

**OMB #: 0938-0707**

**Exp. Date:**

**WEST VIRGINIA'S APPLICATION FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**Preamble**

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

Form CMS-R-211

**WEST VIRGINIA'S APPLICATION FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))**

State/Territory:

**State of West Virginia**  
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**



(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name:	<b>Robert W. Ferguson, Jr.</b>	Position/Title: <b>Cabinet Secretary, Department of Administration</b>
Name:	<b>Sharon L. Carte</b>	Position/Title: <b>Executive Director, WV Children's Health Insurance Agency</b>

**According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, Baltimore, Maryland 21244.**

**Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)**

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1.  Obtaining coverage that meets the requirements for a separate child health program (Section 2103); OR

1.1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); OR

1.1.3.  A combination of both of the above.

1.2.  Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3.  Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4. Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Original Plan		General Description*
Effective:	July 1, 1998	A Medicaid expansion for children ages 1 to 5 from 134% up to 150% PFL
Implemented:	July 1, 1998	
Amendments		General Description*
#1 Effective:	April 1, 1999	Expanded coverage for children ages 6 to 18 from 101% to 150% FPL under a benchmark coverage program based on state's public employees insurance program
Implemented:	April 1, 1999	
#2 Effective:	October 1, 2000	Combines Medicaid expansion (Phase 1- Ages 1 to 5) with benchmark coverage (Phase II – Ages 6 to 18) into one program under benchmark coverage
Implemented:	October 1, 2000	
#3 Effective:	November 1, 2000	Expands coverage to 200% FPL and includes cost sharing through copayments
Implemented:	October 23, 2000	
#4 Effective:	July 1, 2002	Technical amendments to comply with federal statute of August 24, 2001. Also, expansion of pharmacy copayments to families below 150% FPL; and inclusion of annual and lifetime benefit limits.
Implemented:	July 1, 2002	

West Virginia's Application for the State Children's Health Insurance Program

- #5 Effective: January 1, 2006  
Implemented: January 1, 2006  
Institutes a formulary for generic and/or preferred brand drugs for all therapeutic classes (with medical necessity exceptions when demonstrated by physicians) and grandfathering exceptions to changes for seven drug classes related to mental conditions.
- #6 Effective: January 1, 2007  
Implemented: January 1, 2007  
Expansion from 201% to 220% FPL through the addition of premium sharing with a limited dental benefit. Also, copayments for sick visits are excluded when a medical home is designated.
- #7 Submitted: June 11, 2007  
Withdrawn: August 31, 2007  
A special Health Services Initiative to allow for paid comprehensive wellness exams for uninsured children about to enter Kindergarten which included a basic coverage guarantee for subsequent diagnosis and treatment related to any conditions detected as a result of the exams and/or related screens.
- #8 Effective: September 1, 2008  
Implemented: January 1, 2008  
A special Health Services Initiative allowing for paid comprehensive wellness exams for uninsured children about to enter Kindergarten which includes referral but no coverage guarantee for subsequent diagnosis and treatment related to conditions detected as a result of the exam and/or related screens.
- #9 Effective: January 1, 2009  
Implemented: January 1, 2009  
Expanded coverage from 220% to 250% FPL through premium sharing. Also, eliminated use of income disregards when determining maximum upper income limit.
- #10 Effective: July 1, 2010  
Implemented: July 1, 2010  
This amendment combines provisions made effective the prior year to comply with CHIPRA provisions along with an expansion of CHIP dental services to the premium sharing group (above 200% FPL income) which had previously had a maximum \$150 annual limit.
- Effective: July 1, 2011  
Implemented: July 1, 2011  
Expanded coverage from 251% FPL to a maximum gross income limit of 300% FPL. Makes other changes to comply with CHIPRA provisions including elimination of annual and lifetime plan limits, and assurance of mental health parity accompanied by service limit changes necessary for this assurance.
- #11 Effective: October 1, 2011  
Implemented: October 1, 2011  
To change to a prospective payment system reimbursement methodology for Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's).

\*More detailed descriptions for each amendment are provided at Section 2.1.

(Please see Section 2.1 for a complete description of State Plan Amendments for West Virginia's Title XXI Program.)

**Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))**

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

West Virginia has two public health insurance programs targeted to low-income children: the West Virginia Medicaid program (WV Medicaid) and the West Virginia Children's Health Insurance Program (WVCHIP). Currently, no public-private partnerships provide creditable coverage.

The WV Medicaid program offers health insurance coverage to all children in the state who meet the following eligibility net income criteria:

- birth to age 1: income up to 150% of the Federal Poverty Level (FPL)
- ages 1 through 5: income up to 133% of the FPL
- ages 6 through 18: income up to 100% of the FPL

WV Medicaid also uses deductions and disregards in computing income for eligibility determination, as allowed and approved in its State Plan, and as described in Section 4.3. of this Plan.

WV Medicaid extended 12 month coverage to all eligible children effective June 2001.

State Legislation establishing the West Virginia Children's Health Insurance Program was signed into law in April 1998; further, this legislation provided for the creation of an oversight body, the Children's Health Insurance Board whose role is to review and monitor the program's fiscal standing and approve an annual fiscal plan.

The original baseline for uninsured children in households with family incomes greater than Medicaid eligibility limits and up to 200% Federal Poverty Level (FPL) was 14,000. This was based on Lewin Group, Inc. estimates using the Household and Income and Tax Simulation Model (HITSM) and pooled 1995 and 1996 West Virginia Current Population Survey. The current program has been developed through several phases:

1. WVCHIP was first implemented July 1, 1998 (effective date of July 1, 1998). This is described as Phase I of the program.
  - This start-up phase was a Medicaid expansion providing coverage for children ages 1 to 5 in families with household incomes greater than 133% and up to 150% FPL.
2. STATE PLAN AMENDMENT #1
  - WVCHIP Phase II was implemented April 1, 1999 (effective date of April 1, 1999).
    - This was a benchmark equivalent coverage program whose actuarial-base was the West Virginia Public Employees Insurance Agency Preferred Provider Benefit Plan.

➤ This phase expanded coverage to children from ages 6 to 18 in families with household incomes greater than 100% FPL and up to 150% FPL.

3. STATE PLAN AMENDMENT #2

This State Plan Amendment combined WVCHIP Phase I and Phase II effective October 1, 2000.

➤ The State submitted an amendment June 26, 2000 to withdraw the Phase I Medicaid expansion program and incorporate it into the Phase III benchmark equivalent program.

➤ In September 2000, the State notified the 1425 participants in the Medicaid expansion (Phase I) program of the change through a cover letter. Participants were also provided with a side-by-side comparison of the Phase I program benefits with those of Phase II.

4. STATE PLAN AMENDMENT #3

WVCHIP Phase III was implemented October 23, 2000 (effective date of October 23, 2000).

➤ Eligibility for the benchmark equivalent coverage was expanded to children in families with incomes up to the 200% FPL.

➤ Cost sharing in the form of co-payments for specified services (see Section 8.2) was included for families with household incomes greater than 150% up to 200%.

5. STATE PLAN AMENDMENT #4

➤ Effective July 1, 2002 the State Plan is amended with required updates and amendments effective under federal statute August 24, 2001 and to expand participation in pharmacy co-payment to families in households with incomes below 150% FPL. It also eliminated the \$5 co-payment for generic drug use.

➤ This amendment also includes a lifetime benefit limit of \$1 million which is part of the original benchmark program noted above.

➤ This amendment also includes an annual benefit limit of \$200,000 per participant.

6. STATE PLAN AMENDMENT #5

➤ Effective January 1, 2006, the State Plan is amended to reflect a formulary that includes approved generic and/or preferred brand drugs for all therapeutic classes.

➤ There is no coverage for non-listed drugs except where clinical documentation from a physician demonstrates medical necessity. For a few listed therapeutic classes, Over the Counter (OTC) medications approved.

➤ Upon implementation, program participants who are currently taking a drug that is used to treat, or is sensitive to, mental conditions, can continue to have their current prescription(s) covered even if their current medication is not on the Preferred Drug List when it is in one of the following seven drug classes:

Antipsychotics; Serotonin Selective Response Inhibitors (SSRI's); Central Nervous System Stimulants; Anticonvulsants; Sedative Hypnotics; Aliphatic Phenothiazines; and Attention Deficit Disorder Drugs.

- Program participants who are newly prescribed a drug used to treat, or is sensitive to, mental conditions in one of the seven drug classes named above will have coverage from the Preferred Drug List at the time the new prescription is filled, except where there has been a demonstrated need for exception due to medical necessity.

7. STATE PLAN AMENDMENT #6

- Effective January 1, 2007, the State Plan is amended to expand coverage to those children in households at or under 220% FPL net income when they are willing to participate in a premium payment option.
  - This amendment also modifies cost sharing provisions and cost sharing maximum limits described in Section 8 to permit increased copayments for enrollees at income levels above 200% FPL.
  - Copayments for non-well visits are modified at all enrollee income levels to afford an incentive for designating and using a medical home.
  - Children in households between 201% to 220% FPL (WVCHIP Premium) who have had group health care coverage in the 12 month "look back period" are not eligible.
  - For children in the WVCHIP Premium group (201 to 220% FPL) there is no vision coverage as specified in Section 6.2.12; also dental coverage for this group is limited to \$150.00 per child per year as specified in Section 6.2.17.

8. STATE PLAN AMENDMENT #7

- A special health services initiative to allow for payment of comprehensive wellness exams for uninsured children about to enter Kindergarten was submitted on June 11, 2007 and withdrawn on August 31, 2007.

9. STATE PLAN AMENDMENT #8

- Effective January 1, 2008, the state plan is amended at Section 3.1 to allow a special health service initiative (HSI), named Kids First, that assures Comprehensive Wellness Exams performed at either local school sites or in provider offices are reimbursed for the estimated five percent of children ages four to five who are entering kindergarten without any health insurance. Of the approximately 21,000 children entering kindergarten, the age at which compulsory school attendance begins in this state, about 1,100 are estimated to be without any insurance. These exams performed by medical providers will be offered on site at schools, school based health clinics or in provider offices, and Title XXI funds will be used to reimburse exam costs.
  - In order to promote participation by medical providers and parents, exams will be offered on site at schools at Kindergarten Round-ups. Local education authorities for West Virginia's 55 school districts will draw up Memoranda of Understanding with all providers of medical services willing and available to provide exams on site at school or in their medical office and to provide follow-up services to children at either sliding fee-scale or reduced cost, regardless of insurance status.
  - The kindergarten entry point will also be used as an opportunity to provide all families information about the joint application process through the state's WVCHIP and Medicaid programs, and to assist them in obtaining a medical home.

