

**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)(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 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).

There are two public health insurance programs targeted at low-income children in the State of West Virginia: Medicaid and the West Virginia Children's Health Insurance Program. There are no public-private partnerships which provide creditable coverage.

The Medicaid program offers health insurance coverage to all children in the State of West Virginia who meet eligibility criteria. At present, the following income eligibility criteria apply:

- ▶ **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**

Medicaid uses deductions and disregards in computing income for eligibility determination, as approved by the Health Care Financing Administration (HCFA).

State legislation establishing the West Virginia Children's Health Insurance Program (WV CHIP) was signed into law in April 1998. The goal of the program is to ensure that all children in the State of West Virginia receive necessary and preventive health care. State legislation further established an oversight body, the West Virginia Children's Health Insurance Board, whose role is to develop fiscally responsible plans for health services or health insurance for children. To date, there have been two phases to the program's implementation. On July 1, 1998, Phase I of the program began by offering Medicaid expansion coverage to children ages 1 through 5 with household income greater than 133% of the FPL up to 150% of the FPL. At June 30, 2000, 1,452 children were enrolled in Phase I.

Phase II of WV CHIP was approved by HCFA in April 1999. Phase II provides benchmark equivalent coverage to the State of West Virginia Public Employees Insurance Agency Preferred Provider Benefit plan. Children ages 6 through 18 whose income exceeds 100% of the FPL up to 150% are eligible to participate. As of June 30, 2000, 10,245 children were enrolled in Phase II.

On June 26, 2000, the State of West Virginia submitted a state plan amendment to withdraw the Phase I Medicaid expansion and incorporate the Phase I children into Phase II of WV CHIP.

This state plan amendment proposes to increase income eligibility requirements from their current level to 200% of the FPL and is known as Phase III of the West Virginia Children's Health Insurance Program (WV CHIP). Along with the increase in the income level for program eligibility, the West Virginia Children's Health Insurance Agency, which administers WV CHIP, will impose co-payments on participants whose income is over 150% of the FPL. According to federal regulation, Native Americans will be exempted from this cost-sharing requirement.

West Virginia demographic 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). Lewin estimated that 14,000 children would be eligible to enroll in Phase III.

West Virginia believes that the Lewin Group is a reputable and reliable source for the number of estimated eligible population for the Children's Health Insurance Program. It is our understanding that the Health Care Financing Administration has utilized the Lewin Group for the same type of data compilation.

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

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):

Currently there are two public health coverage programs in West Virginia: the West Virginia Title XIX Medicaid program and the Title XXI West Virginia Children's Health Insurance Program.

Outreach activities for WV CHIP are performed by various groups. The West Virginia Children's Healthy Kids Coalition is comprised of numerous community groups including the WV Council of Churches. The Healthy Kids Coalition has secured private funding from the Robert Wood Johnson

Foundation and the Benedum Foundation, among others. Those grants provide for outreach and specialized efforts with local communities to encourage potentially eligible parents to enroll. There are 9 outreach coordinators working in 32 counties throughout the state for the Healthy Kids Coalition. Primary Care Centers, Federally Qualified Health Centers (FQHC's), and Rural Health Clinics (RHC's) also provide outreach for the program through a volunteer effort.

Outreach is also accomplished through the Family Resource Networks (FRNs). The FRNs are local community-based organizations charged with redesigning services for children and families. FRNs engage in strategic planning, interagency coordination and ongoing evaluation activities. There are 45 FRNs serving all 55 counties of West Virginia.

The school system is another key source for identifying children who need health coverage. Through a cooperative agreement with the West Virginia State Department of Education, all free or reduced lunch and textbook applications include a section on Medicaid and WV CHIP. This application is distributed to all school children in the State. School officials refer interested parties to the West Virginia Children's Health Insurance Agency for follow-up. 5,000 potentially eligible children were identified through this process in 1999.

