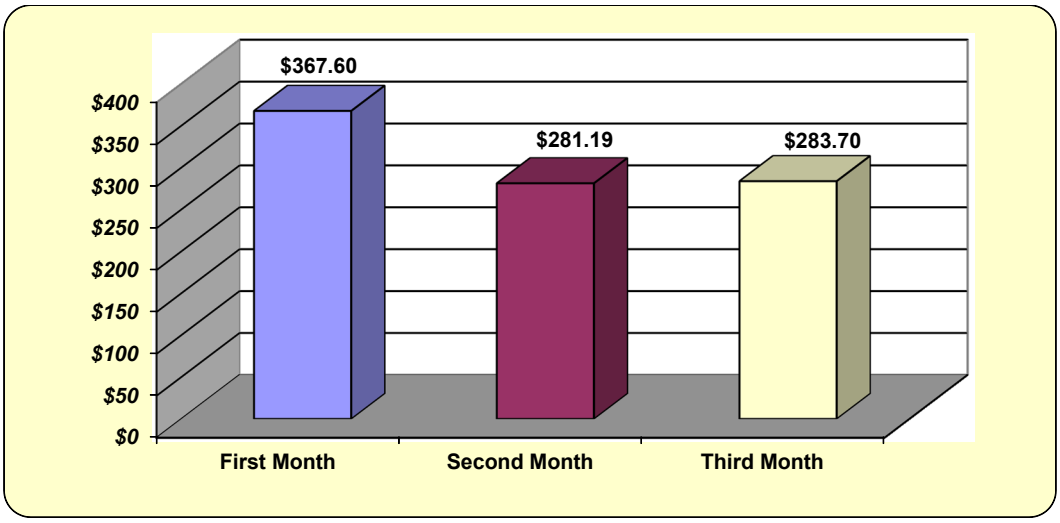


Table 13: Average Claimant Costs in First Three Months
Showing Pent Up Demand For Services Upon Enrollment



WVCHIP Set of Pediatric Core Measures 2010

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 14 measures in the national measure set. 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 year to expand further our set of reported measures. This set of measures is expected to be studied and evaluated and will become mandatory reporting for all states' CHIP and Medicaid child health programs in 2013.

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 part of additional HEDIS® specifications in the numerator of the measure.

Table 14
Pediatric Core Measure #5 - Childhood Immunization Status

Specification: HEDIS 12: The percentage of children 2 years of age during calendar year 2011 who were continuously enrolled 12 months prior to the child's section birthday, and who had four diptheria, 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) 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 2011	Number Receiving Each Immunization 2011	% Year 2011
2 years old	DTaP (four immunizations)	42	31	73.8
	IPV (three immunizations)	42	39	92.9
	MMR (one immunization)	42	42	100
	Hib (two immunizations)	42	40	95.2
	Hepatitis B (three immunizations)	42	25	59.5
	VZV (one immunization)	42	42	100
	PCV (four immunizations)	42	23	54.7
	Hep A (two immunizations)	42	40	95.2
	RV (two or three immunizations)	42	40	95.2
	Influenza two immunizations)	42	41	97.6
	Total continuously enrolled	**42**	**42**	**86.41**

Age Group	Immunization Type	Number of Continuously Enrolled 2010	Number Receiving Each Immunization 2010	% Year 2010
2 years old	DTaP (four immunizations)	44	34	77.3
	IPV (three immunizations)	44	44	100
	MMR (one immunization)	44	44	100
	Hib (two immunizations)	44	44	100
	Hepatitis B (three immunizations)	44	27	61.4
	VZV (one immunization)	44	44	100
	PCV (four immunizations)	44	29	65.9
	Hep A (two immunizations)	44	44	100
	RV (two or three immunizations)	44	43	100
	Influenza two immunizations)	44	44	100
	Total continuously enrolled	**44**	**44**	**90.4**

