West Virginia
Children's Health Insurance Program

Annual Report 2013

This page is intentionally left blank.

West Virginia
Children's Health Insurance Program

2013 Annual Report

Earl Ray Tomblin, Governor

Earl Ray Tomblin, Governor
State of West Virginia

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

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

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

Our Mission

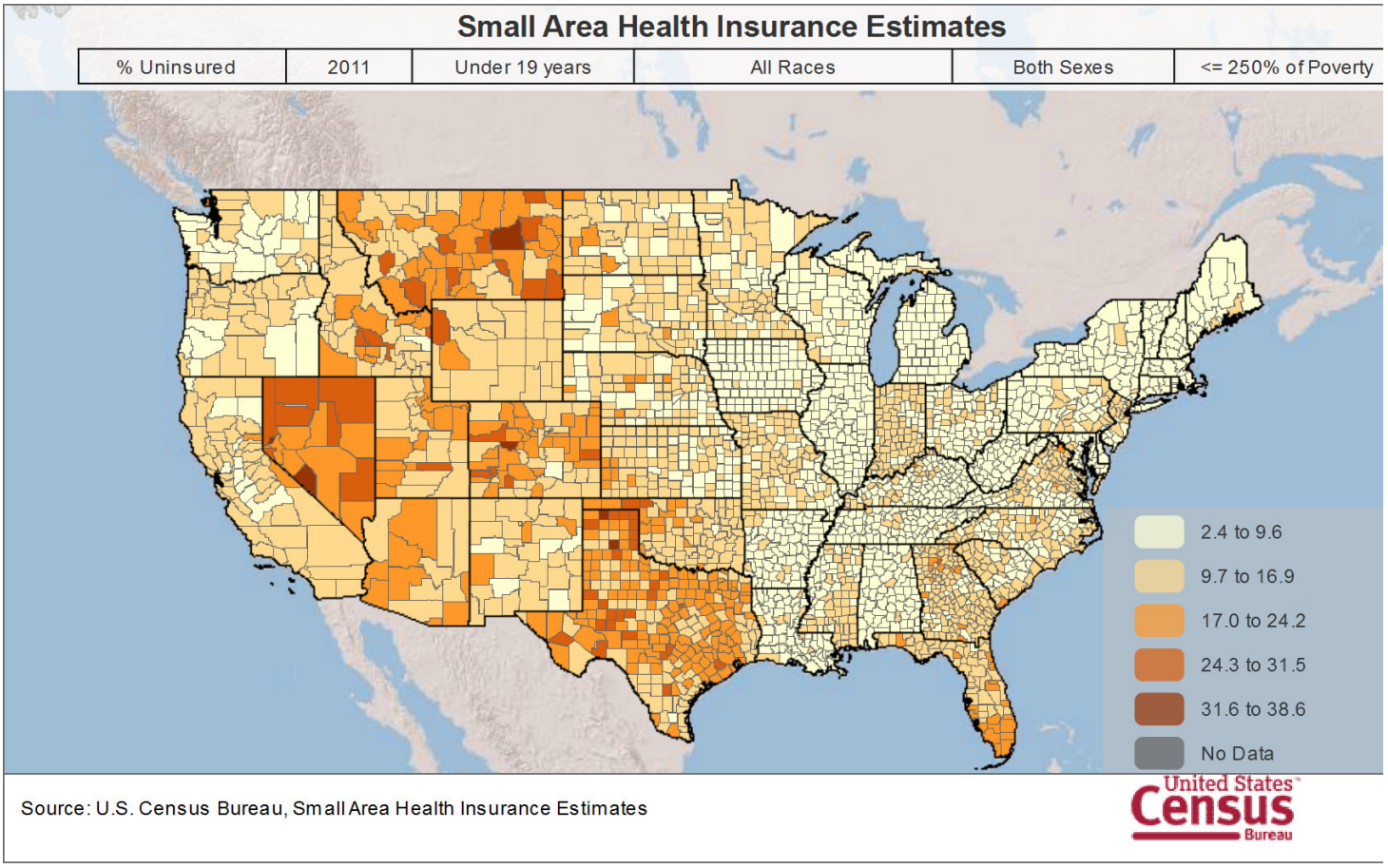
To provide quality health insurance to eligible children
and strive for a health care system in which all
West Virginia children have access to health care coverage.

Our Vision

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

Table of Contents

Health Insurance Coverage Estimates
Percent Uninsured, 2011*



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

**Census data of this kind is based on updated survey data with 2011 being the most recent.*

Introductory Section

"CHIP is a life jacket to our home, thank you."

Parent quotation from a response to a 2001 CHIP survey.

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 18, 2013

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., Cabinet Secretary
West Virginia Department of Administration

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

Ladies and Gentlemen:

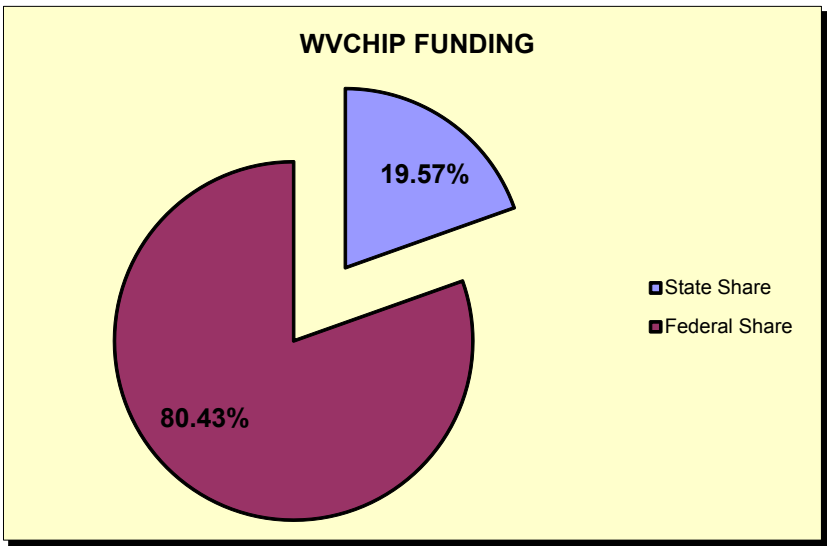
It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2013. This report was prepared by the Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented 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.

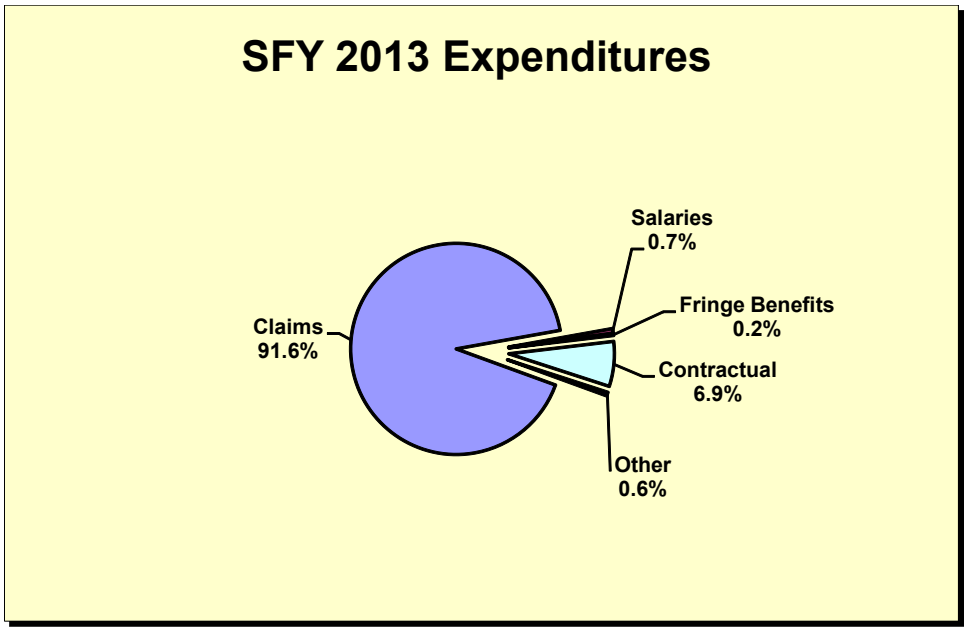
FINANCIAL PERFORMANCE AND OUTLOOK

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, 2013 were 80.43% federal share and 19.57% 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, 2013 confirms this requirement will be met through SFY 2020, assuming that state appropriations remain at the current level as SFY 2013, $9,987,312, and considering projected enrollment and program costs trends.

Based on estimated funding, enrollment, and costs, the June 30, 2013 Actuarial report projected no federal funding shortfalls for SFYs 2014 through 2020. All projections assume federal allotments will remain at the same level as the 2013 allotment, $48,275,692.



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. This increase means many children that are now income eligible for WVCHIP will transfer enrollment to Medicaid (currently estimated at around 9,000), 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.

INITIATIVES

This year was one of intensive management activity for WVCHIP in preparation for the full implementation of the Affordable Care Act (ACA). Continuing 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 ACA was another major focus and effort. More detail on both of these efforts can be found in the Management's Discussion and Analysis.

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 and members of the Legislature for their continued support of children's health care coverage. Gratitude is expressed to the members of WVCHIP's Board of Directors for their leadership and direction. Our most sincere appreciation is extended to Secretary Ross Taylor, whose leadership and support has helped the Agency embrace this year's challenges. Finally, this report would not have been possible without the dedication and effort of WVCHIP's Executive Director, Sharon L. Carte. Respectfully, we submit this Annual Report for the West Virginia Children's Health Insurance Program for the year ended June 30, 2013.

Sincerely,

Stacey L. Shamblin, MHA
Chief Financial Officer

Principal Officials

Earl Ray Tomblin, Governor
State of West Virginia

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

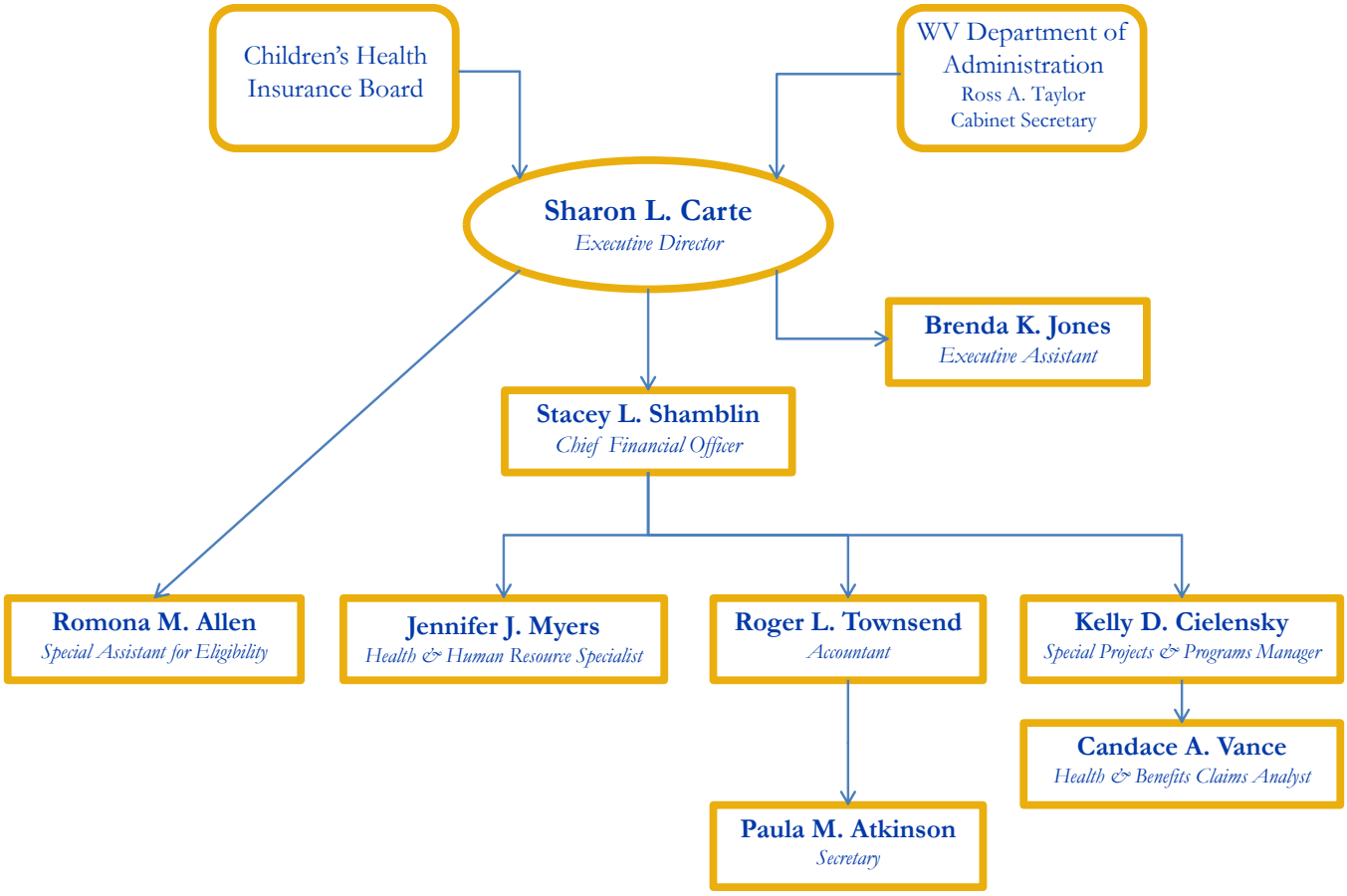
Board Members

Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Karen L. Bowling, Department of Health & Human Resources, Cabinet Secretary
The Honorable Ron Stollings, West Virginia Senate, Ex-Officio
The Honorable Don Perdue, West Virginia House of Delegates, Ex-Officio
Margie Hale, Citizen Member
Travis Hill, Citizen Member
Larry Hudson, Citizen Member
VACANT, 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
Jennifer J. Myers, Health & Human Resource Specialist
Stacey L. Shamblin, Chief Financial Officer
Roger L. Townsend, Accountant
Candace A. Vance, Health and Benefits Claims Analyst

Staff Organizational Chart



Financial Section

Over 150,000 children have now had the benefit of health care coverage in West Virginia since CHIP began.....

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM
For the Year Ended June 30, 2013

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, 2013. We encourage readers to consider this information in conjunction with the additional information that is furnished in the footnotes which are found following the financial statements. Please note that these financial statements are unaudited and for management purposes only.

HISTORY AND BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 on a cash basis for the state fiscal year and is located after the notes to the financial statements.

FINANCIAL HIGHLIGHTS

The following financial statements summarize the financial position and the results of operations for the years ended June 30, 2013 and 2012. (See pages 16 and 17.)