- In this initiative the costs of any services resulting from any exam findings are to be paid by the parent. To facilitate access to health services a service practitioner directory will be prepared to include information about existing health resources including offerings of sliding fee schedules by the community health centers network.
- Children whose insurance plan does not cover these same wellness exams may be offered the exam, but there will be no reimbursement using Title XXI HSI funds. All claimed expenditures for this initiative are subject to WVCHIP's ten-percent administrative cap of total expenditures. A revised budget is submitted as part of this plan amendment.

The goal of Kids First is to assure that as many children in West Virginia as possible have the same opportunity to enter school healthy and ready to learn by providing a wellness exam performed by a medical practitioner. Many children with commercial insurance, as well as those enrolled in either WVCHIP or Medicaid, already have access to this special preventive service. Under this initiative, children without insurance will be also be able to access this important exam.

#### 10. STATE PLAN AMENDMENT #9

- Effective January 1, 2009, the State Plan is amended at Sections 4.2 through 4.4 to expand coverage to children in families with household incomes up to and including 250% FPL in gross income through disregarding all gross income from 200% up to and including 250% FPL to meet the targeted low income child criteria at 42 CFR 457.310 This expansion also makes the following provisions:
  - The same standard income deductions as used by West Virginia's Title XIX program to calculate net income are used to assign participants to copayment levels and to determine premium payment participation, also referred to as enrollment groups.
  - No changes are made to cost sharing amounts and provisions in Section 8.2.1, or to premium sharing costs or provisions in Section 8.2.3.
  - Substitution of Coverage requirements remain the same, that is, applicants with net household incomes over 200% FPL are subject to a twelve (12) month look back review period, and are not eligible if they have had creditable group health coverage during the look back period. Applicants with net household incomes at or below 200% FPL are subject to a six (6) month look back period. Exceptions to the look back period remain the same as specified in Section 4.4.4.2.
  - Clarification: To determine WVCHIP eligibility, the State will use one income criterion only based on gross income. Families with gross incomes up to and including 250% FPL may be eligible for WVCHIP. Net income refers to gross income minus applicable Medicaid deductions. Net income is used to determine the child's enrollment group.
  - A revised budget is submitted as part of this amendment reflecting funding for the additional projected population to be covered



11. STATE PLAN AMENDMENT #10

This state plan amendment provides coverage for children in families with gross incomes up to 300% FPL. It also makes necessary changes to assure covered services and other provisions are in compliance with the Children's Health Insurance Program Reauthorization Act (specifically dental services and mental health parity) and the Patient Protection and Affordable Care Act (removal of lifetime and annual benefit limits).

Changes to Section 4: Eligibility Standards and Methodology include:

➤ Expansion to 300% FPL: Effective July 1, 2011 the State Plan is amended at Section 4.13 to expand coverage to children in families with household gross incomes from 250% to 300% FPL by disregarding all gross income over 200% up to and including 300% FPL income levels to meet targeted low income criteria at CFR 457.310.

➤ A reduction in waiting periods is described in Section 4 Eligibility Standards and Methodology [4.17; 4.3; and 4.4.4]. This change reduces the waiting period from six (6) months to three (3) months for all applicants with incomes at or below 200% FPL and from twelve (12) months to three (3) months for those applicants with incomes over 200% FPL to 300% FPL. Methods for Monitoring Substitution [Section 4.4.4.1] remain the same except for notational changes in the waiting period duration.

Section 6 Coverage Requirements for Children's Health Insurance is amended to make changes necessary to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009. The Lifetime Benefit Limit of \$1 million dollars is eliminated, as is the \$200,000 annual limit in accordance with provisions in the Patient Protection and Affordable Care Act.

Other Specific Coverage changes in this section include:

➤ Mental Health Parity: Effective July 1, 2011, coverage limits for all services, both mental health and non-mental health related services have been reviewed to assure compliance with the mental health parity requirements of CHIPRA, Section 502. The Actuarial Certification includes the elimination of service limits for inpatient and outpatient mental health services [6.2.10 and 6.2.11] as well as inpatient substance abuse treatment services and outpatient substance abuse services [6.2.18 and 6.2.19].

➤ Section 6.2.12 eliminates the limitation on eyeglasses or contacts lenses to enrollees over 200% FPL net income in order to assure all enrollees have the same coverage for eyeglasses or contacts up to \$125 per year effective July 1, 2010.

➤ Section 6.2.17 eliminates the annual limit of \$150 preventive dental services to those enrollees with incomes over 200% FPL who then have the same dental coverage as those enrollees at or below 200% FPL effective July 1, 2010.

➤ Section 6.2-D provides for the coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions, and specifies the periodicity schedule. The actuarial certification is attached to this amendment as Attachment #1 includes these changes effective July 1, 2010.

➤ Section 6.2.22 eliminates the 20 visits per year limit for physical therapy, occupational therapy, and speech therapy services effective July 1, 2011.

➤ Section 6.2.24 The limitation on eye exams for enrollees over 200% FPL and above is eliminated to provide the same coverage to all enrollees for eye exams (one visit per year) and prescriptive lenses (i.e. one set per year) effective July 1, 2010.

➤ Section 6.2.28 Early Intervention Services provided by the state's Birth-To-Three Program under the Individuals with Disabilities in Education Act are added to coverage for children ages birth through three years who have been assessed and met medical necessity criteria for developmental delay(s). Both assessments and services must be provided from a network of early intervention service providers certified by the WV Birth-to-Three Program effective July 1, 2010.

Section 8 Cost Sharing and Payment is amended at 8.2.3 and 8.5 to reflect copayment requirements for non-preventive dental services; and at 8.7 to assure a 30-day grace period for members required to make premium payments.

#12 State Plan Amendment 11

This plan amendment changes the reimbursement methodology for the state's Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's) from fee for service to a prospective payment system in accordance with the Children's Health Insurance Program Reauthorization Act of 2009, Section 503. A separate CHIP PPS model approach was chosen to effect this change to help assure WVCHIP child enrollees access to services, particularly for mental health and dental services, in the predominantly rural areas of the state. Other details and documents related to this change include:

➤ This change impacts 25 FQHC's and 54 RHC's across the State of West Virginia serving 1 in 5 CHIP enrollees at 174 clinic sites and school-based centers.

➤ A stakeholder's advisory group met in 2010-2011 and an accounting firm was selected through a competitive process by management to assist develop the methodology. The methodology is summarized in Attachment A: "West Virginia Children's Health Insurance Program, FQHC/RHC Prospective Payment System (PPS), System Overview and Options"

➤ All centers submitting Medicare cost reports from the base years were informed of these rates and appeal rights by certified mail in June 1, 2011.

➤ A revised budget in Section 9.10 accounts for the total cost in federal and state funds for these changes including required retroactive payments is estimated to be \$4.0 million.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Application and Enrollment Process:

- West Virginia seeks to enroll all eligible uncovered children in the State's CHIP and Medicaid programs through a joint application form. The 2-page (back and front) form is accompanied by a 4-page (back and front) information guide, and return mail postage-paid envelope.
- WVCHIP maintains a website at [www.chip.wv.gov](http://www.chip.wv.gov) with an application available for downloading, responses to frequently asked questions; information updates; and a summary of benefits guide. The website also has a Spanish version of the application and directions on where to find help with translation services, if needed. Helpful information such as the current enrollment, an outreach activities calendar, and a contact list of outreach coordinators who can assist with the application is provided. It is also compliant with website requirements at Section 508 of the Rehabilitation Act (29 U.S.C.794d).
- In addition to application forms and guides, the WVCHIP maintains and distributes standard informational materials bearing the program logo including:
  - ◆ Business envelope size insert with the WVCHIP toll-free number, website address and qualifying income guidelines;
  - ◆ Posters promoting the availability of free/low cost insurance with the WVCHIP toll-free number and website address;
  - ◆ Posters with child wellness and immunization schedules (bearing the logo, WVCHIP Call Center number, and website address)
  - ◆ Posters with child wellness and immunization schedules (bearing the logo, WVCHIP Call Center number and website address) are distributed to pediatrician and family practice physician offices, clinics and other health care settings;
  - ◆ A prevention brochure describing the prevention benefits available through WVCHIP coverage.
- All applications are processed through the electronic eligibility system known as "RAPIDS", operated by the West Virginia Department of Health Human Resources (WVDHHR); this allows for all CHIP applicants to be screened for Medicaid first. In 2001, about 10,000 children were found eligible for Medicaid as a result of the screening of CHIP applications.
- On-going application distribution and application assistance occurs through the CHIP Call Center with a toll-free telephone line. Callers may request mailed applications, or assistance in completing the application with their responses filled in and mailed to them within 24 hours, Spanish and hearing impaired translation services as requested. The CHIP Call Center mails and distributes all standard program material including applications and new enrollee welcome kits with the summary plan description.
- Local WVDHHR offices located in 53 of the state's 55 counties also provide application distribution and assistance. WVDHHR now administers the redetermination or re-enrollment applications through 2 customer call units with toll-free telephone units for quicker turn around.

Cooperative Efforts Through Other State Government Agencies:

- Through a cooperative agreement between the WVDHHR and the West Virginia Hospital

Association, WVDHHR eligibility workers are outstationed in selected hospitals throughout the state to facilitate outreach and eligibility determination for both WVCHIP and Medicaid.

➤ Within the WVDHHR, the Office of Maternal, Child and Family Health distributes WVCHIP printed materials to the medical community as part of their outreach and community-based efforts, as do Bureau of Public Health workers.

➤ The Bureau of Employment Programs contacts WVCHIP for participation at workshops for laid-off workers, and "One-Stop" service centers operated by the West Virginia Workforce Investment Board also distributes WVCHIP information.

➤ The Department of Education has a check-off box on its free and reduced lunch application form that allows parents/guardians to indicate an interest and consent to have the joint WVCHIP/Medicaid form mailed to them. Addresses are compiled through the Department's information system which generates a centralized mailing list for all participating local county school Boards. This list is made available to the WVCHIP about two months after the beginning of the school year.

➤ The West Virginia State Supreme Court mandates through an administrative order that family law judges must provide WVCHIP applications and other program information to every parent of a dependent child at the first appearance before the court. This allows WV Family Courts to facilitate children's access to coverage when considering child support decisions. WVCHIP supplies copies of the joint application to all family law judges and county circuit clerks on an ongoing basis.

