

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

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(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,

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

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

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 (or minutes) 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: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State’s Medicaid plan (Title XIX); **OR**
- 1.3. A combination of both of the above.

Section 2. General Background and Description of State Approach to Child Health Coverage
(Section 2102 (a)(1)-(3)) and (Section 2105)(~)(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 section 2110(c)(2)). 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).

West Virginia statistical information is based on Lewin Group estimates using the Household Income and Tax Simulation Model (HITSM) and the pooled 1995 and 1996 West Virginia sub sample of the Current Population Survey (CPS). West Virginia is expecting 10,760 children to enroll in Phase II between the ages of 6-18 who are currently uninsured in WV according to the Lewin Group statistics. There are a total of 22,901 children potentially eligible for this CHIP Phase II who may have limited health coverage. Currently the West Virginia CHIP experience has shown that 73.7% of eligible children for Title XXI actually apply.

SEE ATTACHMENT 2 for the average monthly number of children potentially eligible for the WV CHIP at various income eligibility levels by current source of health insurance in 1998 is provided.

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

The West Virginia Title XXI State Plan will be conducted in compliance with all civil rights issues.

Currently there are two public health coverage programs in West Virginia; the West Virginia Title XIX Medicaid program and the Bureau for Public Health Pediatric Health Services (PHS) funded by Title V, Maternal and Child Health Block Grant which is administered in conjunction with the Medicaid EPSDT Program by the West Virginia Department of Health and Human Resources (DHHR) Office of Maternal and Child Health within the Bureau for Public Health. Eligible PHS

children will receive direct-mail applications and an informational letter encouraging enrollment in WV CHIP. The PHS program is not considered credible health coverage (\$30.00 Screening, \$15.00 Acute Care).

Eligibility for the West Virginia Medicaid Program is determined by the WV DHHR. There are fifty-four (54) local offices in West Virginia's fifty-five (55) counties.

Phase II will be administered by the PEIA contractor. The contract plan will stipulate that the current community healthcare facilities, which are providing low-income families with healthcare services, be brought into the provider network. The intent is to provide consistency of healthcare for these children.

Out-stationed workers are currently available in selected hospitals across the State through a cooperative agreement with the West Virginia Department of Health and Human Resources (WV DHHR) and the West Virginia Hospital Association. In addition, trained eligibility workers, using lap-top computers, accept applications at selected sites. Primary Care Centers, Federally Qualified Health Centers (FQHC's), and Rural Health Clinics (RHC's) are also included in the out-stationed worker program through a volunteer effort. Through a cooperative agreement with the West Virginia State Department of Education, all free or reduced lunch and textbook applications also include a section on Medicaid coverage which allows school officials to provide the Department of Health and Human Resources (DHHR) with the name, address and social security number of anyone wishing to obtain information about Medicaid coverage. The Department then provides coverage information to the individual making the request.

Print material on Department of Health and Human Resources programs as well as applications for service are made available not only by county offices but also at physicians' offices, hospitals, Federally Qualified Health Centers, Rural Health Centers and Child Care Centers. West Virginia operates a toll-free "Family Matters Hotline" which provides information and referral about assistance programs including WV CHIP and Medicaid and is available 24 hours per day. Information is available to any caller via this toll free number.

The Title V-Pediatric Health Services (PHS) program operated by the Department's Bureau for Public Health, Office of Maternal and Child

Health, provides EPSDT equivalent well-child examinations and acute care for children age birth to 21 whose family income is equal to, or less than, 150% of FPL. This program has typically targeted and performed outreach to children who have not been able to qualify for Medicaid. Outreach is done through the WV DHHR Bureau for Public Health, county health departments, Immunization Program, and the Children With Special Health Care Needs Program. While these children will be encouraged to enroll under Title XXI, the Title V-Pediatric Health Services program is looking at modifying eligibility to cover up to age 21. WV CHIP will only provide services to children ages 6 through 18.

- 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:

The Blue Cross/Blue Shield “Caring Program” has been operational in West Virginia since March 1997 and covers children with family incomes equal to, or less than, 150% of FPL for primary care and out-patient diagnostic and treatment services. There are currently approximately nine hundred (900) children covered under this program. Outreach for this program is conducted through public service announcements. Outreach and case finding is also performed by schools, school based health clinics, and day care centers. Eligible children will be referred for enrollment into Title XXI during implementation of WV CHIP Phase II.