WV CHIP also leverages the activities of state agency personnel for outreach. DHHR'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. The goal is to inform communities about the program and to facilitate eligible children to enroll in the program. The Office of Maternal and Child Health regularly interfaces with the medical community and distributes WV CHIP brochures and applications. Also, Bureau of Public Health family outreach workers, who live in the communities where they work, provide information to families about the availability of WV CHIP, and assist with applications. WV CHIP applications will be made available through the DHHR Truancy Diversion programs, as well as at the "one-stops" established through the implementation of the Workforce Investment Act.

WV CHIP/Medicaid applications are made available not only by county DHHR offices, but also at physicians' offices, hospitals, Federally Qualified Health Centers, Rural Health Clinics and Child Care Centers.

Approximately 600 telephone calls per month are made to the toll-free WV CHIP Hotline (1-877-WVA-CHIP). The WV CHIP Hotline is a toll-free statewide 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 are available from the Hotline. The Hotline is staffed by the third-party administrator from 8:00 a.m. through 4:30 p.m., with voice mail activated after hours. In April 2000, the Hotline staff began tracking where the caller heard about WV CHIP and how they obtained the toll-free number.

WV CHIP has used public service announcements and has worked directly with the public school system to enroll eligible children. The WV CHIP Board has approved a statewide advertising campaign to publicize the Phase III expansion. This campaign will include radio and television advertising to raise awareness of the program. Statewide media announcements will encourage potentially eligible parents to call the WV CHIP Hotline at 1-877-WVACHIP to receive an application and program information.

In addition, DHHR has received the results of a research report conducted by Ryan-McGinn-Samples Research, Inc. Ryan-McGinn-Samples surveyed a statistically valid sample of individuals who are eligible to participate in DHHR's major programs, including Medicaid and WV CHIP. The report noted that respondents preferred direct mail as a means of receiving information about programs and that they valued messages from their clergy and medical professionals. The West Virginia Children's Health Insurance Agency will incorporate the results of this research to achieve maximum effectiveness in enrolling uninsured children.

WV CHIP (Title XXI) and Medicaid (Title XIX) have developed and successfully used an abbreviated, two-page, postage-paid, return-mail application form. The application will be revised for Phase III and will continue to be made available at 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. Applications can also be obtained at the local DHHR offices. 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.

WV CHIP/Medicaid applications are processed for WV Chip eligibility determination by DHHR eligibility staff. Eligibility determination is facilitated by DHHR workers stationed in selected hospitals across the State through a cooperative agreement between DHHR and the West Virginia Hospital Association. In addition to the WV CHIP application process, the DHHR integrated eligibility system identifies applicants whose income exceeds the Medicaid eligibility level and determines whether they are eligible for WV CHIP.

As required by recent legislation passed by the West Virginia legislature, the WV CHIP 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.

- 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:

West Virginia's public-private partnership with the Healthy Kids Coalition is discussed fully in Section 2.2.1. In addition, to increase outreach and enrollment DHHR uses trained, out-stationed eligibility staff in several major hospitals statewide through a contract with the West Virginia Hospital Association.

- 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)

All WV CHIP/Medicaid applications are first screened for Medicaid eligibility through the integrated eligibility system known as RAPIDS (Recipient Automated Payment and Information Data System). If the child is ineligible for Medicaid, RAPIDS determines whether the child is eligible for WV CHIP.

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 provides health insurance benefits through a plan managed by the Children’s Health Insurance Agency, within the Department of Administration, using the same third-party administrator as the state employee health insurance plan. Primary care centers and school-based health centers, which provide low-income families with health care services, are included in the provider network to assure consistency of treatment for children served by these facilities.

- 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 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. PEIA’s third-party administrators provide the State of West Virginia’s Title XXI program with medical necessity, pre-certification, prior approval, fraud detection, audit and extensive utilization reporting.

PEIA provides the following quality assurance services to the WV CHIP 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))

- 4.1.1. X Geographic area served by the Plan: **State of West Virginia**
4.1.2. X Age: **0-18** (Infants were not covered previously under WV CHIP.)