➤ As required by recent legislation passed by the West Virginia legislature, the WVCHIP Insurance Board will develop and administer a plan whereby applications for enrollment may be taken by primary care centers or other health care providers and transmitted electronically for eligibility screening.

➤ Members of the Governor's Health Umbrella Group planned and financed the West Virginia Healthcare Survey, a survey of over 16,000 households. Conducted by the Institute for Health Policy Research at West Virginia University, the survey results for the first report on children show that West Virginia's rate of insurance coverage from all sources for all children up through age 18 is 93.4%, considerably higher than that reported in other states. Survey sampling was able to identify numbers of uninsured children at the county level enabling better targeting of outreach efforts by WVCHIP and Medicaid.

➤ Each year families are encouraged to provide documentation of a HealthCheck screen at Kindergarten "Round-ups" for public school entry. Children who do not present documentation of HealthCheck screen are encouraged to have one performed at their medical home and provide documentation to the school for entry. Children presenting as having no screen and no access to health insurance to obtain a screen will be provided one under a special Health Service Initiative (HSI) using Title XXI funds to reimburse the provider. Children participating in this HSI are screened for WVCHIP/Medicaid eligibility prior to reimbursement for the exam. Children found eligible are enrolled in the appropriate program.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership: None.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The WVCHIP Agency Office and the CHIP Call Center provide referrals to families not meeting either WVCHIP or Medicaid income limits to primary care networks which include Federally Qualified Health Clinics and Rural Health Clinics which accept payment on a sliding fee scale basis.

Both the WVCHIP Agency Office and the Call Center also refer families with specialized needs, such as dental services, special needs children, early intervention services to the Office of Maternal, Child and Family Health (OMCFH). OMCFH has provider networks and recruits providers for these specialized program areas.

### **Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

#### *TITLE XXI, The West Virginia Children's Health Insurance Program*

The State of West Virginia provides Title XXI services in a separate program known as WVCHIP in a fee for service delivery system managed by the Children's Health Insurance Agency within the WV Department of Administration. A publicly appointed Board has fiscal oversight for the program. At inception the comprehensive benefit plan was benchmarked after the state's public employee's plan (PEIA) and it uses both the same provider networks and same contractual third party administrator as the PEIA for claims payment. The third party administrator oversees utilization management processes such as prior authorization, precertification, and medical necessity reviews for some services beyond set service limits. WVCHIP uses the same rates as PEIA (which are higher than those of the state's Title XIX program and adjusted according to RBRVS updates). At enrollment all families are asked to select a medical home from a list of qualified providers, and are encouraged to do so by the waiving of copayments for non-well visits. This plan has traditionally included Federally Qualified Health Centers (FQHC's) and RHC's (rural Health Centers) participating on a fee for services basis in order to assure access in the more rural areas of the state.

#### *The Role of Federally Qualified and Rural Health Centers*

West Virginia's community health care system includes 54 RHC's and 25 FQHC's with over 170 clinic sites statewide (including 58 school-based centers). These centers are vital to delivery of primary care and preventive services to low income children, particularly in the more predominate rural areas. These centers serve about 1 in 5 of all West Virginians with 55% of their patient base living in below poverty level households. About 1 in 5 WVCHIP enrollees are also served by these community health centers. In 2009 WVCHIP began planning to convert fee for service payment methodology used for these centers to a Prospective Payment System (PPS). WVCHIP formed a stakeholder advisory group and retained an accounting firm to assist management in development of PPS for FQHC's and RHC's in order to comply with Section 503 of CHIPRA. WVCHIP has chosen to construct a separate CHIP PPS methodology with an intent to assure access and account for both dental and mental health services provided by FQHC's and RHC's. A report summarizing this methodology "*WEST VIRGINIA CHILDREN'S HEALTH PROGRAM FQHC/RHC Prospective Payment System, System Overview and Options*" is enclosed as Attachment A. June 1, 2011, all qualifying centers were notified of their respective rates under the PPS methodology by certified letter, and informed of appeal rights. This methodology change was approved, with advance public notice, by the CHIP Board at its July 28, 2011 meeting as part of financial plan for the upcoming state fiscal year. The payment methodology change for FQHC's/RHC's is effective October 1, 2011 and payments will be made retroactive to October, 2009 as required by CHIPRA.

*"Kids First": A Health Services Initiative*

The goal of this initiative is to assure that West Virginia children start Kindergarten healthy and ready to learn.

The Kids First Initiative is a collaborative among three state government agencies; Department of Education, Department of Administration, and Department of Health and Human Resources, that enlists the West Virginia medical community, families, and community-based supports to improve child health and early learning.

All West Virginia children entering kindergarten will receive a health screen to identify risks to healthy growth and development. The West Virginia medical community, which includes private practicing physicians, community health centers, hospital-based clinics, and local health departments, is a participating partner in Kids First. Medical clinicians will be offering wellness screenings at their service sites, or alternate school settings, using the Kids First protocol, which meets the Bright Futures, American Academy of Pediatric standards. The offering of wellness screens in children's medical homes supports West Virginia's efforts to encourage primary medical homes for all children.

For populations who do not receive wellness screenings in their selected medical homes, screenings will be made available by participating community medical providers on-site at Kindergarten Round-ups (enrollment). On-site school screenings will be offered to all unscreened children presenting to Kindergarten regardless of insurance status. Caveat: WVCHIP resources will not be used to offset screening costs for children who are insured, nor will they be used to supplant school funding or resources for wellness screenings. The school is serving as an additional screening site for children who were not screened prior to Kindergarten Round-ups and is offered at the school for the convenience of parents and participating providers. No funds to providers for this project will come from schools, or their districts. Conversely, no funds from WVCHIP, Title XXI, will go to schools to cover costs of alternate service sites for wellness screenings, or for the screening services. Payments for wellness screenings for insured kids, including those covered by WVCHIP or Medicaid, will be made by the appropriate payer according to its benefit plan. WVCHIP, Title XXI Health Service Initiative (HSI) funding will pay for screening services for uninsured children only. Parents of children who are covered by private insurance are responsible to pay for the screen if the private insurance does not cover the cost for any reason. The West Virginia Office of Maternal, Child, and Family Health (OMCFH) will act as a "central depository" for provider billings of these wellness exams for uninsured children. OMCFH will access Medicaid and WVCHIP enrollment files to determine if the child was subsequently enrolled in either program. If so, the claim form for the exam will be forwarded to the appropriate Agency for payment. The remaining claim forms will then be forwarded to WVCHIP to check against commercial insurance files. If it is determined the child has commercial insurance, the claim will be returned to the provider instructing them to bill the appropriate party. WVCHIP will pay the wellness exam claims for all children identified as uninsured through this process using Title XXI HSI funding subject to the 10% administrative cap.

Schools currently advertise Kindergarten enrollment events in local newspapers and media outlets as well as notices sent home to parents and day care centers. All of these efforts will continue with costs covered by local school districts. Promotional costs within the Kids First budget will be used for printing additional promotional materials to encourage Kids First health screens prior to kindergarten entry.

Existing state government resources will be used to bring community stakeholders together. We plan to utilize public service announcements and promotion through the annual "State of the State" address by the Governor. The West Virginia Chapter of the American Academy of Pediatrics will encourage participation by their membership. WVCHIP, Medicaid, PEIA and BlueCross BlueShield insurers and the Community Health Center Network will notify their age-eligible children through direct mailings, encouraging well-child exams.

To assure that every child eligible for government sponsored health coverage is identified, uninsured children who present at the school without having been screened will be evaluated for WVCHIP/Medicaid eligibility at Kindergarten Round-ups. School sites will offer on-line eligibility access and hard copy applications for families wishing to apply for government sponsored health services.

Parents of uninsured children who are identified with deficits by the wellness screenings will be referred to existing programs and services available in the community to address deficits utilizing the referral network established by the schools. Information will be made available by a brochure and also a document outlining a referral network will be made available online. The network will include participating medical providers that agree to offer services to families on a sliding fee scale. Parents are responsible to cover costs of any follow-up services that may be needed.

#### *HealthCheck In WV*

The HealthCheck exam enjoys widespread acceptance by physicians, many of whom use it for all children regardless of payer source. In at least one WV county, it is already the preferred protocol to document compliance with screening requirements. The current HealthCheck document form is a single page that covers all American Academy of Pediatrics "Bright Futures" guidelines. The form has been also redesigned to allow parents to share information required by education authorities without divulging other more sensitive information, if they wish. This modification preserves family privacy without diminishing the form's usefulness as a medical record.

#### *WV Kindergarten Entry*

In West Virginia, kindergarten is mandatory under school law and WV's most recent kindergarten enrollment was 21,173. Each year school districts hold kindergarten pre-enrollment orientations ("Round-ups") in the six months preceding kindergarten entry to orient children and their families, to document children's immunizations, and to provide those health screens as required under the state's school law. Current estimates show that 5% (or about 1,100) of WV children entering kindergarten will not have any source of insurance coverage. Both the "Round-ups" and the actual kindergarten entry dates serve as points of entry at which schools can confirm whether or not children have had a HealthCheck exam and allow parents to provide documentation of such.

#### *Role of WV Public Payers*

In West Virginia, three state public payers, WV Medicaid, WVCHIP, and the WV Public Employees Insurance Agency, cover more than two thirds of children in the state. All three payers cover comprehensive prevention screens that meet either the HealthCheck protocols or the requirements of comprehensive wellness exams as described in the Current Procedure Terminology found for preventive



medicine under CPT codes 99381-99385 for new patients & 99391-99395 for established patients. The 3 payers will assist the initiative in these ways:

- 1) Adoption of the HealthCheck protocol as a requisite part of the medical record for billing of CPT codes by WVCHIP and the PEIA, with the HealthCheck form or an approved equivalent thereof required as documentation;
- 2) Providing initial reminder notices to parents of all age appropriate children actively enrolled to assure that a HealthCheck exam is obtained in the months prior to kindergarten entry, and to encourage them to provide the necessary physician documentation to school authorities.
- 3) Each year on or around March 1, state payers will identify to school authorities those children of qualifying age who have had a HealthCheck exam since September 1 of the prior year.
- 4) No later than June 30 each year, after each school district has held its "Round-ups," they will identify by district those children NOT yet having presented a HealthCheck form to help assure that those children with demonstrated coverage are excluded from the estimate of children requiring a HealthCheck exam, for kindergarten entry that year.