- Total assets increased approximately $1,083,869, or 6% in comparison to the previous year-end amount. This increase is primarily a result of higher ending balances of "Cash and Cash Equivalents" and the "Due From Other Funds" lines. The "Due From Other Funds" line represents the state share of costs to cover unpaid insurance claims liability and accounts payable.
- Total liabilities increased by approximately $1,488,983, or 29%, over last year. The majority of the increase is attributable to the increase in the estimate of Unpaid Insurance Claims Liability. In this section, Deferred Revenues reflect state general appropriations that have been "drawn-down" but not yet used to match with federal funds to pay program expenses.
- Total fund equity decreased approximately $405,115, or 3%, in comparison to the previous year end amount. The decrease is reflective of the reduction in general appropriation of state revenues to CHIP coupled with increases in the state share required to fund the program compared to the prior year.
- Total revenues reflect an 3% increase, around $1,918,663, when compared to the prior year. While federal and premium revenues increased, investment income decreased about 39% and state revenues remained flat.
- Medical, dental and prescription drug expenditures comprise approximately 92% of WVCHIP's total costs. These expenditures increased $1,144,881, or 2% compared to the prior year.
- Administrative costs accounted for 8% of overall expenditures. These expenditures increased approximately $629,043, or 16%. Expenditures under the multi-state quality grant (T-CHIC) are reflected in the outreach and health promotion line and are 100% federally funded. More detail on increases in administrative costs is included in the next section.

FINANCIAL ANALYSIS

Costs

A 2% trend in medical, dental, and prescription drug claims is much lower than the 8% 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: +1.0%
- Service Utilization: +1.3%
- Price/Fee Increases: -1.3%

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

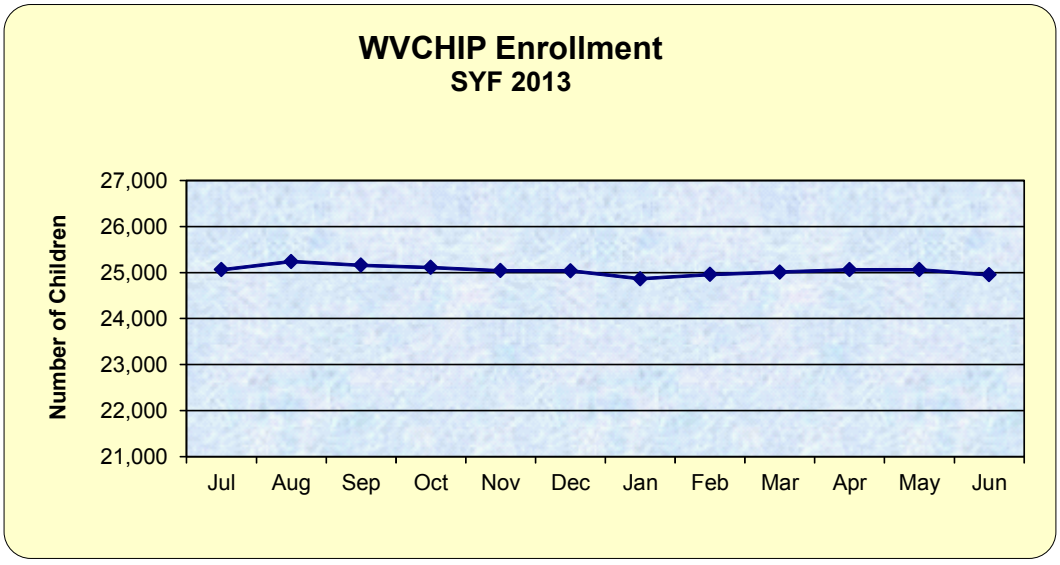
Enrollment

Monthly enrollment increased steadily during the year, with an overall increase in enrollment of 1.0% 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%	14,587	+0.5%
CHIP Blue (Phase III)	151% - 200%	8,337	-1.2%
WVCHIP Premium	201% - 300%	2,123	+15.2%

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 2013, enrollment increased to 2,168 members, a 15.2% increase over the prior year.



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 consistent with WVCHIP's experience during SFY 2013. 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 1.3% 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

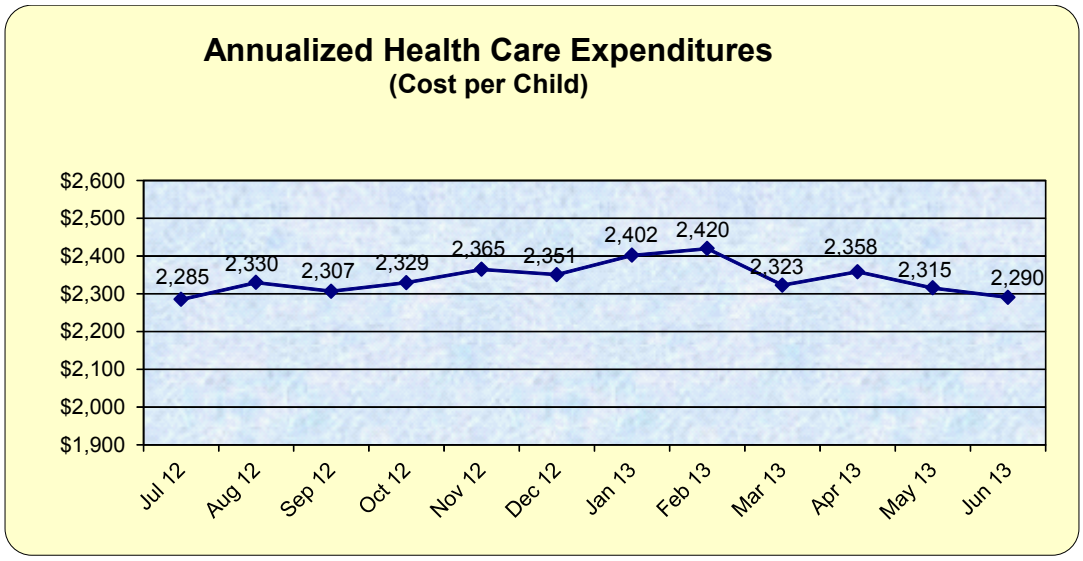
The amount WVCHIP pays providers for particular services is also determined by a number of factors; fee schedules adopted by the plan or rates negotiated with providers, whether the service is provided in West Virginia or outside the state; and service availability, among others. A combination of all these factors contributed to lower plan prices in SFY 2013. During State Fiscal Year 2013, prices decreased around 1.3%. The decrease in prices is a result of many factors, such as lower inflationary updates to fee schedules and also a slight shift in services provided in-state. Services provided out-of-state are typically double the cost of service provided in-state.

The average cost per claim for all medical and dental providers increased 2.4%, from $164 in SFY 2012 to $168 in SFY 2013. Costs to in-state service providers increased 3.3% during this time, from an average $150 in SFY 2012 to $155 in SFY 2013. For out-of-state providers, the average cost per claim decreased 5.1%, from $455 in SFY 2012 to $432 in SFY 2013. Utilization of out-of-state service providers increased slightly this fiscal year - 5.0% of all claims paid by WVCHIP were to out-of-state providers. This percentage was 4.7% during SFY 2012. The decrease in prices is reflected in the decreased the portion of WVCHIP dollars going out-of-state from 13.1% in SFY 2012 to 12.7% in SFY 2013.

WVCHIP has a very high generic drug utilization rate, 83.7% in SFY 2013, up from 78.8% in SFY 2012. While generic drugs cost much less than brand name drugs, the price for generic drugs increased 7.5% during this time, from $30.39 in SFY 2012 to $32.59 in SFY 2013, resulting in increased costs to the plan. It should be noted that during this same time brand drug costs increased 1.6%, from $187.64 in SFY 2012 to $209.58 in SFY 2013. 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 2013 was $2,290. 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 1.8% 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 increased 16% over the prior year. One category of administrative costs shows significant increases, Program Administration with 37%. The increase in Program Administration was mainly due to activities necessary to prepare WVCHIP for ACA, including changes to the Recipient Automated Payment and Information Data System (RAPIDS) and CHIP's enrollment system, as well as surveying WVCHIP parents regarding their awareness of ACA. Increases in administrative costs also reflect an audit of the Third-Party Administrator (TPA) and contractual increases in administration fees for TPA and PBM (Pharmacy Benefit Manager) services. It should be noted that the activities under WVCHIP's participation in a multi-state quality initiative with Oregon and Alaska (T-CHIC) are 100% federally funded and reflected in the Outreach & Health Promotion line. WVCHIP spent $892,980.90 on T-CHIC activities.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2013 and 2012
(Accrual Basis)

	June 30, 2013	June 30, 2012	Variance	
Assets:				
Cash & Cash Equivalents	$14,321,126	$13,698,457	$622,669	5%
Due From Federal Government	4,132,444	3,946,228	186,216	5%
Due From Other Funds	1,005,495	728,597	276,898	38%
Accrued Interest Receivable	6,823	10,149	(3,326)	-33%
Fixed Assets, at Historical Cost	95,744	94,332	1,412	1%
Total Assets	$19,561,632	$18,477,763	$1,083,869	6%
Liabilities:				
Accounts Payable	$ 186,160	$ 198,370	$ (12,210)	-6%
Deferred Revenue	1,482,369	1,330,608	151,761	11%
Unpaid Insurance Claims Liability	4,951,779	3,602,347	1,349,432	37%
Total Liabilities	$ 6,620,308	$ 5,131,325	$1,488,983	29%
Fund Equity	$12,941,324	$13,346,439	$(405,115)	-3%
Total Liabilities and Fund Equity	$19,561,632	$18,477,763	$1,083,869	6%

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, 2013 and June 30, 2012
(Modified Accrual Basis)

	June 30, 2013	June 30, 2012	Variance	
Revenues:				
Federal Grants	$47,256,492	$45,410,962	$1,845,530	4%
State Appropriations	10,925,578	10,925,514	64	0%
Premium Revenues	862,043	738,516	123,527	17%
Investment Income:				
Investment Earnings	78,432	128,890	(50,458)	-39%
Total Revenues	**$59,122,545**	**$57,203,882**	**$1,918,663**	**3%**
Expenditures:				
Claims:				
Outpatient Services	$15,078,062	$14,585,881	$492,181	3%
Physicians and Surgical	12,238,690	10,738,855	1,499,835	14%
Prescribed Drugs	9,554,564	10,584,175	(1,029,611)	-10%
Dental	8,262,262	7,825,136	437,126	6%
Inpatient Hospital Services	4,181,422	4,725,123	(543,701)	-12%
Outpatient Mental Health	1,637,170	1,550,096	87,074	6%
Durable & Disposable Equipment	1,198,865	1,345,606	(146,741)	-11%
Inpatient Mental Hospital	1,008,706	938,927	69,779	7%
Vision	834,924	806,448	28,476	4%
Therapy	752,243	650,288	101,955	16%
Medical Transportation	431,872	468,565	(36.693)	-8%
Other Services	145,148	170,702	(25,554)	-15%
Less Collections*	(439,783)	(650,537)	210,755	-32%
Total Claims	54,884,145	53,739,265	1,144,881	2%
General and Admin Expenses:				
Salaries and Benefits	562,452	497,454	64,998	13%
Program Administration	2,562,568	1,872,099	690,469	37%
Eligibility	392,340	387,310	5,030	1%
Outreach & Health Promotion	982,223	1,044,839	(62,616)	-6%
Current	160,013	228,851	(68,838)	-30%
Total Administrative	4,659,596	4,030,553	629,043	16%
Total Expenditures	**59,543,741**	**57,769,818**	**1,773,924**	**3%**
Excess of Revenues Over (Under) Expenditures	**(421,196)**	**(565,935)**	**144,739**	**-26%**
Unrealized Gain (loss) On Investments**	**16,081**	**(25,770)**	**41,851**	**-162%**
Fund Equity, Beginning	**13,346,439**	**13,938,145**	**(591,705)**	**-4%**
Fund Equity, Ending	**$12,941,324**	**$13,346,439**	**$(405,115)**	**-3%**

* 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, 2013

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, 2013, 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	$ 1,298,349	———	———
Investments			
	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$ 2,525,198	$2,525,198	Cash Liquidity
	$10,497,579	$10,497,579	Short Term Bond Pool
Total	$13,022,777		

Note 3

Accounts Payable:

PEIA Piggyback Contracts (TPA, PBM, etc.)	$ 133,925
DHHR & WVOT (Eligibility)	31,000
WV Community Voices	6,250
Other	14,985
Total Accounts Payable	$ 186,160

Note 4

Risk Management Unpaid Claims Liabilities

Claims Payable, Beginning of Year	$ 3,602,347
Incurred Claims Expense	54,992,148
Payments:	
Claim Payments for Current Year	49,201,627
Claim Payments for Prior Year	4,441,089
Claims payable, year to date	$ 4,951,779

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 2013
For the Twelve Months Ended June 30, 2013

	Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Actual Amt Jun-13	Actual Amt May-13	Actual Amt Apr-13
Projected Cost	$58,620,048	$58,620,048	$55,932,811	$2,687,237	5%	$4,885,004	$4,025,776	$5,222,950	$5,379,857
Premiums	1,166,599	1,166,599	$862,043	($304,556)	-26%	$97,217	68,764	71,981	75,372
Subrogation & Rebates	575,990	575,990	$439,783	(136,207)	-24%	$47,999	62,749	12,867	0
Net Benefit Cost	56,877,459	56,877,459	$54,630,985	$2,246,474	4%	$4,783,787	3,894,263	5,138,102	5,304,485
Salaries & Benefits	$580,500	$580,500	$562,452	$18,048	3%	$48,375	$50,169	$47,879	$45,993
Program Administration	4,223,273	4,223,273	$2,570,101	1,653,172	39%	$351,939	237,982	185,456	241,632
Eligibility	420,000	420,000	$396,541	23,459	6%	$35,000	105,234	2,125	93,718
Outreach & Health Prom.	1,000,000	1,000,000	$976,615	23,385	2%	$83,333	0	195,994	29,462
Current Expense	250,000	250,000	$166,097	83,903	34%	$20,833	14,865	18,001	10,147
Total Admin Cost	$6,473,773	$6,473,773	$4,671,806	$1,801,967	28%	$539,481	$408,250	$449,455	$420,952
Total Program Cost	$63,351,232	$63,351,232	$59,302,791	$4,048,441	6%	$5,323,269	$4,302,513	$5,587,557	$5,725,437
Federal Share 80.43%	51,206,801	51,206,801	$47,754,567	3,452,234	7%	4,302,798	3,460,511	4,494,072	4,604,969
State Share 19.57%	12,144,431	12,144,431	$11,548,223	596,208	5%	1,020,471	842,002	1,093,485	1,120,468
Total Program Cost *	$63,351,232	$63,351,232	$59,302,791	$4,048,441	6%	$5,323,269	$4,302,513	$5,587,557	$5,725,437

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2012 Report.

Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES

Planning and Implementation for Affordable Care Act

This year has been remarkable for numerous and intensive efforts by management as it prepares for full implementation of the Affordable Care Act starting in January 2014. WVCHIP has implemented a number of changes this past year in order to comply with the Affordable Care Act (ACA). Many planning and implementation activities took place this year, most notably:

- A survey of parents and other adults in CHIP member households to determine their potential interest and other related factors to enrolling health coverage through this State's federal/state Marketplace.
- Transitioning from the previous income eligibility determination methodology to one based on Modified Adjusted Gross Income (MAGI).
- Revising and aligning all CHIP-related eligibility groups with those of Medicaid for submission of technical State Plan Amendments related to eligibility determination.
- Reviewing and revising all electronic income verifications required to assure the single streamlined electronic application process.
- Eliminating the required waiting period during which a child must have had no other insurance prior to CHIP enrollment in order to assure no access barriers would exist for children between CHIP and Qualified Health Plan coverage.
- Redesigning the premium program to comply with regulations regarding premium collections and program enrollment.
- Planning for the transition of WVCHIP kids in families with incomes up to 133% FPL to the Medicaid program which helps to decrease the number of families which could have one child enrolled in CHIP and another on Medicaid.
- WVCHIP staff developed a guide for parents with children whose income was likely to make them eligible through tax credits to gain health coverage in the Marketplace. The guide was drafted in cooperation with the appropriate staff of WV Department of Health and Human Resources and the Offices of the Insurance Commissioner. A copy of this guide can be found online at http://www.chip.wv.gov/news/Pages/Starting-To-Shop-in-the-Marketplace-for-your-Health-Care-Coverage.aspx.