- 4.1.3. X Income: **Exceeds Medicaid maximum up to and including 200% of the FPL**
- 4.1.4. 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: **Ineligible if previously covered in the last six months, except as noted at 4.4.3.**
- 4.1.8. X Duration of eligibility: **12 months**
- 4.1.9. 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)) **Consistent with Phases I and II of WV CHIP and through a cooperative agreement between DHHR and the West Virginia Department of Administration, eligibility for Phase III will be processed through the DHHR Recipient Automated Payment and Information Data System (RAPIDS). WV CHIP/Medicaid applications are processed for eligibility determination for WV CHIP by DHHR eligibility staff. 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 eligibility for WV CHIP is determined. During the eleventh month of coverage, a redetermination of eligibility for the West Virginia Children’s Health Insurance Program is made.**

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 are higher than those for Title XIX, as more 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 WV CHIP eligibility. Income is verified at the time of application with an annual redetermination of eligibility. The same deductions and disregards for income that have been used in Title XIX are also used in Title XXI: for example, the definition of household is the same.

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.

- 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)) 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. 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. Questions on the application allow WV CHIP to determine whether the child has been covered under insurance prior to application. If so, there is a six-month waiting period for availability of coverage. Exceptions may be made for the following reasons:

- ▶ **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**

- 4.4.4. The provision of child health assistance to targeted low-income children in the

state who are Indians (as defined in section 4© 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 are targeted through statewide outreach efforts specifically outlined in Section 5. As specified in the regulations, Native Americans are exempt from cost sharing. This requirement will be addressed by the program's claims processing system and through education of the provider community.**

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

(Section 2102)(b)(3)(E)) **The State offers two public programs for low-income children: Medicaid and WV CHIP. The West Virginia Department of Health and Human Resources Recipient Automated Payment and Information Data System (RAPIDS) integrated eligibility system determines which program the child is eligible for.**

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))

Please refer to Section 2.2.1. for a full description of outreach activities.

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

(Section 2102(c)(2))

Eligibility determination is made through the West Virginia Department of Health and Human Resources Recipient Automated Payment and Information Data System (RAPIDS) integrated eligibility system. Applicants are first screened for Medicaid eligibility. WV CHIP adheres to the “crowd out” policy, which will not permit children who have had insurance in the last six months to participate, except for the items noted at 4.4.3.

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. Benchmark coverage; (Section 2103(a)(1))

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. X Benchmark-equivalent coverage; 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).

(Section 2103(a)(2))

See ATTACHMENT 3 for a complete description of the Public Employees Insurance Agency Preferred Provider Benefit plan, the benchmark benefit plan.

The actuarial consulting firm of William M. Mercer has analyzed the benefit package for Phase III as approved by the West Virginia Children's Health Insurance Policy Board and utilized the Lewin estimates of the population of potential eligibles. The Board has approved a co-payment scale for enrolled children who fall into the over 150% - 200% FPL category. Dental and vision services are excluded from co-pays. For the actuarial certification, see ATTACHMENT 4.

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. X 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. X 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. X 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. X Surgical services (Section 2110(a)(4))
- 6.2.5. X 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. X Prescription drugs
(Section 2110(a)(6)) **Prescription benefit services are covered with mandatory generic substitution, which includes oral contraceptives.**
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. X Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. X 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. 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 necessary.

- 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 as medically necessary.

- 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 with either prior approval and/or determined medical necessity. 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. X Disposable medical supplies

(Section 2110(a)(13)) As medically necessary.

