West Virginia
Children's Health Insurance Program

Annual Report 2011

West Virginia
Children's Health Insurance Program

2011 Annual Report

Earl Ray Tomblin, Governor

Earl Ray Tomblin, Governor
State of West Virginia

Robert W. Ferguson, Jr., Cabinet Secretary
West Virginia Department of Administration

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

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

Our Mission

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

Our Vision

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

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Introductory Section

West Virginia Children's Health Insurance Program
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December 19, 2011

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

Robert W. Ferguson, Jr., Cabinet Secretary
West Virginia Department of Administration

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

Ladies and Gentlemen:

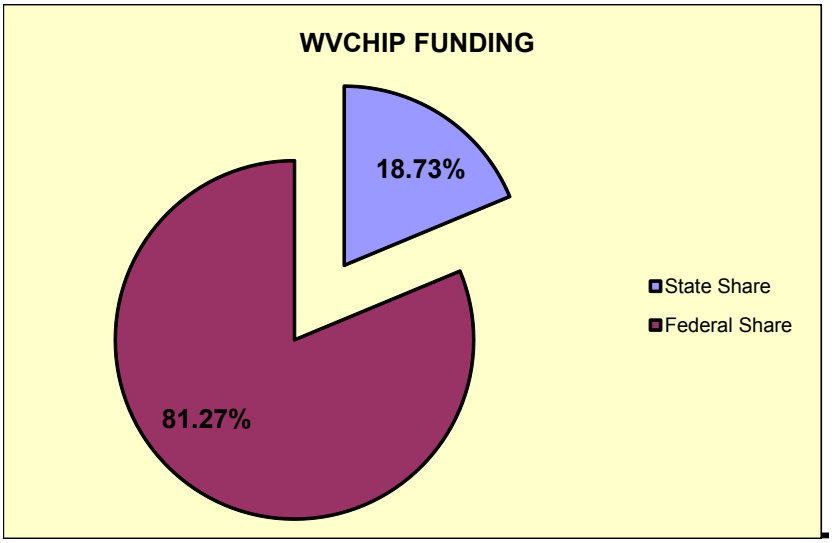
It is a privilege to submit to you the Annual Report of the West Virginia Children's Health Insurance Program (WVCHIP) for the fiscal year ended June 30, 2011. This report was prepared by the Financial Officer of WVCHIP. Management of WVCHIP is responsible for both the accuracy of the data presented 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.

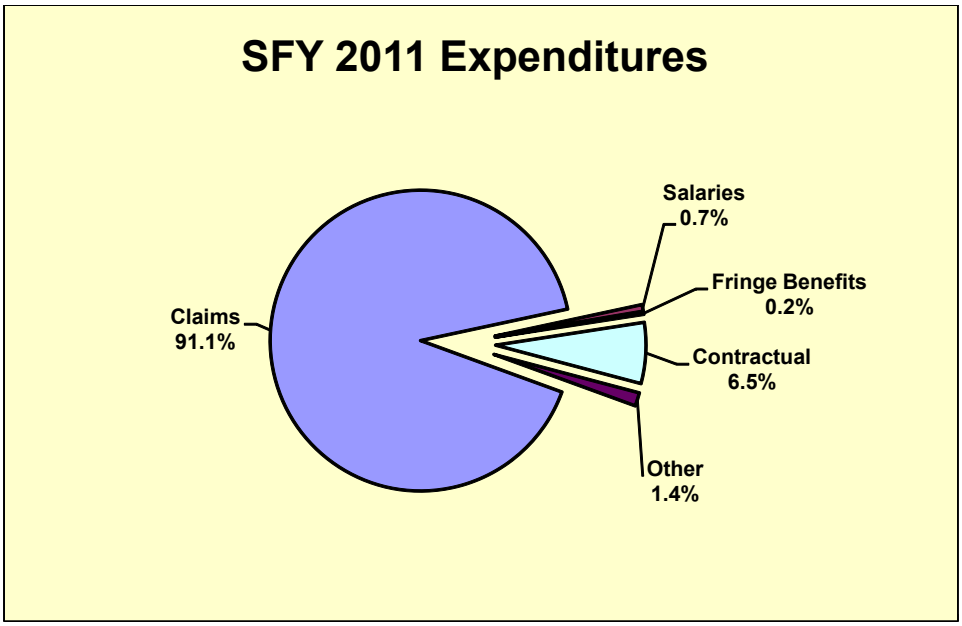
FINANCIAL PERFORMANCE AND OUTLOOK

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, 2011, were 81.27% federal share and 18.73% 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, 2011 confirms this requirement will be met through SFY 2018, assuming that state appropriations remain at the current level as SFY 2011, $10,925,514, and considering projected enrollment and program costs trends.

Based on estimated funding, enrollment, and costs, the June 30, 2011 Actuarial report projected no federal funding shortfalls for SFYs 2012 through 2018. All projections assume federal allotments will remain at the same level as the 2012 allotment, $43,068,980.



REAUTHORIZATION BY UNITED STATES CONGRESS

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

HEALTH CARE REFORM

Congress passed the Affordable Care Act (ACA) which was signed into law on March 23, 2010. Health care 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 health care reform is the increase in the income eligibility limit for the state Medicaid program. Effective January 1, 2014, the upper income limit for Medicaid will increase to 133% FPL. This increase means many children that are now income eligible for WVCHIP will transfer enrollment to Medicaid. Currently, the estimate is that WVCHIP will lose around 11,433 kids on this date, but this estimate will be revised once new eligibility rules put in place under the ACA are determined. Other impacts of the ACA are still being determined.

INITIATIVES

This year at WVCHIP was a very active one involving implementation of some significant program changes. The reauthorization of the CHIP program, passed in February 2009, mandates that WVCHIP change its methodology used to pay Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). Historically, WVCHIP reimbursed FQHCs and RHCs for services using the same fee-for-service methodology as for other providers. This required WVCHIP to change to a prospective payment (PPS) methodology and adjust claims for this methodology back to October 1, 2009. In the spring of 2011,

WVCHIP submitted a state plan amendment to increase program eligibility to 300% of the Federal Poverty Level (FPL). The program continued its monitoring and analysis of eligibility and enrollment information transfers among its various partners. This work culminated with changes to the WVCHIP Premium group that allow premium paying families to enroll in the program back to the month of application and also provided them with an option to make payments online. WVCHIP changed its eligibility re-determination process from requiring a full-application every other year to a passive renewal process every year. This change took place in partnership with the state's Medicaid program. WVCHIP continued its partnership efforts with Oregon and Alaska CHIP programs under a multi-state grant that focuses on increasing the quality of health care provided to children. Also, WVCHIP actively participates with other state agencies to prepare the state for health care reform, mainly through meetings coordinated by the Governor's Office of Health Enhancement and Lifestyle Planning (GOHELP).

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, 2011. The federal fiscal year ends September 30 and further documentation is submitted to CMS based on that period. Certain statistical information such as pediatric quality reports, by nature, is presented on a calendar year basis as required.

ACKNOWLEDGMENTS

Special thanks are extended to Governor Earl Ray Tomblin, at whose request the Board took up the issue of further expansion to 300% FPL, and members of the Legislature for their continued support. Gratitude is expressed to the members of WVCHIP's Board of Directors for their leadership and direction. Our most sincere appreciation is extended to Secretary Robert W Ferguson, Jr., 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, 2011.

Sincerely,

Stacey L. Shamblin, MHA
Financial Officer

Principal Officials

Earl Ray Tomblin, Governor
State of West Virginia

Robert W. Ferguson, Jr., Cabinet Secretary
West Virginia Department of Administration

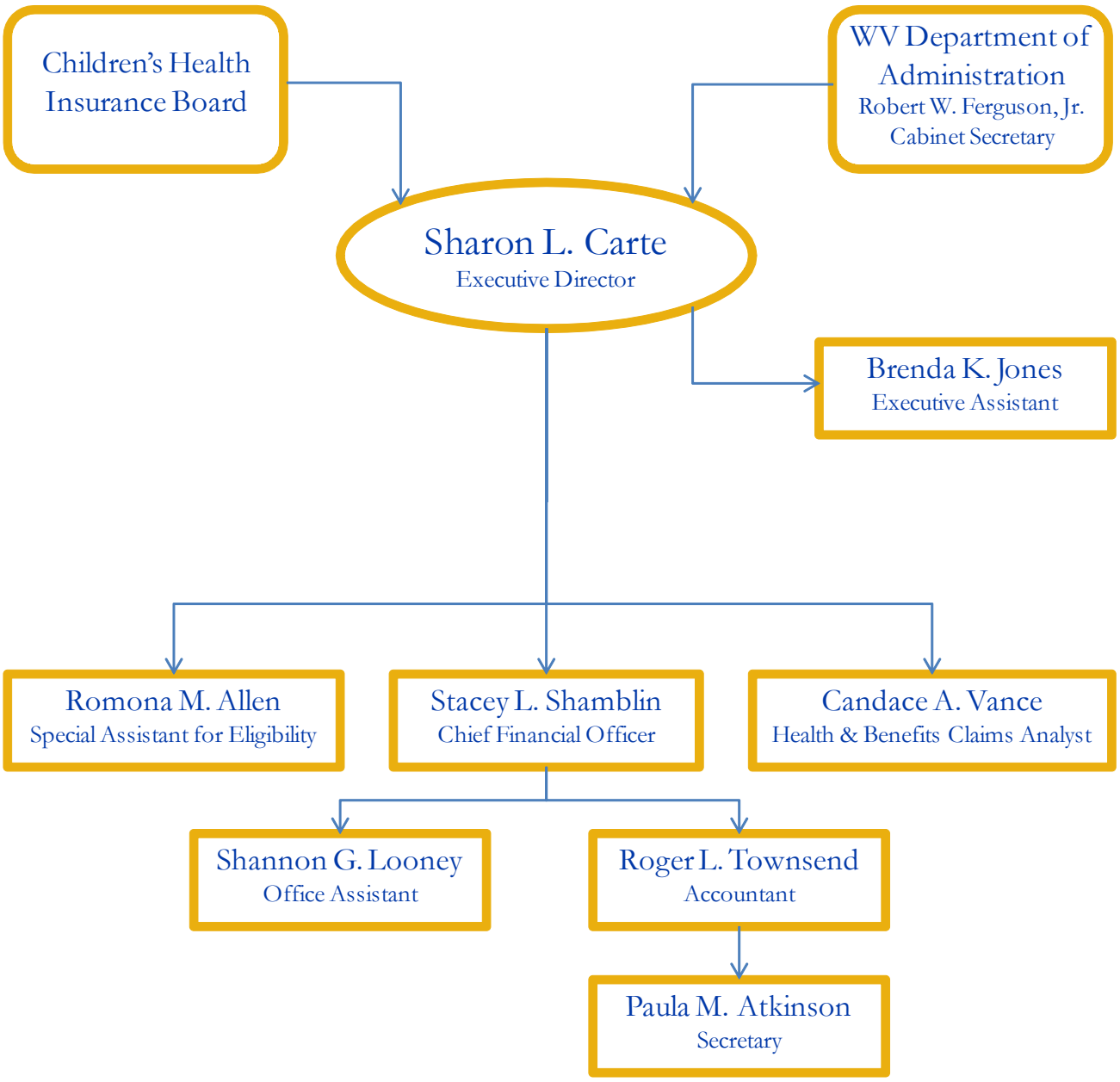
Board Members

Sharon L. Carte, Chair
Ted Cheatham, Public Employees Insurance Agency, Director
Michael J. Lewis, Department of Health & Human Resources, Cabinet Secretary
The Honorable Ron Stollings, West Virginia Senate, Ex-Officio
The Honorable Don Perdue, West Virginia House of Delegates, Ex-Officio
Lynn T. Gunnoe, Citizen Member
Margie Hale, Citizen Member
Travis Hill, Citizen Member
Larry Hudson, Citizen Member
VACANT, Citizen Member
VACANT, Citizen Member

Staff

Sharon L. Carte, Executive Director
Romona M. Allen, Special Assistant for Eligibility
Paula M. Atkinson, Secretary
Brenda K. Jones, Executive Assistant
Shannon G. Looney, Office Assistant
Stacey L. Shamblin, Financial Officer
Roger L. Townsend, Accountant
Candace A. Vance, Health and Benefits Claims Analyst

Staff Organizational Chart



Financial Section

MANAGEMENT'S DISCUSSION AND ANALYSIS

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM
For the Year Ended June 30, 2011

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, 2011. 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). (NOTE: The limit was 250% FPL during SFY 2011.) When Congress amended the Social Security Act in 1997 to create Title XXI "State Children's Health Insurance Program" (SCHIP), federal funding was allocated to the states for such programs over a ten year period. The West Virginia Legislature established the legal framework for this State's program in legislation enacted in April 1998. The program was reauthorized through 2013 on February 4, 2009. On March 3, 2010, the passage of the Affordable Care Act (ACA) extended federal appropriations through 2015 and increased the share of the 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. Children in this group are enrolled in WVCHIP Premium.

OVERVIEW OF THE FINANCIAL STATEMENTS

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

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

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

In addition to these two basic statements and the accompanying notes; required supplementary information is presented in the Management Discussion and Analysis section and the Budget-to-Actual Statement presented for the year. The Budget-to-Actual Statement compares the program's actual expenditures to amounts budgeted for the state fiscal year and is located after the notes to the financial statements.

FINANCIAL HIGHLIGHTS

The following financial statements summarize the financial position and the results of operations for the years ended June 30, 2011 and 2010. (See pages 16 and 17.)

- Total assets increased approximately $475,241, or 3% in comparison to the previous year-end amount. This increase is primarily a result of a higher ending balance of cash and cash equivalents, and reflects the Program's increased carry-over funding for the next year. There decreases in every other asset line. A decrease of 42% in accrued interest receivable is reflective of the down-turn in the overall economy. The Agency switched its investments from the state's money-market fund to its short-term bond pool in November 2009.
- Total liabilities decreased by approximately $835,579 from last year. The majority of the decrease is attributable to a decrease in the estimate of Unpaid Insurance Claims Liability.
- Total fund equity increased approximately $1,310,820, or 10%, in comparison to the previous year end amount.
- Total revenues reflect a 6% increase, around $2,957,457, when compared to the prior year. While the state appropriation decreased, federal revenues increased, as well as premium revenues. Investment income decreased about 41%.
- Medical, dental and prescription drug expenditures comprise approximately 92% of WVCHIP's total costs. These expenditures increased $3,758,089, or 9% compared to the prior year.
- Administrative costs accounted for 8% of overall expenditures. These expenditures increased approximately $406,367, representing an increase of 11%. Increases in administrative expenditures also include increases in amounts the program spent on outreach and health promotion. The program sponsored the State Championship for Dance Dance Revolution in the spring of 2011. Also, expenditures under the multi-state quality grant are reflected in the outreach and health promotion line. Current expenses increased 54% mostly due to increases in fees charged by the West Virginia Office of Technology (WVOT) for computer and communication services and one-time costs to relocate the WVCHIP administrative offices.

FINANCIAL ANALYSIS

Costs

A 9% trend in medical, dental, and prescription drug claims is slightly higher 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: -1.6%
- Service Utilization: +0.2%
- Price/Fee Increases: +10.4%

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

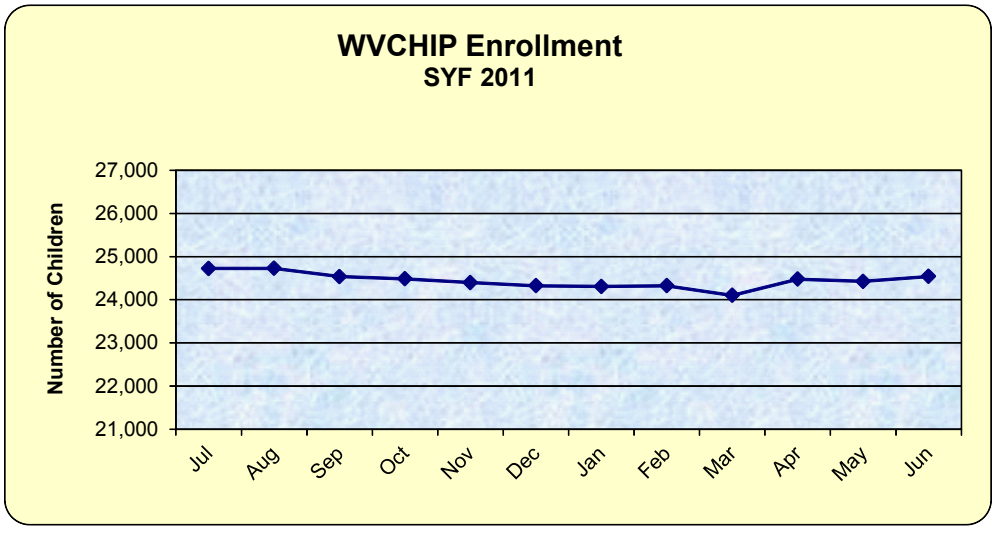
Enrollment

Monthly enrollment decreased steadily during the year, with an overall decrease in enrollment of 1.6% compared to last year.