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 (lead state) and Alaska in the multi-state fourth 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 change their practice model to become person-centered or family-centered medical homes. This year's activity included:

- Each practice assessed readiness for Person-Centered Medical Home (PCMH) 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 of nine of the ten practices covering topics such as Self Management support skills; developing Quality Improvement programs, Motivational Interviewing, care coordination strategies and other medical home enhancement topics.
- Continued monthly "Virtual Practice" webinars.
- Continued quarterly meetings with the T-CHIC Advisory Council composed mostly of primary care practice physician champions.
- Evaluation of data gathered with PCMH-related tools such as the Consumer Assessment of Healthcare Providers, Clinic and Group Version (CAHPs, C&G) across all the grantee practices and states.
- An annual planning and evaluation conference hosted by West Virginia in Shepherdstown which was attended by grantee staff from all three states and physician staff from an area grantee practice and the T-CHIC Advisory Council.

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

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

Parent quotation from a response to a 2001 CHIP survey.

West Virginia Children's Health Insurance Program
Report of Independent Actuary
June 30, 2013 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 2013 ("FY 2013") through Fiscal Year 2020 ("FY 2020"). 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 $10,925,578 in FY 2013 and assumed to be $9,987,312 in FY 2014 and in future years. At the Federal level, the Federal funding for West Virginia is $48,275,692 in FY 2013 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, participants' premiums are assumed to remain the same as of March 23, 2010 for children in the 250% to 300% FPL group under the Affordable Care Act's Maintenance of Effort provision.

Under the Baseline Scenario, the projected cost of the CHIP Program in FY 2013 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 2020. And we are not projecting any deficits in the Federal funding through FY 2020 based on current approved funding levels under the assumption of Medicaid eligibility and an increase in Federal participation of the Patient Protection and Affordable Care Act ("PPACA").

It should also be noted that this projection reflects the current information on the availability of Federal funding. We have not assumed any future Federal redistributions for Fiscal Years 2003 through 2012 in this projection. The Federal share of program expenditure is currently at 80.43% for Federal Fiscal Year 2013 and 79.76% for Federal Fiscal Year 2014 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 is fairly constant with the last report, as of June 2013 has decreased slightly since March 2013. The current program enrollment as of June 2013 consists of 24,950 children total: 14,769 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"), 8,013 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 2,168 children as part of WVCHIP Premium.

WVCHIP Blue children are required to make co-payments as part of the benefit structure of the program. Since the March 31, 2013 Quarterly Report with March 2013 enrollment data, overall enrollment has decreased by 60 children. WVCHIP Gold has increased enrollment by 143 children, WVCHIP Blue has decreased enrollment by 213 children and WVCHIP Premium has increased enrollment by 10 children.

The monitoring and analysis of claim trends is critical to the accurate forecast of future costs of the program. While the program's enrollment has decreased in recent months, there has been some moderation of cost trends. Current claim trend experience has been financially favorable over the past several years with the notable exception of recent dental trends. Dental trends have increased due to higher reimbursement levels which became effective at the beginning of FY 2011. We have maintained the FY 2013 medical claim trend assumption of 8.5%, dental claim trend of 8% and prescription drugs claim trend assumption of 6% as assumed in the March 31, 2013 Quarterly Report, based on trend experience consistent with these assumptions.

Administrative expenses for West Virginia CHIP are $4,992,918 in FY 2013, representing a 23% increase over FY 2012 administrative expenses of $4,049,965. West Virginia CHIP management team assumes a 5% administrative expense trend in future years. In Fiscal Year 2013, reimbursement from subrogation was $97,185 and prescription drug rebates totaled $342,598. West Virginia CHIP management team assumes a 4% trend on drugs rebates and subrogation in future years.

Under the State fiscal year basis, we have calculated that the incurred claim costs under the Baseline Scenario assumptions for FY 2013 to be $55,070,767. The updated projection for FY 2014 claims is $49,193,667.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

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

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

While this forecast assumes Federal funding levels based on the FY 2013 allotment level, CHIPRA has several mechanisms to adjust Federal expenditures to levels required by the State programs. The Federal funds formula allows for re-basing of the allotment every two years, and there is a contingency fund established separate from the funds allotted to the State of West Virginia that will be used to offset any shortfalls it might experience in Federal funding.

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

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

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

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

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

PLAN ELIGIBILITY AND BENEFIT STRUCTURE

Under the submitted West Virginia CHIP Premium expansion plan ("WVCHIP Premium"), the CHIP expansion to 220% began enrollment effective in January 2007. Subsequently, WVCHIP Premium was expanded to 250% FPL effective in January 2009 and to 300% FPL effective in July 2011. Premiums are assumed to cover 20% of the policy cost for children in the 200% to 300% FPL eligibility group. The monthly premiums are $35 for families with one child in the program and $71 for families with more than one child in the program. We have assumed the same premium level as of March 23, 2010 in all projection years to maintain the 20% cost share threshold in the 200% to 300% FPL group. As of June 2013, there are 2,168 children enrolled in WVCHIP Premium.

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

Effective January 1, 2014, Medicaid eligibility will expand to individuals and families with income up to 133% FPL. We have assumed that approximately 10,800 children in WVCHIP Gold will move to Medicaid under the HCR Bill. At the same time, a projection of 2,800 children will be moving to the CHIP Program due to the MAGI conversion change.

CCRC Actuaries has teamed up with Dr. Jonathan Gruber of Massachusetts Institute of Technology ("MIT") who performed the economic analysis, and Mike Madalena who assisted in data management, manipulation and analysis, to perform various actuarial and economic analyses for The West Virginia Offices of the Insurance Commissioner ("WVOIC") with regard to the West Virginia Health Marketplace ("The Marketplace") as defined by the PPACA. This report assumes migration assumptions that are consistent with The Marketplace report dated June 24, 2013. Overall, we are projecting that CHIP enrollment will decrease by approximately 9,370 to 16,000 children on January 1, 2014.

The CHIP Program will serve the remaining children up to 300% FPL, with the potential for additional members whose parents have applied for coverage through the Health Insurance Exchanges program. In addition, the Health Care Reform ("HCR") Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016.

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

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

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

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

Medical costs have been adjusted to reflect the expense of the "Birth to Three" program, administered by 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 2013 and beyond.

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

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

In addition, this report includes the following anticipated costs from CHIPRA requirements and the FY 2013 State Plan Amendment:

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

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

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

- Addition of the vision benefit for WV CHIP Premium members.

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

PLAN ENROLLMENT

We have updated our projection based on the enrollment through June 2013. WVCHIP Gold enrollment has increased in recent months. The program had enrollment at the end of FY 2012 of 25,114 children, with 14,241 under WVCHIP Gold, 8,691 under WVCHIP Blue, and 2,182 under WVCHIP Premium. Current enrollment as of June 2013 is 24,950 children, with 14,769 under WVCHIP Gold, 8,013 under WVCHIP Blue, and 2,168 under WVCHIP Premium.

It is noteworthy that WVCHIP Premium enrollment has been higher than our projected levels made at the implementation of this component of the Program. Based on our observation of the historical WVCHIP Premium enrollment increase, we are changing the original growth assumptions from 38 to 60 new enrollees per month, combined with actual WVCHIP Premium enrollment through June 2013, and we will continue to monitor the projected enrollment by actual results and make adjustments as necessary.

The following table summarizes the FY 2012 to FY 2013 enrollment information using end of month enrollment information by WVCHIP Gold, WVCHIP Blue, WVCHIP Premium and in total:

Date	WVCHIP Gold	WVCHIP Blue	WVCHIP Premium	Total	Annual % Growth
Jun-03	14,243	7,554		21,797	8.8%
Jun-04	15,015	8,417		23,432	7.5%
Jun-05	15,571	8,944		24,515	4.6%
Jun-06	15,907	8,928		24,835	1.3%
Jun-07	15,658	9,181	100	24,939	0.4%
Jun-08	15,227	8,902	289	24,418	-2.1%
Jun-09	14,727	9,164	664	24,555	0.6%
Jun-10	15,385	8,381	1,058	24,824	1.1%
Jun-11	14,649	8,505	1,386	24,540	-2.1%
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%
Jul-12	14,354	8,595	2,113	25,062	3.0%
Aug-12	14,573	8,571	2,096	25,240	2.9%
Sep-12	14,646	8,467	2,046	25,159	2.1%
Oct-12	14,507	8,486	2,115	25,108	1.8%
Nov-12	14,557	8,395	2,089	25,041	0.8%
Dec-12	14,548	8,353	2,134	25,035	0.6%
Jan-13	14,431	8,328	2,103	24,862	-0.3%
Feb-13	14,598	8,251	2,109	24,958	1.2%
Mar-13	14,626	8,226	2,158	25,010	0.5%
Apr-13	14,688	8,208	2,164	25,060	0.2%
May-13	14,741	8,145	2,176	25,062	-0.2%
Jun-13	14,769	8,013	2,168	24,950	-0.7%

The tables below summarize the projected fiscal year June 30th ending enrollment assumptions for Baseline Scenario, by WVCHIP Gold & Blue, and WVCHIP Premium. Effective January 1, 2014, we have assumed that a net of approximately 9,370 children in WVCHIP Gold will move to Medicaid under the HCR Bill after the MAGI conversion and the migration assumptions that are consistent with The Marketplace report.

Baseline Scenario (300% FPL)

Ending Enrollment	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020
WVCHIP Gold & Blue	22,782	13,412	13,412	13,412	13,412	13,412	13,412	13,412
WVCHIP Premium	2,168	2,888	3,248	3,248	3,248	3,248	3,248	3,248
Total	24,950	16,300	16,660	16,660	16,660	16,660	16,660	16,660

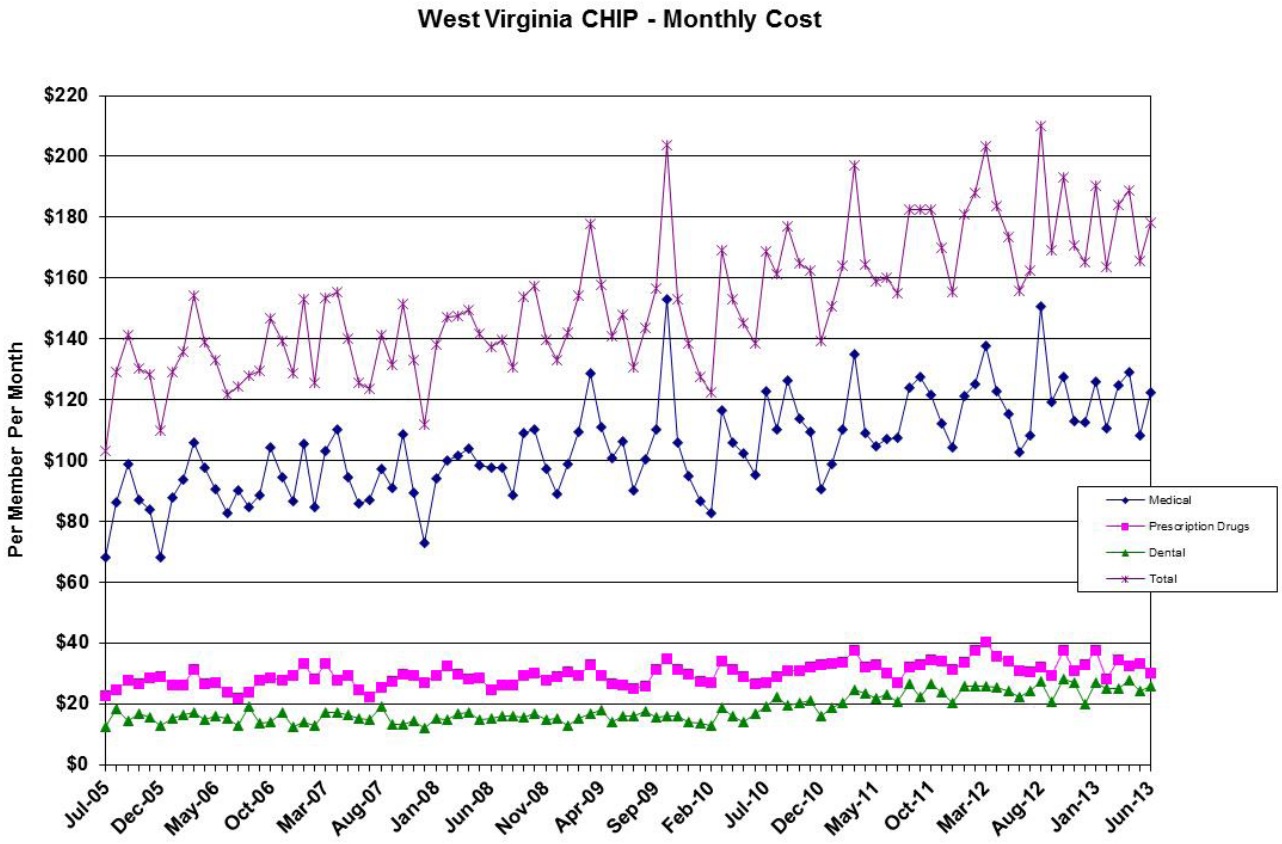
CLAIM COST AND TREND ANALYSIS

The plan has experienced favorable claim experience with overall 12-month trend of 1.3%. We have continued to utilize the medical, dental and prescription drugs trend assumptions from the March 31, 2013 Quarterly Report. The 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 experience remains favorable compared to our trend assumptions for each trend component. The table below summarizes WV CHIP experience over the last six months, nine months and twelve months as of June 30, 2013. Overall trend experience has been favorable, with a composite trend of 1.3% over the last twelve months. Note that Prescription Drugs trends are gross of prescription drug rebates received from Express Scripts and Bayer.

Trend Period	Six Months	Nine Months	Twelve Months
Medical	-0.5%	1.0%	2.1%
Dental	3.5%	4.4%	4.2%
Prescription Drugs	-7.7%	-4.7%	-3.6%
Composite	-1.3%	0.4%	1.3%

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 2013. 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, State funding is $10,925,578 in FY 2013, and we have assumed that State funding to be $9,987,312 in FY 2014 and in future years. At the Federal level, the Federal funding for West Virginia is $48,275,692 in FY 2013, and we have assumed that Federal funding remains constant in the future.

The updated incurred claims for FY 2013 is $55,070,767 based on the fiscal year 2013 average enrollment of 25,046 children and the incurred claim per member per month cost data assumption of $183.24, as summarized in the following table.