#### *Role of Participating Providers*

In order to help assure that parents of uninsured children may gain access to a variety of providers who have agreed to participate in the Kids First Initiative, including those offering sliding fee scales, the Office of Maternal Child and Family Health will assist local education authorities by providing a participating provider directory for each of the eight educational regions of the state. These directories will include providers such as primary care practices, dentists, *optical services practitioners: eye, ear, nose and throat specialists and audiologists*, along with 32 federally qualified community health centers operating at over 120 sites which include school based clinics which can play a key role in providing on site exams and follow-up services necessary to correct or ameliorate any conditions or deficits identified through screening exams.

As children and their parent(s) present at kindergarten orientation or "Round-ups", four scenarios are envisioned:

- 1) The insured child has been screened and provides (or mails) a copy of the HealthCheck protocol to school authorities.
- 2) The child has insurance, but has not had a HealthCheck screen since the start of the current school year (September 1); the parent chooses to have a screening at the school and allows insurance to be billed, or the parent opts to have the child's medical home provider perform the screen at his/her office and returns with HealthCheck documentation. The provider bills the appropriate insurance.
- 3) The child is uninsured and the parent agrees to an on-site HealthCheck exam at no cost. The family is provided a joint WVCHIP/Medicaid application and is screened for program eligibility. The appropriate program will cover costs of the exams for children subsequently enrolled as a result of this

process. For those children deemed uninsured, WVCHIP Title XXI HSI funds will be used to reimburse medical providers for the exam services.

4) The child has insurance, but well-child exams are not covered. Parents are responsible to pay for the exam for this child. They will be referred to providers who have signed the Memorandum of Understanding with the school district offering exam services on a sliding fee scale or "pro bono."

*Any child's family choosing not to participate in Healthcheck screening will be provided with the standard school screening as required under WV Code, also referred to as a "limited-domain" screen. No Title XXI HSI funds are used to provide "limited domain" screens, nor to reimburse schools for the use of their facilities to provide well-child exams on-site.*

During the orientation, school personnel will provide copies of the joint WVCHIP/Medicaid applications and/or online application assistance when feasible. Families will also be provided with an informational brochure on the availability of health care resources in their region with special attention to the availability of those with sliding fee scales. Families will be encouraged to establish a medical home for regular prevention.

*Role of WV Department of Education and Local Education Authorities*

- Assure that each school district has a Memorandum of Understanding (MOU) identifying its panel of providers responsible for providing HealthCheck exams for children *at school sites*.
- Provide regional workshops on developing the MOU in West Virginia's eight educational regions.
- Assure that participating providers educate parents about the medical home concept and its benefits for children, and assist with linking and enrolling them with one, if desired.
- Provide and coordinate data, reporting and information flow as required among WVCHIP, other state payers, the WV Department of Education's Office of Healthy Schools, and WV DHHR's HealthCheck Program.
- Under the local Memorandum of Understanding, it is the responsibility of participating providers to assist in locating services beyond their service capacity/scope or outside its own referral network. *Providers will work* to locate such needed services from any *other* provider or network within the state, and will also ask for assistance from programs operated by the state that may assist in locating these services. For example, a provider sees a child with a resulting finding that the child has a jaw misalignment making chewing difficult and that the correction of this is beyond their service capacity both within the center itself and its network, it can then turn to the statewide HealthCheck program *and other programs within the Bureau for Public Health* which will make inquiry to all participating providers or any other network which it finds can provide the service.
- Collect and report data for the 55 school districts on the numbers of uninsured and insured children who 1) present a documented Healthcheck exam given prior to Kindergarten Roundups

and 2) those who receive a Healthcheck exam at in the school or school based clinic during each school district's Roundup period

*Role of Commercial Payers*

The state solicits commercial payers who at present reimburse for comprehensive well child exams to voluntarily assist in promoting this initiative through the issuance of reminder notices to parents and publicizing of the Kids First initiative.

For those children with commercial insurance whose coverage excludes such exams or whose use of cost sharing may discourage parents to seek such exams, referrals will be made to the same list of Kids First participating providers in their locale. All HealthCheck exam service claims provided under this initiative will be electronically cross checked for other insurance sources.

*Data Collection and Tracking*

The state will establish data collection and tracking to determine the effectiveness of this initiative. Commercial payers will be solicited to share any data or quality measures concerning well child visits they can provide as part of this effort. Parents are encouraged to share copies of HealthCheck forms completed for exams furnished on-site at the school with their child's regular medical provider.

*Services Exclusion*

This initiative specifically excludes consideration of any coverage for inpatient services or long term care services or treatment of catastrophic illnesses or any follow-up services resulting from exams.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

The utilization controls used by the Public Employees Insurance Agency (PEIA), which administers the state employee health insurance plan, are also used in the Title XXI program. WVCHIP and PEIA both contract with the same medical benefit manager; they also contract with the same pharmacy benefit manager. These third-party administrators (TPAs) provide the State of West Virginia's Title XXI program with medical necessity, pre-certification, prior approval, fraud detection, audit and extensive utilization reporting.

The TPA provides the following quality assurance services to the WVCHIP program:

- ◆ Claims audits
- ◆ Audits of customer service representatives
- ◆ Monitoring of calls from customer service, PPR and membership areas
- ◆ Individual audits upon request from management to identify specific processing issues
- ◆ Routine QA reports to management for use in evaluating employee and departmental performance
- ◆ Monthly management reporting

**Section 4. Eligibility Standards and Methodology. (Section 2102(b))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1.  Geographic area served by the Plan: State of West Virginia

4.1.2.  Age: 0-18 (As amended 4/1/99.)

4.1.3.  Income: Families with gross household incomes up to and including 300% FPL are eligible for WVCHIP effective July 1, 2011.

WVCHIP participating income levels exceed Medicaid limits (as noted in Section 2.1) up to and including 200% FPL as amended (10/23/2000); effective 1/1/2007 coverage is expanded to those families between 201% FPL to 220% FPL household income levels who participate in premium cost sharing through the WVCHIP Premium plan (hereinafter "WVCHIP Premium"). Effective January 1, 2009 WVCHIP Premium is expanded to an upper income level of 250% FPL based on gross income and premium cost sharing as proposed October 3, 2008. Effective July 1, 2011, WVCHIP Premium is expanded to an upper income level of 300% FPL based on gross income and premium cost sharing as proposed on March 31, 2011.

WVCHIP's rules for counting income are the same as those under this State's Title XIX program as set forth in the WV Income Maintenance Manual and include both earned and unearned income to define gross income. Income deductions are used only to assign participants to the appropriate level of cost sharing – copayments and premiums (see Section 8 for cost sharing amounts). They are not part of eligibility determination which is based solely on gross income and a disregard of all gross income from 200% up to and including 300% FPL.

4.1.4.  Resources (including any standards relating to spend downs and disposition of resources): \_\_\_\_\_

4.1.5.  Residency: State resident

4.1.6.  Disability Status (so long as any standard relating to disability status does not restrict eligibility): \_\_\_\_\_

4.1.7.  Access to or coverage under other health coverage: Any child under a group health plan or under health insurance coverage, as defined in §2791 of the Public Health Service Act (42 USC §300gg-91(a) and (b)(1)) shall not be eligible for the program.

Current or past coverage under an employer group plan for "look back" periods of three months may exclude an applicant from coverage. (Exceptions for involuntary loss of coverage and lack of cost effective insurance are noted in Section 4.4.4.1.).

Because part-time, contractual, or temporary public employees receive no subsidy from government sources and parents must pay full premium costs, [children of these public employees](#)

who have otherwise met the eligibility requirements are not excluded from eligibility for coverage under Title XXI.

4.1.8.  Duration of eligibility: 12 months

4.1.9.  Other standards (identify and describe): The State specifies on its joint WVCHIP/Medicaid application form that social security numbers are required for the applicant.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1.  These standards do not discriminate on the basis of diagnosis.

4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3.  These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment.  
(Section 2102)(b)(2)) (42CFR 457.350)

Joint Applications: Applicants for Medicaid and WVCHIP are determined eligible by processing joint applications through an automated electronic eligibility determination system termed Recipient Automated Payment Information and Data System (RAPIDS), and by final eligibility worker review at 54 county offices. WVCHIP establishes eligibility under signed agreement between the WV Department of Administration, of which WVCHIP is a division, and the WV Department of Health and Human Resources (DHHR) which is responsible for the State's Title XIX Program.

Intake: Paper applications can be received by mail, local office walk-ins, and appointments. Electronic applications can be submitted on personal computers through [www.wvinroads.org](http://www.wvinroads.org) with follow-up mailing to submit documentation. Registered community partners such as the program call center, federally qualified health centers, or hospitals can also submit electronic applications via [www.wvinroads.org](http://www.wvinroads.org).

Determination of Medicaid Eligibility and Subsequent Determination of CHIP Eligibility: Applications are first determined through automated criteria to be within Medicaid income limits using an upper net income limit of 150% FPL for a child ages birth to one (1) year; 133% FPL for a child over one year through five (5) years of age; and 100% FPL for children six (6) years of age through 21 years of age (See Section 2.1). In determining the upper income limits for Medicaid, standard income deductions are allowed for the following: each working parent or legally aged child (\$90 per month); child support disregard (\$50 per month); and child care expenses (\$175 per month per child over age 2 and \$200 per month for children age 2 and under). Applicants exceeding these limits are then evaluated for WVCHIP eligibility. Applicants found to be under or at the gross income limit of 300% FPL are then determined WVCHIP eligible. All gross income from 200% up to and including 300% FPL is disregarded in determining that applicants meet the targeted low income child criteria at 42 CFR 457.310. For those determined to be WVCHIP eligible, coverage is retroactive to the first day of the month of application,

except for those who participate in WVCHIP Premium who start enrollment upon receipt of the 1<sup>st</sup> premium payment and indicate their choice to enroll either retroactive to the 1<sup>st</sup> of the month of application or the following month.

Assignment of Participants to Levels of Cost Sharing or Enrollment Group: *(NOTE: In this section any reference to "net income" is made for purposes of assignment to a level of cost sharing and not as an eligibility determinant.)*

As they are determined eligible, participants are assigned to three levels of cost sharing: a) minimum copayments; b) full copayments; and c) WVCHIP Premium (monthly premiums plus full copayments). To assign appropriate levels of cost sharing, the standard Medicaid income deductions are applied to gross income to determine net income.

a) Any net income above the upper Medicaid limit to 150% FPL (*minimum copayments*);

b) The 151% to 200% FPL net income range (*full copayments*);

c) Net income above 200%FPL (*full copayments plus premiums*); and,

Cost sharing amounts for these three levels of participation are specified in Section 8.2.