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

GROUP	FPL	AVG MONTHLY ENROLLMENT	PERCENT INCREASE
CHIP Gold (Phases I&II)	100% - 150%	14,890	-2.4%
CHIP Blue (Phase III)	151% - 200%	8,346	-3.8%
WVCHIP Premium	201% - 250%	1,211	+35.6%

WVCHIP Premium is the newest enrollment group and includes children in families with income above 200%FPL up to and including 250%FPL. Initially, 12 children were enrolled in this group when it was "rolled-out" in February 2007. By June 2011, enrollment increased to 1,386 members. Enrollment in this group continues to grow, even more so since eligibility was expanded to 300% FPL on July 1, 2011. By the end of November 2011, 1,847 children were enrolled. Enrollment has grown 33.3% since June 2011.



Utilization

It is easy to assume that a health plan would incur lower costs with decreased enrollment: fewer members = payments for fewer services = decreased costs. This is not a correct assumption of WVCHIP's experience during SFY 2011, however. Increased payments due to service utilization changes are caused by factors more dynamic than simply the number of members covered by the plan. Not only do changes in plan membership cause the plan to pay for more or less services, but other factors including provider practices and service guidelines; services mandated or recommended by either law or professional organizations; the benefit package and utilization management strategies adopted by the plan; as well as many more factors. A combination of these many factors contributed an increase of 0.2% in claims expenditures for the year.

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

Prices/Fees

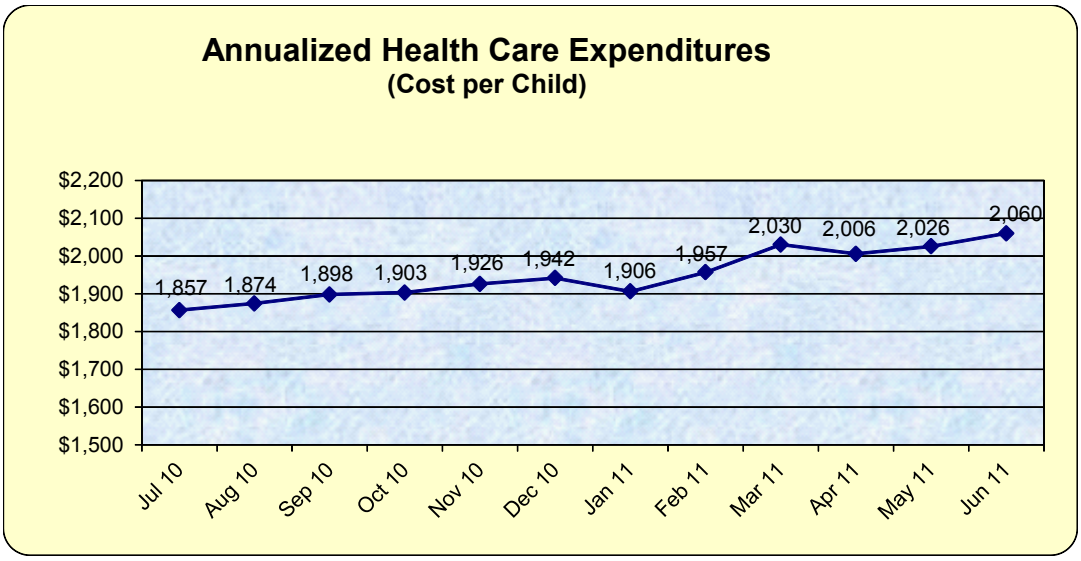
The amount WVCHIP pays providers for particular services is also determined by a number of factors; fee schedules adopted by the plan or rates negotiated with providers, whether the service is provided in West Virginia or outside the state; and service availability, among others. A combination of all these factors contributed to price inflation. During State Fiscal Year 2011, prices increased around 10.4%. The increase is a result of many factors, including 1) increases in dental fees to remain consistent with Medicaid's fee-schedules; 2) payment for Birth-to-Three services utilized by WVCHIP members up to age three; 3) increases in the costs of drugs; and 4) general increase in costs across all service categories.

The average cost per claim for all medical and dental providers increased 7.7%, from $143 in SFY 2010 to $154 in SFY 2011. Costs to in-state service providers increased 6.1% during this time, from an average $131 in SFY 2010 to $139 in SFY 2011. For out-of-state providers, the average cost per claim increased 19%, from $384 in SFY 2010 to $457 in SFY 2011. Utilization of out-of-state service providers remained flat across both fiscal years – 4.7% of all claims paid by WVCHIP were to out-of-state providers during both fiscal years. The increase in prices, however, increased the portion of WVCHIP dollars going out-of-state from 12.3% in SFY 2010 to 13.9% in SFY 2011.

WVCHIP has a very high generic drug utilization rate, 77.9% in SFY 2011, up from 75.5% in SFY 2010. While generic drugs cost much less than brand name drugs, the price for generic drugs increased 6.1% during this time, resulting in increased costs to the plan. It should be noted that during this same time brand drug costs increased 16.6%. 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 2011 was $2,060. 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 10.3% 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 11% over the prior year. Two categories of administrative costs drove this increase, Outreach & Health Promotion, and Current Expenses. The largest increase was in Outreach & Health Promotion, 159%, and was mainly due to WVCHIP's participation in its multi-state quality initiative with Oregon and Alaska. It should be noted that the activities under this initiative are 100% federally funded. The increase in the current expenses line reflects one-time costs to move the WVCHIP administrative offices and increases to the West Virginia Office of Technology (WVOT) for computer and communication services.

West Virginia Children's Health Insurance Program
Comparative Balance Sheet
June 30, 2011 and 2010
(Accrual Basis)

	June 30, 2011	June 30, 2010	Variance	
Assets:				
Cash & Cash Equivalents	$13,672,896	$12,330,346	$ 1,342,550	11%
Due From Federal Government	2,947,830	3,686,029	(738,199)	-20%
Due From Other Funds	550,255	668,625	(118,370)	-18%
Accrued Interest Receivable	10,463	18,060	(7,597)	-42%
Fixed Assets, at Historical Cost	66,595	69,738	(3,143)	-5%
Total Assets	$17,248,039	$16,772,798	$ 475,241	3%
Liabilities:				
Due To Other Funds	$ 255,639	$ 355,530	$ (99,891)	-28%
Deferred Revenue	372,074	465,645	(93,571)	-20%
Unpaid Insurance Claims Liability	2,682,181	3,324,298	(642,117)	-19%
Total Liabilities	$ 3,309,894	$ 4,145,473	$(835,579)	-20%
Fund Equity	$13,938,145	$12,627,325	$1,310,820	10%
Total Liabilities and Fund Equity	$17,248,039	$16,772,798	$ 475,241	3%

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, 2011 and June 30, 2010
(Modified Accrual Basis)

	June 30, 2011	June 30, 2010	Variance	
Revenues:				
Federal Grants	$ 41,607,772	$38,493,281	$3,114,491	8%
State Appropriations	10,425,628	10,599,637	(174,009)	-2%
Premium Revenues	473,193	344,894	128,299	37%
Investment Income:				
Investment Earnings	254,498	143,476	111,022	77%
Unrealized Gain On Investments*	(92,971)	129,375	(222,346)	-172%
Total Investment Income	161,527	272,851	(111,324)	-41%
Total Revenues	**$52,668,120**	**$49,710,663**	**$2,957,457**	**6%**
Expenditures:				
Claims:				
Outpatient Services	$12,301,604	$12,140,132	$161,472	1%
Physicians and Surgical	9,896,684	9,652,122	244,562	3%
Prescribed Drugs	9,679,814	8,766,472	913,342	10%
Dental	6,734,483	5,114,170	1,620,313	32%
Inpatient Hospital Services	3,989,797	3,427,734	562,063	16%
Outpatient Mental Health	1,447,905	1,315,472	132,433	10%
Durable & Disposable Equipment	1,188,207	1,205,763	(17,556)	-1%
Inpatient Mental Hospital	843,569	779,170	64,399	8%
Vision	798,420	710,974	87,446	12%
Therapy	538,550	489,443	49,107	10%
Medical Transportation	373,914	311,294	62,620	20%
Other Services	184,360	109,820	74,540	68%
Less Collections**	(802,863)	(606,211)	(196,652)	32%
Total Claims	47,174,444	43,416,355	3,758,089	9%
General and Admin Expenses:				
Salaries and Benefits	488,107	493,312	(5,205)	-1%
Program Administration	2,350,337	2,461,031	(110,694)	-4%
Eligibility	400,688	406,420	(5,732)	-1%
Outreach & Health Promotion	746,912	288,303	458,609	159%
Current	196,812	127,423	69,389	54%
Total Administrative	4,182,856	3,776,489	406,367	11%
Total Expenditures	**51,357,300**	**47,192,844**	**4,164,456**	**9%**
Excess of Revenues Over (Under) Expenditures	**1,310,820**	**2,517,819**	**(1,206,999)**	**-48%**
Fund Equity, Beginning	**12,627,325**	**10,109,506**	**2,517,819**	**25%**
Fund Equity, Ending	**$13,938,145**	**$12,627,325**	**$1,310,820**	**10%**

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

Unaudited - For Management Purposes Only - Unaudited

West Virginia Children's Health Insurance Program
Notes to Financial Statements
For the Twelve Months Ended June 30, 2011

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 Investments

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, 2011, 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	$ 332,769	———	———
Investments			
	Amount Unrestricted	Fair Value	Investments Pool
Investment with Board of Treasury Investments	$ 4,018,148	$4,018,148	Cash Liquidity
	$ 9,321,979	$9,321,979	Short Term Bond Pool
Total	$13,340,127		

Deposits	
Cash and Cash Equivalents as Reported	$13,672,896
Less: Investments Disclosed as Cash Equivalents	$13,340,127
Carrying Amount of Deposits as Disclosed in this Footnote	$ 332,769
Investments	
Investments as Reported	----------
Add: Investments Disclosed as Cash Equivalent	$13,340,127
Carrying Value of Investments as Disclosed in this Footnote	$13,340,127

Note 3

Due to other funds:

Public Employees Insurance Agency Piggyback Contracts	$ 177,808
DHHR & WVOT (Eligibility)	44,899
Other	32,932
Total due to other funds	$ 255,639

Note 4

Unpaid Insurance Claims Liabilities

Claims Payable, Beginning of Year	$ 3,324,298
Incurred Claims Expense	47,174,444
Payments:	
Claim Payments for Current Year	38,667,778
Claim Payments for Prior Year	9,148,783
Claims payable, year to date	$ 2,682,181

Note 5

Contingencies

WVCHIP receives significant financial assistance from the U.S. Government in the form of grants. 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 2011
For the Twelve Months Ended June 30, 2011

	Budgeted for Year	Year to Date Budgeted Amt	Year to Date Actual Amt	Year to Date Variance*		Monthly Budgeted Amt	Jun-11	May-11	Apr-11
Projected Cost	$48,263,300	$48,263,300	$49,267,425	($1,004,125)	-2%	$4,021,942	$4,499,940	$4,259,846	$3,946,567
Premiums	350,000	$350,000	473,193	($123,193)	35%	$29,167	42,774	45,101	37,046
Subrogation & Rebates	543,140	$543,140	913,939	(370,799)	68%	45,262	206,892	20,256	54,182
Net Benefit Cost	47,370,160	47,370,160	$47,880,293	($510,133)	-1%	$3,947,513	4,250,274	4,194,490	3,855,339
Salaries & Benefits	$580,500	$580,500	$487,669	$92,831	16%	$47,675	$38,355	$38,792	$41,519
Program Administration	3,346,959	$3,346,959	2,445,738	901,221	27%	252,913	189,602	16,338	160,039
Eligibility	420,000	$420,000	425,678	(5,678)	-1%	35,000	110,219	0	0
Outreach	300,000	$300,000	748,688	(448,688)	-150%	25,000	199,603	2,426	221,857
Current Expense	160,000	$160,000	174,538	(14,538)	-9%	13,333	26,034	11,194	25,477
Total Admin Cost	$4,807,459	$4,807,459	$4,282,311	$525,148	11%	$373,922	$563,813	$68,750	$448,892
Total Program Cost	$52,177,619	$52,177,619	$52,162,604	$15,015	0%	$4,321,435	$4,814,087	$4,263,240	$4,304,230
Federal Share 81.27%	42,216,962	$42,216,962	$42,531,361	(314,399)	-1%	3,536,230	3,939,368	3,488,609	3,522,152
State Share 18.73%	9,960,657	$9,960,657	$9,631,243	329,414	3%	785,205	874,720	774,631	782,079
Total Program Cost **	$52,177,619	$52,177,619	$52,162,604	$15,015	0%	$4,321,435	$4,814,087	$4,263,240	$4,304,230

* Positive percentages indicate favorable variances
** Budgeted Year Based on CCRC Actuary 6/30/2010 Report.

Unaudited - Cash Basis For Management Purposes Only - Unaudited

MAJOR INITIATIVES.

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

The CHIP Reauthorization Act (CHIPRA), passed in February 2009, mandates all CHIP programs to pay FQHCs and RHCs under a PPS starting October 1, 2009. Historically, WVCHIP paid FQHCs and RHCs on a fee-for-service basis. Under PPS, WVCHIP will reimburse FQHCs and RHCs a per-visit rate that covers each center's reasonable cost, just as Medicaid programs are required to do. WVCHIP opted to determine each center's rate, or reasonable costs per visit, specific to children and the WVCHIP benefit. WVCHIP decided against using the Medicare calculated rates because the mix of services utilized under the two programs are different. WVCHIP convened an advisory group consisting of representatives of primary care centers to plan the project in the spring of 2010 and released an RFQ to determine these rates in July 2010. Under the new methodology, each center will receive a per-visit rate that covers reasonable costs of providing WVCHIP members with services. These rates will be adjusted annually for medical inflation using the Medicare Economic Index (MEI). There are no cost settlements under the new PPS. WVCHIP expects reimbursements to centers to increase, by approximately $1.9 million per year. Once rates are determined, WVCHIP is required to pay centers under the new methodology retroactive to October 1, 2009. This retro-active adjustment is expected to add around $2.0 million in one-time costs to the program. WVCHIP will implement this new PPS starting January 1, 2012.

Review and Modification of Electronic Enrollment Processes

In the spring of 2009 a group of WVCHIP partners started work on reviewing processes used to transfer enrollment data from the point of origination to the end user, either the third-party administrator or the pharmacy benefit manager. Representatives from the West Virginia Department of Health and Human Resources, RAPIDS, Wells Fargo, TPA, and the state's Office of Technology, responsible for the maintenance and upkeep of WVCHIP's enrollment database, as well as WVCHIP employees participate in this group. The goal of this group is to identify and correct process errors and establish more efficient processes, to lower error rates due to data transfers, and improve customer services, as well as protect WVCHIP funding and private member information. One result of this project is a new enrollment database that is more secure, allows WVCHIP employees to directly make necessary changes, and is located on the state's mainframe. In SFY 2010, this group began work to provide WVCHIP Premium members with the option of making monthly premium payments on-line, and also to provide them a mechanism to enroll in WVCHIP Premium on the first day of the month their application was submitted, to be consistent with the rest of the program and to lessen the likelihood that some children would experience a gap in coverage. In December 2010, WVCHIP Premium members were provided the option to make their premium payments online. Also, it was necessary for WVCHIP to establish a new website to make the online payment system possible. Everyone is welcome to visit the new site at www.chip.wv.gov.