Category	Current Report FY2013 Baseline Incurred Claims	Current Report FY2013 Baseline Per Member Per Month	3/31/13 Report FY2013 Baseline Per Member Per Month	12/31/12 Report FY2013 Baseline Per Member Per Month
Medical	$37,714,267	$125.49	$125.41	$136.20
Prescription Drugs	9,779,355	32.54	33.68	34.62
Dental	7,577,145	25.21	24.75	25.69
Total	$55,070,767	$183.24	$183.84	$196.50

The Baseline Scenario financial forecast for the Federal and State fiscal years 2013 through 2020 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 2020.

At the Federal level, we are not projecting the Federal funding shortfall through FY 2020 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 2011 to 2013. IBNR projections have been higher to reflect current claim backlog experience in recent months.

STATEMENT OF ACTUARIAL OPINION

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

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

In my opinion, all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the future fiscal years 2013 through 2020 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 2013 through FY 2020 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 15, 2013

Chris Borcik
Fellow of the Society of Actuaries
Member of the American Academy of Actuaries
Senior Actuarial Consultant
CCRC Actuaries, LLC
Reisterstown, Maryland
July 15, 2013

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2013 Quarterly Report

Baseline Scenario - 300% FPL

Available Funding - Beginning of the Year	2013	2014	2015	2016	2017	2018	2019	2020
Federal 2012	$32,590,658	$0	$0	$0	$0	$0	$0	$0
Federal 2013	48,275,692	33,498,996	0	0	0	0	0	0
Federal 2014	0	48,275,692	40,786,022	5,168,271	0	0	0	0
Federal 2015	0	0	48,275,692	48,275,692	7,612,506	0	0	0
Federal 2016	0	0	0	48,275,692	48,275,692	3,771,275	0	0
Federal 2017	0	0	0	0	48,275,692	48,275,692	0	0
Federal 2018	0	0	0	0	0	48,275,692	44,073,829	0
Federal 2019	0	0	0	0	0	0	48,275,692	31,634,514
Federal 2020	0	0	0	0	0	0	0	48,275,692
State 2011	$2,860,818	$0	$0	$0	$0	$0	$0	$0
State 2012	10,925,514	2,466,810	0	0	0	0	0	0
State 2013	10,925,578	10,925,578	3,224,234	0	0	0	0	0
State 2014	0	9,987,312	9,987,312	4,297,656	1,848,042	1,848,042	1,848,042	1,848,042
State 2015	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2016	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2017	0	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312
State 2018	0	0	0	0	0	9,987,312	9,987,312	9,987,312
State 2019	0	0	0	0	0	0	9,987,312	9,987,312
State 2020	0	0	0	0	0	0	0	9,987,312

Program Costs	2013	2014	2015	2016	2017	2018	2019	2020
WVCHIP Gold & Blue & Premium								
Medical Expenses	$37,714,267	$33,208,694	$27,618,587	$29,966,166	$32,513,291	$35,276,920	$38,275,458	$41,528,872
Prescription Drugs Expenses	9,779,355	8,412,643	6,835,310	7,245,429	7,680,155	8,140,964	8,629,422	9,147,187
Dental Expenses	7,577,145	6,641,188	5,497,806	5,937,631	6,412,641	6,925,653	7,479,705	8,078,081
Administrative Expenses	4,443,238	2,746,569	2,883,898	3,028,092	3,179,497	3,338,472	3,505,395	3,680,665
WVCHIP New Premium								
Medical Expenses	$0	$633,390	$1,770,935	$2,064,858	$2,240,371	$2,430,802	$2,637,420	$2,861,601
Prescription Drugs Expenses	0	171,323	467,975	533,072	565,057	598,960	634,898	672,992
Dental Expenses	0	126,429	351,861	408,369	441,038	476,321	514,427	$555,581
Administrative Expenses	549,680	768,843	907,916	953,312	1,000,977	1,051,026	1,103,578	$1,158,756
Total Program Costs								
Medical Expenses	$37,714,267	$33,842,085	$29,389,522	$32,031,024	$34,753,661	$37,707,722	$40,912,879	$44,390,474
Prescription Drugs Expenses	9,779,355	8,583,966	7,303,285	7,778,501	8,245,211	8,739,924	9,264,320	9,820,179
Dental Expenses	7,577,145	6,767,617	5,849,667	6,346,000	6,853,680	7,401,974	7,994,132	8,633,662
Administrative Expenses	4,992,918	3,515,412	3,791,813	3,981,404	4,180,474	4,389,498	4,608,973	4,839,422
Premiums (WVCHIP Premium)	$804,389	$969,397	$1,202,462	$1,230,885	$1,230,885	$1,230,885	$1,230,885	$1,230,885
Program Revenues - Interest	$132,637	$125,487	$124,516	$130,278	$170,735	$224,341	$277,946	$331,551
Program Revenues - Drugs Rebates	439,783	457,374	475,669	494,696	514,484	535,063	556,466	578,725
Net Incurred Program Costs Excluding Interest	$58,819,513	$51,282,307	$44,656,157	$48,411,349	$52,287,658	$56,473,171	$60,992,953	$65,874,127
Net Paid Program Costs	59,169,513	51,775,307	45,214,157	48,108,349	51,977,658	56,138,171	60,629,953	65,482,127
Federal Share	$47,367,354	$40,988,666	$35,617,751	$45,831,457	$52,116,923	$56,248,830	$60,715,007	$65,542,575
State Share of Expenses - Net of Interest	11,319,522	10,168,154	8,913,890	2,449,614	0	0	0	0
Beginning IBNR	$4,970,000	$4,620,000	$4,127,000	$3,569,000	$3,872,000	$4,182,000	$4,517,000	$4,880,000
Ending IBNR	4,620,000	4,127,000	3,569,000	3,872,000	4,182,000	4,517,000	4,880,000	5,272,000

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2013 Quarterly Report

Baseline Scenario - 300% FPL

Funding Sources - End of the Year	2013	2014	2015	2016	2017	2018	2019	2020
Federal 2012	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2013	33,498,996	0	0	0	0	0	0	0
Federal 2014	0	40,786,022	5,168,271	0	0	0	0	0
Federal 2015	0	0	48,275,692	7,612,506	0	0	0	0
Federal 2016	0	0	0	48,275,692	3,771,275	0	0	0
Federal 2017	0	0	0	0	48,275,692	0	0	0
Federal 2018	0	0	0	0	0	44,073,829	0	0
Federal 2019	0	0	0	0	0	0	31,634,514	0
Federal 2020	0	0	0	0	0	0	0	14,367,631
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State 2011	$0	$0	$0	$0	$0	$0	$0	$0
State 2012	2,466,810	0	0	0	0	0	0	0
State 2013	10,925,578	3,224,234	0	0	0	0	0	0
State 2014	0	9,987,312	4,297,656	1,848,042	1,848,042	1,848,042	1,848,042	1,848,042
State 2015	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2016	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312	9,987,312
State 2017	0	0	0	0	9,987,312	9,987,312	9,987,312	9,987,312
State 2018	0	0	0	0	0	9,987,312	9,987,312	9,987,312
State 2019	0	0	0	0	0	0	9,987,312	9,987,312
State 2020	0	0	0	0	0	0	0	9,987,312
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State Shortfall – 90% Funding Requirement	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***

CCRC Actuaries, LLC

415 Main Street
Reisterstown, MD 21136

Email: info@ccrcactuaries.com

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

November 21, 2013

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 2013. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2014 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 2020 based on the assumption that future funding remains constant. After the September 30, 2013 Quarterly Report was issued in October 2013, several changes have occurred in the program:

- Enrollment for the CHIP Program has increased slightly from 24,950 in June 2013 to 24,990 as of October 2013.

- October 2013 claim experience showed the projected incurred FY 2014 expenditures to be $45,949,211, a decrease of $92,730 from $ 46,041,941 in the September 30, 2013 Quarterly Report.

- The categories of FY 2014 medical, dental and prescription drug expenses in the current claim experience through October 2013 showed favorable experience over the September 30, 2013 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2014 is now projected to be $187.36, down from the projected $188.94 PMPM cost in the September 30, 2013 Quarterly Report.

- Medical PMPM for Fiscal Year 2014 is now projected to be $128.60, down from the projected $129.28 PMPM cost in the September 30, 2013 Quarterly Report.

- Dental PMPM for Fiscal Year 2014 is now projected to be $25.67, down from the projected $25.87 PMPM cost in the September 30, 2013 Quarterly Report.

- Prescription Drugs PMPM for Fiscal Year 2014 is now projected to be $33.09, down from the projected $33.78 PMPM cost in the September 30, 2013 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 43)* 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 helps access electronic applications, answer questions, and actively guide an applicant through the process.

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

WVCHIP Premium Survey and Reaching Out to CHIP Parents

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

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

Health Collaborative Efforts

Collaborations are important to allow multiple agencies and entities inside and outside state government to integrate efforts related to a statewide mission for the health of West Virginia's children. WVCHIP prioritizes prevention efforts to support our State's Healthy People 2010 objectives for children.

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

- ★ Continued participation in efforts to promote healthy lifestyles with the 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 the spring of 2013, WVCHIP planned and participated in the spring retreat of the United Methodist Women to inform them about key issues in oral health and to provide training and technical assistance enabling them to survey lower income families on oral health issues.

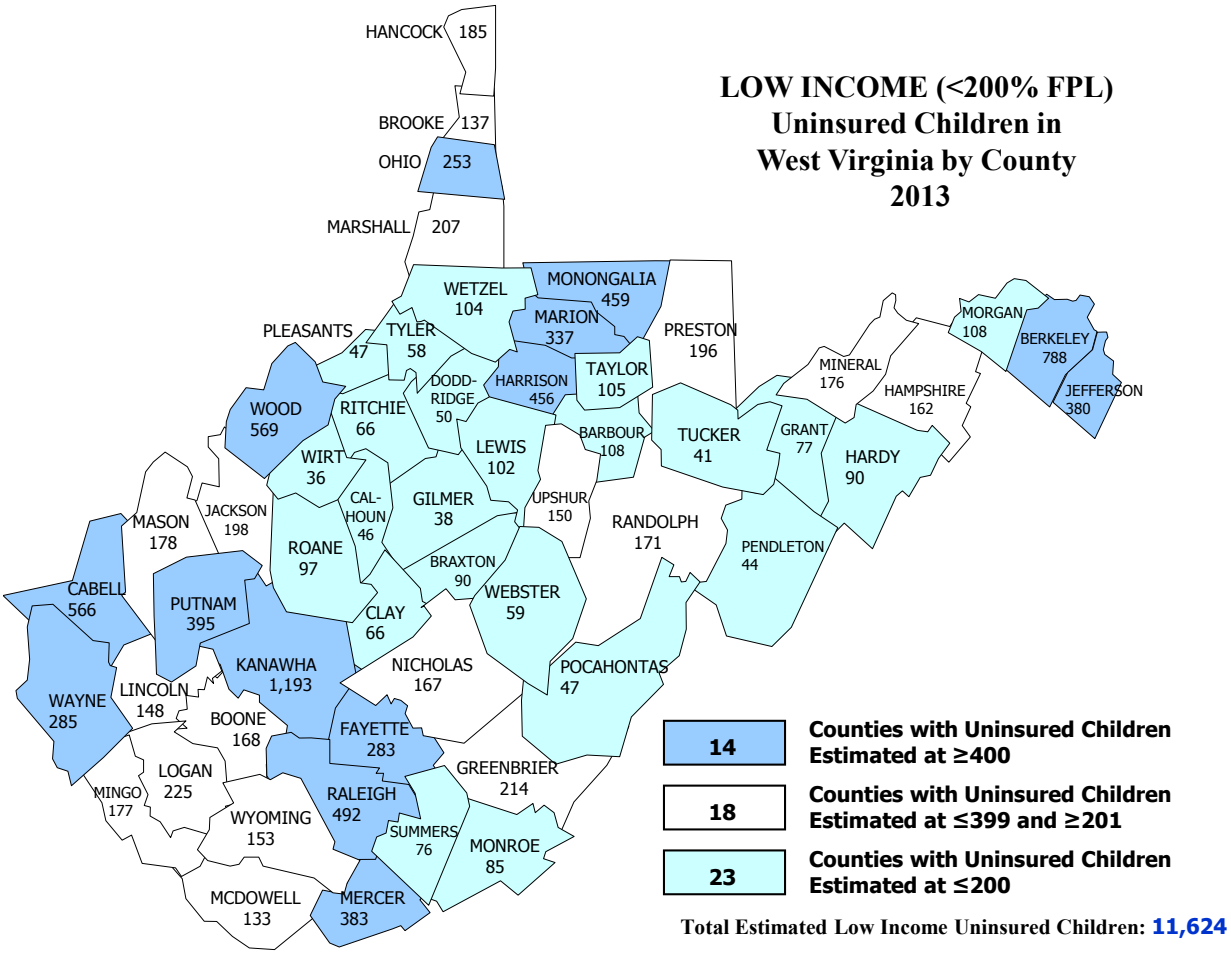
- ★ Recognizing some children's health coverage is jeopardized when parents lose employer coverage due to workforce reductions, WVCHIP continued to support dislocated workers this year. Staff members or outreach partners were on hand as part of teams to provide CHIP information at sessions throughout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

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

- ★ WVCHIP was a sponsor of the West Virginia Perinatal Partnership, a group of health care practitioners seeking to drive quality improvement for women in pregnancy and birth outcomes for newborns. Under the auspices of the Partnership, WVCHIP and the Benedum Foundation sponsored a review of the status of developmental screening for preschool in West Virginia. A report was to be published in next fiscal year on the findings.

- ★ As part of its strategy to target teens, WVCHIP was a sponsor of the state high school basketball tournament that provided information about the CHIP program through a listing and radio spots in the tournament program.

Targeted Outreach For Uninsured Children



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

Statistical Section

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

Parent quotation from a response to a 2001 CHIP survey.

All statistics are for the fiscal year ended June 30, 2013, unless noted otherwise.