Applicants with net incomes at or under 200% FPL gross income may participate with no premium payment. Those applicants with net incomes above 200% FPL can only participate through premium payment. While Medicaid income deductions are used to determine these levels of cost sharing or the enrollment group, eligibility determination is based on gross income up to and including 300% FPL.

Willingness to Participate in Premium Sharing: *(NOTE: In this section any reference to "net income" is made for purposes of assignment to a level of cost sharing and not as an eligibility determinant.)*

All applicants determined to have net incomes above 200% FPL receive a letter stating that they are denied coverage under regular WVCHIP, but may be eligible to participate in WVCHIP Premium if willing to pay a monthly premium. Single Child families are asked to pay a \$35 per month rate (\$420 per annum), and Two or More Child families are asked to pay \$71 per month rate (or \$852 per annum). Applicants are advised as to the premium amount and the conditions for initial payment and disenrollment upon non-payment of premium.

Unwillingness to Participate in Premium Sharing: Applicants with net incomes above 200% FPL who receive the letter advising them of the requirement for premium sharing who respond that they are unable to pay, or who do not respond, receive a denial letter.

Three Month Coverage Look Back Period: All applicants are subject to a three month look back period for previous coverage.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3)) Income limits for eligibility for Title XXI are higher than those for Title XIX, and are fully described in Section 2.1. The DHHR eligibility staff screens applications first for Medicaid eligibility utilizing the RAPIDS. If the child is not Medicaid eligible, the RAPIDS integrated eligibility system automatically checks for WVCHIP eligibility. Income is verified at the time of application with an annual redetermination of eligibility. The Title XXI program uses the same standard deductions as used by Title XIX when determining levels of cost sharing, but they are not used for eligibility determination which is based on gross income.

Once eligibility is verified, the child is covered for twelve months. To the extent that new information regarding income exists and the child becomes eligible for Medicaid, the parent/guardian is notified and is given the option to seek Medicaid coverage.

West Virginia's Office of Technology (WVOT - the state's data and information services agency) maintains enrollee data files for both WVCHIP and the Public Employees Insurance Agency (PEIA). At the time of enrollment, WVOT sends a data file of WVCHIP enrollees that is checked against those of the PEIA for those insured agencies which are state, county, or municipal employers. WVCHIP informs any applicants shown as eligible for coverage under the State's insurance plan of this coverage that they will be terminated unless they can show employer documentation permitting an exception.

WVCHIP contracts with an outside vendor to compare WVCHIP enrollment data to data from commercial and group insurance plans on a monthly basis. Families of children who are found through these matches as having other insurance are sent a letter asking them to verify the other insurance or to document that they no longer have coverage. The letter informs them that if they do have other coverage they are no longer eligible to participate in WVCHIP and the child's WVCHIP coverage is terminated. Children of families that do not respond are also terminated.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2)) West Virginia uses the same process mechanisms to determine eligibility for Title XIX and Title XXI. Eligible children will be enrolled in the appropriate program as determined by eligibility criteria.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4)) West Virginia uses the same process mechanisms to determine eligibility for Title XIX and Title XXI. Eligible children will be enrolled in the appropriate program as determined by eligibility criteria.

4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))



4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The State of West Virginia assures that insurance provided under Title XXI will not substitute for coverage under group health plans. The State monitors substitution through its application process. The State also employs a third party liability contractor to perform electronic cross checking against most known group health insurance databases on a monthly basis. Any enrollee found to have coverage through a group health plan is sent a letter of termination.

All applicants at or below 200% FPL net income must specify coverage held for any child in the past three months. All applicants who have held coverage within the past three months receive notices of denial, unless they meet one of the exceptions below.

- Employer terminates coverage
- Job is involuntarily terminated and family loses benefits
- Private insurance not cost-effective; i.e, if employee's family coverage exceeds 10% of family gross annual income
  
- Loss of coverage for child due to change in employment
- Loss of coverage outside the control of an employee
- Death of the policyholder

The total number of applicants receiving denials due to showing group health coverage within the three month substitution elimination period is reported and analyzed as a percentage of all denials.

West Virginia's Office of Technology (WVOT - the state's data and information services agency) maintains enrollee data files for both WVCHIP and the Public Employees Insurance Agency (PEIA). At the time of enrollment, WVOT sends a data file of WVCHIP enrollees that is checked against those of the PEIA for those insured agencies which are state, county, or municipal employers WVCHIP informs any applicants shown as eligible for coverage under the State's employee insurance plan of this coverage and informs them that they will be terminated unless they can show employer documentation permitting an exception.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

All applicants above 200% FPL net income must specify coverage held from the previous 3 months. All such applicants receive a denial unless they have documentation to support an exception as listed below.

- Employer terminates coverage
- Job is involuntarily terminated and family loses benefits
- Private insurance not cost-effective; i.e, if employee's family coverage exceeds 10% of family gross annual income
- Loss of coverage for child due to change in employment
- Loss of coverage outside the control of an employee
- Death of the policyholder

4.4.4.3.  Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

All applicants above 250% FPL net income must specify coverage held from the previous 3 months. All such applicants receive a denial unless they have documentation to support an exception as listed below.

- \* Employer terminates coverage
- \* Job is involuntarily terminated and family loses benefits
- \* Private insurance not cost-effective; i.e, if employee's family coverage exceeds 10% of family gross annual income
- \* Loss of coverage for child due to change in employment
- \* Loss of coverage outside the control of an employee
- \* Death of the policyholder

4.4.4.4.  If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

The State of West Virginia assures the provision of child health assistance to targeted low-income children in the State who are American Indians. All children in the state who may be eligible for assistance are targeted through statewide outreach efforts specifically outlined in Section 5. Native Americans are exempt from cost sharing through self-declaration on the WVCHIP application form. This requirement will be addressed by the program's claims processing system and through education of the provider community.

## **Section 5. Outreach (Section 2102(c))**

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

Please refer to Section 2.2.1. for a full description of outreach activities through cooperative efforts of other government agencies.

### Distribution of CHIP Applications and Information by Community Organizations

- CHIP applications and information have been made available through participating community organizations including hospitals, physician practices, pharmacy chains, dental offices, pediatric clinics, primary care centers; also, willing businesses and retailers such as discount stores, grocers, convenience stores, and fast food restaurants have also participated.
- The WV Council of Churches, a multi-denominational organization distributed CHIP information materials to its 4000 member churches for inclusion in their weekly bulletins or use in church ministries.

### Community-Based Outreach

- WVCHIP has provided an aggressive multimedia outreach program including television, radio and print advertisement, participation in local public events such as health fairs, parades, and West Virginia's many state and local festivals.
- WVCHIP coordinates with the West Virginia Governor's Office to assist Governor Bob Wise who actively promotes the program while attending public events; the Governor walked door-to-door with community volunteers in 15 of West Virginia's rural counties in 2001.
- The West Virginia Healthy Kids Coalition (WVHKC) is comprised of numerous community-based organizations including primary care centers (including Rural Health Centers and FQHCs); Family Resource Centers (FRNs); child care centers; and faith-based organizations. WVCHIP and the WVHKC closely to coordinate and jointly participate in outreach activities throughout the State and in local communities.
- With the WV Council of Churches acting as its fiscal agent, the WVHKC has secured grant funding from the Claude Worthington Benedum Foundation and the Robert Wood Johnson Foundation. WVCHIP and WVDHHR officials participate in regular monthly meetings with WVHKC members. Through these meetings and other input, WVHKC serves as a major vehicle for receiving community feedback on CHIP eligibility policies and enrollment/re-enrollment processes, as well as participating in outreach and promoting CHIP at the community level.
- Family Resource Networks funded through contracts through the Governor's Cabinet on Children

and Families are community-based organizations which do strategic planning, interagency coordination and on-going evaluation of services for children and families in a designated county or multi-county area of the state. There are 45 FRNs serving all 55 counties. FRNs are also active partners in CHIP outreach and serve as members of the WVHKC.

➤ The West Virginia Primary Care Outreach Project has trained outreach coordinators at 35 primary care clinics throughout the state to facilitate Medicaid and CHIP outreach and eligibility. Over 1000 children were found eligible for either Medicaid or CHIP through the Project's efforts in 2001.

**Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.) (42CFR 457.410(a))

6.1.1.  Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1.  FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)

6.1.1.2.  State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3.  HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

A complete description of the WV Public Employees Insurance Agency Preferred Provider Benefit plan, the benchmark equivalent benefit plan, was provided as Attachment 3 of the State Plan Amendment which was effective April 1, 1999. This plan includes a lifetime benefit limit of \$1,000,000 (see page 43 of the original Attachment).

An actuarial certification which considers changes to be implemented July 1, 2002 concerning pharmacy co-payment (section 8) and annual and lifetime benefit maximums (section 6) is provided as Attachment # 1 for State Plan Amendment #4.

6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4.  Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)

6.1.4.1.  Coverage the same as Medicaid State plan

6.1.4.2.  Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

6.1.4.3.  Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

coverage

6.1.4.4.  Coverage that includes benchmark coverage plus additional

state-based coverage

6.1.4.5.  Coverage that is the same as defined by existing comprehensive

6.1.4.6.  Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7.  Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:

(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1.  Inpatient services (Section 2110(a)(1)) Confinement in a hospital including semi-private room, special care units, confinement for detoxification, and related services and supplies during the confinement.

6.2.2.  Outpatient services (Section 2110(a)(2)) Diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital, alternative facility or physician's office are covered. Certain outpatient procedures may require pre-certification.

6.2.3.  Physician services (Section 2110(a)(3)) Professional services of a physician or other licensed provider for treatment of an illness, injury or medical condition. Includes outpatient and inpatient services (such as surgery, anesthesia, radiology, and office visits).

6.2.4.  Surgical services (Section 2110(a)(4))

6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5)) Diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital outpatient setting or in an ambulatory surgical facility are covered. Immunizations are covered.

6.2.6.  Prescription drugs (Section 2110(a)(6)) Prescription benefit services are covered with mandatory generic substitution, including oral contraceptives. Formulary coverage includes generic and brand drugs, with prior approval through a step therapy process for some brand drugs in some drug classes. Non-formulary drugs are at 100% cost to the participant, except where medical necessity is shown for clinical exception.