Age Group	Immunization Type	Number of Continuously Enrolled 2009	Number Receiving Each Immunization 2009	% Year 2009
2 years old	DTaP (four immunizations)	39	30	77.0
	IPV (three immunizations)	39	39	100
	MMR (one immunization)	39	37	95.0
	Hib (two immunizations)	39	39	100
	Hepatitis B (three immunizations)	39	23	59.0
	VZV (one immunization)	39	39	100
	PCV (four immunizations)	39	32	82.0
	Hep A (two immunizations)	39	32	100
	RV (two or three immunizations)	39	39	100
	Influenza two immunizations)	39	39	100
	Total continuously enrolled	**39**	**39**	**91.3**

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

Table 15
Pediatric Core Measure #6 - Immunizations for Adolescents

Specification: HEDIS 12: The percentage of adolescents reaching 13 years of age during calendar year 2011 and were continuously enrolled 12 months prior to the adolescent's 13th birthday, and who had one dose of meningococcal vaccine (MCV4) and one tetanus, diptheria toxoid and acellular pertussis vaccine (Tdap) or one tetanus, diptheria 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 2011	% Year 2010	% Year 2009
Adolescents	**Administration**	1,880	1341			
13 Years old	**Combination (Meningococcal, Tdap/TD)**		**1,341**	**71.3**	**72.2**	**68.0**
	Meningococcal		1,341	71.3	72.2	68.0
	Tdap/TD		1,465	77.9	76.8	73.7
	Total continuously enrolled	**1,880**	**1,880**	**74.6**	**72.2**	**68.0**

Table 16
Pediatric Core Measure #7 - BMI-Nutition and Counseling

Specification: HEDIS 12: The percentage of members 3-17 years of age continuously enrolled for calendar year 2011 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, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 97802-97804

Age Group	Continuously Enrolled	BMI/Nutrition & Counseling	% with Measure for Year 2011	% with Measure for Year 2010	% with Measure for Year20 09
Age 3	244	1	0.41	0.41	0.00
Age 4	276	1	0.36	0.00	0.00
Age 5	238	0	0.00	0.00	0.00
Age 6	312	7	0.23	0.00	0.00
Age 7-11	3090	8	0.26	0.01	0.07
Age 12 and up	4515	21	0.47	0.13	0.11
Total	8675	38	0.44	0.11	0.08

Table 17
Pediatric Core Measure #8 - Developmental Screening

Specification: HEDIS 11: The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding their first, second, or third birthday. CPT Code 96110 (Developmental testing, with interpretation and report)

Age Group	Continuously Enrolled	Developmental Screening	% with Measure for Year 2011
Age 1	38	12	31.6
Age 2	230	95	41.3
Age 3	244	67	27.7
Total	512	174	34

Table 18

Pediatric Core Measure #10 - Well Child Visits for Children in First 15 mo of Life

Specification: HEDIS 12: The percentage of members who turned 15 months old during calendar year 2011 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 2011
21	0	1	4.76
21	1	0	0.00
21	2	1	4.76
21	3	0	0.0
21	4	0	0.0
21	5	0	0.0
21	6 or more	19	90.5
Total		**21**	**100.0**

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2010
10	0	0	0.0
10	1	0	0.0
10	2	0	0.0
10	3	1	10.0
10	4	1	10.0
10	5	3	30.0
10	6 or more	4	40.0
Total		**9**	**90.0**

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2009
9	0	0	0.0
9	1	1	11.1
9	2	0	0.0
9	3	1	11.1
9	4	1	11.1
9	5	4	44.4
9	6 or more	2	22.2
Total		**9**	**100.0**

Table 19
Pediatric Core Measures #11 & 12 - Well Child Visits for Birth to Six Years and Adolescent Well Visits

Specification for Birth to Six Visits: HEDIS 12: The number of children ages three to six years enrolled for calendar year 2011 who had a well-child visit with a PCP as defined by CPT Codes: 99382, 99383, 99392, and 99303