- 6.2.14. X Home and community-based health care services (See instructions) (Section 2110(a)(14)) **Home health care services are covered. This benefit requires approval for more than five visits and is subject to a maximum of 25 two-hour visits per year.**
- 6.2.15. X Nursing care services (See instructions) (Section 2110(a)(15))
Skilled nursing services are limited to an annual maximum of 180 days.
- 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 abortions. All services require prior approval unless a medical emergency exists endangering the life of the mother.**
- 6.2.17. X Dental services
(Section 2110(a)(17)) **Routine semi-annual exams, preventive, therapeutic and emergency services are covered. Does not cover cosmetic procedures, orthodontics or dentures, except in the case of mandibular degeneration.**
- 6.2.18. X 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. Covered benefit up to 30 days per year for inpatient care and limited to 60 visits per year for partial hospitalization and day programs.**
- 6.2.19. X Outpatient substance abuse treatment services
(Section 2110(a)(19)) **Coverage limited to 26 visits per year requiring pre-certification from the third-party administrator. May be extended as medically necessary.**
- 6.2.20. X Case management services (Section 2110(a)(20))
Case management provided by the third-party administrator, Intracorp.
- 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 when ordered by a physician. Additional visits must be precertified and case-managed by the third party administrator.**
Occupational therapy assistance in re-learning daily living/retraining work activities covered to \$1,000 maximum per year with prior approval.
Speech therapy covered to \$1,000 authorization year maximum when

determined medically necessary.

Hearing services covered to include annual exams and hearing aids when determined medically necessary 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 2102(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 West Virginia Children's Health Insurance Program utilizes the Public Employees Insurance Agency's claims processing and utilization management contractors, Acordia National and Intracorp, to provide comprehensive quality

assurance program, 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 WV CHIP provider network of those providers barred from participation in Medicare/Medicaid**

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**

WV CHIP 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 WV CHIP 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, WV CHIP will receive utilization management reports detailing the top diagnostic categories of CHIP beneficiaries from Intracorp, the third-party administrator for utilization management services, which will better position the

program to track trends and facilitate the development of appropriate intervention strategies.

WV CHIP will have access to comparative data from other states through Intracorp's "Center of Excellence in State Government." 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.

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

Well-child screening rate by age (American Association of Pediatricians standards)

Infants

Ages 1 through 4 years

Ages 5 through 11 years

Ages 12 through 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
The same tools in place for the benchmark-equivalent plan will be used for WV CHIP.
- 7.1.2. X Performance measurement
The same tools in place for the benchmark-equivalent plan will be used for WV CHIP.
- 7.1.3. X Information strategies
The same tools in place for the benchmark-equivalent plan will be used for WV CHIP.
- 7.1.4. X Quality improvement strategies
The same tools in place for the benchmark-equivalent plan will be used for WV CHIP.

- 7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services.
(2102(a)(7)(B)) **The State of West Virginia Department of Insurance 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.

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. **YES This state plan amendment for Phase III of WV CHIP includes a co-pay schedule for enrollees with incomes over 150% through 200% of FPL. Native Americans are excluded from cost-sharing.**
- 8.1.2. **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 : _____ NA
- 8.2.2. Deductibles: _____ NA
- 8.2.3. Coinsurance: _____ NA

8.2.4. Other: **Enrollees with income over 150% through 200% of FPL are required to cost-share according to a co-pay schedule of \$250 per child up to an annual family maximum of \$750**

The cost-sharing provision is new and affects only Phase III enrollees whose income exceeds 150% FPL up to 200% FPL as we expand to 200% of the FPL. Enrollees whose income is at or below 150% of the FPL will not be affected.

Co-Pay Schedule:

Non-Well Visits	\$15 per visit
Inpatient Services	\$25 per admission
Outpatient Services	\$25 per procedure
Emergency Room	\$35 per visit (waived if admitted)
Prescriptions	\$5 generic/\$10 brand (mail orders same)
Dental services	No co-pay requirement
Vision services	No co-pay requirement
Out-of-pocket maximum	\$250 per child/\$750 per family per year

Our third-party administrator will monitor co-pays and when the maximum is reached (\$250 year per child and \$750 per year per family), the family will receive a letter stating they have reached their maximum for the year. The Plan may impose a maximum on the prescription and medical components of the total co-pay

maximums.