Effective January 1, 2006, program participants who are currently taking a drug that is used to treat, or is sensitive to, mental conditions, can continue to have their current prescription(s) covered even if their current medication is not on the Preferred Drug List when it is in one of the following seven drug classes:

Antipsychotics; Serotonin Selective Response Inhibitors (SSRI's); Central Nervous System Stimulants; Anticonvulsants; Sedative Hypnotics; Aliphatic Phenothiazines; and Attention Deficit Disorder Drugs.

Program participants who are newly prescribed a drug used to treat, or is sensitive to, mental conditions in one of the seven drug classes named above will have coverage from the Preferred Drug List at the time the new prescription is filled, except where there has been a demonstrated need for exception due to medical necessity.

- 6.2.7.  Over-the-counter medications (Section 2110(a)(7)) These are permitted in some therapeutic classes as listed on the Preferred Drug List when accompanied by a prescription.
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9.  Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9)) Pre-pregnancy family services and supplies, excluding tubal ligations and vasectomies, are covered. Oral contraceptives are included within pharmacy benefit services. Contraceptive devices and contraceptive implants will be covered under medical services.
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10)) Inpatient Hospitalization, partial hospitalization and day programs for mental health and chemical dependency are covered when ordered by a licensed provider and precertified as medically necessary.
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)) Coverage for short-term individual or group outpatient mental health evaluation and referral, diagnostic, therapeutic, and crisis intervention services, as medically necessary.
- 6.2.12.  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12)) Coverage for the initial purchase and reasonable replacement of standard implant and prosthetic devices, and for the rental or purchase (at the Plan's discretion) of standard durable medical equipment, when prescribed by a physician. Prosthetics and durable medical equipment purchases or rentals must be pre-certified.
- Eyeglasses or contact lenses are limited to \$125 per each 12-month period of eligibility for all enrollees. This amount may be increased with either prior approval and/or determined medical necessity. An actuarial certification is made for changes effective January 1, 2007 for State Plan Amendment #6. Hearing aids are covered if determined to be medically necessary with prior approval. Effective July 1, 2000, all infants at the time of birth will be screened for hearing loss. All information on children with a medically confirmed hearing loss will be reported to the Office of Maternal and Child Health by the hospital.
- 6.2.13.  Disposable medical supplies (Section 2110(a)(13)) As medically necessary.
- 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14)) Home health care services are covered when prescribed by a physician. This benefit requires prior approval when more than seven visits are ordered.
- 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15)) Skilled nursing services are covered when precertified for medical necessity.
- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)) A physician shall provide written certification of medically necessary abortions. All services require prior approval unless a medical emergency exists endangering the life of the mother.

- 6.2.17.  Dental services (Section 2110(a)(17)) Routine semi-annual exams, x-rays, and other dental services necessary to prevent disease, restore oral structures to health and function, and to treat emergency conditions. For more detail on covered dental services, see Section 6.2.-D.
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18)) Inpatient substance abuse treatment is covered when ordered by a licensed provider and precertified as medically necessary.
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19)) Services are covered when ordered by a licensed provider and require pre-certification by the third-party administrator. They may include evaluation, referral, diagnostic, therapeutic, and crisis intervention services on an outpatient basis including those in a physician's office.
- 6.2.20.  Case management services (Section 2110(a)(20)) Medical case management provided by the third-party administrator.
- 6.2.21.  Care coordination services (Section 2110(a)(21)) Provided by the third-party administrator
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22)) Physical therapy, occupational, and speech therapy, ordered by a physician is a covered benefit with prior medical necessity reviews for services beyond 20 visits per year. Additional services beyond 20 visits must be pre-certified and case-managed by the third party administrator.

Hearing services covered to include annual exams and hearing aids when determined medically necessary and with prior approval/authorization.

- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24)) Eye exams for prescriptive lenses are limited to one visit per year for all enrollees.
- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26)) Ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide necessary treatment.
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

Early Intervention Services provided by this state's Birth-To-Three (Individuals with Disabilities and Education Act) Program are covered for children ages birth through three years who have been assessed and met medical necessity criteria for developmental delay(s). Both assessments and services must be provided from a network of early intervention service providers certified by the WV Birth-to-Three Program.

Any lifetime or annual benefit limit is eliminated as part of State Plan Amendment #10 effective [July 1, 2011].



6.2.-D The State will provide dental coverage to children through one of the following. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

- 6.2.1.-D  State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:
1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
  2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1110-D1555) (must follow periodicity schedule)
  3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
  4. Endodontic (i.e., root canals) (CDT codes: D3110-D3999)
  5. Periodontic (treatment of gum disease) (CDT codes: D4210-D4999)
  6. Prosthodontic (dentures) (CDT codes: D5110-D5899, and D6200-D6999)
  7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7140-D7991)
  8. Orthodontics (i.e., braces) (CDT codes: D8010-D8699)
  9. Palliative treatment (D9110)
  10. Adjunctive General Services (D9220-D9242) (D9310-9420)
  11. Emergency Dental Services

6.2.1.2-D  Periodicity Schedule. The State has adopted the following periodicity schedule:

- State-developed Medicaid-specific
- American Academy of Pediatric Dentistry
- Other Nationally recognized periodicity schedule
- Other (description attached)

6.2.2-D  Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1.-D  FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.2.2.2-D  State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.2.2.3.-D  HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

6.3. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2.  The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)

6.4.1.  Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above.; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2.  Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health

insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

## Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

The West Virginia Children's Health Insurance Program utilizes the Public Employees Insurance Agency's claims processing and utilization management contractor, Wells Fargo, to provide comprehensive quality assurance addressing:

- Appropriateness of care
- Quality of care
- Compliance with immunization schedules; tracking of well-baby and well-child exams
- Provision of case management services to children with special needs
- Exclusion from the WVCHIP provider network of those providers barred from participation in Medicare/Medicaid

Claims Review: From the claims processing standpoint quality and appropriateness of care review, several sources are utilized: Unbundling code review is integrated into the Wells Fargo claims system. This alerts the Claims Examiner as to whether the procedure is coded correctly.

For each claims examiner, a standard set of policies is in place to alert the examiner as to whether a claim needs to be sent to the nurse for review. Wells Fargo also utilizes an over limit review by the nurse for all claims in excess of \$10,000 for inpatient treatment and in excess of \$7,500 for outpatient procedures.

Clinical Review: Wells Fargo performs provider reviews for utilization activities as well as health care patterns. Guidelines and resources provide case managers with evidence and outcome-based tools that ensure the delivery of high quality care in the most appropriate setting. Great West Health Management Guidelines, are the tools utilized to assess quality and appropriateness of care based on national standards. Registered nurses (RN=s) and physician advisors obtain the clinical information from the treating physician using Great West as a guideline and then utilize their medical expertise on a case-by-case basis to determine what is appropriate. If a RN finds the proposed treatment does not fall within the guidelines, the case is then referred to a physician advisor.

WVCHIP will pursue the above objectives through a variety of strategies, including:

- ◆ Identification of children with special needs through the pre-certification process, claims review and self-identification by parents and guardians in response to literature sent through the benefit welcome kit
- ◆ Tracking of complaint data received by the toll-free number, the WVCHIP central office, and the contract agencies

- ◆ An annual satisfaction survey of parents/guardians
- ◆ Through discussions with the health care community via provider workshops, newsletters and periodic contacts with their association representatives
  - ◆ Through consumer education utilizing newsletters to beneficiary families, information dissemination with outreach workers and public relations activities

On a monthly basis, WVCHIP will receive utilization management reports detailing the top diagnostic categories of CHIP beneficiaries from its third-party administrator for utilization management services, which will better position the program to track trends and facilitate the development of appropriate intervention strategies.

WVCHIP will have access to comparative data. Not only will this data enable the program to better assess its standing in relation to national trends, but it will permit a broader discussion on innovative approaches used elsewhere.

Will the state utilize any of the following tools to assure quality?

(Check all that apply and describe the activities for any categories utilized.)

7.1.1.  Quality standards. The same tools in place for the benchmark-equivalent plan will be used for WVCHIP.

7.1.2.  Performance measurement. The same tools in place for the benchmark-equivalent plan will be used for WVCHIP.

7.1.3.  Information strategies. The same tools in place for the benchmark-equivalent plan will be used for WVCHIP.

7.1.4.  Quality improvement strategies. The same tools in place for the benchmark-equivalent plan will be used for WVCHIP.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)  
The State of West Virginia Insurance Commission is responsible for compliance with laws on access and on prudent lay-person standards for emergency care.

See section 7.1 for monitoring and complaint tracking related to utilization control strategies.

7.2.1. Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The use of prevention services will be monitored through the following HEDIS measures:

- Well Child Visits measured for birth through six years of age.
- Well Child Adolescent visits 6 years to 19 years.

- Access to Primary Care Visits measured for children ages 1 to 19 years who had visits coded to primary care services only.
- Dental Visits measured for children ages 2 to 18 who had a dental check-up coded to preventive dental services only.
- Vision Visits measured for children of all ages who received vision services from a physician or ophthalmologist coded for preventive vision services only.
- WVCHIP added the following preventive measures in its 2010 Annual Report:
  - Childhood immunizations for 2 year-olds
  - Adolescent immunizations for 13 years-olds
  - BMI – Nutrition and counseling for ages 2 – 17 years

WVCHIP reports annually on these measures, both in its Annual Framework Report and in the WVCHIP Annual Report submitted to the WV Legislature each year.

7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

WVCHIP's utilization manager reviews inpatient stays of WVCHIP children for medical appropriateness.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

WVCHIP reports HEDIS measures annually on the appropriate treatment of three chronic conditions:

Proper Use of Asthma Medications

- Reports children with persistent asthma enrolled for the prior year and the current annual report period who were prescribed appropriate medication.

Diabetic Care

- Reports the number of children enrolled an entire year with Type 1 and 2 diabetes shown to have had a blood (HbA1c) test; a serum cholesterol level screening; and in eye exam are a screen for kidney disease.

Emotional/Behavioral Conditions

- Follow-up after hospitalization for mental illness – 6 years and older
- Follow-up care for children prescribed ADHD medications

Families are notified of the availability of case management services upon enrollment through their copy of the WVCHIP Summary Plan Description.

Medical case management cases are also identified at the time of pre-admission certification and at all subsequent continued stay reviews Specialists identify potential case management cases as quickly as possible.