- 2.3.** Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:
(Section 2102)(a)(3)

Under Phase II of West Virginia’s Title XXI plan, the state will contract with the Public Employees Insurance Agency (PEIA), to include children age 6 through age 18 whose family’s household income is equal to or less than 150% of the Federal Poverty Level. WV CHIP will use the same application for phase I and phase II of the Title XXI program. The CHIP application is mailed to each school child’s residence, and then returned to the local county DHHR office in a postage-paid envelope. The local DHHR offices’s eligibility staff processes the application and investigates the availability of children’s health coverage. Currently staff interview clients to insure that only those eligible, targeted low-income children are covered. By process using the DHHR’s computerized eligibility system-RAPIDS (Recipient Automated Payment and Information Data System) eligibility staff check children’s eligibility for Medicaid (Title XIX). This

process includes performing data matches with multiple Insurance carriers to determine if creditable healthcare coverage exists for the child. Outreach efforts described in Sections 2.2.1 in addition to Section 5.

The contract plan will stipulate that the provider network will be expanded to the include facilities that were previously treating low income children such as:

- **Primary Care Centers**
- **School Based Health Centers**

Phase II children will have the freedom to choose the provider of their choice.

Section 3. General Contents of State Child Health Plan (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: (Section 2102)(a)(4)

The State of West Virginia will provide health insurance benefits through a plan managed by The Children's Health Policy Board and administered through a contract with PEIA, a program offering fee-for-service benefits under Phase II. Benefits and claims processing will be administered by PEIA, and eligibility will be determined by local county DHHR offices. The West Virginia Department of Health and Human Resources (WV DHHR), Office of Family Support, computerized eligibility determination system Recipients Automated Payment Information Data System (RAPIDS) will forward Title XXI eligibility information to the PEIA. PEIA will then send notification of eligibility, provide information about the Benefit Plan, and will process claims.

- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

The same utilization controls used in PEIA will also be used in Title XXI programs. The PEIA is set forth in West Virginia Code Section 5-16-1 ET SEQ. Medical necessity, pre-certification, prior-approval, fraud detection, audit and extensive reporting detailing utilization are provided for by PEIA and in its contract with its Claims Processing contractor, Blue Cross/Blue Shield of West Virginia.

WV PEIA quality assurance responsibilities include but are not limited to the following:

- **Performs departmental audits for Claims area.**
- **Performs departmental audits for Customer Services Representatives.**
- **Performs departmental audits for Inventory areas.**
- **Determines quality and payment percentages that are used on Team Performance Measurements.**
- **Monitors calls from Customer Services, PPR and Membership areas.**
- **Individual audits upon request from Management to identify specific processing issues.**
- **Prepares routine QA reports to Management for use in Evaluating employee and departmental performances.**

- **Performs claims audits for NMIS.**

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))

- 4.1.1. x Geographic area served by the Plan: **State of West Virginia**
- 4.1.2. X **Age: 6-18**
- 4.1.3. x **Income: 150% FPL**
- 4.1.4. cl **Resources (including any standards relating to spend downs and disposition of resources):** _____
- 4.1.5. x Residency: **State resident**
- 4.1.6. **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** _____
- 4.1.7. x Access to or coverage under other health coverage: _____
- 4.1.8. x Duration of eligibility: **12 months**
- 4.1.9. cl Other standards (identify and describe):

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))

- 4.2.1. X These standards do not discriminate on the basis of diagnosis.
- 4.2.2. X 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. X 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)) **Phase II Eligibility will be made through WV Department of Health and Human Resources (WV DHHR) Recipient Automated Payment and Information System (RAPIDS). This system is used to determine eligibility for all categories of Medicaid. Eligibility is determined according to categorical levels involving a cascade of options in the data system. Medicaid eligibility (Title XIX) is first determined. If not eligible for Medicaid, then the child is eligible to enroll in Title XXI through the PEIA administrator.**

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow up screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan.
(Section 2102)(b)(3)(A)) **Income limits for eligibility for Title XXI will be higher than those for Title XIX. Screening will determine eligibility under the appropriate program. Though a face-to-face interview is required for Title XIX, this policy will not be in place for Title XXI. During the application process, the existing Title XIX eligibility system (RAPIDS) will be queried to ascertain if the child has Medicaid coverage. The application will first be processed for Title XIX eligibility; Title XXI will be pursued only if the child is ineligible for regular Title XIX services; and only for children without existing health care coverage, and who have been uninsured for the prescribed period of time (Section 4.4.3). Income will be assessed at time of application with an annual redetermination of eligibility. The same disregards for income that have been used in Title XIX will also be used in Title XXI, for example, the definition of household will be the same, etc. Computerized edits in RAPIDS will prevent enrollment in Title XXI if income is within Title XIX threshold levels.**

Recertification is a twelve (12) month continuous eligibility process.