Modification of the Eligibility Redetermination Process

Children who are determined eligible for WVCHIP are allowed a 12-month continuous enrollment period without having to redetermine eligibility. By the end of the twelfth month, each member is required to redetermine eligibility or disenroll. The usual process is for the family to complete and submit a full application. WVCHIP adopted a passive renewal process in 2003 in an effort to make it easier for busy families to re-enroll their children. Under the passive renewal process, a pre-populated form is sent to each family listing information they provided and was verified during their last eligibility determination. The family reviews information on the form, and if there are no changes in the information, simply signs and returns the form. The child was then enrolled for another 12-months. If changes were indicated, the family was required to fill out a complete application. WVCHIP alternated between a full eligibility determination and a passive redetermination every-other year. Starting in 2011, the state's Medicaid program decided to adopt this passive renewal process as well. In concert with Medicaid, WVCHIP moved to a passive renewal process every year for its member families to further streamline the re-enrollment process. This is likely to increase the retention rate making it less likely that children will experience gaps in coverage due to the eligibility redetermination process.

Health Care Reform

This is the Agency's second year of participation in the mult-state pediatric demonstration quality grant project in partnering with the states of Alaska and Oregon. Known as the Tri-State Children's Health Improvement Consortium (T-CHIC), this five-year project seeks to show the impact of patient-centered care delivery models and health information technology on the quality of children's health care by a variety of indicators that will be assessed for their validity and utility in driving quality improvement.

The second year of this project transitioned from planning activity to hiring of a project manager, Jean Fisher, who successfully recruited 10 primary care practices (five Federally Qualified Health Centers, three academic practices, one Rural Health Center, and one private practice) as project participants. Each practice was assisted in the recruitment and hiring of one full-time care coordinator funded by the grant. This summer, a T-CHIC Advisory Council was identified to meet monthly to provide guidance to the project. The Advisory Council physician members are:

William A. Neal, MD, Cardiologist, WVU and Advisory Council Chairperson
James Arbogast, MD, Chair, Family Medicine, WVU
Craig Boivert, MD, Chair, Medical Home Program, WVU School of Medicine
James Commerci, MD, Geriatrician, Private Family Practice
James Lewis, MD, University Pediatrics, Neurodevelopment
Patricia Kelly, MD, University Pediatrics, Adolescent Physician, Cabell-Midland High School Health Center

This year saw the Agency's continued participation in coordinating health care activities and federal grant opportunities related to health care reform through the Governor's Office of Health and Lifestyle Enhancement (GoHELP). The West Virginia Legislature also enacted legislation this past year to allow creation of a health care exchange and its governing board.

Once created, the health care exchange will be very important since those CHIP-child enrollees and their parents who will not be covered under the Medicaid expansion starting in 2014, will begin selecting coverage from plans offered through this exchange. Planning and work during these next two years to operationalize our state's exchange promises to be very exciting and challenging ones as the Agency prepares to enter health care reform.

CONTACTING WVCHIP's MANAGEMENT

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

Required Supplementary Information

West Virginia Children's Health Insurance Program
Report of Independent Actuary
June 30, 2011 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 2011 ("FY 2011") through Fiscal Year 2018 ("FY 2018"). West Virginia enabling legislation of the CHIP Program requires that an actuary provide a written opinion that all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the fiscal year for which the plan is proposed.

CHIP Program management requested CCRC Actuaries to produce the Baseline Scenario which includes the current WVCHIP Premium expansion to 300% of the Federal Poverty Level ("FPL"). State funding is assumed to be $10,425,628 in FY 2011, $10,925,514 in FY 2012 and in future years. At the Federal level, the Federal funding for West Virginia is assumed to be $41,268,373 in FY 2011 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 the assumption of CMS approval effective July 1, 2011. Under this scenario, participant premiums are assumed to cover 25% of the policy cost for children in the 250% to 300% FPL group.

Under the 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 250% FPL eligibility group and 25% of the policy cost for children in the 250% to 300% FPL group. The monthly premiums are $35 for families with one child in the program and $71 for families with more than one child in the program. We have assumed the premiums will increase with policy cost increases in the future to maintain the 20% cost share threshold in the 200% to 250% FPL and 25% cost share threshold in the 250% to 300% FPL group. As of June 2011, there are 1,386 children enrolled in WVCHIP Premium.

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.

Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), CHIPRA reauthorizes CHIP for four and a half years through the end of September 2013, and resulted in $69 billion in funding for the national program. While this forecast assumes Federal funding levels based on the FY 2011 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.

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

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

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 2011 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. As a result, WVCHIP must make retroactive payments to centers for these services by September 30, 2011. Retrospective payments are estimated to be approximately $1,991,775 for claims with dates of services October 1, 2009 and after that were paid through June 30, 2011. This additional retro-active adjustment will be made during State Fiscal Year 2012. Claims received after July 1, 2011 will be processed under the new prospective payment methodology regardless of the date of service included on the claim. An estimate of $2,000,000 is included in projections for State Fiscal Years 2012 and after.

This projection includes an additional $500,000 for vaccines purchased through the Vaccines for Children program using federally contracted rates. This amount is the result of a review conducted by CDC on billings for these services.

Furthermore, we also included in the projection an additional $20,000 to allow primary care physicians to apply fluoride varnish in connection with a well-child exam for members ages 1 thru 4.

In addition, this report includes the following anticipated costs from CHIPRA requirements and the FY 2012 State Plan Amendment:

- Reduction in the length of the waiting period from 6 to 3 months for WVCHIP Gold (Below 150% FPL) and WVCHIP Blue (Between 150% and 200% FPL), and from 12 to 3 months for WV CHIP Premium (Between 200% and 300% FPL).
- Elimination of annual and lifetime benefit maximums effective July 1, 2011.
- Removal of the limit in dental coverage for WV CHIP Premium members, and include coverage for Orthodontic services.
- Addition of the vision benefit for WV CHIP Premium members.
- Addition of approximately $400,000 in the autism service benefits.

It should be noted that this report incorporates some of the provisions of the Patient Protection and Affordable Care Act ("PPACA"), a product of the Health Care Reform ("HCR") Bill. PPACA includes a large number of health-related provisions to take effect over the next several years, particularly, an additional two years extension to CHIPRA reauthorization through September 30, 2015, the expanding Medicaid eligibility starting on January 1, 2014 and an increase in Federal funding participation in FY 2016 through 2019.

Effective January 1, 2014, Medicaid eligibility will expand to individuals and families with income up to 133% FPL. We have assumed that approximately 11,433 children in WVCHIP Gold will move to Medicaid under the HCR Bill. The CHIP Program will serve the remaining children up to 300% FPL. In addition, the HCR Bill addresses a 23% increase in Federal participation for FY 2016 through 2019, which would make the CHIP Program 100% federally funded starting October 1, 2015, the first day of Federal FY 2016.

Under the Baseline Scenario, the projected cost of the CHIP Program in FY 2011 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 2018. And we are not projecting any deficits in the State and Federal financing through FY 2018 based on current approved funding levels under the assumption of Medicaid eligibility and an increase in Federal participation of PPACA. Under the Expansion to 300% FPL scenario, we are not projecting any deficits in the State and Federal financing through FY 2018 based on current approved funding levels at the Federal and State level.

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 2010 in this projection. The Federal share of program expenditure is currently at 81.27% for Federal Fiscal Year 2011, and it decreases slightly to 80.83% for Federal Fiscal Year 2012 and it remains unchanged through September 30, 2015.

Enrollment for the program as of June 2011 has increased since March 2011. The current program enrollment as of June 2011 consists of 24,540 children total: 14,649 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"), 8,505 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 1,386 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, 2011 Quarterly Report with March 2011 enrollment data, overall enrollment has increased by 440 children. WVCHIP Gold has increased enrollment by 112 children, WVCHIP Blue has increased enrollment by 228 children and WVCHIP Premium has increased enrollment by 100 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 2011 medical claim trend assumption of 8%, dental claim trend of 8% and prescription drugs claim trend assumption of 6% as assumed in the March 31, 2011 Quarterly Report, based on trend experience consistent with these assumptions.

Administrative expenses for West Virginia CHIP are projected to be $4,282,309 in FY 2011, representing a 16% increase over FY 2010 administrative expenses of $3,677,593. West Virginia CHIP management team assumes a 5% administrative expense trend in future years. Drugs rebates are projected to be $703,251 in FY 2011. West Virginia CHIP management team assumes a 4% drugs rebates trend in future years.

Under the State fiscal year basis, we have calculated that the incurred claim costs under the Baseline Scenario assumptions for FY 2011 to be $49,289,347. The updated projection for FY 2012 claims is $55,162,843.

PLAN ENROLLMENT

We have updated our projection based on the enrollment through June 2011. WVCHIP Gold enrollment has decreased in recent months. The program had enrollment at the end of FY 2010 of 24,824 children, with 15,385 under WVCHIP Gold, 8,381 under WVCHIP Blue, and 1,058 under WVCHIP Premium. Current enrollment as of June 2011 is 24,540 children, with 14,649 under WVCHIP Gold, 8,505 under WVCHIP Blue, and 1,386 under WVCHIP Premium.

It is noteworthy that WVCHIP Premium enrollment continues to be significantly below projected levels made at the implementation of this component of the Program. For the purposes of this report, we are continuing to utilize the original growth assumptions, combined with actual WVCHIP Premium enrollment through June 2011, and will continue to adjust projected enrollment by actual results.

The following table summarizes the FY 2008 to FY 2010 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%
Jul-08	15,077	8,784	298	24,159	-2.7%
Aug-08	15,134	8,813	309	24,256	-2.6%
Sep-08	15,125	8,827	303	24,255	-2.6%
Oct-08	15,126	8,867	335	24,328	-2.9%
Nov-08	15,096	8,966	348	24,410	-2.4%
Dec-08	15,111	8,925	338	24,374	-2.1%
Jan-09	15,058	8,951	345	24,354	-2.1%
Feb-09	15,020	8,910	374	24,304	-0.4%
Mar-09	14,848	9,160	419	24,427	-0.6%
Apr-09	14,678	9,270	473	24,421	-0.8%
May-09	14,705	9,247	572	24,524	-0.2%
Jun-09	14,727	9,164	664	24,555	0.6%
Jul-09	14,804	9,056	673	24,533	1.5%
Aug-09	14,953	8,875	731	24,559	1.2%
Sep-09	15,137	8,866	775	24,778	2.2%
Oct-09	15,181	8,897	812	24,890	2.3%
Nov-09	15,294	8,772	849	24,915	2.1%
Dec-09	15,349	8,786	918	25,053	2.8%
Jan-10	15,386	8,713	924	25,023	2.7%
Feb-10	15,352	8,561	927	24,840	2.2%
Mar-10	15,480	8,515	984	24,979	2.3%
Apr-10	15,443	8,364	1,016	24,823	1.6%
May-10	15,372	8,351	1,043	24,766	1.0%
Jun-10	15,385	8,381	1,058	24,824	1.1%
Jul-10	15,267	8,370	1,088	24,725	0.8%
Aug-10	15,275	8,389	1,062	24,726	0.7%
Sep-10	15,186	8,269	1,080	24,535	-1.0%
Oct-10	15,104	8,255	1,123	24,482	-1.6%
Nov-10	14,928	8,309	1,160	24,397	-2.1%
Dec-10	14,809	8,330	1,184	24,323	-2.9%
Jan-11	14,721	8,337	1,247	24,305	-2.9%
Feb-11	14,788	8,284	1,252	24,324	-2.1%
Mar-11	14,537	8,277	1,286	24,100	-3.5%
Apr-11	14,743	8,417	1,315	24,475	-1.4%
May-11	14,667	8,412	1,345	24,424	-1.4%
Jun-11	14,649	8,505	1,386	24,540	-2.1%

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

Baseline Scenario (300% FPL)

Ending Enrollment	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
WVCHIP Gold & Blue	23,154	23,154	23,154	11,721	11,721	11,721	11,721	11,721
WVCHIP Premium	1,386	1,782	2,118	2,454	2,622	2,622	2,622	2,622
Total	24,540	24,936	25,272	14,175	14,343	14,343	14,343	14,343

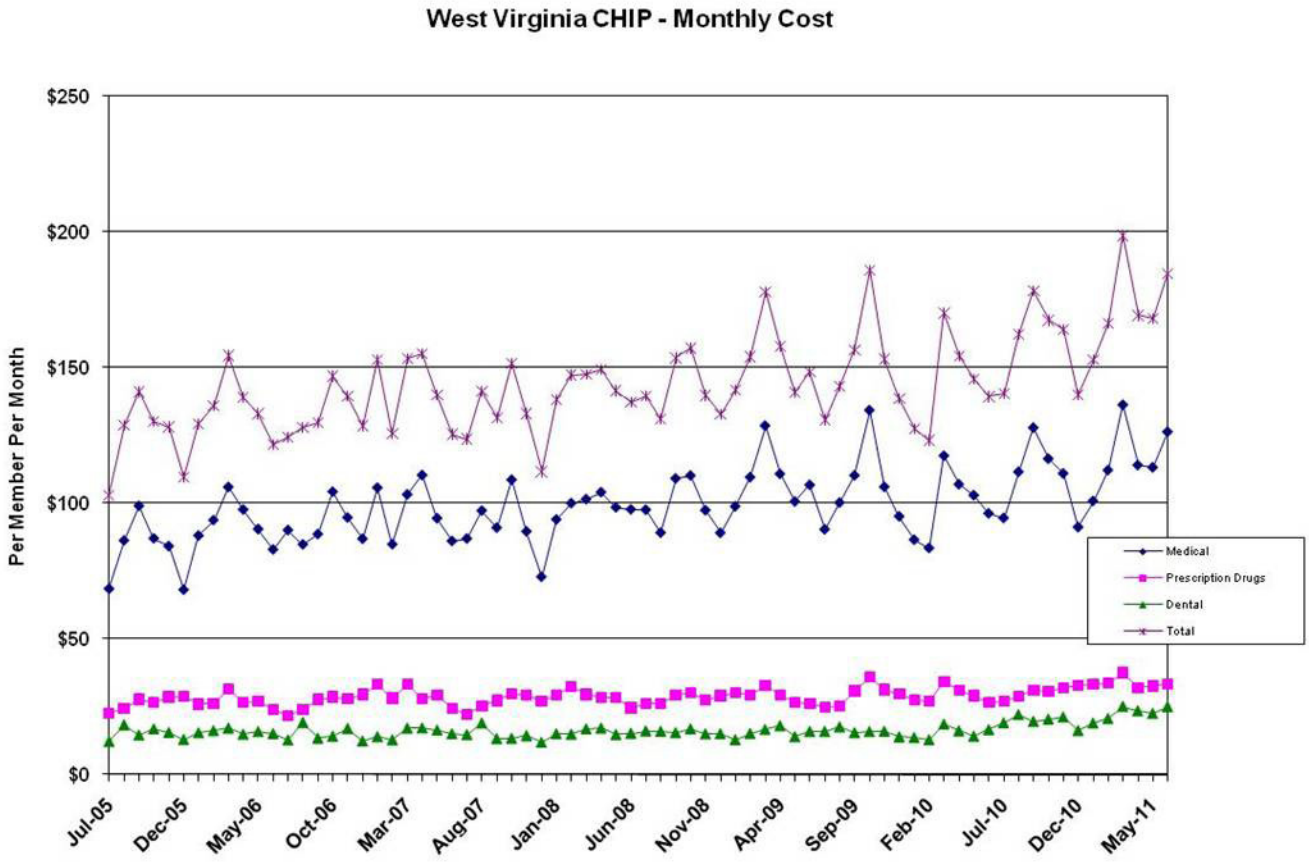
CLAIM COST AND TREND ANALYSIS

We have continued to utilize the medical, dental and prescription drugs trend assumptions from the March 31, 2011 Quarterly Report. The trend assumptions are 8% 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 with the exception of dental trends. It is noteworthy to comment that most recently, dental trend rates have remained above the 8% trend assumption due to higher reimbursement levels. As we review trends over different time periods, the twelve months analysis reflects lower overall trend than the six months and the nine months analysis. The table below summarizes WV CHIP experience over the last six months, nine months and twelve months as of June 30, 2011. Overall trend experience has been favorable, with a composite trend of 12.7% 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	18.4%	10.0%	10.2%
Dental	47.6%	40.6%	36.3%
Prescription Drugs	15.3%	9.3%	8.9%
Composite	20.9%	13.0%	12.7%

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 2011. 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. The trends for each of the three categories are relatively flat over the seven years period.