Specification for Adolescent Visits: HEDIS 12: The number of adolescents from ages 12 to 19 enrolled during calendar year 2011 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 2011	% Prior Year 2010	% Prior Year 2009
Well Child					
Less Than Or Equal To 15 Months	21	20	95.2	90.0	100
Third Year Of Life	244	190	77.9	75.9	74.6
Fourth Year Of Life	276	221	80.1	78.0	80.0
Fifth Year Of Life	238	189	79.4	76	80.8
Sixth Year Of Life	312	214	68.6	64.2	61
Total	**1,091**	**834**	**76.4**	**73.4**	**73.6**
Adolescents					
12 To 19 Years of Age	4,515	1,724	38.2	33.8	37.1
Total	**4,515**	**1,724**	**38.2**	**33.8**	**37.1**

Table 20
Pediatric Core Measure #13 - Preventive Dental Services

Specification: EPSDT 416 Measure: Unduplicated number of children enrolled for the calendar year 2011 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 2011	% Year 2010	% Year 2009
37,699	16,273	43.2	42.4	41.6

Table 21
Pediatric Core Measure #14 - Access to Primary Care

Specification: HEDIS 12: Percentage of children and adolescents ages 12 months to 6 years that had a visit with a PCP during calendar year 2011 and for children 7 years to 19 years who had a visit during calendar year 2011 or the previous calendar year 2010, 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 2011	% Prior Year 2010	%Prior Year 2009
12 to 24 Months	60	57	95.0	98.2	98.2
25 Months to 6 Years	1,274	1,227	96.3	96.4	97.2
7 to 11 Years	3,090	2,808	90.9	88.4	91.1
12 to 19 Years	4,515	3,934	87.1	84.9	88.3
Total	**8,939**	**8,026**	**89.8**	**87.7**	**90.5**

Table 22
Pediatric Core Measure #17 - Dental Treatment Services

Specification: EPSDT 416 Measure: Unduplicated number of children enrolled for calendar year 2011 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 12B

Unduplicated Number of Children	Number of Children with Treatment Dental Visits	% Year 2011	% Year 2010	% Year 2009
37,699	14,091	37.4	36.5	33.7

Table 23
Pediatric Core Measure #18 - Emergency Department Utilization

Specification: HEDIS 12: Rate of ED visits per 1,000 member months among children up to age 19, continuously enrolled and eligible during the calendar year 2011. CPT Codes: 99281-99288

	Number of Members	Member Months	Number of ER Encounters	Rate per 1,000 members
For Year 2011:				
Ages:				
<1	72		0	0.00
1 through 9	28,800		1,132	39.31
10 to 19	78,468		3,008	38.33
TOTAL:	**107,340**		**4,140**	**38.57**
For Year 2010:				
Ages:				
<1	12		0	0
1 through 9	27,924		1,010	36.17
10 to 19	79416		2,968	37.37
TOTAL:	**107,352**		**3,978**	**39.06**
For Year 2009:				
Ages:				
<1	0		0	0.00
1 through 9	28,200		1,303	46.21
10 to 19	76,356		3,403	44.57
TOTAL:	104,556		4,706	45.01

Table 24
Pediatric Core Measure #20 - Annual Number Emergency Department Encounters by Asthma Patients

Specification: State of Alabama, Measure Steward: Emergency department (ED) utilization for all children ≥1 year of age diagnosed with asthma or treated with at least two short-acting beta adrenergic agents who had more than one asthma-related ED visit during the measurement year.