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan.
(Section 2102)(b)(3)(B)) **The State will use 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. That the insurance provided under the state child health plan does not

substitute for coverage under group health plans.

(Section 2102)(b)(3)(C) health care **The State of West Virginia assures that insurance provided under Title XXI will not substitute for coverage under group health plans. A six month “look-behind “at time of application will help determine other available health care coverage. Questions on the application will allow DHHR to determine whether the child has been covered under insurance prior to application. Exceptions will be made if the child has lost Title XIX eligibility due to a change in family income or a parent has lost employer-sponsored coverage due to termination of employment, or the employer has ceased to provide employer-sponsored health care coverage.**

- 4.4.4.** The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 40 of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c).

(Section 2102)(b)(3)(D)) **The State of West Virginia assures the provision of child health assistance to targeted low-income children in the State who are Indians. All children in the state who may be eligible for assistance will be targeted through outreach efforts specifically outlined in Section 5. Through statewide coverage, the provision of health assistance will be ensured to targeted low-income children in the state who are Indians.**

- 4.4.5.** Coordination with other public and private programs providing creditable coverage for low-income children.

(Section 2102)(b)(3)(E)) **The State of West Virginia assures coordination with other public and private programs providing creditable coverage for low-income children. The West Virginia “Caring Program” participants will be encouraged to enroll in Title XXI in Phase II as well as the eligible children from the Department’s (DHHR) Pediatric Health Services (PHS) Title V grant. Refer to Section 4.4.2 . for coordination efforts with the State Medicaid program.**

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

- 5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program:

(Section 2102(c)(1))

While Phase I of WV CHIP provides Medicaid-expansion coverage to children ages 1-5, Phase II of West Virginia's Title XXI program will target children ages 6 through 18 years with family income equal to or less than 150% of the Federal Poverty Level (FPL.) The Department's Recipient Automated Payment and Information Data System (RAPIDS) will be used to identify households with children who have previously applied for Medicaid (Title XIX) and / or Phase I of the Children's Health Insurance Program (CHIP) Title XXI but have been denied because of the child's age and / or incomplete information. These households will be mailed an application form and letter of explanation encouraging them to apply for Phase II of WV CHIP.

West Virginia's three other health programs currently providing coverage to low-income children are:

- 1) Medicaid (Title XIX,)**
- 2) Pediatric Health Services Program (Title V,) and**
- 3) the Blue Cross / Blue Shield "Caring Program."**

The Pediatric Health Services Program, funded under Title V, Maternal and Child Health Block Grant is administered in conjunction with Medicaid EPSDT Program by the Department of Health and Human Resource's (DHHR) Office of Maternal and Child Health Services program. Pediatric Health Services provides EPSDT equivalent well-child examinations and acute care for children ages birth to 21 with family incomes less than, or equal to, 150% of the FPL. The children participating in this program ages 6-18 will be eligible for Phase II of Title XXI. These children (approximately 12,000) are being mailed an informational letter and application form encouraging their application for Phase II of Title XXI.

The Blue Cross / Blue Shield "Caring Program" has been operating since March 1997 for children of family incomes less than or equal to 150% of the FPL providing primary care and out-patient diagnostic treatment services. These children (approximately 524) will also be contacted by direct mail with an informational letter and application form encouraging their application for Phase II of Title XXI.

Current Outreach efforts for Phase I will continue and expand for Phase II.

Out-stationed Workers

The WV Department of Health and Human Resources (WV DHHR) is using an abbreviated 2-page eligibility form that is provided to applicants in a postage-paid return-mail envelope. The Department receives these applications and then routes them to the applicants' local county DHHR office. However, to increase outreach and enrollment, the Department is using trained, out-stationed eligibility staff in several major hospitals statewide through a contract with the WV Hospital Association. Also, DHHR is planning to use these out-stationed staff trained with lap-top computers to circulate during non-traditional hours and accept applications for Title XXI at appropriate community sites such as schools, pediatric clinics, primary care centers, Federally Qualified Health Centers and Rural Health Clinics.