Table 1: Enrollment

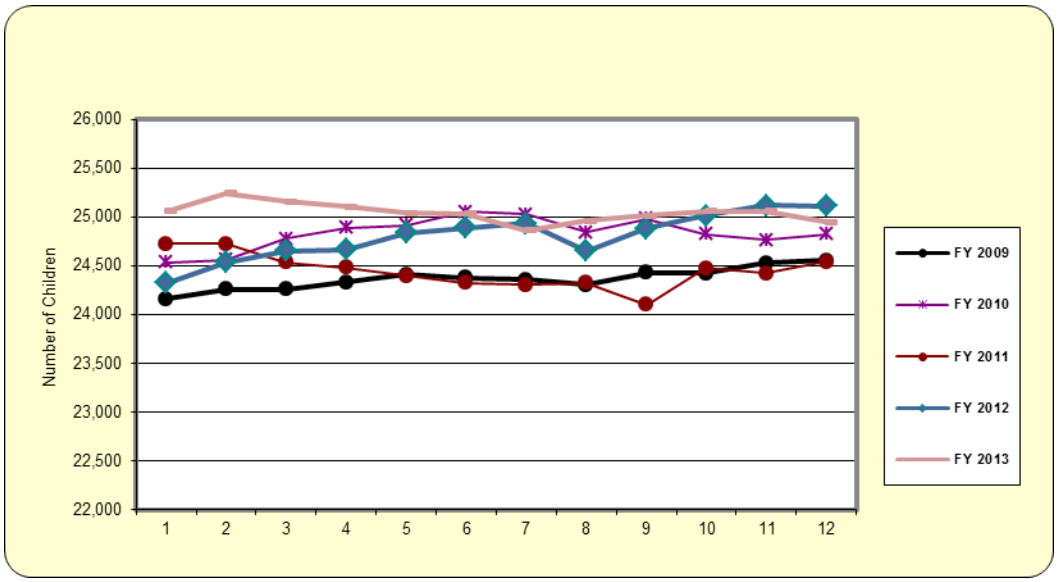
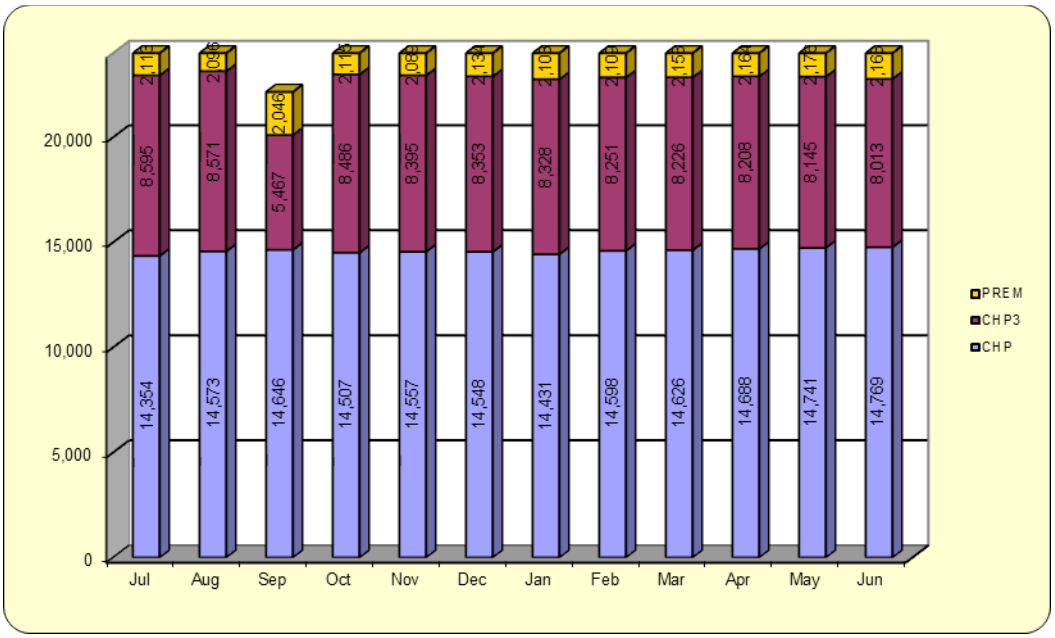
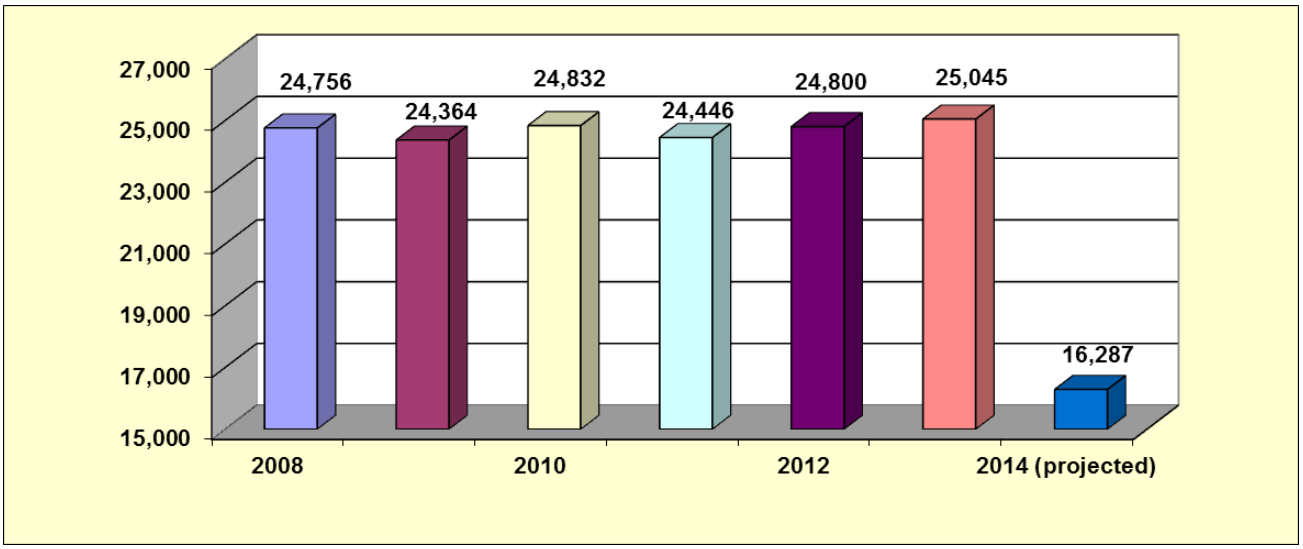


Table 2: Enrollment Detail



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

Table 3: Average Enrollment
SFY 2007 - 2014



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

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

Total unduplicated number of children ever enrolled as of June 30, 2013 in WVCHIP since inception:
150,815

Table 4: Enrollment By Gender

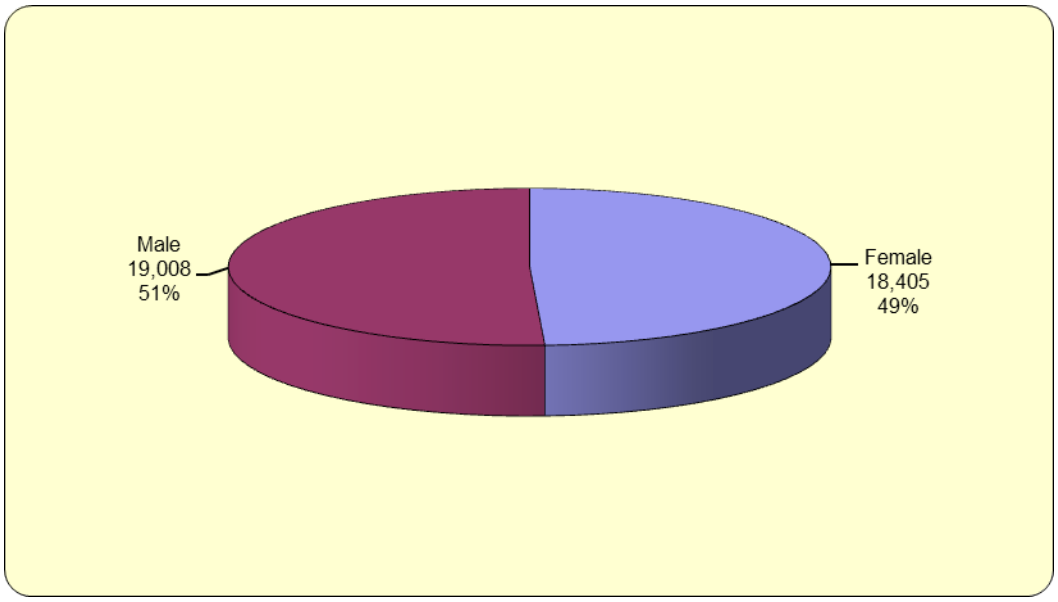


Table 5: Enrollment By Age

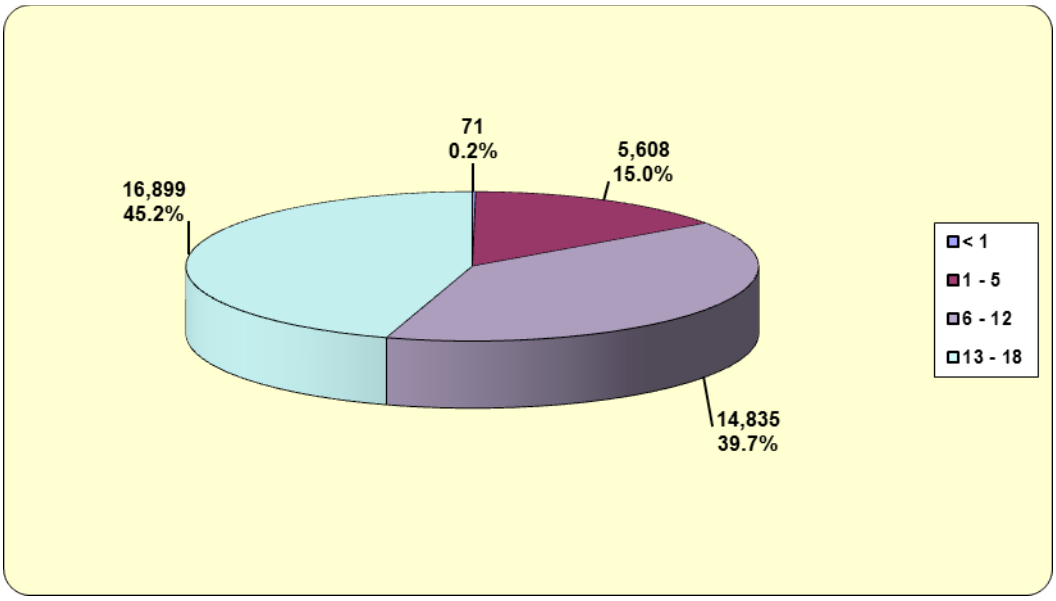
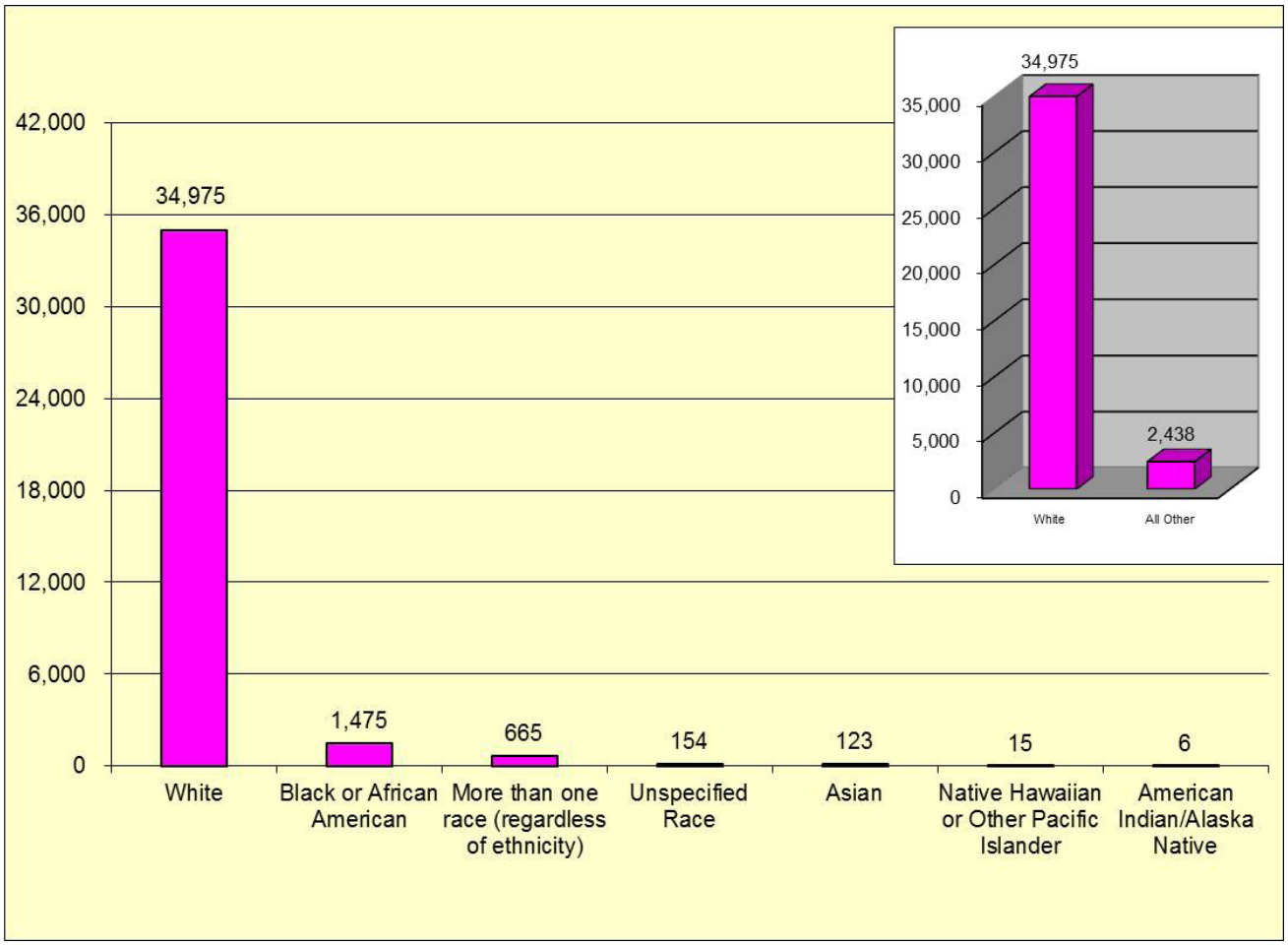
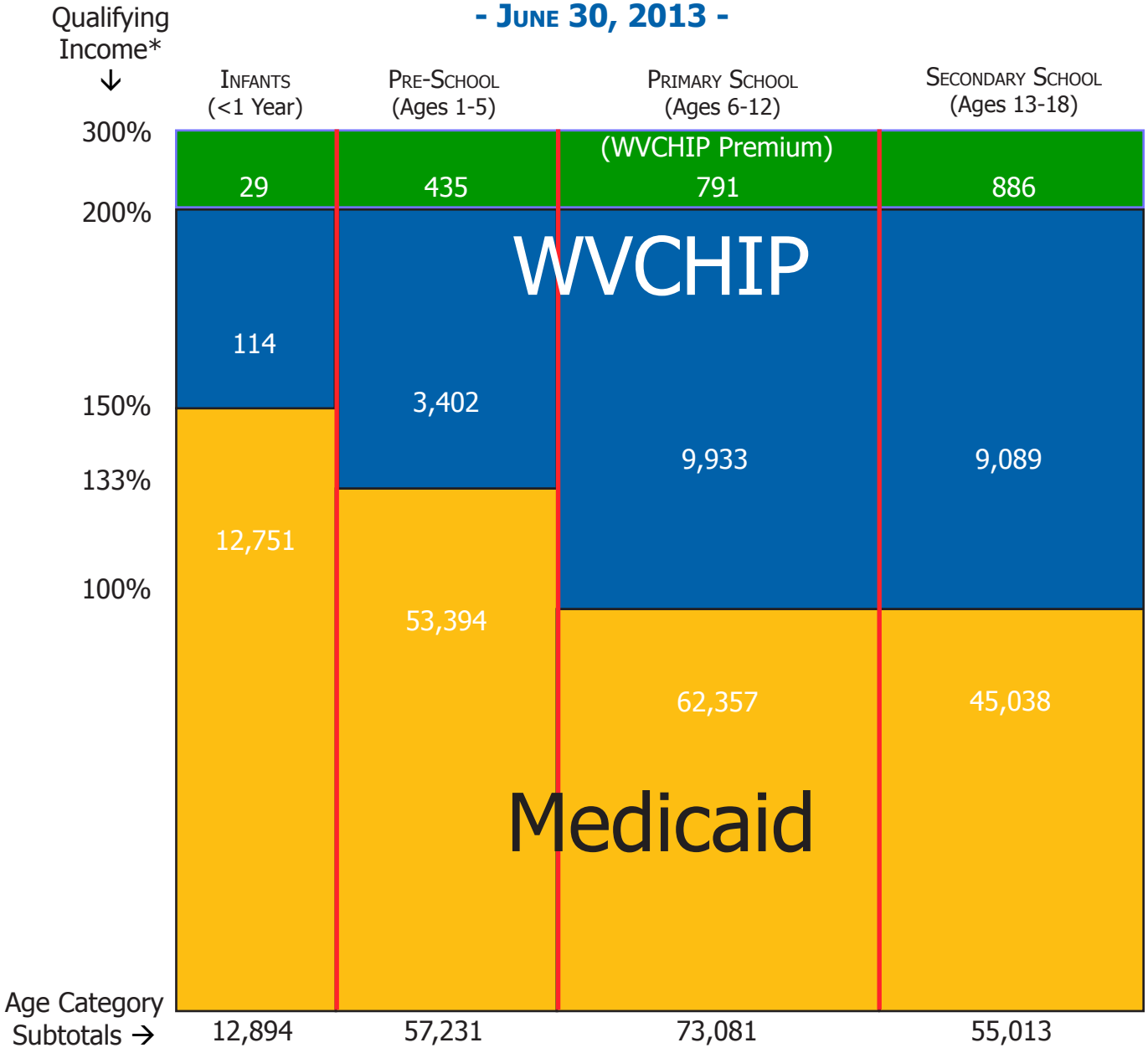