	Number of Asthmatics over Age 1	Number with ED Encounter for Asthma	% with Asthma ED Encounter
Total for 2011:	**809**	120	14.8
Total for 2010:	**803**	109	13.5
Total for 2009:	**850**	127	14.9

Table 25
Pediatric Core Measure #21 - Follow-Up Care for Children Prescribed ADHD Medication

Specification: HEDIS 12: The percentage of children 6-12 years of age newly prescribed with attention-deficity/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period, one of which occurs within 30 days of dispensing of the first ADHD medication. Two rates are reported, the initiation phase and the maintenance phase, as defined by CPT Codes: 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99204, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99040, 99411, 99412, 99150, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 99221-99223, 99233, 99238, 99239, 99251-99255

Age Group	# Continuation & Maintenance Members	# Members on Medication with follow-up visits	% Compliance for 2011 Year	% Compliance for 2010 Year	% Compliance for 2009 Year
6 years	1	1	100	100	100
7 years	6	6	100	100	100
8 years	28	28	100	100	100
9 years	48	48	100	100	100
10 years	56	56	100	100	100
11 years	61	61	100	100	100
12 years	65	65	100	100	100
Total	**265**	**265**	**100**	**100**	**100**

100% compliance because this service is by precertification.

Table 26
Pediatric Core Measure #22 - Diabetic Care

Specification: HEDIS 12 with added adult measure criteria applied to children also. The core measure shows percentage of pediatric patients with Type I and II diabetes with a hemoglobin HbA1c test in a 12-month measurement period. The adult criteria also includes the number of children enrolled for calendar year 2010 with Type I and II diabetes who also had - a serum cholesterol level (LDL-C) screening; an eye exam, and a screen for kidney disease, as defined by CPT Codes: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-00245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99304-99310; 99315, 99316, 99318, 99324-99328, 99334-99337, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291, 99281-99285.

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	0	0	0.00	0	0	0	0
6 to 11 Years	23	20	86.9	22	95.7	8	34.8
12 to 18 Years	51	45	88.2	49	96.1	13	25.5
Total % Year 11	75	65	86.7	72	96.0	21	28.0
Total % Prior Year 10	68	56	82.3	65	95.5	17	25.0
Total % Prior Year 09	60	53	88.3	59	98.3	18	30

Table 27

Pediatric Core Measure #23 - Follow-Up After Hospitalization for Mental Illness

Specification: HEDIS 12: The percentage of discharges for members 6 years of age and older 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 defined by CPT Codes: 90801, 90802, 90804-90815, 90816-90819, 90821-90824, 90826-90829, 90845-90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99402-99404, 99411, 99412, 99510.

# 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 7 days of Discharge Year 2011
118	31	26.3	65	55.1

#6 years & older Hospitalized with Mental Health DX Year 2010	# of follow-up visits within 7 days of Discharge Year 2010	% of follow-up visits within 7 days of Discharge Year 2010	# of follow-up visits within 30 days of Discharge Year 2010	% of follow-up visits within 30 days of Discharge Year 2010
92	18	19.5	46	50.0

#6 years & older Hospitalized with Mental Health DX Year 2009	# of follow-up visits within 7 days of Discharge Year 2009	% of follow-up visits within 7 days of Discharge Year 2009	# of follow-up visits within 30 days of Discharge Year 2009	% of follow-up visits within 30 days of Discharge Year 2009
117	32	27.4	64	54.7

Table 28
West Virginia Measure - Vision Visits

Specification: HEDIS-Type Data: The number of children continuously enrolled for calendar year 2010 who received a vision visit for CPT Codes: 92012-92014, 92002-92004, 99172-99173, 92081-92083, 99174