Diagnoses identified through the utilization management system that warrant review for chronic, high-cost, or special needs consideration will be referred to an individual case manager who will coordinate care as appropriate. Flagged diagnoses may reflect such conditions as:

- Asthma
- Cerebral Palsy
- Diabetes
- Seizure Disorders
- Leukemia
- Sickle Cell Anemia
- Emotional/Behavioral Conditions

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

The third party administrator assures that all decisions for prior authorizing health services are made within 14 days of receipt of a request for the services.

**Section 8. Cost Sharing and Payment (Section 2103(e))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

8.1.1.  YES

8.1.2.  NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: YES – Applicants above the 200% FPL net income level who are willing to pay a monthly premium amount are enrolled in WVCHIP Premium-. There is a two rate premium structure: a Single Child rate and a rate for Two or More Child families. These rates are shown in the table below:

WVCHIP Premiums		
Enrolled Children per household	Monthly Premium	Annual Premium Cost
1	\$35.00	\$420.00
2 or More	\$71.00	\$852.00

8.2.2. Deductibles: None

8.2.3. Coinsurance or copayments: As described below.

Copayments Under WVCHIP's Plan

A) Pharmacy Benefits Copayments

All WVCHIP families participate in a two tier copayment structure for pharmacy benefits under the Plan. Copays are assessed according to family net (i.e. gross income minus Medicaid deductions described in Section 4.3.) income level as follows:

ABOVE 200% FPL net income:  
\$0 for generic prescription drugs  
\$15 for formulary brand drugs  
 (As amended 1/1/2007)

ABOVE 150% FPL net income:  
 \$0 for generic prescription drugs  
 \$10.00 for formulary brand drugs  
 (As amended 1/1/2006)



BELOW 150% FPLnet income:  
\$0 for generic prescription drugs  
\$5.00 for formulary brand drugs  
(As amended 1/1/2006)

B) Non-Well Visit Copayments

Non Well Physician Visits Schedule

All enrollees who do not designate a medical home pay a graduated copayment for non-well physician visits as follows:

Enrollees at and under 150% FPL net income levels: \$5.00 per visit  
(waived when visit is to enrollee's designated medical home)

Enrollees above 150% FPL net income levels: \$15.00 per visit  
(waived when visit is to enrollee's designated medical home)

Enrollees above 200% FPL net income levels: \$20.00 per visit  
(waived when visits are to enrollee's designated medical home)

C) Other Medical Benefit Copayments Schedule for Enrollees Above 150% FPL Net Income Levels

Inpatient Service \$25.00 per admission

Outpatient Service \$25.00 per procedure

Emergency Room \$35.00 per visit (waived when admitted)

Dental Services \$25.00 per non-preventive procedures capped at \$100 per year per member or \$150 per year per family; applies to enrollees with net incomes over 200% FPL

Vision Services \$0

Preventive Services \$0

MAXIMUM COPAYMENT LIMITS FOR FAMILIES AT AND UNDER 200% FPL NET INCOMES

Maximum limits for all pharmacy and medical copayments imposed by the Plan are set as follows:

One Child Family: \$100 prescription maximum; \$150 medical maximum

Two Child Family: \$200 prescription maximum; \$300 medical maximum

Three or More Child Family: \$300 prescription maximum; \$450 medical maximum

MAXIMUM COPAYMENT LIMITS FOR FAMILIES ABOVE 200% FPL NET INCOMES

Maximum limits for all pharmacy and medical copayments imposed by the Plan are set as follows:

One Child Family: \$150 prescription maximum; \$200 medical maximum

Two Child Family: \$250 prescription maximum; \$400 medical maximum

Three or More Child Family: \$350 prescription maximum; \$600 medical maximum

8.2.4. Other: None

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b)) The State informs the public and individuals of cost sharing amounts and any changes to these amounts, including cumulative maximums, through its application form, printed posters available in clinics and other outreach sites, on its website at [www.chip.wv.gov](http://www.chip.wv.gov), and to individual participants who receive a Summary Plan Description (SPD) on enrolling and at the time of re-enrollment. Plan participants are notified at least 30 days in advance of proposed changes to cost sharing and asked for comments. Comments are reviewed by the Children's Health Insurance Board prior to approving proposed changes.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1.  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
- 8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
- 8.4.3.  No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e)) The State (WV) assures that the total cost of premiums and copayments (as described in Sections 8.2.1. and 8.2.3. respectively) do not exceed 5% of a family's total annual income as shown in the tables below:

A) Single Child Family Annual Premium/Copayment Maximum Cost  
(as a % of family income levels)

Family Size	At or Under 200% FPL			Over 200% FPL				
	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
2	\$250	\$29,420	0.8%	\$420	\$450	\$870	\$44,130	1.9%
3	\$250	\$37,060	0.7%	\$420	\$450	\$870	\$55,590	1.6%
4	\$250	\$44,700	0.6%	\$420	\$450	\$870	\$67,050	1.3%

B) Two Child Family Annual Premium/Copayment Maximum Cost  
(as a % of family income levels)

Family Size	At or Under 200% FPL			Over 200% FPL				
	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
3	\$500	\$37,060	1.3%	\$852	\$800	\$1,652	\$55,590	2.9%
4	\$500	\$44,700	1.1%	\$852	\$800	\$1,652	\$67,050	2.5%
5	\$500	\$52,340	0.9%	\$852	\$800	\$1,652	\$78,510	2.1%

C) Three or More Child Family Annual Premium/Copayment Maximum Cost  
(as a % of family income levels)

Family Size	At or Under 200% FPL			Over 200% FPL				
	Max. Copay	Income	Exp %	Annual Premium	Max. Copay	Total Exp	Income	Exp %
4	\$750	\$44,700	1.7%	\$852	\$1,100	\$1,952	\$67,050	2.9%
5	\$750	\$52,340	1.4%	\$852	\$1,100	\$1,952	\$78,510	2.5%
6	\$750	\$59,980	1.3%	\$852	\$1,100	\$1,952	\$89,970	2.2%

The State assures that families are exempt from cost sharing upon reaching the maximum co-pays through processes administered by separate medical and pharmacy benefit managers:

Medical Plan Process

The claims processing systems used by WVCHIP's third party administrator (TPA) tracks co-payments as claims are processed by accumulating co-payment amounts on a per patient basis. For families with more than one child, individual children are linked to the family group through a number assigned to the parent/guardian in order to track the family cap.

Should a provider attempt to collect a co-payment when the parent/guardian knows the cap has been met, the provider may verify the accumulated amount from an available "fax back" system in which the provider calls a toll-free number. After entering the patient's ID number, a form with the

applicable co-payment is faxed to the provider. Another option is that, upon reaching the maximum, the parent/guardian may use their Explanation of Benefits form, generated by the TPA, to show a provider that their co-pay cap has been met. WVCHIP's TPA assures that medical and dental claims which are procedure code specific to well-baby, well child, and preventive dental visits, or other preventive services such as immunizations, have no copayments through its claims billing system. The claims processor maintains a separate subgroup file for those enrollees at and under 150% net FPL to assure that copayments amount no higher than those permitted under 457.555 are allowed. WVCHIP also assures that its members are aware of this through its program materials.

#### Prescription Plan Process

The Pharmacy Benefit Manager similarly tracks co-pays through an electronic Point of Sale (POS) system, which is accumulated as each prescription is filled. Upon reaching the cap, the message is conveyed to individual pharmacies through the POS that no co-pay is due, and none is collected.

8.6. Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

Native Americans are excluded from cost-sharing by self-declaration on the joint WVCHIP/Medicaid application.

WVCHIP will notify applicants that membership in designated tribes excludes families from cost sharing. Applications can be obtained through a toll-free telephone line for the WVCHIP Call Center or Helpline. Although West Virginia does not have any designated tribes, the Call Center will maintain a list of designated tribes in case applicants do not know if their tribe is a designated tribe. Applicants so choosing to identify themselves as members of a designated tribe will then be issued a card indicating they are exempt from co-pays. When beneficiaries disclose designated tribal membership, it will be accepted unless it is questionable.

8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

WVCHIP does not disenroll participants who fail to make copayments; however, failure to make premium payments within 30 days after the due date is cause for disenrollment. Monthly premium payments are a requirement for continued participation in the WVCHIP Premium program. Members who have failed to make a premium payment are notified seven (7) days after the due date that they have missed a premium payment and that they have until the end of the month to make the payment or they will be disenrolled. If the premium payment is not made by the end of the grace period (6 days are added to allow additional time for mail) disenrollment occurs at the end of the grace period. If the member applies later and is determined eligible, enrollment will not occur until member makes up the missed payment.

8.7.1. Please provide an assurance that the following disenrollment protections are being applied:

State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))

The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. (42CFR 457.570(b))

In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2.  No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3.  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.  
(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

8.8.4.  Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5.  No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

8.8.6.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

**Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)**

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

1. Expand eligibility to uninsured children from birth through age 18 years whose incomes exceed the limit for Medicaid eligibility up to and including 250% FPL gross household income limit.

2. Identify previously uninsured children from birth through age 18 years who are potentially eligible for West Virginia's Title XXI Program through ongoing and new outreach activities.

3. Children who are enrolled in West Virginia's Title XXI Program will have a designated source of primary health care.

4. West Virginia's Title XXI Program will result in the improved health of children enrolled in the program by focusing on preventive measures as well as the management of chronic diseases or conditions.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Performance Goal/Objective 1:

Title XXI benefits will be utilized by the current 24,000+ enrollees as well as the additional children found eligible under the expansion to the 300% FPL gross income limit. Existing data systems and processes will be leveraged for the processing of program applications, recipient information, service utilization, billing, and provider information.

Performance Goal/Objective 2:

WVCHIP has an annual plan for ongoing outreach efforts and for new initiatives that are to be implemented each year. Outreach activities such as those specified in Section 2.2.2. will be in place.

Performance Goal/Objective 3:

All children who are eligible for West Virginia's Title XXI program will have sufficient access to primary care providers that are willing to operate as medical homes.

Performance Goal/Objective 4:

WVCHIP will promote the concept of Patient-Centered Medical Homes in written guidelines to its consumers, and in participation in statewide planning activities with other payers as it relates to this concept.