Table 6: Enrollment By Race/Ethnicity



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	34,975	93.5%	401,761	93.9%
Black or African American	1,475	3.9%	14,535	3.4%
More than one race (regardless of ethnicity)	665	1.8%	6,412	1.5%
Unspecified Race	154	0.4%	1,282	0.3%
Asian	123	0.3%	2,992	0.7%
Native Hawaiian or Other Pacific Islander	15	0.0%	85	0.0%
American Indian/Alaska Native	6	0.0%	855	0.2%
Total	**37,413**	**100.0%**	**427,924**	**100.0%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2013 -



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

Total WVCHIP Enrollment **24,679** **Total WV Medicaid Enrollment** **173,540**

Total # of Children Covered by WVCHIP and Medicaid - 198,219

Table 8: Annual Re-Enrollment and Non-Responses Upon Renewal
July 2012 through June 2013

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
Wyoming	303	88	35	39.8%	44	14.5%
Hardy	146	40	14	35.0%	22	15.1%
Summers	153	47	17	36.2%	25	16.3%
Pendleton	103	25	3	12.0%	17	16.5%
Webster	113	35	6	17.1%	19	16.8%
Calhoun	96	32	11	34.4%	17	17.7%
Doddridge	116	47	21	44.7%	22	19.0%
Gilmer	67	21	5	23.8%	13	19.4%
Ohio	428	137	29	21.2%	86	20.1%
Grant	187	62	21	33.9%	38	20.3%
Marshall	289	82	16	19.5%	60	20.8%
Upshur	311	103	18	17.5%	66	21.2%
Pocahontas	127	44	17	38.6%	27	21.3%
Raleigh	1,040	303	46	15.2%	224	21.5%
Clay	133	46	10	21.7%	29	21.8%
Morgan	243	84	25	29.8%	53	21.8%
Tucker	110	28	4	14.3%	24	21.8%
Wood	1,023	362	77	21.3%	228	22.3%
Roane	278	88	10	11.4%	62	22.3%
Jefferson	402	130	24	18.5%	90	22.4%
Greenbrier	507	191	54	28.3%	114	22.5%
Mason	242	82	8	9.8%	55	22.7%
Putnam	647	235	44	18.7%	149	23.0%
Taylor	165	78	21	26.9%	38	23.0%
Mercer	281	96	18	18.8%	65	23.1%
Nicholas	311	114	30	26.3%	72	23.2%
Braxton	185	63	13	20.6%	43	23.2%
Brooke	240	77	15	19.5%	56	23.3%
Randolph	406	125	18	14.4%	95	23.4%
Preston	404	115	12	10.4%	95	23.5%
Mingo	645	216	39	18.1%	152	23.6%
Hancock	318	116	16	13.8%	75	23.6%
Pleasants	93	32	9	28.1%	22	23.7%
Wetzel	196	67	16	23.9%	47	24.0%
Monongalia	198	76	21	27.6%	48	24.2%
Wirt	74	24	4	16.7%	18	24.3%
Berkeley	1,170	450	83	18.4%	285	24.4%
Lincoln	276	125	40	32.0%	68	24.6%
Barbour	239	78	15	19.2%	61	25.5%
Marion	582	202	25	12.4%	150	25.8%
Monroe	232	75	9	12.0%	60	25.9%
Mineral	312	110	20	18.2%	82	26.3%
Harrison	787	299	49	16.4%	209	26.6%
Lewis	217	89	17	19.1%	58	26.7%
Ritchie	114	55	16	29.1%	31	27.2%
Jackson	360	146	30	20.5%	99	27.5%
McDowell	955	401	104	25.9%	263	27.5%
Kanawha	1,933	895	238	26.6%	533	27.6%
Cabell	848	393	90	22.9%	247	29.1%
Wayne	471	229	48	21.0%	138	29.3%
Boone	252	109	20	18.3%	74	29.4%
Logan	429	191	32	16.8%	127	29.6%
Hampshire	269	114	24	21.1%	80	29.7%
Tyler	98	38	6	15.8%	30	30.6%
Fayette	691	351	68	19.4%	241	34.9%
Totals	**20,815**	**7,861**	**1,681**	**21.4%**	**5,146**	**24.7%**
12-Mo. Ave.		***655***	***140***	***21.4%***	***429***	***24.7%***

Median

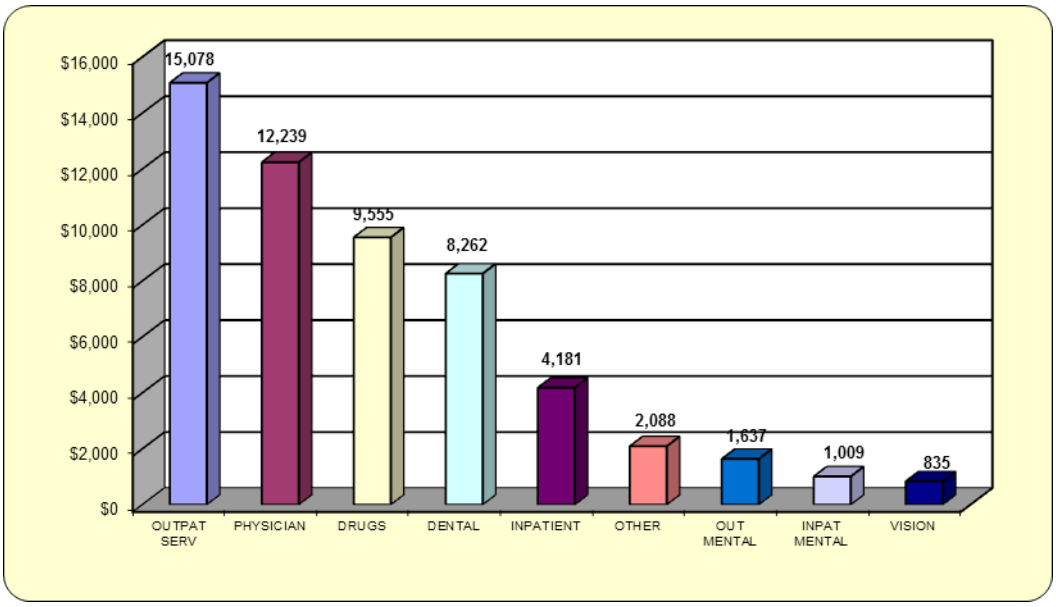
Table 9: Enrollment Changes By County
As % Difference from July 2012 through June 2013

County	Total Enrollees July 2012	Total Enrollees June 2013	Difference	% Change	
Lincoln	314	376	62	16%	
Jefferson	488	555	67	12%	
Hardy	175	196	21	11%	
Pleasants	114	124	10	8%	
Calhoun	120	130	10	8%	
Randolph	489	529	40	8%	
Boone	304	327	23	7%	
Braxton	216	231	15	6%	
Gilmer	72	77	5	6%	
Doddridge	138	146	8	5%	
Wetzel	230	243	13	5%	
Taylor	214	225	11	5%	
Wyoming	393	411	18	4%	
Nicholas	387	403	16	4%	
Kanawha	2,301	2,387	86	4%	
Marshall	348	361	13	4%	
Clay	190	196	6	3%	
Webster	150	154	4	3%	
Mingo	383	392	9	2%	
Upshur	387	396	9	2%	
Harrison	929	947	18	2%	
Pendleton	120	122	2	2%	
Monroe	225	228	3	1%	
Berkeley	1,381	1,395	14	1%	
Jackson	431	434	3	1%	
Tucker	135	135	0	0%	
Marion	692	691	-1	0%	**Median**
Raleigh	1,269	1,261	-8	-1%	
Putnam	778	772	-6	-1%	
Greenbrier	612	606	-6	-1%	
Monongalia	799	790	-9	-1%	
Grant	205	202	-3	-1%	
Logan	519	510	-9	-2%	
Hancock	388	380	-8	-2%	
Wayne	518	507	-11	-2%	
Pocahontas	157	153	-4	-3%	
Preston	489	475	-14	-3%	
Barbour	283	274	-9	-3%	
Cabell	1,029	991	-38	-4%	
Ohio	510	491	-19	-4%	
Roane	315	302	-13	-4%	
Wirt	94	90	-4	-4%	
Brooke	281	267	-14	-5%	
Fayette	823	777	-46	-6%	
Summers	210	198	-12	-6%	
Mason	300	282	-18	-6%	
Mercer	1,165	1,093	-72	-7%	
Morgan	272	253	-19	-8%	
Wood	1,229	1,131	-98	-9%	
McDowell	308	283	-25	-9%	
Mineral	312	284	-28	-10%	
Hampshire	319	286	-33	-12%	
Ritchie	144	129	-15	-12%	
Lewis	282	245	-37	-15%	
Tyler	126	107	-19	-18%	
Totals	**25,062**	**24,950**	**-112**	**0%**	
12-Mo. Ave.		***24,800***	***-9***	***0%***	

Table 10: Enrollment Changes By County
As % of Children Never Before Enrolled from July 2012 through June 2013

County	Total Enrollees July 2012	Total Enrollees June 2013	New Enrollees Never in Program	New Enrollees As % of June 2013	
Hardy	175	196	85	43%	
Hancock	388	380	154	41%	
Jefferson	488	555	214	39%	
Wetzel	230	243	85	35%	
Webster	150	154	53	34%	
Marshall	348	361	123	34%	
Harrison	929	947	320	34%	
Mason	300	282	94	33%	
Cabell	1,029	991	323	33%	
Berkeley	1,381	1,395	450	32%	
Brooke	281	267	85	32%	
Ritchie	144	129	40	31%	
Raleigh	1,269	1,261	390	31%	
Monongalia	799	790	236	30%	
Lewis	282	245	73	30%	
Taylor	214	225	67	30%	
Morgan	272	253	75	30%	
Jackson	431	434	128	29%	
Kanawha	2,301	2,387	698	29%	
Wayne	518	507	147	29%	
Upshur	387	396	114	29%	
Wood	1,229	1,131	323	29%	
Nicholas	387	403	115	29%	
Ohio	510	491	140	29%	
Pleasants	114	124	35	28%	
Boone	304	327	92	28%	
Marion	692	691	193	28%	**MEDIAN**
Mineral	312	284	79	28%	
Randolph	489	529	146	28%	
Pendleton	120	122	33	27%	
Wirt	94	90	24	27%	
Clay	190	196	52	27%	
Lincoln	314	376	98	26%	
Braxton	216	231	60	26%	
Greenbrier	612	606	156	26%	
Putnam	778	772	198	26%	
Fayette	823	777	199	26%	
Wyoming	393	411	103	25%	
Summers	210	198	49	25%	
Mercer	1,165	1,093	269	25%	
Monroe	225	228	56	25%	
Logan	519	510	124	24%	
Grant	205	202	49	24%	
Mingo	383	392	95	24%	
Preston	489	475	114	24%	
Hampshire	319	286	66	23%	
Barbour	283	274	63	23%	
McDowell	308	283	65	23%	
Roane	315	302	69	23%	
Tyler	126	107	24	22%	
Gilmer	72	77	17	22%	
Doddridge	138	146	29	20%	
Pocahontas	157	153	29	19%	
Tucker	135	135	25	19%	
Calhoun	120	130	23	18%	
Totals	**25,062**	**24,950**	**7,166**	**29%**	
12-Mo. Ave.		***24,800***	***597***	***2.6%***	