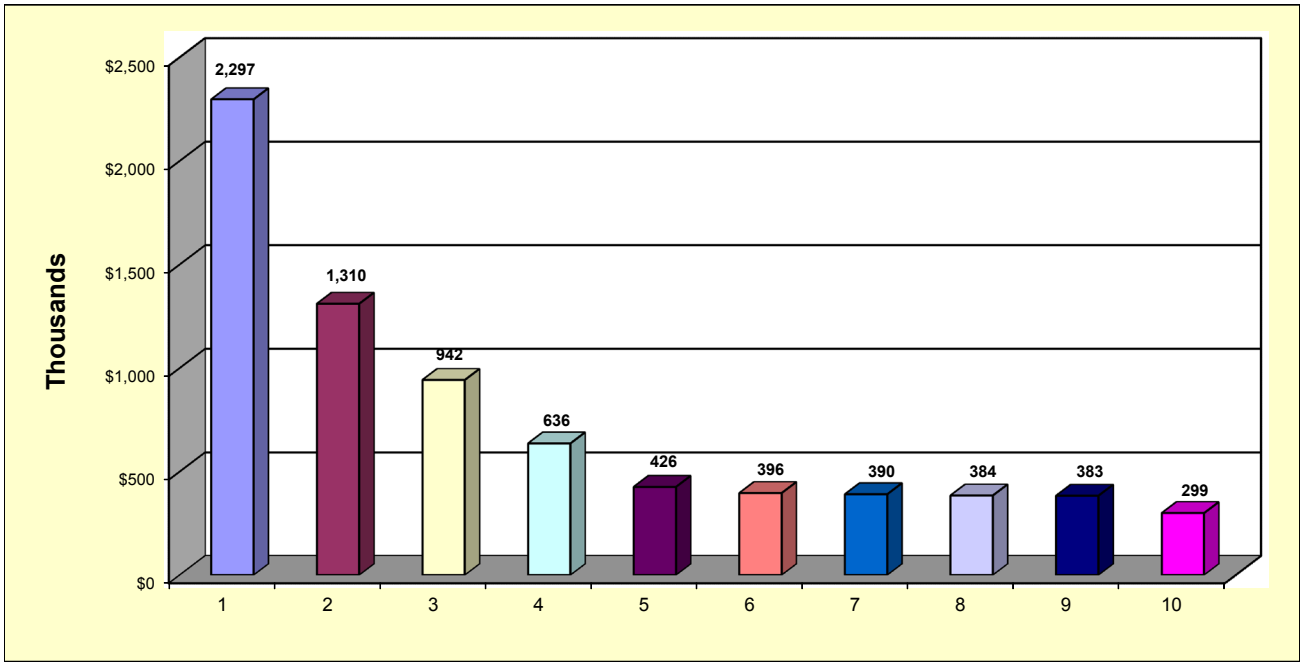
Age Group	Number of Continuously Enrolled Children	Number Having Vision Checkup Visit	% Year 2011	%Prior Year 2010	% Prior Year 2009
Under 1 Year	6	0	0.00	0.00	0.00
1 to 5 Years	1,022	165	16.1	14.5	15.7
6 to 11 Years	3,402	1,178	34.6	32.9	33.7
12 to 18 Years	4,515	1,767	39.1	37.0	38.1
Total	**8,945**	**3,110**	**34.8**	**33**	**33.9**

Table 29
West Virginia Measure - Proper Use of Asthma Medications

Specification: HEDIS-Type Data (Adult criteria applied to children): This estimates the number of children, ages 5-19 years, enrolled for the entire 2010 calendar year as well as the complete year prior with persistent asthma who were prescribed appropriate medications.

Age Group	Asthma Patients	Number with Proper Uses of Medication	% Year 2011	% Year 2010	% Year 2009
5 - 9 years	274	240	87.6	88.1	89.5
10-17 years	421	370	87.9	88.1	85.1
18-19 years	32	28	87.5	91.8	75.7
Total	727	638	87.8	88.3	86.3

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	Clinic Visit - All Inclusive - Encounter	(T1015)
4	Individual Psychotherapy Insight	(90806)
5	ER Exam - Extended - New Patient	(99284)
6	Office Visit - Intermediate - New Patient	(99203)
7	Therapeutic Activities, 15 Minutes	(97530)
8	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
9	ER Exam - Intermediate - New Patient	(99283)
10	ER Exam - Comprehensive - New Patient	(99285)