FINANCIAL PROJECTION – STATE FISCAL YEARS 2011-2018

Under the Baseline Scenario, we have assumed State funding to be $10,425,628 in FY 2011, $10,925,514 in FY 2012 and in future years. At the Federal level, the Federal funding for West Virginia is assumed to be $41,268,373 in FY 2011, and we have assumed that this funding remains constant in the future.

The updated incurred claims for FY 2011 is $49,289,347 based on the fiscal year 2011 average enrollment of 24,446 children and the incurred claim per member per month cost data assumption of $168.02, as summarized in the following table.

Category	Current Report FY2011 Baseline Incurred Claims	Current Report FY2011 Baseline Per Member Per Month	3/31/11 Report FY2011 Baseline Per Member Per Month	12/31/10 Report FY2011 Baseline Per Member Per Month
Medical	$34,154,522	$116.43	$113.86	$110.55
Prescription Drugs	9,124,110	31.10	31.13	31.21
Dental	6,010,715	20.49	20.52	19.45
Total	$49,289,347	$168.02	$165.51	$161.21

The Baseline Scenario financial forecast for the Federal and State fiscal years 2011 through 2018 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 2018. At the Federal level, we are not projecting the Federal funding shortfall through FY 2018 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 2009 to 2011. IBNR projections have been recently lower to reflect current claim experience as illustrated.

STATEMENT OF ACTUARIAL OPINION

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

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

In my opinion, all estimated program and administrative costs of the agency under the plan, including incurred but unreported claims, will not exceed 90 percent of the funding available to the program for the future fiscal years 2011 through 2018 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 2011 through FY 2018 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 27, 2011

Chris Borcik
Associate of the Society of Actuaries
Member of the American Academy of Actuaries
Senior Actuarial Consultant
CCRC Actuaries, LLC
Reisterstown, Maryland
July 27, 2011

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2011 Quarterly Report

Baseline Scenario - 300% FPL

Available Funding - Beginning of the Year	2011	2012	2013	2014	2015	2016	2017	2018
Federal 2009	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2010	36,535,630	0	0	0	0	0	0	0
Federal 2011	41,268,373	35,137,346	0	0	0	0	0	0
Federal 2012	0	41,268,373	29,195,136	0	0	0	0	0
Federal 2013	0	0	41,268,373	19,200,618	0	0	0	0
Federal 2014	0	0	0	41,268,373	17,622,574	0	0	0
Federal 2015	0	0	0	0	41,268,373	26,095,553	0	0
Federal 2016	0	0	0	0	0	41,268,373	26,043,587	0
Federal 2017	0	0	0	0	0	0	41,268,373	20,698,064
Federal 2018	0	0	0	0	0	0	0	41,268,373
State 2009	$2,004,988	$0	$0	$0	$0	$0	$0	$0
State 2010	10,599,637	3,110,073	0	0	0	0	0	0
State 2011	10,425,628	10,425,628	2,682,235	0	0	0	0	0
State 2012	0	10,925,514	10,925,514	1,714,619	0	0	0	0
State 2013	0	0	10,925,514	10,925,514	2,732,656	0	0	0
State 2014	0	0	0	10,925,514	10,925,514	6,145,417	4,050,258	4,050,258
State 2015	0	0	0	0	10,925,514	10,925,514	10,925,514	10,925,514
State 2016	0	0	0	0	0	10,925,514	10,925,514	10,925,514
State 2017	0	0	0	0	0	0	10,925,514	10,925,514
State 2018	0	0	0	0	0	0	0	10,925,514

Program Costs	2011	2012	2013	2014	2015	2016	2017	2018
WVCHIP Gold & Blue								
Medical Expenses	$30,548,756	$34,378,328	$37,128,594	$30,198,853	$21,922,731	$23,676,549	$25,570,673	$27,616,327
Prescription Drugs Expenses	8,666,244	9,153,932	9,703,168	7,746,002	5,519,045	5,850,188	6,201,199	6,573,271
Dental Expenses	5,709,085	6,233,248	6,731,908	5,475,454	3,974,883	4,292,873	4,636,303	5,007,207
Administrative Expenses	4,010,648	4,196,379	4,406,198	3,484,267	2,459,129	2,582,085	2,711,189	2,846,749
WVCHIP Premium								
Medical Expenses	$1,613,990	$2,318,499	$3,030,960	$3,821,585	$4,632,978	$5,070,217	$5,475,834	$5,913,901
Prescription Drugs Expenses	457,866	645,545	828,289	1,025,008	1,219,624	1,310,010	1,388,610	1,471,927
Dental Expenses	301,630	433,291	566,439	714,195	865,831	947,544	1,023,348	$1,105,216
Administrative Expenses	271,661	380,626	485,873	597,446	705,596	750,900	788,445	$827,867
Total Program Costs								
Medical Expenses	$32,162,746	$36,696,827	$40,159,555	$34,020,438	$26,555,709	$28,746,766	$31,046,507	$33,530,228
Prescription Drugs Expenses	9,124,110	9,799,477	10,531,457	8,771,010	6,738,669	7,160,197	7,589,809	8,045,198
Dental Expenses	6,010,715	6,666,539	7,298,347	6,189,648	4,840,714	5,240,418	5,659,651	6,112,423
Administrative Expenses	4,282,309	4,577,005	4,892,071	4,081,713	3,164,725	3,332,985	3,499,634	3,674,616
FQHC/RHC Payment	1,991,775	2,000,000	2,190,391	1,858,885	1,455,335	1,575,607	1,701,655	1,837,787
Premiums (WVCHIP Premium)	$458,803	$680,592	$890,560	$1,122,571	$1,359,155	$1,482,907	$1,596,329	$1,718,427
Program Revenues - Interest	$248,393	$263,827	$264,604	$254,168	$265,148	$301,956	$397,196	$515,034
Program Revenues - Drugs Rebates	703,251	731,381	760,636	791,061	822,703	855,611	889,835	925,428
Net Incurred Program Costs Excluding Interest	$52,409,602	$58,327,876	$63,420,625	$53,008,063	$40,573,295	$43,717,454	$47,011,092	$50,556,397
Net Paid Program Costs	52,162,602	57,799,876	62,986,625	53,819,063	41,549,295	43,446,454	46,728,092	50,251,397
Federal Share	$42,666,657	$47,210,583	$51,262,891	$42,846,417	$32,795,394	$41,320,339	$46,613,896	$50,041,363
State Share of Expenses - Net of Interest	9,494,552	10,853,466	11,893,130	9,907,478	7,512,753	2,095,159	0	0
Beginning IBNR	$4,010,000	$4,257,000	$4,785,000	$5,219,000	$4,408,000	$3,432,000	$3,703,000	$3,986,000
Ending IBNR	4,257,000	4,785,000	5,219,000	4,408,000	3,432,000	3,703,000	3,986,000	4,291,000

APPENDIX A

West Virginia Children's Health Insurance Program

June 30, 2011 Quarterly Report

Baseline Scenario - 300% FPL

Funding Sources - End of the Year	2011	2012	2013	2014	2015	2016	2017	2018
Federal 2009	$0	$0	$0	$0	$0	$0	$0	$0
Federal 2010	0	0	0	0	0	0	0	0
Federal 2011	35,137,346	0	0	0	0	0	0	0
Federal 2012	0	29,195,136	0	0	0	0	0	0
Federal 2013	0	0	19,200,618	0	0	0	0	0
Federal 2014	0	0	0	17,622,574	0	0	0	0
Federal 2015	0	0	0	0	26,095,553	0	0	0
Federal 2016	0	0	0	0	0	26,043,587	0	0
Federal 2017	0	0	0	0	0	0	20,698,064	0
Federal 2018	0	0	0	0	0	0	0	11,925,074
Federal Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State 2009	$0	$0	$0	$0	$0	$0	$0	$0
State 2010	3,110,073	0	0	0	0	0	0	0
State 2011	10,425,628	2,682,235	0	0	0	0	0	0
State 2012	0	10,925,514	1,714,619	0	0	0	0	0
State 2013	0	0	10,925,514	2,732,656	0	0	0	0
State 2014	0	0	0	10,925,514	6,145,417	4,050,258	4,050,258	4,050,258
State 2015	0	0	0	0	10,925,514	10,925,514	10,925,514	10,925,514
State 2016	0	0	0	0	0	10,925,514	10,925,514	10,925,514
State 2017	0	0	0	0	0	0	10,925,514	10,925,514
State 2018	0	0	0	0	0	0	0	10,925,514
State Shortfall	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***
State Shortfall – 90% Funding Requirement	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***	***$0***

CCRC Actuaries, LLC

415 Main Street
Reisterstown, MD 21136

Email: info@ccrcactuaries.com

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

December 14, 2010

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 November 2011. We conclude that the plan will continue to meet the statutory requirement of 10% reserve in FY 2012 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 2018 based on the assumption that future funding remains constant. After the September 30, 2011 Quarterly Report was issued in October 2011, several changes have occurred in the program:

- Enrollment for the CHIP Program has slightly increased from 24,540 in June 2011 to 24,835 as of November 2011.

- November 2011 claim experience showed the projected incurred FY 2012 expenditures to be $54,732,413, a decrease of $311,494 from $ 55,043,907 in the September 30, 2011 Quarterly Report.

- The categories of FY 2012 medical, dental and prescription drug expenses in the current claim experience through November 2011 showed favorable experience over the September 30, 2011 Quarterly Report.

- Overall current PMPM cost for Fiscal Year 2012 is now projected to be $183.85, down from the projected $185.41 PMPM cost in the September 30, 2011 Quarterly Report. Medical PMPM for Fiscal Year 2012 is now projected to be $126.74, down from the projected $128.38 PMPM cost in the September 30, 2011 Quarterly Report. Dental PMPM for Fiscal Year 2012 is now projected to be $23.63, slightly up from the projected $23.19 PMPM cost in the September 30, 2011 Quarterly Report. Prescription Drugs PMPM for Fiscal Year 2012 is now projected to be $33.47, slightly down from the projected $33.84 PMPM cost in the September 30, 2011 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 enrollment and utilized our trend assumptions with the claim lag data. Actuarial methods, considerations and analyses relied on in forming my opinion conforms to the appropriate standard of practice as promulgated by the Actuarial Standards Board.

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

Sincerely,

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

Program Outreach and Health Awareness

A Continuing Community Partnership

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

A Targeted Approach

Based on health insurance survey data from the U.S. Census Bureau's "2010 Annual Social and Economic Supplement," WVCHIP continues to prioritize outreach efforts to the top fifth of our counties *(shown on page 44)* in the State with either higher estimated numbers or percentages of uninsured children. Some potential impact of these efforts at the county level can be seen in the Statistical Section in Tables 9 and 10 *(shown on Page 52 and 53)*.

Public Information via the Helpline, Website, and WVinRoads

WVCHIP continues to make application and program information available through its 1-877-982-2447 toll-free Helpline, which averages over 1,700 calls a month and mails out about 400 applications a month. Information is also available through the agency's website at www.chip.wv.gov where program guidelines and applications can be downloaded and printed. The WVCHIP website provides a wealth of information to the public about the agency, its governance, applying and enrolling, benefits, major annual reports, program statistics, and other program and health related information.

An online electronic application process that allows people to apply from the convenience of home and print out their own applications is available by the WVDHHR Rapids Project at www.wvinroads.org. Many *INROADS* users who have evaluated the online application process have commented on its ease of use, costs avoided from travel to pick up applications, and time savings from having to wait in line at local offices.

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

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

For above approaches to outreach, WVCHIP turns to the WV Healthy Kids and Families Coalition (WVHKF), a group of community and faith-based organizations. The WV Council of Churches serves as the fiscal agent for this group which also includes local community health centers, school nurses, child care agencies, and faith based community programs among others. Their efforts include a monthly e-bulletin that goes out to all members interested in children's health issues as well as organizing West Virginia's annual "Growing Healthy Kids" conference. This conference has included nationally recognized speakers for key topics such as oral health, prenatal care, as well as workshops for preventive health and mental health.

Many participating coalition members keep CHIP applications at their work sites and help refer applicants to either the CHIP Helpline or local DHHR offices for assistance. Last year as many as 100 statewide partners ordered health informational materials from WVCHIP's website to promote children's health coverage at local events sponsored in their communities.

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

Health Collaborative Efforts

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

The following projects and collaborative efforts were implemented in fiscal year 2011:

- ★ Continued participation in efforts to promote healthy lifestyles with the West Virginia Immunization Network, Action for Healthy Kids Coalition, and West Virginia Oral Health Coalition.
- ★ WVCHIP continued to promote full periodic and comprehensive well-child visits recommended by pediatricians in a "HealthCheck" Campaign. WVCHIP sponsored health messages focusing on vision, dental, development, and hearing screenings that appeared in Child Care Provider Quarterly Magazine. WVCHIP supports the "HealthCheck" form as a standard form or model for provider use in all well-child exam visits.
- ★ WVCHIP participates on the Oral Health Advisory Board to advise implementation of the State's Oral Health Plan, first reported to the Legislature in 2010. In 2011, WVCHIP took a lead role in collaboration with the WVU School of Dentistry to help establish an oral health program for infants and toddlers that could be delivered in primary care physician offices.
- ★ Recognizing some children's health coverage was jeopardized when parents lost employer coverage due to workforce reductions, WVCHIP continued to support dislocated workers this year. Staff members or outreach partners were on hand as part of the Governor's Rapid Response teams to provide CHIP information at 6 sessions throughout the State to several hundred dislocated workers.
- ★ WVCHIP information flyers and pocket slide guidelines on the "ABC's of Baby Care" were provided in Day One Program packets to be distributed to all new mothers at participating West Virginia hospitals.
- ★ WVCHIP worked in close collaboration with West Virginia Alliance for Sustainable Families, the lead agency, who, along with community partners working with West Virginia Council of Churches, was awarded a 2 year federal grant in 2010 to promote children's coverage through outreach. They have sponsored a number of public events along with press releases to encourage families to sign up for CHIP in order to be able to get their sports physicals. They also have enabled parents to enroll their children in CHIP at the BB&T bank-mobile bus that goes through West Virginia towns after January to help provide assistance in tax filing.

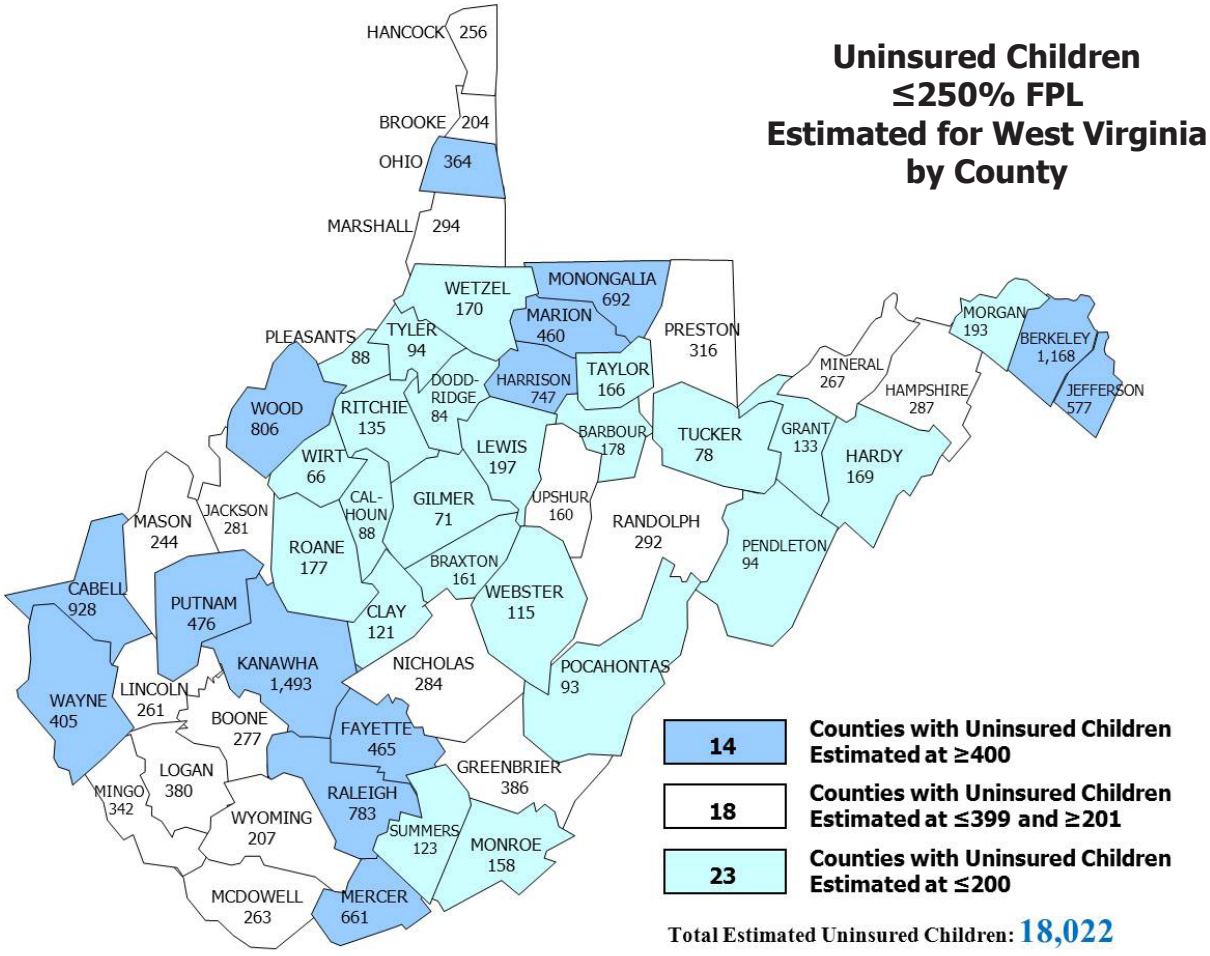
Health Collaborative Efforts (continued)

- ★ 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.