Table 11: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

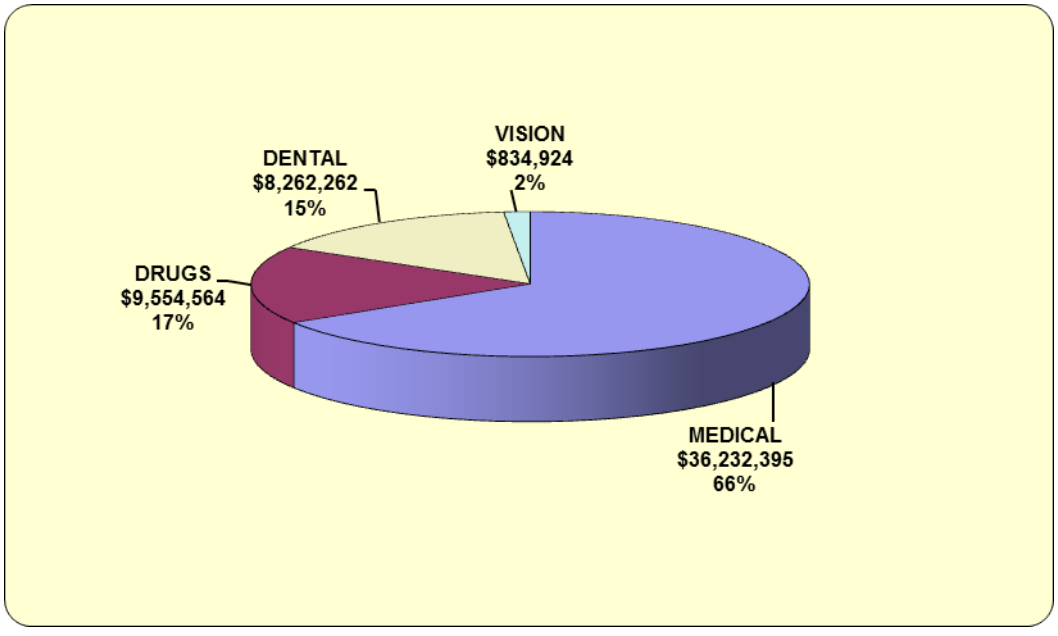


Table 12: Total Program Expenditures

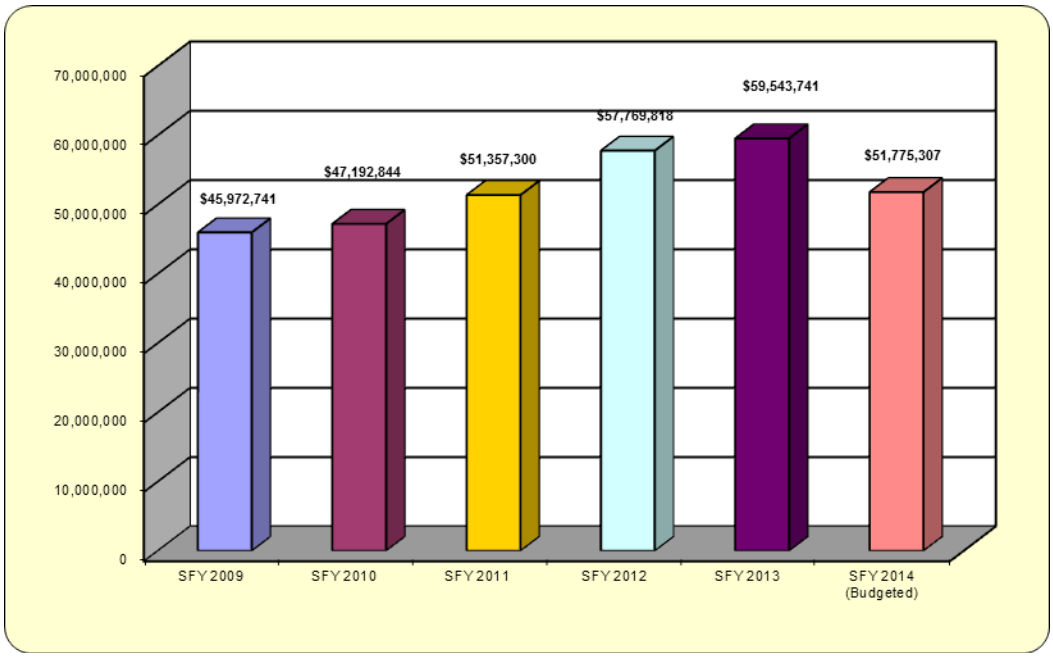
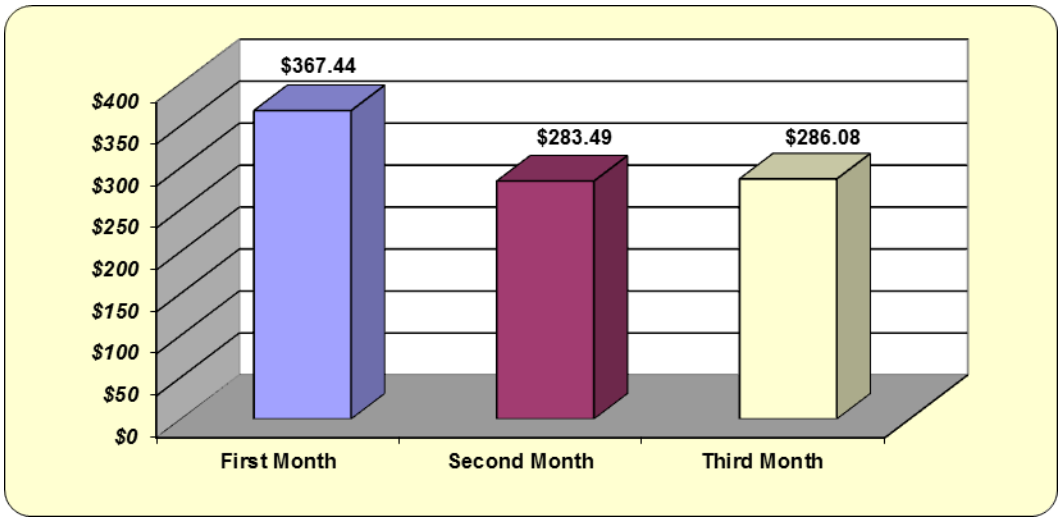


Table 13: Average Claimant Costs in First Three Months
Showing Pent Up Demand For Services Upon Enrollment



WVCHIP Set of Pediatric Core Measures 2013

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

Measure Steward: NCQA/HEDIS: The percentage of children 2 years of age during calendar year 2012 who were continuously enrolled 12 months prior to the child's second birthday, and who had four diphtheria, tetanus, and acellular pertussis (DTAP), three polio (IPV), one measles mumps and rubella (MMR), three H influenza type B (Hib), three hepatitis B (HepB), one chicken pox (VZV), four pneumococcal conjugate vaccines (PCV), two hepatitis A (HepA), two or three rotavirus (RV), and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine (9 combination rates).

Age Group	Immunization Type	Number of Continuously Enrolled 2012	Number Receiving Each Immunization 2012	% Year 2012
2 years	DTaP (four immunizations)	63	49	77.8
	IPV (three immunizations)	63	60	95.2
	MMR (one immunization)	63	63	100.0
	Hib (two immunizations)	63	61	96.8
	Hepatitis B (three immuniz	63	39	61.9
	VZV (one immunization)	63	63	100.0
	PCV (four immunizations)	63	53	84.1
	Hep A (two immunizations)	63	63	100.0
	RV (two or three immuniza	63	62	98.4
	Influenza two immunizatio	63	60	95.2
	Total continuously enrolled	**63**		**90.9**

Age Group	Immunization Type	Number of Continuously Enrolled 2011	Number Receiving Each Immunization 2011	% Year 2011
2 years	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 immuniz	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 immuniza	42	40	95.2
	Influenza two immunizatio	42	41	97.6
	Total continuously enrolled	**42**		**86.4**

Age Group	Immunization Type	Number of Continuously Enrolled 2010	Number Receiving Each Immunization 2010	% Year 2010
2 years	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 immuniz	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 immuniza	44	43	100
	Influenza two immunizatio	44	44	100
	Total continuously enrolled	**44**		**90.4**

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

Table 15
Immunization Status for Adolescents

Measure Steward: NCQA/HEDIS: The percentage of adolescents who turned 13 years of age during calendar year 2012 and who were continuously enrolled 12 months prior to the adolescent's 13th birthday, and who had one dose of meningococcal vaccine (MCV4) and one tetanus, diphtheria toxoid and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoid vaccine (Td) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate.

Age Group	Immunization Type	Number of Continuously Enrolled	Number Receiving Immunizations	% Year 2012	% Year 2011	% Year 2010
Adolescents	**Administration**	1,945				
13 Years old	**Combination (Meningococcal, Tdap/TD)**		1,380	71.5	**71.3**	**72.2**
	Meningococcal		1380	71.5	71.3	72.2
	Tdap/TD		1540	79.1	77.9	76.8
Total continuously enrolled		**1,945**	**1,945**	**75.3**	**74.6**	**72.2**

Table 16
Weight Assessment and Counseling for Nutrition and Physical Activity: BMI Assessment for Children/Adolescents

Measure Steward: NCQA/HEDIS: The percentage of members 3 to 17 years of age continuously enrolled for calendar year 2012 who had an outpatient visit with a PCP or OB/GYN and whose weight is classified based on body mass index (BMI) percentile for age and gender during the measurement year, defined by CPT Codes 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455,

Age Group	Continuously Enrolled	BMI/Nutrition & Counseling	% with Measure for Year 2012	% with Measure for Year 2011	% with Measure for Year 2010
Age 3	233	0	0.00	0.41	0.41
Age 4	277	1	0.36	0.36	0.00
Age 5	296	1	0.34	0.00	0.00
Age 6	297	0	0.00	0.23	0.00
Age 7-11	3346	5	0.15	0.26	0.01
Age 12 and up	4794	10	0.21	0.47	0.13
Total	9243	17	0.18	0.44	0.11

Table 17
Developmental Screening in the First 3 Years of Life

Measure Steward: Oregon Health and Science University: 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 screening, with interpretation and report)

Age Group	Continuously Enrolled	Developmental Screening	% with Measure for Year 2012	% with Measure for Year 2011
Age 1	59	22	37.3	31.6
Age 2	230	94	40.9	41.3
Age 3	233	75	32.2	27.7
Total	522	191	36.6	34.0

Table 18
Well Child Visits in the First 15 months of Life

Measure Steward: NCQA/HEDIS: The percentage of members who turned 15 months old during calendar year 2012 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 2012
11	0	0	0.00
11	1	0	0.00
11	2	0	0.00
11	3	0	0.00
11	4	0	0.00
11	5	0	0.00
11	6 or more	11	100.0
Total		**11**	**100.0**

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	1	1	0.0
10	2	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		**10**	**100.0**

Table 19
Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

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

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

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Year 2012	% Prior Year 2011	% Prior Year 2010
Well Child					
Less Than Or Equal To 15 Months	11	11	100.0	95.2	90.0
Third Year Of Life	233	189	81.1	77.9	75.9
Fourth Year Of Life	277	228	82.3	80.1	78.0
Fifth Year Of Life	296	244	82.4	79.4	76
Sixth Year Of Life	297	190	64.0	68.6	64.2
Total	**1,114**	**862**	**77.4**	**76.4**	**73.4**
Adolescents					
12 To 19 Years of Age	4,794	1,724	36.0	38.2	33.8
Total	**4,794**	**1,724**	**36.0**	**38.2**	**33.8**

Table 20
Percentage of Eligibles that Received Preventive Dental Services

Measure Steward: EPSDT 416 Measure: Unduplicated number of children enrolled for the calendar year 2012 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 2012	% Year 2011	% Year 2010
37,810	16,838	44.5	43.2	42.4

Table 21
Child and Adolescent Access to Primary Care Practitioners

Measure Steward: NCQA/HEDIS: Percentage of children and adolescents ages 12 months to 19 years that had a visit with a PCP including four separate percentages for children ages 12 to 24 months, ages 25 months to 6 years, 7 to 11 years, and 12 to 19 years who had a visit during calendar year 2012 or the previous calendar year 2011, as defined by CPT Codes 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99385, 99391-99395, 99401-99404, 99411-99412, 99420, 99429

Age Group	Number of Continuously Enrolled Children	Number Having Primary Care Visit	%Prior Year 2012	% Prior Year 2011	%Prior Year 2010
12 to 24 Months	76	74	97.4	95.0	98.2
25 Months to 6 Years	1,308	1,273	97.3	96.3	96.4
7 to 11 Years	3,346	3,003	90.5	90.9	88.4
12 to 19 Years	4,794	4,287	89.4	87.1	84.9
Total	**9,524**	**8,637**	**90.7**	**89.8**	**87.7**

Table 22
Percentage of Eligibles that Received Dental Treatment Services

Measure Steward: EPSDT 416 Measure: Unduplicated number of children enrolled for calendar year 2012 receiving dental treatment services as a percentage of the total number of unduplicated enrollees in the program defined by HCPC Codes D1000-D1999 (ADA Codes D1000-D1999) as reported on CMS Form 416, Line 12C

Unduplicated Number of Children	Number of Children with Treatment Dental Visits	% Year 2012	% Year 2011	% Year 2010
37,810	14,423	38.1	37.4	36.5

Table 23
Ambulatory Care-Emergency Department (ED) Visits

Measure Steward: NCQA/HEDIS: Rate of ED visits per 1,000 member months among children up to age 19, continuously enrolled and eligible during the calendar year 2012. CPT Codes: 99281-99288

	Number of Members	Member Months	Number of ER Encounters	Rate per 1,000 members
For Year 2012:				
Ages:				
<1	12		0	0.00
1 through 9	31,188		1,255	40.2
10 to 19	83,100		3,260	39.2
TOTAL:	**114,300**		**4,515**	**39.5**
For Year 2011:				
Ages:				
<1	72		0	0.00
1 through 9	28,800		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**

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

Measure Steward: Alabama Medicaid: Percentage of children ages 2 to 19 years diagnosed with asthma during the measurement year with one or more asthma-related ED visits during the calendar year 2012 of 12 consecutive months.

	Number of Asthmatics over Ages 2-19	Number with ED Encounter for Asthma	% with Asthma ED Encounter
Total for 2012:	**817**	114	13.9
Total for 2011:	**809**	120	14.8
Total for 2010:	**803**	109	13.5

Table 25
Follow-Up Care for Children Prescribed ADHD Medication

Steward Measure: NCQA/HEDIS: The percentage of children 6 to 12 years of age with attention-deficit/hyperactivity disorder (ADHD) medication newly prescribed who have at least three follow-up care visits within a 10-month period, one of which occurs within 30 days of when the first ADHD medication was dispensed. Two rates are reported, the initiation phase and the continuation maintenance phase, as defined by CPT Codes: 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99404, 99411, 99412, 99150, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255

Age Group	# Members Receiving ADHD RX - Initiation Phase	# Members on Medication with 30-day follow-up visit	% Compliance for 2012 Year	% Compliance for 2011 Year	% Compliance for 2010 Year
6 years	3	3	100	100	100
7 years	11	11	100	100	100
8 years	35	35	100	100	100
9 years	60	60	100	100	100
10 years	80	80	100	100	100
11 years	88	88	100	100	100
12 years	87	87	100	100	100
Total	**364**	**364**	**100**	**100**	**100**

100% compliance because this service is by precertification.

Age Group	# Members Receiving ADHD RX - Continuation & Maintenance Phase	# Members on Medication with follow-up visits	% Compliance for 2012 Year	% Compliance for 2011 Year	% Compliance for 2010 Year
6 years	2	2	100	100	100
7 years	3	3	100	100	100
8 years	19	19	100	100	100
9 years	39	39	100	100	100
10 years	52	52	100	100	100
11 years	61	61	100	100	100
12 years	58	58	100	100	100
Total	**234**	**234**	**100**	**100**	**100**

Table 26
Annual Pediatric Hemoglobin (HbA1c) Testing

Measure Steward: NCQA: The percentage of children ages 5 to 17 years with diabetes (Type 1 and 2) that had a Hemoglobin A1c (HbA1c) test during calendar year 2012. NCQA measure with added HEDIS adult measure criteria applied to children also. The core measure shows percentage of pediatric patients with Type 1 and 2 diabetes with a hemoglobin A1c (HbA1c) test in a twelve-month measurement period. The adult criteria also includes the number of children enrolled for calendar year 2012 with Type 1 and 2 diabetes who also had - serum cholesterol level (LDL-C) screening, an eye exam, and a screen for kidney disease. Due to the numerous CPT codes that are included in this measure, they have been omitted for purposes of this report. These codes are available for your review by contacting the WVCHIP office.