**As described in Current Procedure Terminology 2011 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 Clinic Visit - All Inclusive - Encounter: National T Codes established for State Medicaid Agencies for which there are no national codes. T1000-T9999 describes nursing and home health-related services, substance abuse treatment, and certain training-related procedures. *(HCPCS T1015)*

4 Individual Psychotherapy Insight: requiring a face-to-face visit with a therapist for insight oriented, behavior modifying and/or supportive therapy for 45 to 50 minutes *(CPT 90806)*

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 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)*

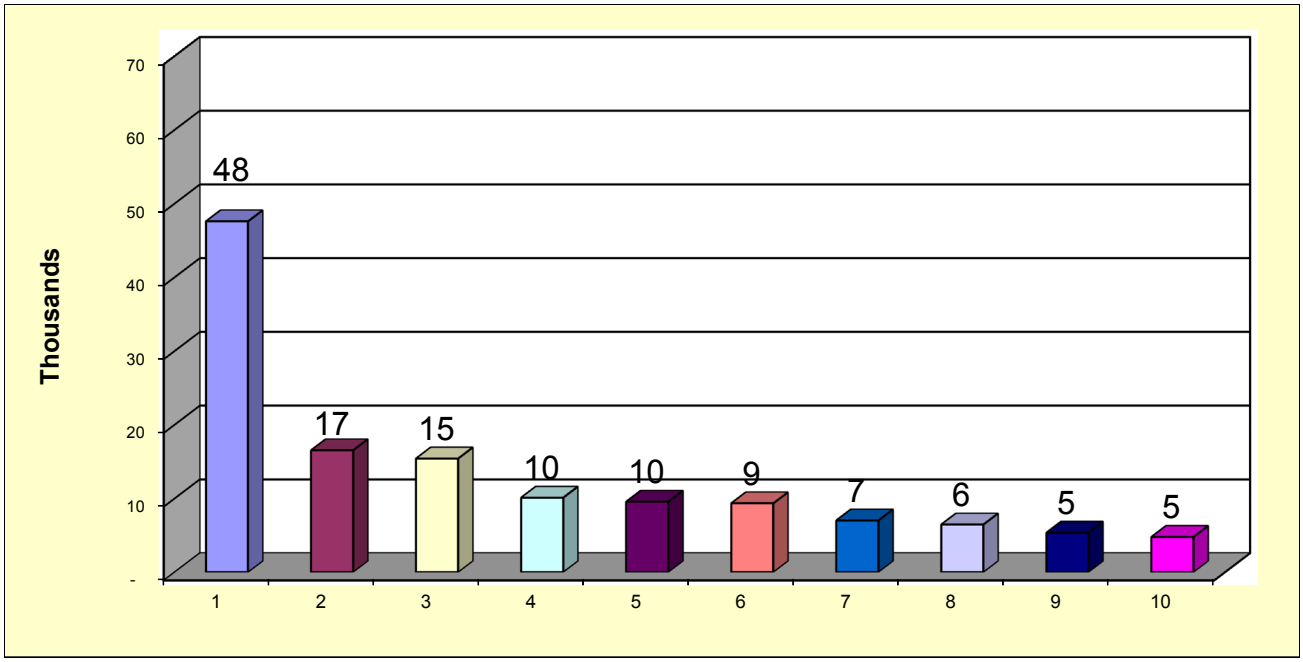
7 Therapeutic Activities: direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) each 15 minutes. *(CPT 97530)*

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

9 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)*

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 significant threat to life or physiologic function; requires three key components including a comprehensive history, an exam, and a medical decision making of high complexity (*CPT 99285)*

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



Key

		CPT Code*
1	Office Visit - Limited - Est. Patient	(99213)
2	Clinic Visit - All Inclusive - Encounter	(T1015)
3	Office Visit - Intermediate - Est. Patient	(99214)
4	Office Visit - Brief - Est. Patient	(99212)
5	Immunization Administration	(90471)
6	Individual Psychotherapy Insight	(90806)
7	Blood Count	(85025)
8	Test for Streptococcus	(87880)
9	ER Exam - Intermediate - New Patient	(99283)
10	Immunization Administration - Each Add. Vaccine	(90472)