The WV DHHR and the WV Department of Education have a cooperative agreement that includes providing a section about Medicaid on all free or reduced lunch and textbook applications. This application is distributed to all school children in the state and will be expanded to include a section on Title XXI.

The "Family Matters Hotline" is a toll-free state-wide telephone number that provides information, resources and referrals to callers about available assistance programs including Medicaid (Title XIX) and WV CHIP (Title XXI). Title XXI applications and program information is available from the hotline which has been publicized with the program.

Special Outreach Efforts

Title XXI (Phase I children 1 through 5) have developed and successfully used an abbreviated, two-page, postage-paid, return-mail application form. This same form will continue to be used for Phase II and will remain available in appropriate community sites such as schools, libraries, pediatric clinics, physicians' and dentists' offices, primary care centers, Federally Qualified Health Centers, Rural Health Clinics, and other willing businesses and retailers that either employ parents with children that are potentially eligible, or provide services to these potentially eligible children. Such businesses and retailers include fast-food restaurants, discount stores, community centers, grocery and convenience stores, and senior centers.

The postage paid, return-mail application allows applicants to apply at no cost. Verification of income is required and must be attached to the return-mail application. Applicants are not required to visit their local DHHR office to

complete program applications.

Outreach for Phase II will include statewide media announcements encouraging potentially eligible parents to call the Family Matters Hotline to receive an application and program information.

Outreach also includes volunteer efforts of the WV Children’s Health Coalition comprised of numerous community groups including the WV Council of Churches. Together the two organizations are securing private funding for outreach and working with local communities for specialized efforts to encourage potentially eligible parents to enroll. The Department’s local county offices’ Community Services Managers have successfully conducted informational meetings in numerous locations statewide. These meetings have been conducted in partnership with other community agencies. Similar meetings may be repeated to further educate communities about Phase II. The goal being to inform communities about the program and to facilitate families or eligible children to enroll in the program.

- 5.2.** Coordination of the administration of this program with other public and private health insurance programs:

(Section 2102(c)(2))

Phase II applications of Title XXI will be made through the WV Department of Health and Human Resources (WV DHHR) Recipient Automated Payment and Information Data System (RAPIDS.) This system determines eligibility for all categories of Medicaid. The system cascades from one categorical level to the next until one is located or the options for coverage are exhausted. The application for Phase II of Title XXI includes information to determine if the child or family has had access to health insurance coverage during six months prior to the application. The CHIP program, related to the “crowd out “ policy, will not permit children who have had insurance in the past 6 months to participate. The application also includes information to determine if a parent’s employer offers health insurance coverage.

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.)

6.1.1. X Benchmark coverage;
(Section 2103(a)(1)) **William M. Mercer (Mercer) is the actuarial consulting firm that has been charged with pricing the benefit package for phase II. Mercer has priced the benefit package based on the Lewin Statistics at 150% of Federal Poverty Level (FPL). Mercer was also asked to respond to our benefit plan if we increase to 200% FPL. For actuarial certification see ATTACHMENT 4.**

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

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

See ATTACHMENT 3 for complete benchmark benefit plan

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)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See **instructions**.

6.1.3. **Existing Comprehensive State-Based** Coverage; (Section 2103(a)(3)) [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))

- 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))
- 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. Hospital services for delivery are covered until member is enrolled in Medicaid.**
- 6.2.2. Outpatient services
(Section 2110(a)(2)) **The PEIA provides benefits for covered diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital, alternative facility or physician's office. Outpatient procedures requiring pre-certification are arthroscopy of the knee; cataract extraction; colonoscopy; laparoscopy (except for sterilization); septoplasty or submucous resection; tonsillectomy with or without adenoidectomy; unless the procedure is performed on an emergency basis.**
- 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). Physician fees for prenatal care and delivery is a covered benefit until member is enrolled in Medicaid.**
- 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)) **The PEIA provides benefits for covered diagnostic services, therapies, laboratory, radiology, and surgeries provided in a hospital outpatient setting or in an ambulatory surgical facility. Immunizations are covered.**
- 6.2.6. Prescription drugs
(Section 2110(a)(6)) **Prescription benefit services are covered with mandatory generic substitution, includes oral contraceptives.**
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))