Performance Goal/Objective 5:

Over time, West Virginia will show increased access and usage of health care services by children from birth through age 18 through HEDIS data and utilization measures. This data will reflect increases in well-child visits and other preventive and access measures until optimum levels are reached. Other outcome data will be developed as necessary to track quality and/or access.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

- Performance Goal 1 is measured by comparing annual Title XIX and Title XXI enrollment levels to population levels of eligible children using available CPS data.
- Performance Goal 2 is measured by the review of ongoing monthly enrollment and re-enrollment reporting data comparing the current six months to the prior six months and 12 months and revising outreach activity annually based on these data..
- Performance Goal 3 is measured by medical home selection data quarterly and annually.
- Performance Goal 4 is a qualitative goal that will be assessed through written reports of its activities until there is implementation activity that leads to more measurable goals.
- Performance Goals 3 and 4 also use an annual review of 7 different HEDIS measures as reported in the Annual Framework Report to assess access and the progress of medical homes toward a true integrated model.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
  - 9.3.7.1.  Immunizations
  - 9.3.7.2.  Well child care
  - 9.3.7.3.  Adolescent well visits
  - 9.3.7.4.  Satisfaction with care
  - 9.3.7.5.  Mental health

- 9.3.7.6.  Dental care
- 9.3.7.7.  Other, please list:
- 9.3.8.  Performance measures for special targeted populations.

9.4.  The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5.  The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750) Under State law, West Virginia must provide to the State Legislature, on at least a quarterly basis, statistical data on the Children's Health Insurance Program which will reflect the total number of children enrolled as a result of the expansion, breakdown by age, the average annual cost of coverage per recipient, and the total cost of these services by provider .

West Virginia will also produce reports on a quarterly basis outlining the number of well-child visits, immunizations, emergency visits, and mental health visits. These services will be broken down by provider specialty and will be compared to access standards for the overall Medicaid child population.

State-adopted legislation (W.Va. Code §9-4A-2b) requires that a report be made to the Governor and the State Legislature regarding outreach activities and the quality and effectiveness of the health care delivered to children in the program. Satisfaction surveys and health status indicators are required. Statistical profiles of the families served shall be included.

9.6.  The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)

- 9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4.  Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b)) WVCHIP Insurance Board meetings are held approximately four times a year. WVCHIP provides notice of Board meetings according to State law through the Secretary of State's



Office. During each Board meeting, time is allotted for public comment and inquiry. Comments are solicited in writing from interested and affected persons.

The WVCHIP state plan amendments are placed in each of the DHHR County offices inviting public comment. Public notice of the state plan amendments will be posted in local Social Security offices.

In addition, press releases are sent to all major daily newspapers in the State.

Providers are notified of plan changes through a quarterly newsletter published by the Public Employees Insurance Agency, the state health insurance agency.

9.9.1. Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

West Virginia has no Federal or State recognized tribes. Public hearings and WVCHIP Board meetings are open to all Native American and advocacy organizations, and these groups are included in advance notice of public meetings and invited to participate in the ongoing design of the program.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

For State Plan Amendment #11 effective October 1, 2011, the following public notice procedures were followed:

- The proposal to change reimbursement methodology was reviewed and approved at the July 28, 2011 meeting of the West Virginia Children's Health Insurance Board as part of its financial plan for the State Fiscal Year 2012. All Board meetings are publicly held with notice published through the WV Secretary of State's office at least 5 days in advance, and with time allotted for public comment as part of the agenda. Planning proposals and updates for this reimbursement change were also discussed at the prior Board meetings: April 29, 2010, November 18, 2010, and April 28, 2011.

- A draft State Plan Amendment for describing the proposed changes will be distributed and posted in all local DHHR offices with notice of a comment period at least 30 days prior to implementation, and also to child and health advocacy organizations such as West Virginia Healthy Kids Coalition and West Virginians for Affordable Health Care.

- All FQHC's and RHC's who submitted Medicare cost reports for the designated base period were notified of their respective rates under the new methodology and appeal rights by certified mail no later than June 1, 2011.

- Notice of the proposed changes and thirty-day comment period to be posted on the Agency's website: [www.chip.wv.gov](http://www.chip.wv.gov) no later than September 1, 2011.
- The WV Children's Health Insurance Board reviews comments received and approved concerning this amendment at its next regularly scheduled meeting.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

➤ An updated budget for Federal Fiscal Year 2012 is provided below:

WVCHIP Budget FFY 2012 \*

Federal Enhanced Match Rate of 80.83%	Federal Fiscal Year Costs Without	Federal Fiscal Year Costs With
Benefit Costs		
Insurance payments		
Managed care	0	0
per member/per month rate @ # of eligibles	0	0
Fee for Service	49,222,871	53,222,871
Total Benefit Costs	49,222,871	53,222,871
Medical	34,168,828	38,168,828
Pharmacy	9,799,477	9,799,477
Dental	6,666,539	6,666,539
(Offsetting beneficiary cost sharing payments) **	(1,411,973)	(1,411,973)
Net Benefit Costs	49,222,871	53,222,871
Administration Costs		
Personnel	681,974	681,974
General administration	421,084	421,084
Contractors/Brokers (e.g., enrollment contractors)	425,661	425,661
Claims Processing	2,640,932	2,640,932
Outreach/marketing costs	407,354	407,354
Other		
Total Administration Costs	4,577,005	4,577,005
10% Administrative Cost Ceiling	5,469,208	5,913,652
Federal Share (multiplied by enh-FMAP rate) 80.83%	43,486,440	46,719,640
State Share *** 19.17%	10,313,436	11,080,236
TOTAL PROGRAM COSTS	53,799,876	57,799,876

Planned use of funds, including --

- Projected amounts to cover additional program costs of \$4,000,000 included in State Plan Amendment #11 follows:

Projected amounts to cover additional program costs of approximately \$2 million per year are based on re-pricing of FQHC's and RHC's fee-for-service claims under the new prospective payment methodology for the 18-month period of July 1, 2009 through December 31, 2010. The average monthly increase based on total additional payments of \$1,717,164 is \$95,398.

$(\$95,398 \times 12 \text{ months} = \$1,144,776 \times 1.08 \text{ (8\% medical inflation)} = \$1,236,358 + \$763,642$   
(estimated amounts for increased dental services in FQHC settings that are not included in the historical claims set used to estimate additional costs – many FQHC's are in the process of establishing dental services in their centers) = \$2,000,000.

Retrospective payments to FQHC's and RHC's are estimated to be \$1,991,775. Retrospective payments under the new prospective payment methodology for claims with dates of service October 1, 2009 and after are required under Section 503 of CHIPRA. These are one-time adjustments that are expected to be paid during the last month of Federal Fiscal Year 2011 and the first few months of Federal Fiscal Year 2012.

Assumption and provisions concerning the budget are noted as follows:

◆ None of the copayments shown in Section 8 are offset. Premiums listed in Section 8 are offset. Also, offset amount includes estimate of drug rebates.

Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

All non-federal funds are appropriated through State general revenues.

## **Section 10. Annual Reports and Evaluations (Section 2108)**

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1.  The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2.  The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3.  The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements. The State agrees to submit yearly, the approved dental benefit package and agrees to submit quarterly, the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website.

**Section 11. Program Integrity (Section 2101(a))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1.  The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1.  42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2.  Section 1124 (relating to disclosure of ownership and related information)

11.2.3.  Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4.  Section 1128A (relating to civil monetary penalties)

11.2.5.  Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6.  Section 1128E (relating to the National health care fraud and abuse data collection program)

**Section 12. Applicant and enrollee protections (Sections 2101(a))**

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.

Eligibility and Enrollment Matters

12.1 Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. All WVCHIP applicants and participants have the right of appeal through the same fair hearing process that is utilized by Medicaid participants for eligibility and enrollment matters.

Health Services Matters

12.2 Please describe the review process for health services matters that complies with 42 CFR 457.1120.

WVCHIP has a Program Specific Review Process for health services matters that assures the participant's right of appeal. Plan participants are informed of the appeals process through written materials describing the program and covered benefits (the Summary Plan Description) that each participant receives upon enrollment. In addition, written notice of the appeals process is provided to affected individuals within 5 days of decisions subject to review. These written materials inform participants that they may appeal any health service matter involving the delay, denial, reduction, suspension or termination of a covered service, including a determination of the type or level of services, or a failure to approve or furnish or provide payment for health services in a timely manner.

EXCEPTION: Plan participants are informed that 1) Matters pertaining to eligibility or enrollment are exempt from review through this process. Nor 2) Any matter or issue which can only be remedied through a change in provisions through the State Plan, Federal or State laws requiring a) an automatic change in eligibility or enrollment or b) a change in coverage as described in this benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

Step 1: INFORMAL FACT FINDING

Plan participants may initiate appeals regarding claims or service denial by contacting the appropriate third party administrator through a toll-free number to verify whether or not a mistake has been made. All appeals must be initiated within 60 days of the participants' learning of the health services matter at issue.

Step 2: WRITTEN RESPONSE BY THE THIRD PARTY ADMINISTRATOR

Plan participants who disagree with the determination made by the third party administrator at the first step may then appeal in writing within 60 days of the participant's

learning of the health services matter at issue, to the appropriate third party administrator by explaining what the problem is and why they disagree with the first step determination. The third party administrator must respond by either reprocessing the claim for payment issues (if that is the resolution) or sending a letter to the plan participant explaining what actions they are prepared to take or the basis for their action. For all complete case files, a written or processed claim, or Explanation of Benefits statement response will be made within 30 days. The case file is considered complete when the participant has provided documentation pertaining to the health services matter at issue, but not longer than 90 days (except by mutual agreement of the parties).

Step 3: REVIEW BY WVCHIP's EXECUTIVE DIRECTOR

For issues not resolved at the second step, the third step is to appeal in writing within 60 days of receiving the written decision of the third party administrator to the Executive Director of the West Virginia CHIP.

Plan participants are asked to provide written statements of facts, issues, letters, explanation of benefits and all other information pertinent to the case. Participants may represent themselves or have an authorized representative at each step. The Director will render a written decision to the insured or his/her authorized representative, taking into account all materials presented at the third step, and explain the reason, and whether the original disposition of the claim/denial to be either upheld or modified. For all complete case files, response is made within 30 days. For issues of appeal regarding clinical/medical matters, the Executive Director may consider a physician review by the Medical Director. The Medical Director is the same individual who serves as Medical Director for the Public Employees Insurance Agency.

For those cases involving emergency conditions where the standard time frame could seriously jeopardize the enrollee's life or health or ability to retain or regain maximum function, an expedited review may take place within 72 hours (or up to a maximum of 14 days, if the enrollee requests an extension). After initiating the first step appeal, participants may go directly to the third step for resolution if necessary.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility. WVCHIP does not participate in premium assistance programs.