**As described in Current Procedure Terminology 2011 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 Clinic Visit - All Inclusive - Encounter: National T Codes established for State Medicaid Agencies for which there are no national codes. T1000-T9999 describes nursing and home health-related services, substance abuse treatment, and certain training-related procedures. *(HCPCS T1015)*

3 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)*

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

6 Individual Psychotherapy Insight: requiring a face-to-face visit with a therapist for insight oriented, behavior modifying and/or supportive therapy for 45 to 50 minutes *(CPT 90806)*

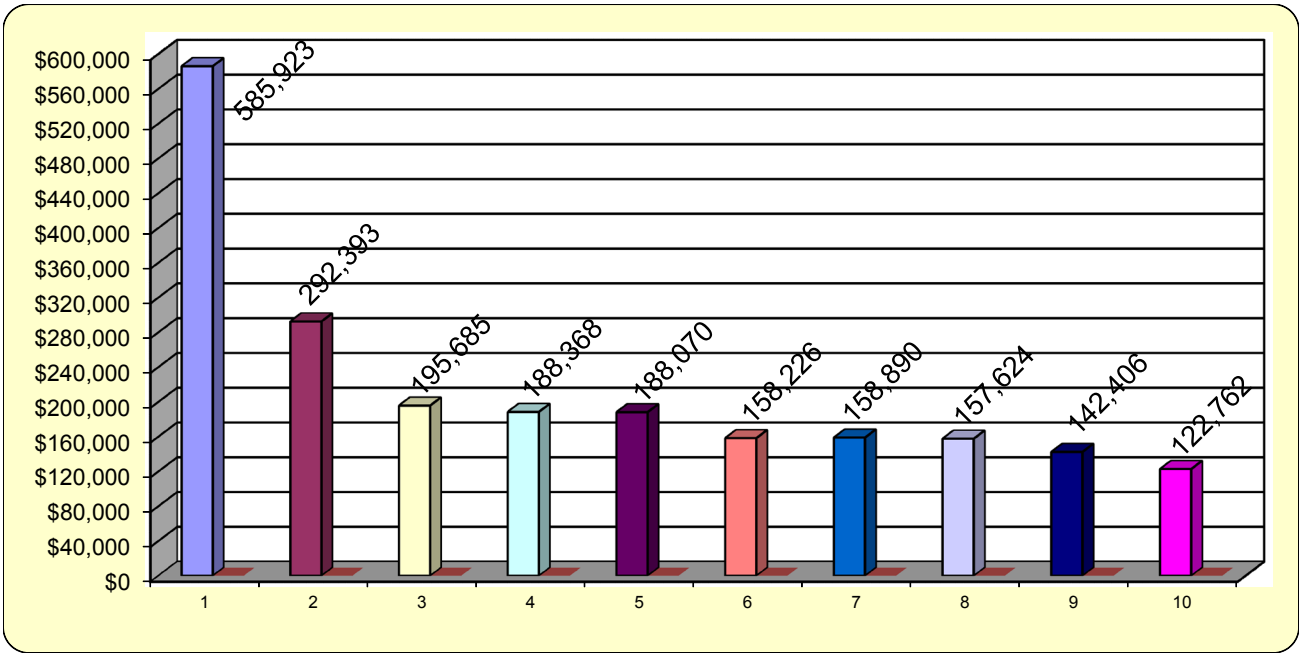
7 Blood Count: automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count *(CPT 85025)*

8 Test for Streptococcus: laboratory testing for Streptococcus bacteria group A as identified by colony morphology, growth on selective media *(CPT 87880)*