- 6.2.9. X Prenatal care and prepregnancy family services and supplies
(Section 2110(a)(9)) **Prenatal care services are covered until member is enrolled in Medicaid. Title XXI plans to expand the network to include those providers that treat Medicaid recipients, so the patient will not have to change providers. The Medicaid transfer process will not have exceptions based on circumstances such as high risk pregnancy. Income limits for pregnant women are simply 150% of Federal Poverty Level. Pre-pregnancy family services and supplies, excluding tubal ligations and vasectomies, are covered. Oral contraceptives are included within pharmacy benefit services.**
- 6.2.10. X 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)) **Partial hospitalization and day programs for mental health and chemical dependency are covered when ordered by a licensed provider. Limited to 30 days per calendar year. May be extended if determined medically necessity.**
- 6.2.11. X 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 is limited to 26 visits per calendar year, for short-term individual or group outpatient mental health evaluation and referral, diagnostic, therapeutic, and crisis intervention services. May be extended with medical necessity.**
- 6.2.12. X 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 contacts are limited to \$100 per each 12-month period of eligibility. This amount may be increased either with prior approval and/or determined medically necessity. Hearing aids are covered if determined medically necessity with prior approval.**

- 6.2.13. X Disposable medical supplies
(Section 2110(a)(13)) **Therapeutic only.**
- 6.2.14. X Home and community-based health care services (See instructions)
(Section 2110(a)(14)) **Home and community-based health care services are covered. Limited to 5 visits with a retrospective prior authorization. There is maximum of 25 2-hour visits per year.**
- 6.2.15. X Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. X 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 abortion. All services require prior approval unless a medical emergency due to the endangerment of the life of the mother.**
- 6.2.17. X Dental services
(Section 2110(a)(17)) **Dental services including routine exams (annual), preventive, therapeutic and emergency services are covered. Does not cover cosmetic procedures, orthodontics or dentures.**
- 6.2.18. X Inpatient substance abuse treatment services and residential substance abuse treatment services
(Section 2110(a)(18)) **Inpatient substance abuse treatment is limited to acute detoxification. Covered benefit up to 30 days per year when determined medically necessary.**
- 6.2.19. X Outpatient substance abuse treatment services
(Section 2110(a)(19)) **More than 26 visits per year (combined with the outpatient mental health visits) require pre-certification from PEIA or the case manager. Psychological testing over and above the 26 visits will also require pre-certification from the mental health case manager or PEIA.**
- 6.2.20. X Case management services (Section 2110(a)(20))
- 6.2.21. X Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
(Section 2110(a)(22)) **Physical therapy is a covered benefit to 20 visits maximum per year with prior approval. Occupational therapy assistance in (re)learning daily living/retraining work activities is covered to \$1,000 maximum per year with prior approval. Speech therapy is covered to \$1,000 authorization year maximum when determined medically necessary. Hearing services covered to include annual exams and hearing aids**

when determined medically necessity and with prior approval/authorization.

- 6.2.22. X Hospice care (Section 2110(a)(23))
- 6.2.23. X 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.**
- 6.2.24. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.25. X Medical transportation (Section 2110(a)(26)) **Ground or air ambulance transportation, when medically necessary, to the nearest facility able to provide necessary treatment.**
- 6.2.26. Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.27. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **Waivers - 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 waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1. **Cost Effective Alternatives.** 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 2 102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. 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))

6.3.1.2. 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; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. 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(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

6.3.2. **Purchase of Family Coverage.** Describe the plan to provide 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))

6.3.2.1. 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))

6.3.2.2. 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))

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))

The PEIA contractor will provide an independent contract specific to address quality standards.

The CHIP Director will interface with the contractor and audit personnel regarding the standards set forth.

Quality of care issues related to care treatment and outcomes will be referred to the Quality Improvement (QI) Department through systematic utilization management flags and reports, from customer service interactions, and directly from parent complaints. QI will investigate all referrals and develop and implement appropriate corrective actions. Records of all quality referrals will be maintained to identify quality of care issue trends among the providers of service.

Diagnoses identified through the utilization management system that warrant review for chronic, high-cost, or special needs consideration will be referred to 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**

Measures for these Children may include:

- **Proportion of children for whom a written health care plan has been developed to treatment and interventions.**
- **Proportion of adolescents for whom a transition plan has been developed.**
- **Proportion of children by condition, who receive special therapies**

- (type, frequency, duration).
- Proportion of children whose specialty care is provided by a board certified special pediatric experience.
- Proportion of children who have hospital stays, and length of stay.