- 8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: **Public notice is described fully in Section 9.9.**
- 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. **X** Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
 - 8.4.2. **X** No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
 - 8.4.3. **X** No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).
 - 8.4.4. **X** No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
 - 8.4.5. **X** No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))
 - 8.4.6. **X** 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. **X** 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. **X** 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. **X** 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))

The plan provides for a co-pay annual maximum of \$750 per family with income over 150% of the FPL, which does not exceed the 5% limit.

Mechanisms will be established to ensure that Native Americans are excluded from cost-sharing.

- 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. Phase III will expand eligibility to uninsured children from birth through age 18 years whose incomes exceed the limit for Medicaid eligibility up to 200% of the FPL.**
 - 2. Previously uninsured children from birth through age 18 years who are potentially eligible for West Virginia's Title XXI Program will be identified through ongoing and new outreach activities. Infants were not previously covered under Phase II of WV CHIP.**
 - 3. Children who are enrolled in West Virginia's Title XXI Program will have an accessible health care source.**
 - 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 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 by the Health Care Financing Administration (HCFA), Title XXI benefits will be available to the approximately 14,000 eligible children under the Phase III expansion. 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:

Beginning upon approval by the HCFA, new initiatives, as well as ongoing outreach efforts, will be implemented. All outreach activities specified in Section 2.2.2. will be in place.

Performance Goal/Objective 3:

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

Performance Goal/Objective 4:

Over time, West Virginia will show increased access and usage of health care services by children from birth through age 18 through statistical data. This data will reflect an increase in well-child visits as well as immunization rates for children in these 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))

- 1. Performance Goal 1 is measured by reconciling RAPIDS eligibility data to enrollment data proved by the third-party administrator.**
- 2. Performance Goal 2 is measured by monthly enrollment reporting compared to the Lewin estimate.**
- 3. Performance Goal 3 will be measured by data collected in an annual survey, as well as exceptions identified through daily operations.**
- 4. Performance Goal 4 will be measured by data and analysis provided by the third-party administrator, Intracorp.**

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.

NOTE: While we are not collecting HEDIS data, we have the capacity to generate information on specific illnesses.

- 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))
- 9.5. 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))

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 (WV CHIP Phase III).

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. 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(c))

WV CHIP Board meetings are held approximately once a month and are advertised in newspapers by registry. WV CHIP is required to give ten days' notice prior to board meetings. Each board meeting held to-date has been well attended, and time was allotted at each meeting for public comment and inquiry. Comments have been solicited in writing from interested and affected persons. The increased eligibility limits provided for in Phase III were based on such input.

The WV CHIP 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 every newspaper and television station in the State.

As more fully described in Section 2.2.1., a statewide radio advertising campaign will increase awareness of Phase III of WV CHIP. In addition, other means of increasing awareness, such as direct mail, will be explored as a result of the Ryan-McGinn-Samples research study.

The WV CHIP plan will be online at the DHHR Internet site for public viewing and comment. Upon completion of the transition from DHHR to the Department of Administration, WV CHIP will design its own web site.

Providers are notified of plan changes through a quarterly newsletter published by the Public Employees Insurance Agency, the state health insurance agency which provides third-party administrator services for WV CHIP.

- 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))

The West Virginia Legislature appropriated \$5,000,000 from general revenue funds in the fiscal year ending June 30, 1999 for the first year of the Title XXI Children's Health Insurance Program, as well as an additional \$3,000,000 in the fiscal year ending June 30, 2000 and \$3,000,000 in the fiscal year ending June 30, 2001. It is anticipated that of the \$8 million appropriated in state fiscal years 1999 and 2000,

over \$5 million will be available for state fiscal year 2001 expenditure.

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))

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 Creditable Coverage</u>		TOTAL
	<u>XIX</u>	<u>OTHER CHIP</u>	
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.