9 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)*

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

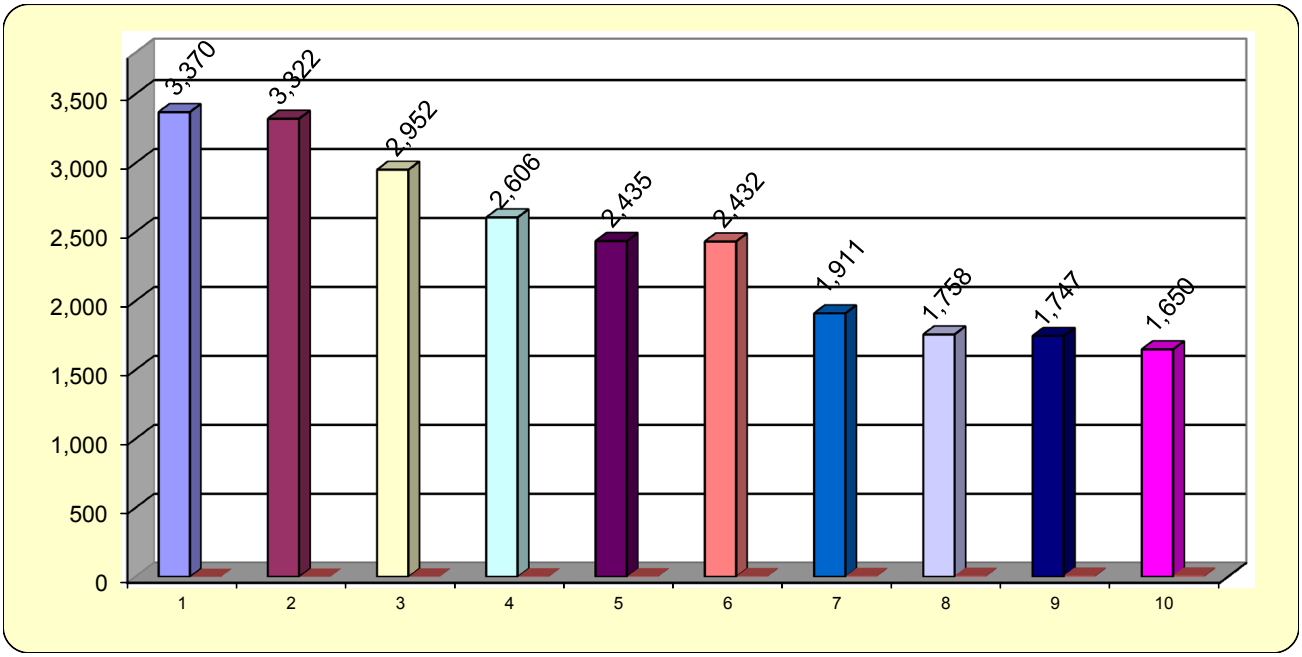
Table 32: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Singulair 5MG	-	Asthma
2	Singulair 10MG	-	Asthma
3	Proair HFA 90 MCG	-	Asthma
4	Singulair 4MG	-	Asthma
5	Novolog 100Unit/ML	-	Diabetes
6	Vyvanse 30MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
7	Vyvanse 40MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
8	Methylphenidate ER 36MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
9	Methylphenidate ER 54MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
10	Dextroamp-amphet ER 20MG	-	Attention Deficit Hyperactivity Disorder (ADHD)

Table 33: Top Ten Prescription Drugs
By Number of Rx



Key

	Drug Brand Name	Major Use Indication
1	Singulair 5MG	- Asthma
2	Proair HFA 90MCG	- Asthma
3	Fluticasone 50MCG	- Allergies
4	Loratadine 10MG	- Allergies
5	Azithromycin 250MG	- Antibiotic
6	Amoxicillin 400MG/5ML	- Antibiotic
8	Amoxicillin 500MG/5ML	- Antibiotic
9	Tri-Sprintec	- Contraception
7	Singulair 10MG	- Asthma
10	Amoxicillin 250MG/5ML	- Antibiotic