The rate of use of acute care services may be measured by the following measures:

- Number and rate of ambulatory visits per 1000 member months, by age.
- Number and rate of emergency room visits per 1000 member months.
- Number and rate of hospital stays per 1000 member months, by age.
- Average lengths of hospital stay.

An annual survey will be conducted to identify opportunities to enhance the services and quality of care rendered to program participants. A random sample of all participating families will be asked to complete a survey to determine, among other measures, the following:

- Proportion of parents that rate the care provided to the child is poor, appropriate, excellent.
- Proportion of parents reporting that they are satisfied with the role in making decisions about their child's care.
- Proportion of parents reporting satisfaction with the availability and choice of primary specialty providers.
- Proportion of parents reporting satisfaction with the amount of time providers spend with the child.
- Proportion of parents who filed formal complaints or grievances.
- Average waiting time for appointments for preventive; primary and specialty care.
- Travel time and distance to receive preventive; primary and specialty care.

The use of prevention services may be evaluated through the following measures:

- Well-child screening rate, by age (American Association of Pediatricians standards)
 - Infants
 - ages 1-4 years.

- ages 5-11 years.
- ages 12-18 years.
- **Appropriate immunizations at age 2 years.**

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. x Quality standards
- 7.1.2. X Performance measurement
- 7.1.3. x Information strategies
- 7.1.4. x Quality improvement strategies

- 7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services.
 (2102(a)(7)(B)) **Department of Insurance laws on access with prudent layperson standards on emergency care.**
See section 7.1 for monitoring and complaint tracking related to utilization control strategies.

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?

8.1.1. c1 YES

8.1.2. x NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))

8.2.1. Premiums: _____

8.2.2. Deductibles: _____

8.2.3. Coinsurance: _____

8.2.4. Other: _____

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: _____

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of 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))

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 19 16(b)(1).

8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6. 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))

8.4.7. cl 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))

8.4.8. 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))

8.4.9. 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))

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 annual income for the year involved: (Section 2103(e)(3)(B))

Title XXI will not participate in cost-sharing at this time.

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

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

8.6.2. 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 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

Section 9. Strategic Objectives and Performance Goals for the 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))**

1. The West Virginia Department Health and Human Resources (WV DHHR), through a contract with PEIA, will implement Phase II of West Virginia's Title XXI Program. Phase II is defined as expanding eligibility to uninsured children ages six (6) through eighteen (18) years that have incomes equal to or less than 150% of the Federal Poverty Level (FPL).

2. Previously uninsured children ages six (6) through eighteen (18) years who are potentially eligible for West Virginia's Title XXI Program will be identified through ongoing and new outreach activities.

3. Uninsured children ages six (6) through eighteen (18) years who have incomes equal to or less than 150% of FPL without insurance coverage will be eligible for health insurance coverage through West Virginia's Title XXI Program.

4. Children who are enrolled in West Virginia's Title XXI Program will have an accessible health care source.

5. West Virginia's Title XXI Program will result in the improved health of children enrolled in the program and will improve the overall health care system by focusing on preventive measures as well as acute care services.

- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))**

Performance Goal Objective 1:

Beginning upon approval, the PEIA will offer Title XXI benefits to the 22,901 eligible children under a Phase II expansion. Data systems are already in place for the processing of program applications, recipient information, service utilization, billing and provider information.

Performance Goal Objective 2:

Beginning upon approval, new initiatives, as well as ongoing outreach efforts, will be implemented. Out-stationed workers and in-office eligibility workers will be prepared to enroll identified qualified children. All outreach activities specified in Section 5 will be in place.

Performance Goal Objective 3:

Beginning upon approval, West Virginia determined 22,901 eligible children will have health insurance coverage offered to them.

Performance Goal Objective 4:

Beginning upon approval, all children who are eligible for West Virginia's Title XXI expansion, will have a system of primary care providers available for immediate access.

Performance Goal Objective 5:

Over time, West Virginia will show increased access and usage of health care services by children ages six (6) through eighteen (18) years through statistical data. This data will reflect an increase in well-child visits as well as immunization rates for children in this coverage groups. Other outcome data will be developed in order to further track usage.

- 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))

Assurance of an Objective Means for Measuring Performance

West Virginia will utilize the Department's current Recipient Automated Payment and Information Data System (RAPIDS) to track enrollment of all children in Phase II of the Title XXI Children's Health Insurance Program.