DanceDance Revolution State Tournament Sponsorship:

WVCHIP was a major sponsor of a statewide tournament in middle schools and high schools that provided information about the CHIP program as part of signing up for participation in the tournament. The tournament culminated in June 2011 with the State Championship in which the top three competitors were awarded monetary prizes.

Targeted Outreach For Uninsured Children



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

Statistical Section

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

Table 1: Enrollment

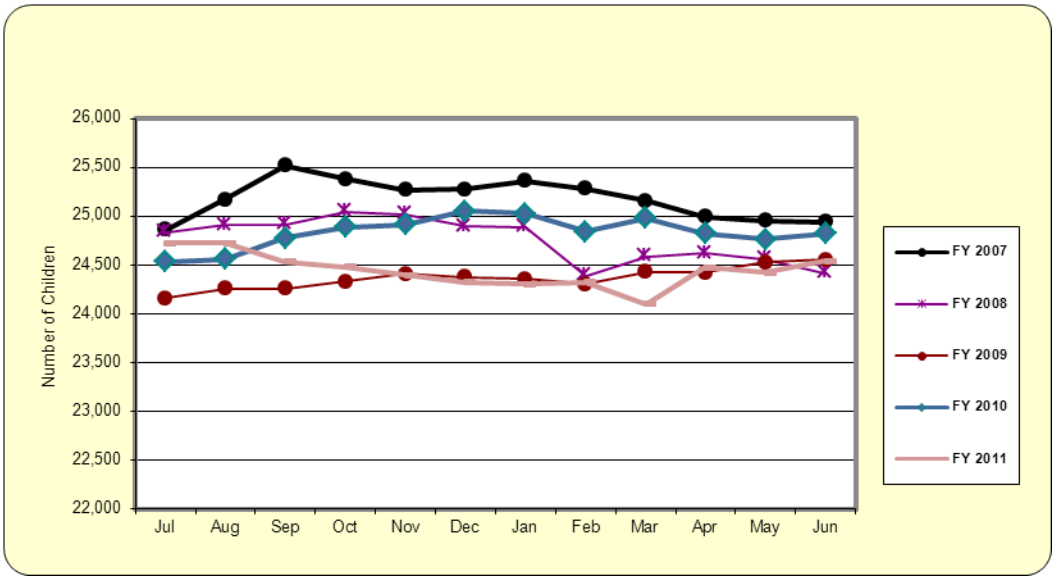
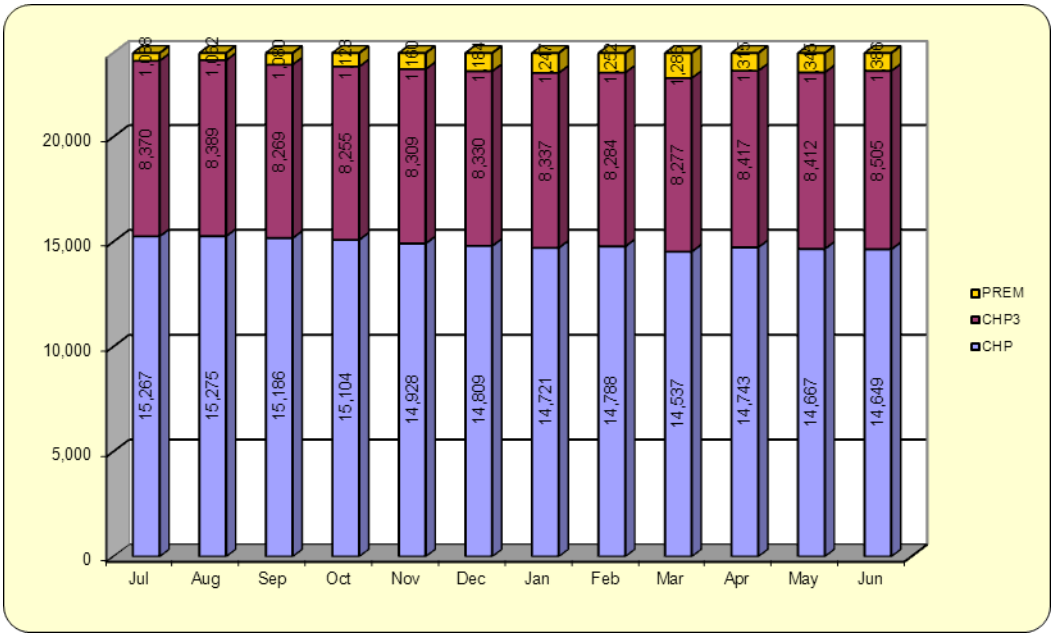
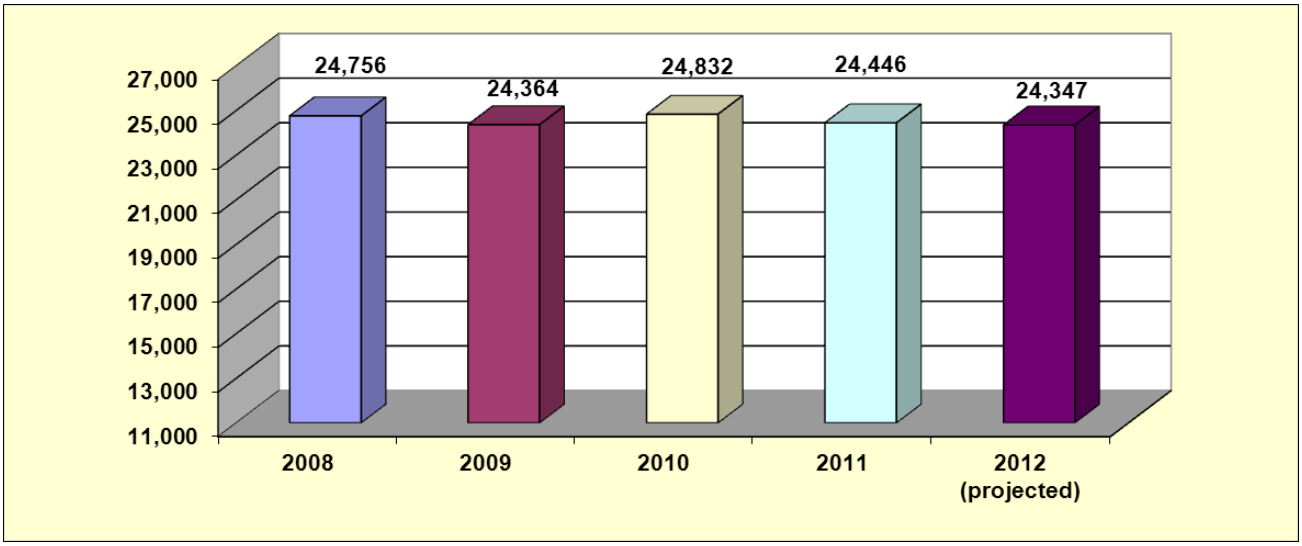


Table 2: Enrollment Detail



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

Table 3: Average Enrollment
SFY 2004 - 2010



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	37,829	-0.2%

Total unduplicated number of children ever enrolled as of June 30, 2011 in WVCHIP since inception:
135,433

Table 4: Enrollment By Gender

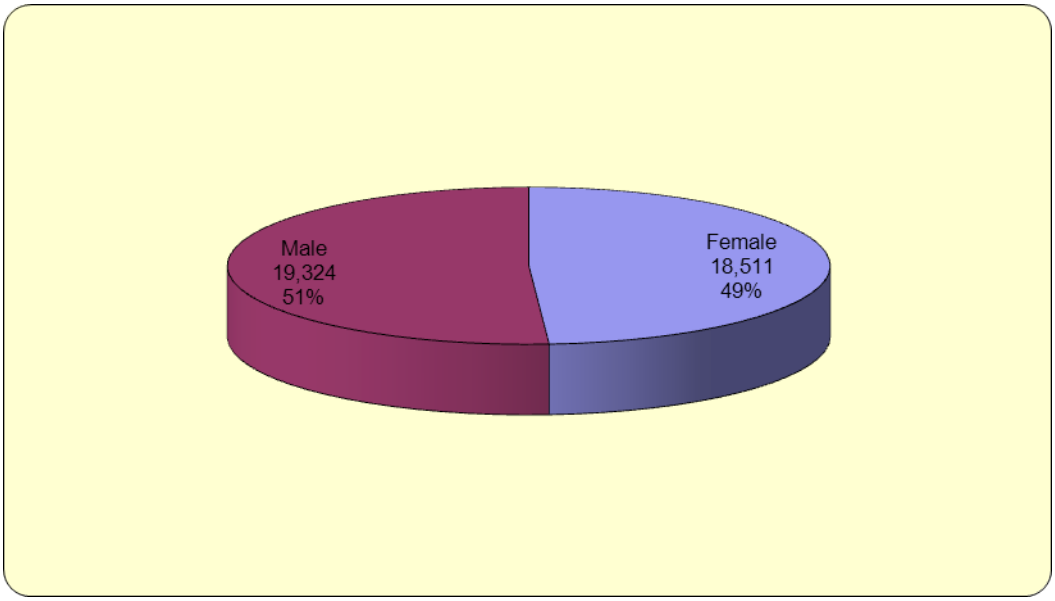


Table 5: Enrollment By Age

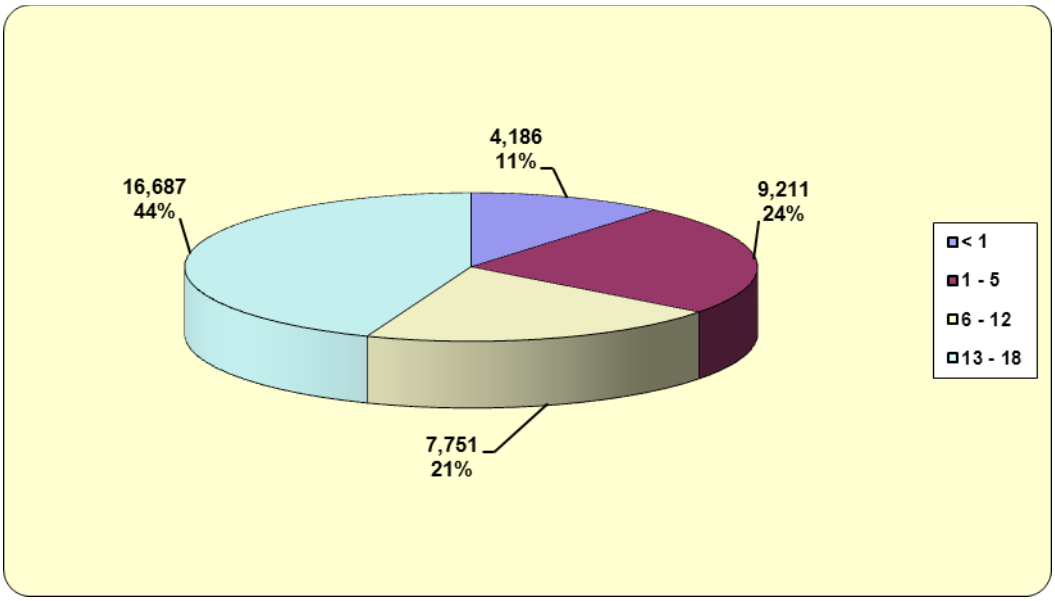
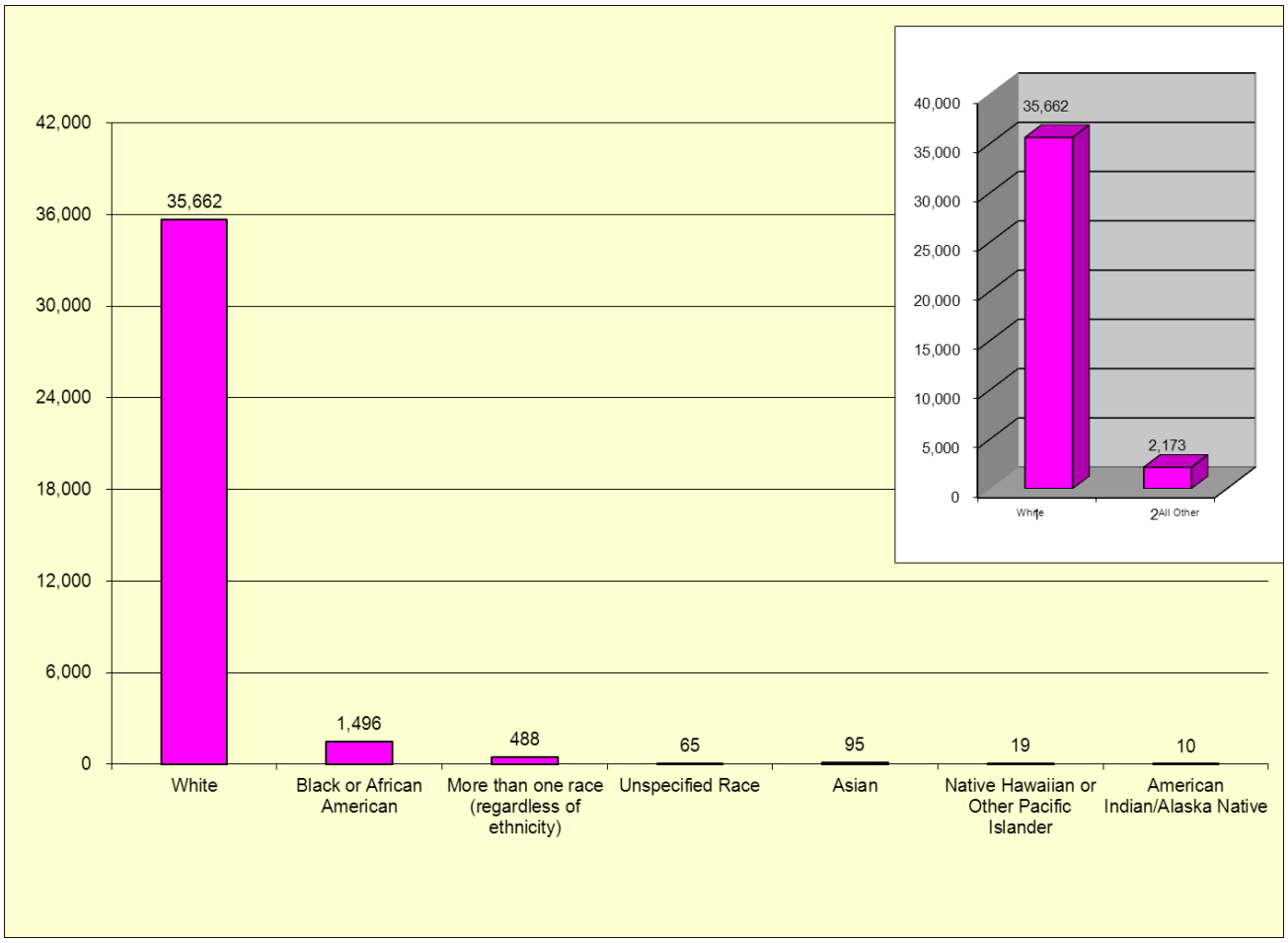
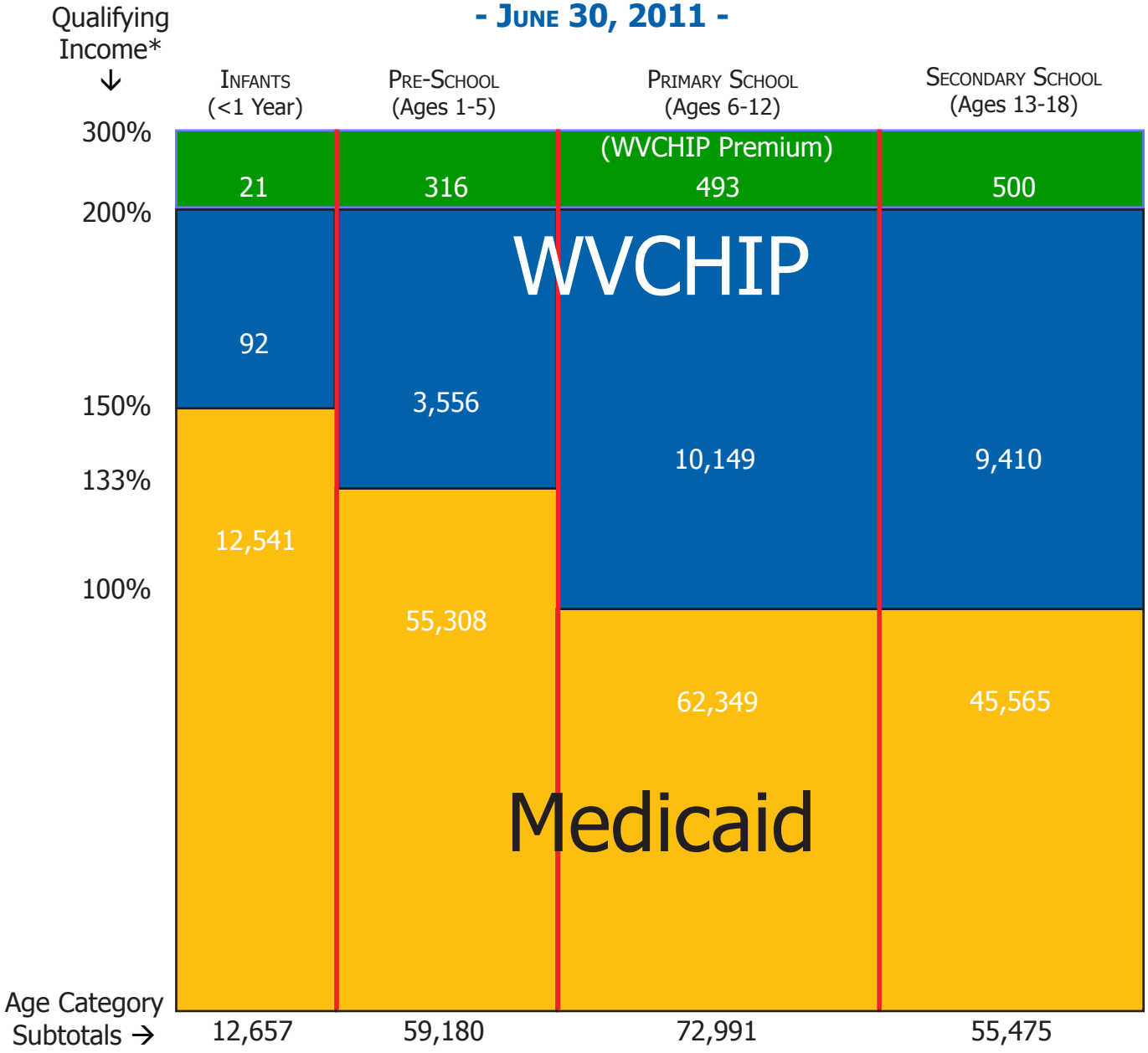