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	0	0	0	0
6 to 11 Years	16	16	100	15	93.8	5	31.3
12 to 18 Years	66	61	92.4	65	98.5	28	42.4
Total % Year 12	82	77	94.0	81	97.6	33	39.8
% Prior Year 11	75	65	86.7	72	96	21	28.0
% Prior Year 10	68	56	82.3	65	95.5	17	25.0

Table 27
Follow-Up After Hospitalization for Mental Illness

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

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

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

#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

Table 28
West Virginia Measure - Vision Visits

Measure Steward: HEDIS-Type Data: The number of children continuously enrolled for calendar year 2012 who received a vision visit for CPT Codes: 92012-92014, 92002-92004, 99172-99173, 92081-92083, 99174

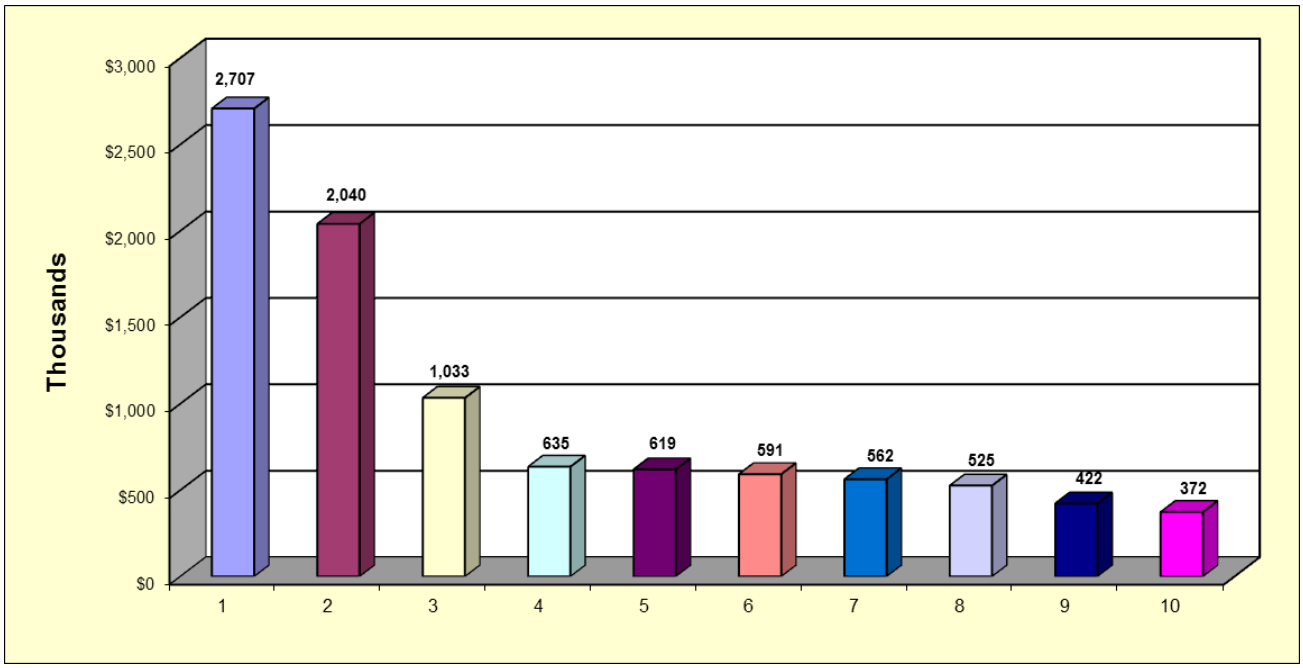
Age Group	Number of Continuously Enrolled Children	Number Having Vision Checkup Visit	% Year 2012	%Prior Year 2011	% Prior Year 2010
Under 1 Year	1	0	0.00	0.00	0.00
1 to 5 Years	1,087	193	17.8	16.1	14.5
6 to 11 Years	3,643	1,296	35.6	34.6	32.9
12 to 18 Years	4,794	1,857	38.7	39.1	37.0
Total	**9,525**	**3,346**	**35.1**	**34.8**	**33**

Table 29
West Virginia Measure - Medication Management for Children with Asthma

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

Age Group	Asthma Patients	Number with Proper Use of Medications 50%	% of children on asthma controller 50% of treatment period Year 2012	Number with Proper Use of Medications 75%	% of children on asthma controller 75% of treatment period Year 2012
5 - 11 years	317	281	88.6	268	85.4
12-19 years	282	230	82.6	222	79.2
Total	599	511	85.3	490	81.8

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	Therapeutic Activities, 15 Minutes	(97530)
5	ER Exam - Extended - New Patient	(99284)
6	Office Visit - Intermediate - New Patient	(99203)
7	ER Exam - Intermediate - New Patient	(99283)
8	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
9	Therapeutic Procedures - Each 15 Minutes	(97110)
10	ER Exam - Comprehensive - New Patient	(99285)

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

Table 30: Top Ten Physician Services
By Amounts Paid

CPT Code Description

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

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

3 Clinic Visit - All Inclusive - Encounter: National T Codes established for State Medicaid Agencies for which there are no national codes. FQHC's and RHC's use this code to bill CHIP for services covered under their encounter rates. *(HCPCS T1015)*

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

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

6 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)*

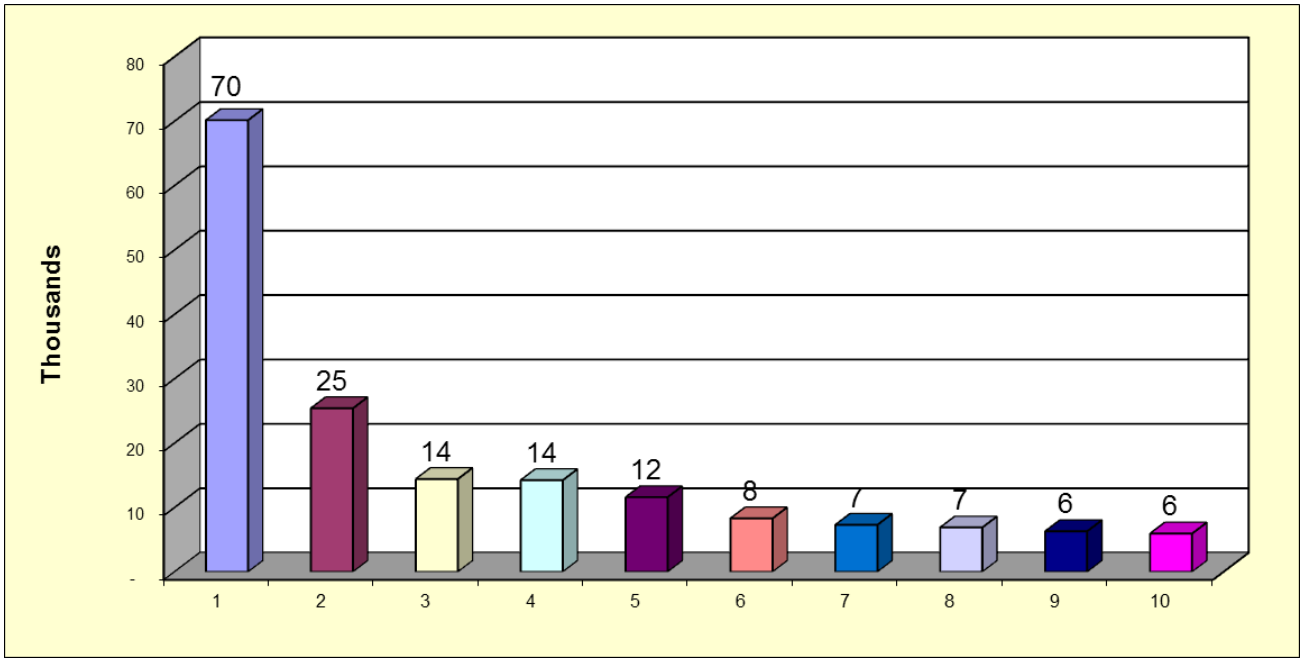
7 ER Exam - Intermediate - New Patient: requiring 1) an expanded problem-focused history; 2) an expanded problem focused examination; and 3) medical decision making of moderate complexity - usually for a problem of moderate severity *(CPT 99283)*

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

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

10 ER Exam - 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	Office Visit - Intermediate - Est. Patient	(99214)
3	Immunization Administration	(90471)
4	Office Visit - Brief - Est. Patient	(99212)
5	Test for Streptococcus	(87880)
6	Blood Count	(85025)
7	Immunization Administration - Each Add. Vaccine	(90472)
8	ER Exam - Intermediate - New Patient	(99283)
9	Therapeutic Procedure - Each 15 Minutes	(97110)
10	Office Visit - Intermediate - New Patient	(99203)

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

Table 31: Top Ten Physician Services
By Number of Transactions

CPT Code Description

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

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

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

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

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

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

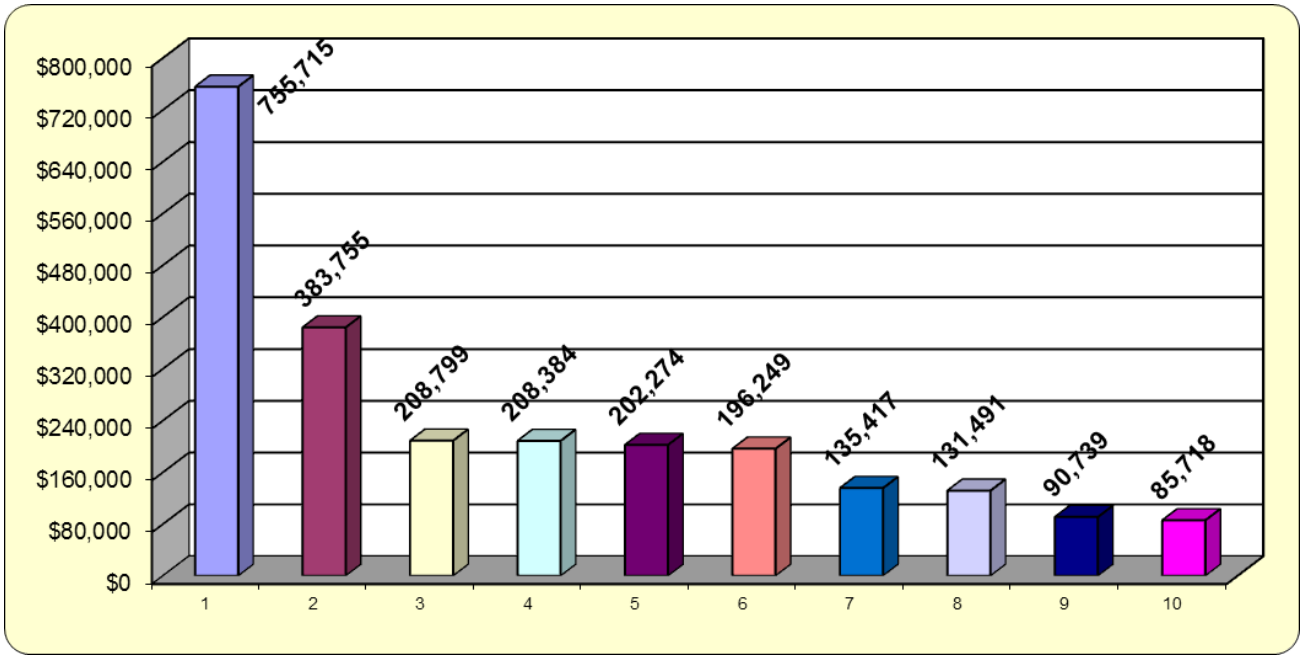
7 Immunization Administration - Each Add. Vaccine: injection of each additional vaccine (over one) whether percutaneous, intradermal, subcutaneous, or intramuscular *(CPT 90472)*

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

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

10 Office Visit - Intermediate - New Patient: for evaluation and management of a new patient taking 30 minutes of face to face time which requires 3 key components: a detailed history and examination and medical decision of low complexity *(CPT 99203)*

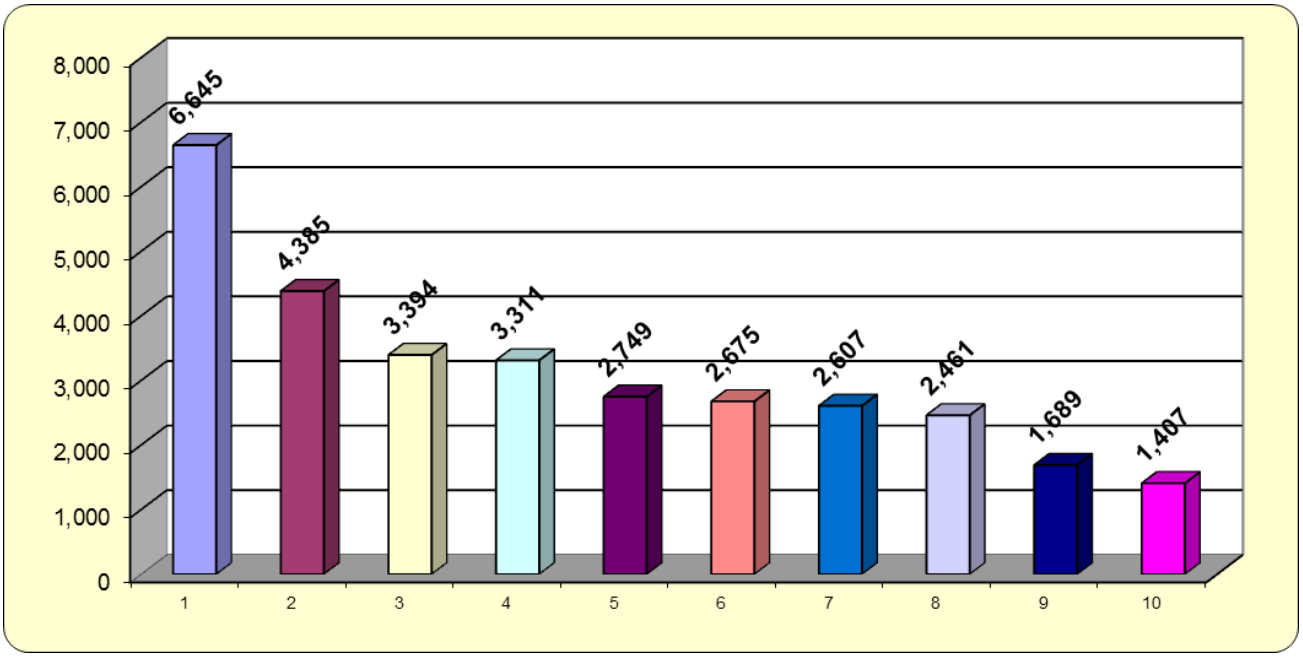
Table 32: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Vyvanse	-	Attention Deficit Hyperactivity Disorder (ADHD)
2	Methylphenidate	-	Attention Deficit Hyperactivity Disorder (ADHD)
3	Tev-Tropin	-	Growth Hormone
4	Abilify	-	Autistic Disorder
5	Novolog	-	Diabetes
6	Proair HFA	-	Asthma
7	Cefdinir	-	Antibiotic
8	Budesonide	-	Crohn's Disease
9	Humatrope	-	Growth Hormone
10	Ciprodex	-	Ear Infections

Table 33: Top Ten Prescription Drugs
By Number of Rx



Key

	Drug Brand Name	Major Use Indication
1	Amoxicillin	- Antibiotic
2	Proair	- Asthma
3	Loratadine	- Allergies
4	Fluticasone Propionate	- Allergies
5	Vyvanse	- Attention Deficit Hyperactivity Disorder (ADHD)
6	Azithromycin	- Antibiotic
7	Montelukast Sodium	- Asthma
8	Promethazine	- Allergies
9	Cefdinir	- Antibiotic
10	Tri-Sprintec	- Contraception