Data will be generated to give statewide demographic information on all children enrolled as part of Phase I and II. WV CHIP will be responsible for reports on service utilization broken down by age and sex. Comparison data will be collected for immunizations, well-child visits, and services by specialty providers. West Virginia, Bureau of Public Health, currently collects data on diabetes and

asthma and will continue to do so for this child population.

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

- 9.3.1. x The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2. **X** The reduction in the percentage of uninsured children.
- 9.3.3. x The increase in the percentage of children with a usual source of care.
- 9.3.4. x The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5. x 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. cl 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. x 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))

- 9.5. x The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

West Virginia must, under State law, provide to the State Legislature, at least on a quarterly basis, statistical data on the Children's Health Insurance Program which will reflect 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 (Medicaid-Title XIX - Phase I and PEIA - Title XXI - Phase II.

West Virginia will also, on a quarterly basis, produce reports which 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 (WV 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. X 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))

9.7. x The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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))

- 9.8.1. X Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. X Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)
- 9.8.3. X Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. X Section 1115 (relating to waiver authority)
- 9.8.5. X Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. X Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. X Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. X Section 1128A (relating to civil monetary penalties)
- 9.8.9. X Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10.x 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(e))

Expansion of the Title XXI Program under Phase II has given interested and affected persons an opportunity to offer comment on the plan at public meetings of the board and will continue this process while developing any proposed plan under §5-16B-6. Comments have been solicited in writing from interested and affected persons. Implementation of Phase II has been based on this input.

The CHIP plan will be placed in each of the county office's inviting public comment and also the Governor's Cabinet on Children and Families will be soliciting public comment.

Also, the CHIP plan will be online at the Department's (WV DHHR) Internet site for public viewing and comment.

On April 9, 1998, Governor Cecil Underwood signed into law the West Virginia's Children's Health Insurance Program. With the signing of this law, all children in West Virginia whose household incomes are up to 150% of the Federal Poverty Level will have access to health care coverage. The CHIP board, created from the legislation, was given the authority to select a benefit plan appropriate for children. A benefit plan was selected and approved by the CHIP board with the assistance of William M. Mercer, Inc., which is the PEIA benchmark plan.

The CHIP board meetings have been held about every two weeks and they are advertised in newspapers and by registry. The CHIP is required to give ten days notice prior to board meetings. Every board meeting has been well-attended, and time was allotted at each meeting for public comment and inquiry.

The CHIP Director has been contacted in writing about comments regarding the benefit plan. These have been submitted to the board for review prior to the scheduled meeting. These issues are discussed and decisions, comments and/or responses are then made.

The CHIP Board sees Title XXI as an ongoing process. The Board will continue to meet, provide oversight and solicit public comment regarding the benefit plan and execution. The CHIP Director will also be the interface for the PEIA contractor who will review and process the claims.

- 9.10.** Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties.

The annualized budget for Phase II of this program is \$15,781,333 with a federal share of \$12,999,242. ATTACHMENT 1 for budget detail.

The West Virginia Legislature appropriated \$5,000,000.00 for the first year of the Title XXI Children's Health Insurance Program. This appropriation has carry-over authority in order to assure sufficient matching funds for future expansion.

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))

10.1.1. x 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

10.1.2. x Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a chart listing the types of information that the state’s annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with</u> <u>Creditable Coverage</u>	Number of Children without Creditable Coverage	TOTAL
	XIX OTHER CHIP		
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
<u>Age</u>			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
<u>Race and Ethnicity</u>			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
<u>Location</u>			
MSA			
Non-MSA			

- 10.2. x State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
 - 10.2.1. x An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
 - 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
 - 10.2.2.1. x The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
 - 10.2.2.2. x The quality of health coverage provided including the types of benefits provided;
 - 10.2.2.3. **X** The amount and level (including payment of part or all of any premium) of assistance provided by the state;
 - 10.2.2.4. **X** The service area of the state plan;
 - 10.2.2.5. **X** The time limits for coverage of a child under the state plan;
 - 10.2.2.6. **X** The state's choice of health benefits coverage and other methods used for providing child health assistance, and
 - 10.2.2.7. **X** The sources of non-Federal funding used in the state plan.
 - 10.2.3. **X** An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

- 10.2.4. **X** A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. **x** An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. **X** A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. **X** Recommendations for improving the program under this Title.
- 10.2.8. **X** Any other matters the state and the Secretary consider appropriate.
- 10.3. **X** The state assures it will comply with future reporting requirements as they are developed.
- 10.4. **X** 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.