Table 6: Enrollment By Race/Ethnicity



Race/Ethnicity	WV CHIP Population	% of WV CHIP Population	WV Population Under 18 Years	% of WV Population Under 18 Years
White	35,662	94.3%	390,718	93.9%
Black or African American	1,496	4.0%	14,147	3.4%
More than one race (regardless of ethnicity)	488	1.3%	6,242	1.5%
Unspecified Race	65	0.2%	1,248	0.3%
Asian	95	0.3%	2,913	0.7%
Native Hawaiian or Other Pacific Islander	19	0.1%	83	0.0%
American Indian/Alaska Native	10	0.0%	832	0.2%
Total	**37,835**	**100.0%**	**416,100**	**100.0%**

Table 7: Health Coverage Of West Virginia Children By WVCHIP And Medicaid - June 30, 2011 -



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

Total WVCHIP Enrollment **24,540** **Total WV Medicaid Enrollment** **175,763**

Total # of Children Covered by WVCHIP and Medicaid - 200,303

Table 8: Annual Re-Enrollment and Non-Responses Upon Renewal
July 2010 through June 2011

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
Webster	124	39	7	17.9%	23	18.5%
Pendleton	102	24	5	20.8%	19	18.6%
Pleasants	75	30	16	53.3%	14	18.7%
Calhoun	98	41	12	29.3%	19	19.4%
Wetzel	169	62	17	27.4%	35	20.7%
Preston	411	118	20	16.9%	87	21.2%
Grant	153	58	22	37.9%	34	22.2%
Roane	243	83	17	20.5%	54	22.2%
Wood	981	374	109	29.1%	220	22.4%
Clay	136	62	22	35.5%	31	22.8%
Morgan	255	97	26	26.8%	59	23.1%
Tyler	95	34	9	26.5%	22	23.2%
Doddridge	129	50	11	22.0%	30	23.3%
Mason	245	79	17	21.5%	57	23.3%
Pocahontas	126	42	7	16.7%	30	23.8%
Raleigh	1,083	377	69	18.3%	258	23.8%
Monongalia	184	64	16	25.0%	44	23.9%
Wirt	104	38	6	15.8%	25	24.0%
Brooke	255	110	32	29.1%	63	24.7%
Braxton	182	72	14	19.4%	45	24.7%
Mineral	322	127	28	22.0%	80	24.8%
Wyoming	358	136	34	25.0%	89	24.9%
Mingo	621	255	61	23.9%	155	25.0%
Lewis	243	104	28	26.9%	61	25.1%
Marshall	314	120	17	14.2%	79	25.2%
Mercer	249	104	28	26.9%	65	26.1%
Putnam	589	230	41	17.8%	154	26.1%
Monroe	204	79	20	25.3%	54	26.5%
Greenbrier	527	225	52	23.1%	140	26.6%
Ohio	446	174	34	19.5%	119	26.7%
Upshur	312	129	20	15.5%	84	26.9%
Lincoln	345	144	33	22.9%	94	27.2%
Ritchie	124	60	20	33.3%	34	27.4%
Wayne	492	196	39	19.9%	137	27.8%
Marion	621	257	59	23.0%	173	27.9%
Hampshire	244	112	36	32.1%	68	27.9%
Hancock	305	116	17	14.7%	85	27.9%
Jackson	347	133	24	18.0%	98	28.2%
McDowell	982	412	81	19.7%	282	28.7%
Harrison	828	390	95	24.4%	242	29.2%
Hardy	142	59	9	15.3%	42	29.6%
Jefferson	386	160	24	15.0%	115	29.8%
Tucker	104	41	8	19.5%	31	29.8%
Randolph	351	148	31	20.9%	105	29.9%
Taylor	183	92	28	30.4%	55	30.1%
Logan	499	233	57	24.5%	151	30.3%
Nicholas	352	140	22	15.7%	108	30.7%
Kanawha	1,935	837	118	14.1%	609	31.5%
Fayette	714	342	80	23.4%	225	31.5%
Boone	278	134	27	20.1%	92	33.1%
Berkeley	1,132	508	78	15.4%	383	33.8%
Cabell	912	457	84	18.4%	312	34.2%
Summers	197	93	15	16.1%	71	36.0%
Barbour	220	109	19	17.4%	83	37.7%
Gilmer	76	38	2	5.3%	32	42.1%
Totals	**21,104**	**8,748**	**1,823**	**20.8%**	**5,876**	**27.8%**
12-Mo. Ave.		***729***	***152***	***20.8%***	***490***	***27.8%***

MEDIAN

Table 9: Enrollment Changes By County
As % Difference from July 2010 through June 2011

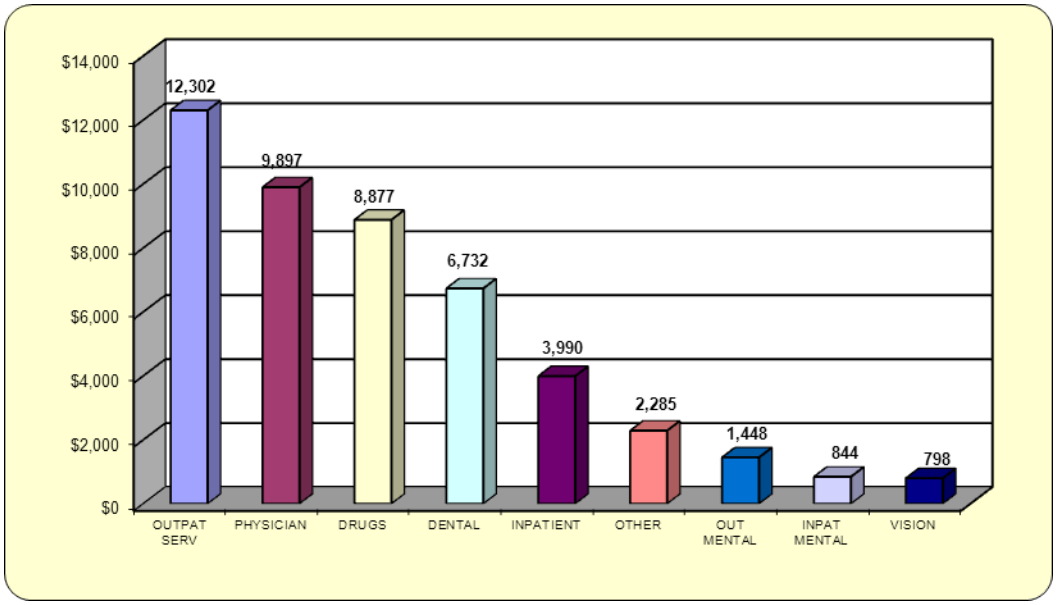
County	Total Enrollees July 2010	Total Enrollees June 2011	Difference	% Change
Wetzel	186	229	43	19%
Pocahontas	143	158	15	9%
Hampshire	287	314	27	9%
Pendleton	108	118	10	8%
Pleasants	98	106	8	8%
Ritchie	139	150	11	7%
Jackson	403	433	30	7%
Tyler	123	132	9	7%
Monroe	220	235	15	6%
Putnam	676	721	45	6%
Hancock	354	377	23	6%
Preston	487	518	31	6%
Randolph	423	449	26	6%
Morgan	253	268	15	6%
Jefferson	446	470	24	5%
Mineral	299	313	14	4%
Taylor	217	226	9	4%
Hardy	160	165	5	3%
Webster	152	156	4	3%
Clay	171	175	4	2%
McDowell	321	328	7	2%
Monongalia	753	769	16	2%
Kanawha	2,291	2,319	28	1%
Summers	211	213	2	1%
Calhoun	116	117	1	1%
Boone	311	313	2	1%
Raleigh	1,270	1,277	7	1%
Mercer	1,147	1,152	5	0%
Doddridge	132	132	0	0%
Wood	1,160	1,148	-12	-1%
Harrison	942	929	-13	-1%
Roane	305	300	-5	-2%
Upshur	395	388	-7	-2%
Braxton	220	216	-4	-2%
Grant	171	167	-4	-2%
Brooke	289	282	-7	-2%
Fayette	831	804	-27	-3%
Berkeley	1,309	1,260	-49	-4%
Tucker	124	119	-5	-4%
Cabell	1,050	1,006	-44	-4%
Lincoln	376	360	-16	-4%
Marion	723	682	-41	-6%
Mingo	374	352	-22	-6%
Mason	291	273	-18	-7%
Barbour	268	251	-17	-7%
Nicholas	404	376	-28	-7%
Lewis	300	279	-21	-8%
Greenbrier	616	572	-44	-8%
Gilmer	88	81	-7	-9%
Ohio	512	471	-41	-9%
Wirt	112	103	-9	-9%
Marshall	356	327	-29	-9%
Logan	577	525	-52	-10%
Wayne	600	544	-56	-10%
Wyoming	435	392	-43	-11%
Totals	**24,725**	**24,540**	**-185**	**-1%**
12-Mo. Ave.		***24,679***	***-15***	***0%***

Median

Table 10: Enrollment Changes By County
As % of Children Never Before Enrolled from July 2010 through June 2011

County	Total Enrollees July 2010	Total Enrollees June 2011	New Enrollees Never in Program	New Enrollees As % of Jun-11	
Hardy	160	165	86	52%	
Hampshire	287	314	128	41%	
Jefferson	446	470	188	40%	
Marshall	356	327	127	39%	
Boone	311	313	120	38%	
Mineral	299	313	119	38%	
Wetzel	186	229	87	38%	
Nicholas	404	376	142	38%	
Hancock	354	377	142	38%	
Berkeley	1,309	1,260	469	37%	
Gilmer	88	81	29	36%	
Barbour	268	251	88	35%	
Monongalia	753	769	267	35%	
Morgan	253	268	93	35%	
Randolph	423	449	152	34%	
Preston	487	518	173	33%	
Kanawha	2,291	2,319	773	33%	
Jackson	403	433	144	33%	
Marion	723	682	226	33%	
Cabell	1,050	1,006	329	33%	
Raleigh	1,270	1,277	414	32%	
Pleasants	98	106	34	32%	
Braxton	220	216	69	32%	
Taylor	217	226	72	32%	
Grant	171	167	53	32%	**Median**
Monroe	220	235	74	31%	
Webster	152	156	49	31%	
Wood	1,160	1,148	358	31%	
Roane	305	300	93	31%	
Wayne	600	544	166	31%	
Putnam	676	721	220	31%	
McDowell	321	328	100	30%	
Mercer	1,147	1,152	351	30%	
Tyler	123	132	40	30%	
Upshur	395	388	117	30%	
Mason	291	273	82	30%	
Pocahontas	143	158	47	30%	
Harrison	942	929	275	30%	
Logan	577	525	155	30%	
Ritchie	139	150	44	29%	
Wirt	112	103	30	29%	
Mingo	374	352	101	29%	
Greenbrier	616	572	164	29%	
Summers	211	213	61	29%	
Fayette	831	804	228	28%	
Lincoln	376	360	98	27%	
Lewis	300	279	74	27%	
Doddridge	132	132	34	26%	
Calhoun	116	117	30	26%	
Wyoming	435	392	99	25%	
Ohio	512	471	116	25%	
Pendleton	108	118	28	24%	
Clay	171	175	40	23%	
Brooke	289	282	62	22%	
Tucker	124	119	25	21%	
Totals	**24,725**	**24,540**	**7,885**	**32%**	
12-Mo. Ave.		***24,679***	***657***	***3%***	

Table 11: Expenditures by Provider Type
Accrual Basis



Expenditures by Provider Type
Accrual Basis

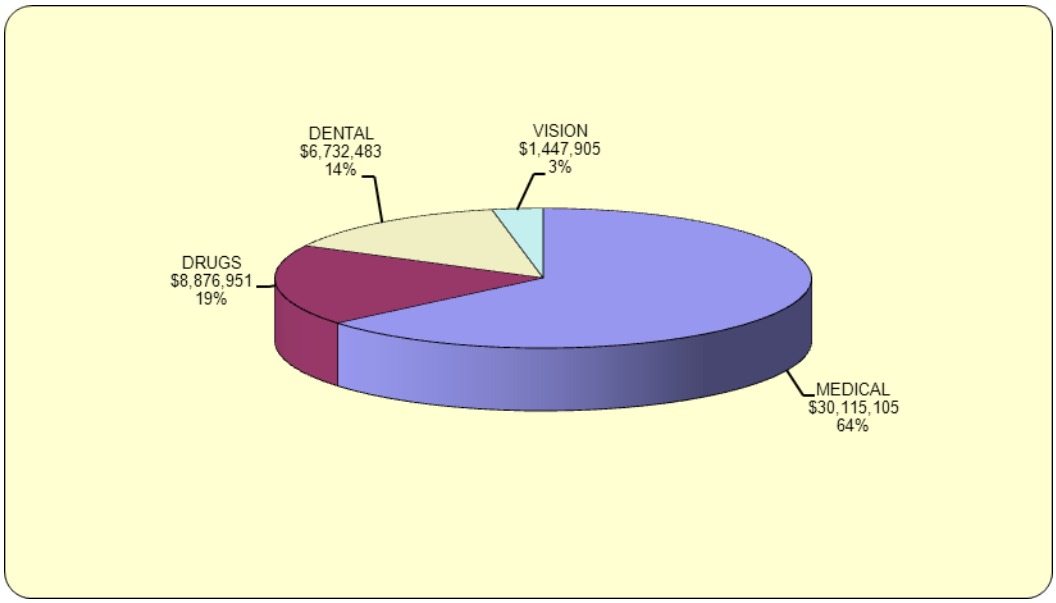


Table 12: Total Program Expenditures

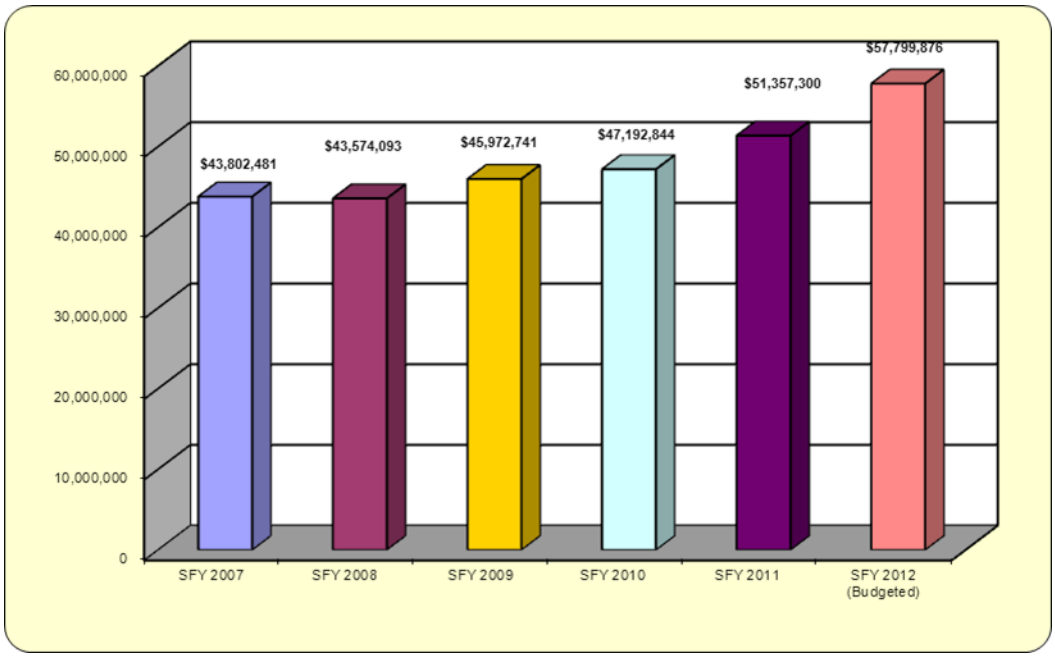
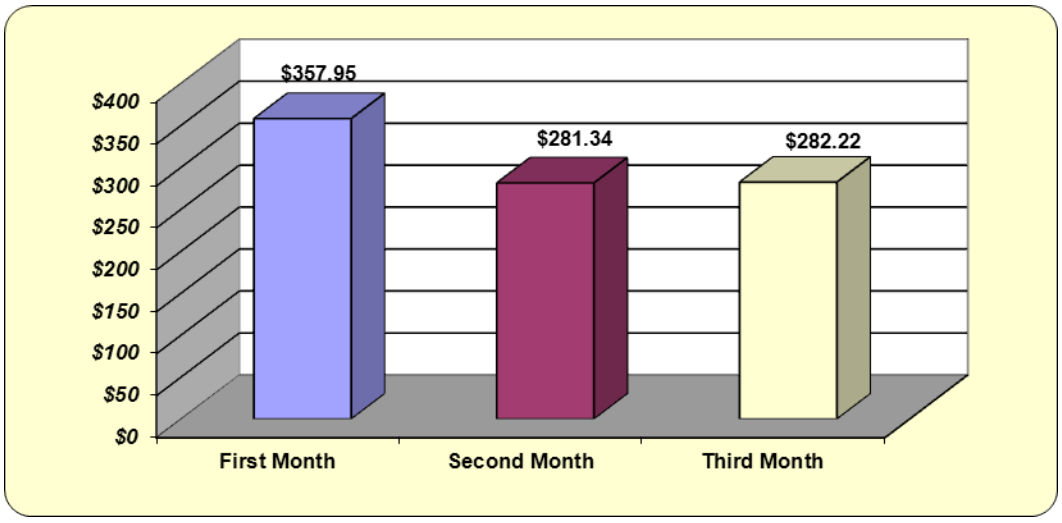


Table 13: Average Claimant Costs in First Three Months
Showing Pent Up Demand For Services Upon Enrollment



WVCHIP Set of Pediatric Core Measures 2010

In early 2010 the Secretary of the U.S. Department of Health and Human Services identified 24 pediatric core measures on which state CHIP and Medicaid programs could begin voluntary reporting. Since WVCHIP currently has no contracts with managed care plans who might already be reporting some of these measures, it must extract this information to the extent possible from claims data. Most of the data is extracted according to specifications developed for the Health Plan Effectiveness Data and Information Set (HEDIS®). Some core measures were developed by other states and for which they are the steward and were included into the core set by national panels of experts. One such example is the Emergency Department Utilization measure developed by the State of Maine. In this year's report, WVCHIP has expanded to report 14 measures in the national measure set. There are four measures which relate to perinatal health for which we hope to receive data gathered by the WV Department of Health and Human Resources in the coming year to expand further our set of reported measures. This set of measures is expected to be studied and evaluated and will become mandatory reporting for all states' CHIP and Medicaid child health programs in 2013.

HEDIS® is a set of standardized health performance measures that identifies only those individuals with a continuous 12 month enrollment period before the treatment or visit data can be included in calculating the measure. This helps to assure that the population measured is comparable from one health plan to another. HEDIS® specifications are annually reviewed and their sponsorship, support, and maintenance is under the aegis of the National Committee of Quality Assurance. HEDIS®-type data are usually those that meet the continuous 12 month enrollment definition for the denominator and which meet part of additional HEDIS® specifications in the numerator of the measure.

Table 14
Pediatric Core Measure #5 - Childhood Immunization Status

Specification: HEDIS 11: The percentage of children 2 years of age during the measurement year who were continuously enrolled 12 months prior to the child's section birthday, and who had four diptheria, tetanus, and acellular pertussis (DTAP), three polio (IPV), one measles mumps and rubella (MMR), two H influenza type B (Hib), three hepatitis B (HepB), one chicken pox (VZV), four pneumococcal conjugate vaccines (PCV), and two influenza (flu) by their second birthday. The measure calculates a rate for each vaccine and nine (9 combination rates).

Age Group	Immunization Type	Number of Continuously Enrolled 2010	Number Receiving Each Immunization 2010.	% Year 10	Number of Continuously Enrolled 2009	Number Receiving Each Immunization 2009	% Year 09
2 years old	DTaP (four immunizations)	44	34	77.3	39	30	77.0
	IPV (three immunizations)	44	44	100	39	39	100
	MMR (one immunization)	44	44	100	39	37	95.0
	Hib (two immunizations)	44	44	100	39	39	100
	Hepatitis B (three immunizations)	44	27	61.4	39	23	59.0
	VZV (one immunization)	44	44	100	39	39	100
	PCV (four immunizations)	44	29	65.9	39	32	82.0
	Hep A (two immunizations)	44	44	100	39	32	100
	RV (two or three immunizations)	44	43	100	39	39	100
	Influenza two immunizations)	44	44	100	39	39	100
	Total continuously enrolled	**44**	**44**	**90.4**	**39**	**39**	**91.3**

Table 15
Pediatric Core Measure #6 - Immunizations for Adolescents

Specification: HEDIS 11: The percentage of adolescents reaching 13 years of age during the measurement year and were continuously enrolled 12 months prior to the adolescent's 13th birthday, and who had one dose of meningococcal vaccine (MCV4) and one tetanus, diptheria toxoid and acellular pertussis vaccine (Tdap) or one tetanus, diptheria toxoid vaccine (Td) by their 13th birthday. The measure calculates a separate rate for each vaccine and combination rate for both vaccines.

Age Group	Immunization Type	Number of Continuously Enrolled	Number Receiving Immunizations	% Year 10	% Year 09
Adolescents	Administration	1,872			
			1,351	**72.2**	**68.0**
13 Years old	Combination (Meningococcal, Tdap/TD)				
	Meningococcal		1,351	72.2	68.0
	Tdap/TD		1,438	76.8	73.7
	Total	**1,872**		**72.2**	**68.0**

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

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

Specification: HEDIS 11: The percentage of members 2-17 years of age continuously enrolled for calendar year 2010 who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year, defined by CPT Codes 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 97802-97804

Age Group	Continuously Enrolled	BMI/Nutrition & Counseling	% with Measure for Year 10	% with Measure for Year 09
Age 2	211	0	0.00	0.00
Age 3	241	1	0.41	0.00
Age 4	246	0	0.00	0.00
Age 5	259	0	0.00	0.00
Age 6	280	0	0.00	0.00
Age 7-11	3046	3	0.01	0.07
Age 12 and up	4581	6	0.13	0.11
Total	8864	10	0.11	0.08

Table 17

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

Specification: HEDIS 11: The percentage of members who turned 15 months old during the calendar year 2010 who had six or more well-child visits with a Primary Care Physician 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 2010
10	0	0	0.00
10	1	0	0.00
10	2	0	0.00
10	3	1	10.0
10	4	1	10.0
10	5	3	30.0
10	6 or more	4	40.0
Total		9	90.0

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2009
9	0	0	0.00
9	1	1	11.1
9	2	0	0.00
9	3	1	11.1
9	4	1	11.1
9	5	4	44.4
9	6 or more	2	22.2
Total		9	100.0

Number of Continuously Enrolled Children	Number of Visits	Number of Children	% of children for Year 2008
17	0	1	5.8
17	1	2	11.7
17	2	1	5.8
17	3	1	5.8
17	4	2	11.7
17	5	7	41.1
17	6 or more	3	17.6
Total		17	100

Table 18
Pediatric Core Measures #11 & 12 - Well Child Visits for Birth to Six Years and Adolescent Well Visits

Specification for Birth to Six Visits: HEDIS 11: The number of children ages birth to six years enrolled for calendar year 2010 who had a well-child visit with a primary care provider as defined by CPT Codes: 99382, 99383, 99392, and 99303

Specification for Adolescent Visits: HEDIS 11: The number of adolescents from ages 12 to 19 enrolled during calendar year 2010 who had an adolescent wellness visit with a primary care provider as defined by CPT Codes: 99393-00385, 99393, and 99395

Age Group	Number of Continuously Enrolled Children	Number Having Well Visit	% Year 10	% Prior Year 09	% Prior Year 08
Well Child					
Less Than Or Equal To 15 Months	10	9	90.0	100	100
Third Year Of Life	241	183	75.9	74.6	64.5
Fourth Year Of Life	246	192	78	80.0	75.8
Fifth Year Of Life	259	197	76	80.8	76.3
Sixth Year Of Life	280	180	64.2	61	62.2
Total	**1,036**	**761**	**73.4**	**73.6**	**70.8**
Adolescents					
12 To 19 Years of Age	4,851	1,643	33.8	37.1	36.7
Total	**4,409**	**1,643**	**33.8**	**37.1**	**36.7**

Table 19
Pediatric Core Measure #13 - Preventive Dental Services

Specification: EPSDT 416 Measure: Unduplicated number of children enrolled for the calendar year 2010 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 2010	% Year 2009
37,786	16,052	42.4	41.6

Table 20
Pediatric Core Measure #14 - Access to Primary Care

Specification: HEDIS 11: The number of children ages 1 to 19 continuously enrolled in calendar year 2010 who received office visits/outpatient services for procedures coded to primary care services 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 10	% Prior Year 09	%Prior Year 08
12 to 24 Months	58	57	98.2	98.2	98.2
25 Months to 6 Years	1,218	1,175	96.4	97.2	95.2
7 to 11 Years	3,046	2,693	88.4	91.1	87.6
12 to 19 Years	4,581	3,891	84.9	88.3	85.2
Total	**8,903**	**7,816**	**87.7**	**90.5**	**90.0**

Table 21
Pediatric Core Measure #17 - Dental Treatment Services

Specification: EPSDT 416 Measure: Unduplicated number of children enrolled for calendar year 2010 receiving dental treatment services as a percentage of the total number of unduplicated enrollees in the program defined by HCPC Codes D1000-D1999 (ADA Codes D1000-D1999) as reported on CMS Form 416, Line 12B

Unduplicated Number of Children	Number of Children with Treatment Dental Visits	% Year 2010	% Year 2009
37,786	13,806	36.5	33.7

Table 22
Pediatric Core Measure #18 - Emergency Department Utilization

Specification: State of Maine, Measure Steward: The number of emergency department visits per member per year of all child and adolescent member enrolled and eligible during the calendar year 2010.

	Number of Members	Number of ER Users	Number of ER Encounters	Number of ER Encounters Per Person	Number of ER Encounters Per User
For Year 2010:	37,786	5,084	12,500	0.33	2.45
For Year 2009	38.465	0.039	14,535	0.37	1.60

Table 23
Pediatric Core Measure #20 - Annual Number Emergency Department Encounters by Asthma Patients

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

	Number of Asthmatics over Age 1	Number with ED Encounter for Asthma	% with Asthma ED Encounter 10
Total for 2010:	803	109	13.5
Total for 2009:	850	127	14.9

Table 24

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

Specification: HEDIS 11: The percentage of children 6-12 years of age newly prescribed with attention-deficity/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period, one of which occurs within 30 days of dispensing of the first ADHD medication. Two rates are reported, the initiation phase and the maintenance phase, as defined by CPT Codes: 90804-90815, 96150-96154, 98960-98962, 99078, 99201-99204, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383, 99384, 99393, 99394, 99401-99040, 99411, 99412, 99150, 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90875, 90876, 99221-99223, 99233, 99238, 99239, 99251-99255

A: Initiation Phase

Age Group	#Members Receiving ADHD Medications	# Members on Medicationwith follow-up visits	% Compliance for 2010 Year	% Compliance for 2009 Year
6 years	2	2	100	100
7 years	15	15	100	100
8 years	37	37	100	100
9 years	46	46	100	100
10 years	59	59	100	100
11 years	88	88	100	100
12 years	95	95	100	100
Total	**342**	**342**	**100**	**100**

B: Maintenance Phase

Age Group	# Continuation & Maintenance Members	# Members on Medication with follow-up visits	% Compliance for 2010 Year	% Compliance for 2009 Year
6 years	1	1	100	100
7 years	5	5	100	100
8 years	17	17	100	100
9 years	29	29	100	100
10 years	47	47	100	100
11 years	65	65	100	100
12 years	76	76	100	100
Total	**240**	**240**	**100**	**100**

Table 25
Pediatric Core Measure #22 - Diabetic Care

Specification: HEDIS 11 with added adult measure criteria applied to children also. The core measure shows percentage of pediatric patients with Type I and II diabetes with a hemoglobin HbA1c test in a 12-month measurement period. The adult criteria also includes the number of children enrolled for calendar year 2010 with Type I and II diabetes who also had - a serum cholesterol level (LDL-C) screening; an eye exam, and a screen for kidney disease, as defined by CPT Codes: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-00245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99304-99310; 99315, 99316, 99318, 99324-99328, 99334-99337, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291, 99281-99285.

Age Group	Diabetic Patients	HB1C Test	Rate of HbA1c Test	Eye Examinations	Rate of Eye Exams	LDLC Test	Rate of LDLC Test
4 to 5 Years	1	0	0.00	1	100	0	100
6 to 11 Years	13	12	92.3	13	100	2	15.3
12 to 18 Years	54	44	81.4	51	94.4	15	27.7
Total % Year 10	68	56	82.3	65	95.5	17	25.0
Total % Prior Year 09	60	53	88.3	59	98.3	18	30.0
Total % Prior Year 08	73	65	89.0	71	97.2	20	27.4

Table 26
Pediatric Core Measure #23 - Follow-Up After Hospitalization for Mental Illness

Specification: HEDIS 11: The percentage of discharges for members 6 years of age and older who were enrolled on the date of discharge and 30 days after discharge, who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days of discharge, and within 30 days of discharge defined by CPT Codes: 90801, 90802, 90804-90815, 90816-90819, 90821-90824, 90826-90829, 90845-90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99402-99404, 99411, 99412, 99510.

# 6 years & older Hospitalized with Mental Health Dx Year 2010	# With follow-up w/i (7) days of Discharge Year 2010	# With follow-up w/i (30) days of Discharge Year 2010	# 6 years & older Hospitalized with Mental Health Dx Year 2009	# With follow-up w/I (7) days of Discharge Year 2009	# With follow-up w/i (7) days of Discharge Year 2009
92	18	46	117	32	64

Table 27
West Virginia Measure - Vision Visits

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

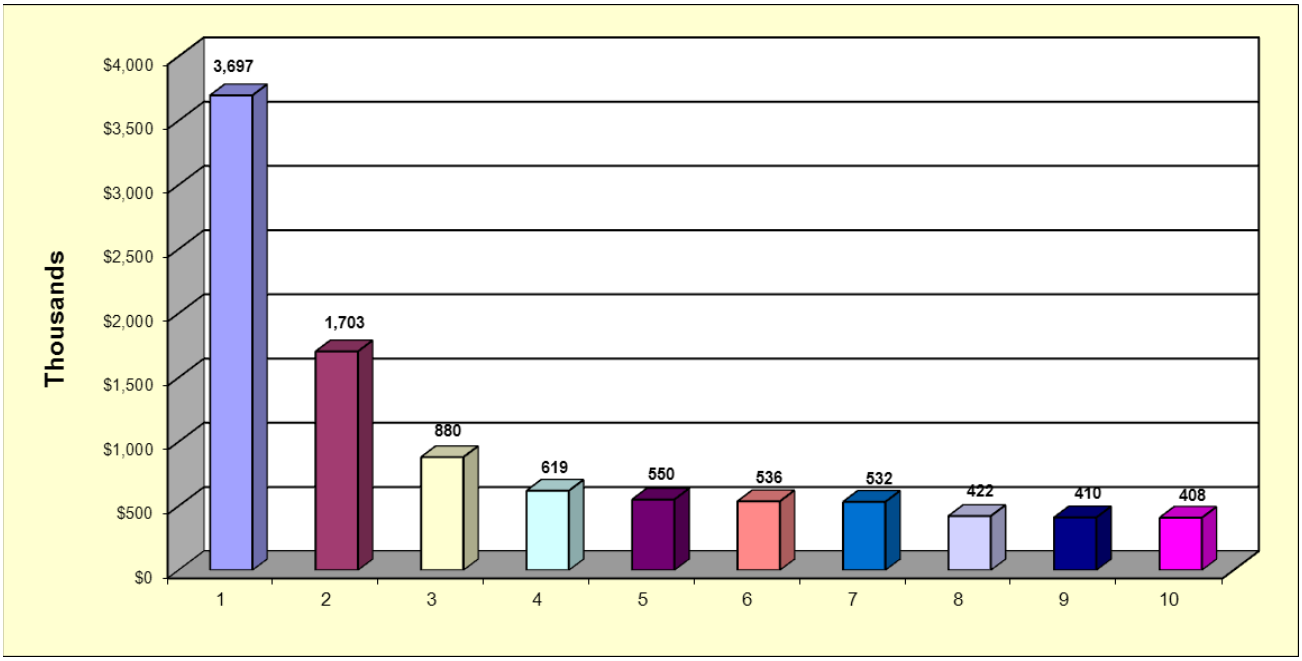
Age Group	Number of Continuously Enrolled Children	Number Having Vision Checkup Visit	% Year 10	%Prior Year 09	% Prior Year 08
Under 1 Year	1	-	0.00	0.00	0.00
1 to 5 Years	996	145	14.5	15.7	14.8
6 to 11 Years	3,326	1,096	32.9	33.7	33.7
12 to 18 Years	4,581	1,697	37	38.1	37.5
Total	**8,904**	**2,938**	**33.0**	**33.9**	**33.4**

Table 28
West Virginia Measure - Proper Use of Asthma Medications

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

Age Group	Asthma Patients	Number with Proper Uses of Medication	% Year 10	% Year 09	% Year 08
5 - 9 years	236	208	88.1	89.5	91.2
10-17 years	395	348	88.1	85.1	88.2
18-19 years	37	34	91.8	75.7	85.7
Total	668	590	88.3	86.3	89.3

Table 29: 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	Individual Psychotherapy Insight	(90806)
4	ER Exam - Extended - New Patient	(99284)
5	ER Exam - Intermediate - New Patient	(99283)
6	Ophthalmological Exam - Comprehensive - Est. Patient	(92014)
7	Office Visit - Intermediate - New Patient	(99203)
8	ER Exam - Comprehensive	(99285)
9	Periodic Comprehensive Wellness Exam Age 5-11 - Est. Patient	(99393)
10	Therapeutic Activities, 15 Minutes	(97530)

**As described in Current Procedure Terminology 2011 by the American Medical Association.*

Table 29: 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 Individual Psychotherapy Insight: requiring a face-to-face visit with a therapist for insight oriented, behavior modifying and/or supportive therapy for 45 to 50 minutes *(CPT 90806)*

4 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)*

5 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)*

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

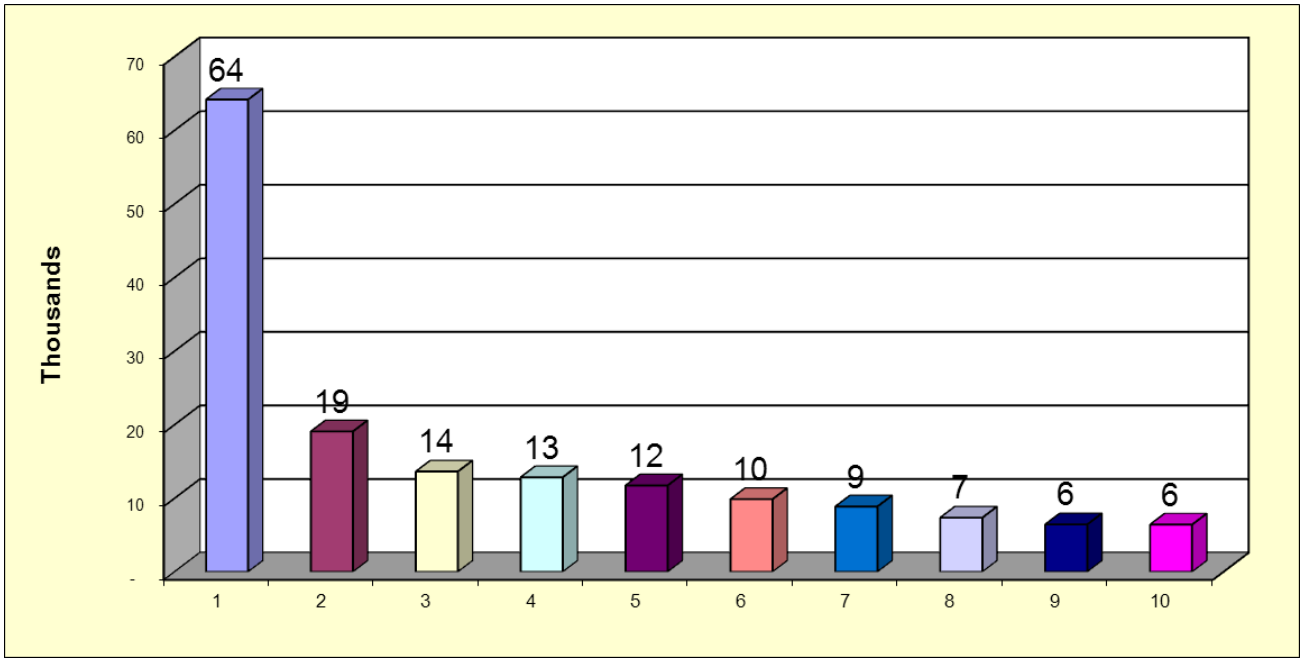
7 Office Visit - Intermediate - New Patient: for a new patient taking about 30 minutes of face-to-face time with the patient and/or family for problems of moderate severity; requires three key components including a detailed history, an exam, and medical decision making of low complexity (*CPT 99203)*

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

9 Periodic Comprehensive Wellness Exam Age 5-11 - Est. Patient: an age and gender specific preventive medical exam that includes appropriate history, exam, any needed counseling/anticipatory guidance/risk factor reduction interventions as well as ordering of appropriate immunizations and laboratory tests for an established patient. These exams are coded to the correct age/stage period and are guided by criteria established by the American Academy of Pediatrics *(CPT 99393)*

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

Table 30: 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	Individual Psychotherapy Insight	(90806)
6	Blood Count	(85025)
7	Test for Streptococcus	(87880)
8	ER Exam - Intermediate - New Patient	(99283)
9	Rx Management	(90862)
10	Immunization Administration - Each Add. Vaccine	(90472)

**As described in Current Procedure Terminology 2011 by the American Medical Association.*

Table 30: 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 Individual Psychotherapy Insight: requiring a face-to-face visit with a therapist for insight oriented, behavior modifying and/or supportive therapy for 45 to 50 minutes *(CPT 90806)*

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

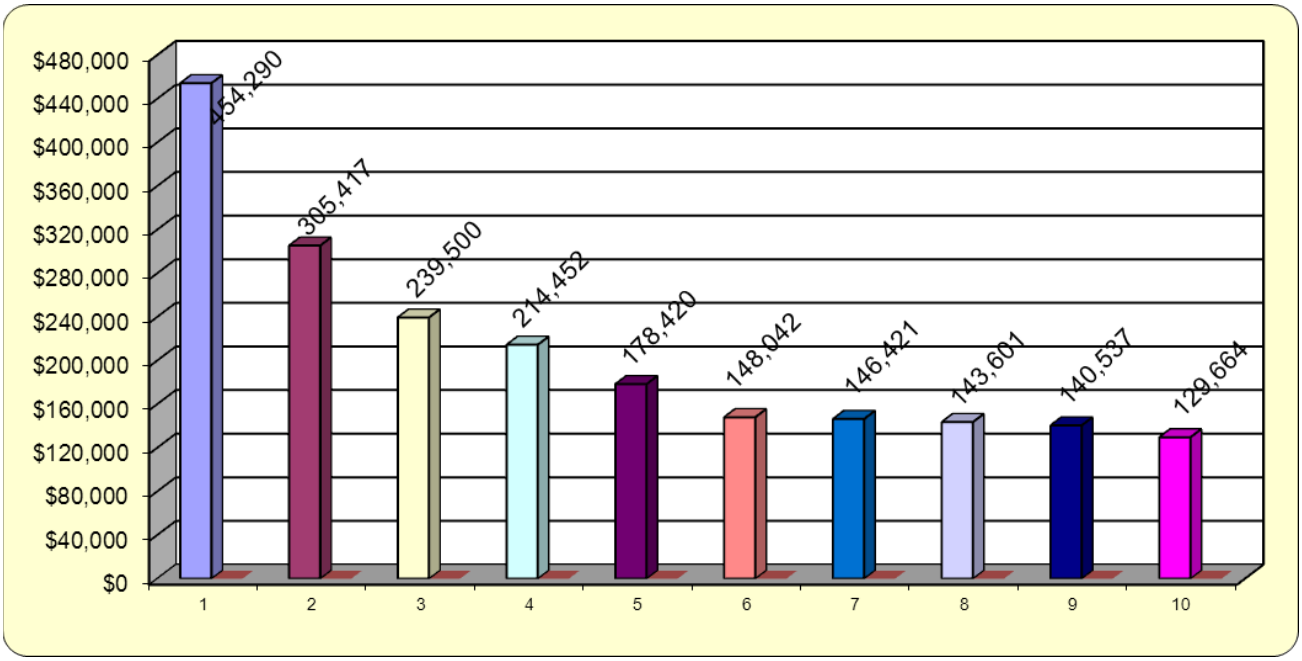
7 Test for Streptococcus: laboratory testing for Streptococcus bacteria group A as identified by colony morphology, growth on selective media *(CPT 87880)*

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 Rx Management: pharmacologic management that includes prescription, use, and review of medication with no more than minimal medical psychotherapy *(CPT 90862)*

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

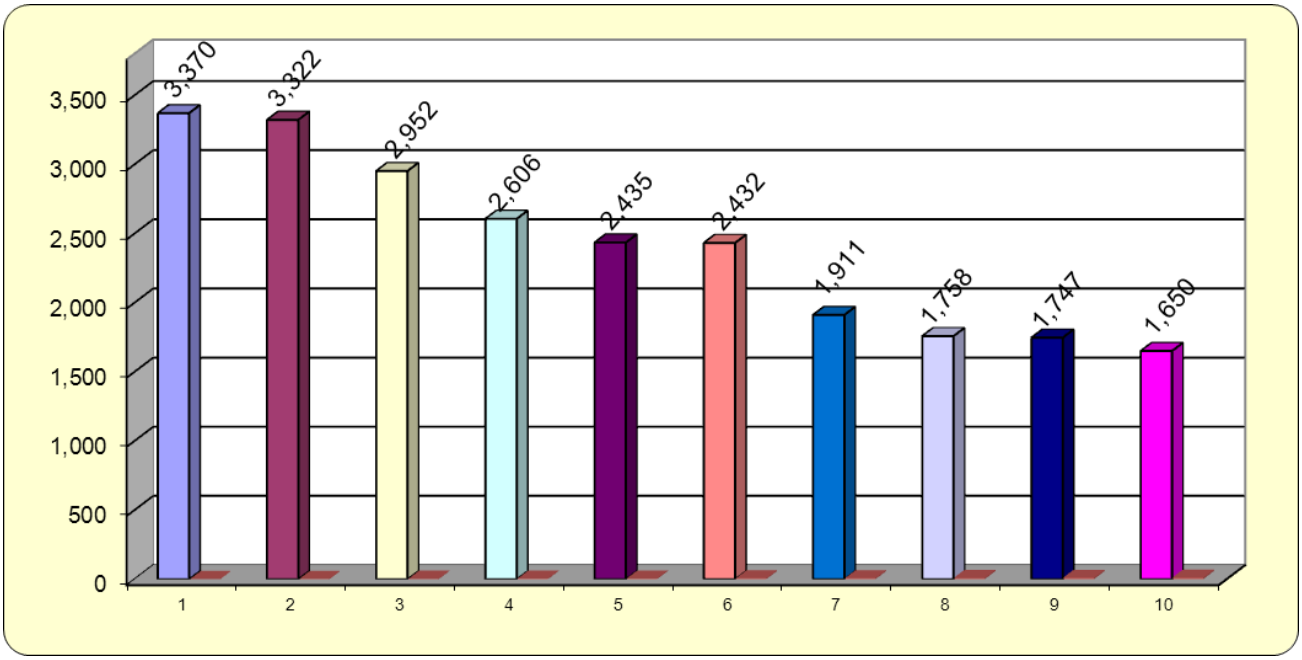
Table 31: Top Ten Prescription Drugs
By Ingredient Cost



Key

	Drug Brand Name		Major Use Indication
1	Singulair 5MG	-	Asthma
2	Concerta ER 36MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
3	Singulair 10MG	-	Asthma
4	Concerta ER 54MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
5	Humatrope 24MG	-	Growth Hormone
6	Novolog 100Unit/ML	-	Diabetes
7	Dextroamp-amphet ER 20MG	-	Attention Deficit Hyperactivity Disorder (ADHD)
8	Singulair 4MG	-	Asthma
9	Proair HFA 90 MCG	-	Asthma
10	Vyvanse 40MG	-	Attention Deficit Hyperactivity Disorder (ADHD)

Table 32: Top Ten Prescription Drugs
By Number of Rx



Key

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