

West Virginia

Total Medicaid Enrollment: 300,189 ("point-in-time" monthly enrollment counts for December 2006)

Source: <http://www.statehealthfacts.org>

Total Population: 1,812,035 (July 2007)

Source: Source: Population Division, U.S. Census Bureau

<http://www.census.gov/popest/states/tables/NST-EST2007-01.xls>

For West Virginia specific information, visit West Virginia's Medicaid Website:

<http://www.wvdhhr.org/bms/>.

Medicaid Eligibility

Maximum Income Limits for Populations Applying for Medicaid as a Percentage of Federal Poverty Guidelines, 2008	
Population Segment	%
Infants (Ages 0 – 1)	150
Children (Ages 1 – 5)	133
Children (Ages 6 – 19)	100
Working Parents ¹	35
Non-Working Parents ¹	18
Pregnant Women	150
Aged and Disabled (OBRA '86), 2001 ²	NA
Supplemental Security Income, 2000	74
Medicaid expansion group (1115 waiver): NA	NA

Source: www.statehealthfacts.org

State Children's Health Insurance Program (SCHIP)

SCHIP coverage applies to uninsured children with incomes that are too high to qualify for Medicaid but are less than or equal to the maximum SCHIP income limits.

Total SCHIP Enrollment: 24,939 ("point-in-time" monthly enrollment counts, June 2007)

Source: <http://www.statehealthfacts.org>

Structure of SCHIP As of August 21, 2007		
Separate State Program	Medicaid Expansion	Combination Program
X		

Source: Centers for Medicare and Medicaid Services

<http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.pdf>

Maximum Income Limits for Children's Separate SCHIP Program as a Percentage of Federal Poverty Guidelines, 2008	
Population Segment	%
Income Eligibility – Separate SCHIP Program ³	220

Source: www.statehealthfacts.org

Services Covered

For information about the services covered by Medicaid, visit the Kaiser Family Foundation's Medicaid Benefits Online Database: www.kff.org/medicaid/benefits.

Delivery System Description

Medicaid Enrollment by Delivery System Type, as of June 30, 2006		
Delivery System	#	%
Fee-for-Service	159,374	53
Managed Care	137,457	47
Total	296,831	100

Source: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp

Medicaid Enrollment by Managed Care Program Type, as of June 30, 2006	
Managed Care Program	#
Commercial MCO ⁴	137,457
Medicaid-only MCO ⁵	0
Health Insuring Organization ⁶	0
Primary Care Case Management ⁷	22,162
Prepaid Inpatient Health Plan ⁸	0
Prepaid Ambulatory Health Plan ⁹	0
PACE ¹⁰	0
Other ¹¹	0

Source: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp

Notes: Individuals can fall within more than one type of managed care program type.

Federal Matching Rate (FMAP)

FMAP¹² for Medicaid and Multiplier¹³ FY 2008
74.25%

Source: www.statehealthfacts.org

Rural Information

The information below defines “Urban” as residing in a metropolitan county and “Rural” as residing in a non-metropolitan county.

Current Population Survey Data

Percent of Residents Enrolled in Medicaid, by Age and Rurality		
Age	Urban % on Medicaid	Rural % on Medicaid
0 – 18	32.8	42.8
19 – 64	6.6	13.9
65 and Over	6.1	11.8

Source: Current Population Survey, 2005 - 2006

State Website Data

Medicaid Data, Urban and Rural		
	Urban	Rural
I. Total Eligibles (February 2003)	127,796	151,090
II. Eligibles per Population	12.82%	18.47%
III. Dollars Spent	NA	NA
IV. Dollars Spent per Eligible	NA	NA

County level data on the above information, visit:

I: West Virginia Department of Health and Human Resources. Health Statistics Center. Selected Sources of Publicly Funded Health Care Coverage in West Virginia. Brief Number 2 Update (March 2004).

<http://www.wvdhhr.org/bph/oehp/hsc/briefs/two/index.htm>

II: Calculation based on Total Eligibles/Total Population. Total Population based upon Bureau of the Census data updated by information from the Office of Management and Budget.

Bureau of the Census, (US). Metropolitan And Micropolitan Statistical Areas And Components, December 2006, With Codes: Department of Commerce; 2007. Available from: http://www.census.gov/population/estimates/metro_general/List1.txt.

Executive Office of the President; Office of Management and Budget; OMB BULLETIN NO. 08-01: Update of Statistical Area Definitions and Guidance on Their Uses. Available from: <http://www.whitehouse.gov/omb/bulletins/fy2008/b08-01.pdf>.

Critical Access Hospitals (CAH)

	Yes	No
CAH Cost Base for Medicaid Patients?	X	

Source: Shawn Belleydier, Assistant Director, Division of Rural Health and Recruitment, 2008.

State Plan Amendment under the Deficit Reduction Act of 2005 (DRA)

The DRA allows states to introduce “benchmark” benefit plans that cover different Medicaid services for different eligibility groups or geographic areas of the state. The following information is based upon the state’s response in their Benchmark Benefit Package State Plan Amendment under the DRA and identifies if the state’s amendment varies Medicaid services geographically. Additional information is available in the state’s approval package at http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp.

Do the services vary geographically?*	Additional detail
No	The alternate benefit package will be available statewide, subject to a phase in on a county by county basis.

Source: State Plan Amendment submitted under transmittal number 06-02.

http://www.cms.hhs.gov/MedicaidGenInfo/08_DRASection.asp

*Response to question A.c. (Geographical Classification) of the State Plan Amendment.

¹ Parents’ eligibility levels are based upon the income threshold applied to a working parent in a family of three.

² This Section 209b states exercise an option that allows states to use their 1972 financial and non-financial standards instead of the federal SSI standards to determine eligibility for the disabled. If a state uses its more restrictive 1972 financial eligibility standards, it must also allow disabled individuals to “spend down” into Medicaid eligibility by deducting incurred medical expenses from income.

³ West Virginia plans to expand SCHIP eligibility to 220 percent of the federal poverty line effective January 2007.

⁴ A commercial managed care organization (MCO) provides comprehensive services to Medicaid and commercial and/or Medicare populations.

⁵ A Medicaid MCO provides comprehensive services to only Medicaid beneficiaries, not to commercial or Medicare populations.

⁶ CMS defines a Health Insuring Organization (HIO) as “a managed care entity which, by law, is exempt from certain rules governing MCO program operation such as the requirement for beneficiaries to have a choice of at least two managed care entities in mandatory programs.”

⁷ CMS defines a Primary Care Case Management (PCCM) provider as: “a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants who contracts directly with the State to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category also includes those PIHPs that contract with the State as “primary care case managers.”

⁸ CMS defines a Prepaid Inpatient Health Plan (PIHP) as a plan that “provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise have responsibility for provision of any inpatient hospital institutional services.” States can offer PIHPs for medical services, mental health, substance abuse disorders, or long-term care services.

⁹ CMS defines a Prepaid Ambulatory Health Plans (PAHP) as a plan that “provides less than comprehensive services on an at-risk or other that state plan reimbursement basis; and does not provide, arrange for, or otherwise have responsibility for provision of any inpatient hospital or institutional services.” States may offer PAHPs for medical services, mental health, substance abuse disorders, dental, transportation or disease management.

¹⁰ CMS defines the Program for All-inclusive Care for the Elderly (PACE) as a “program that provides prepaid, capitated comprehensive, health care services to the frail elderly.”

¹¹ CMS categories managed care organizations as “other” if it is “not considered a PCCM, PIHP, PAHP, Commercial MCO, Medicaid-only MCO, HIO or PACE.”

¹² The Federal Medical Assistance Percentage (FMAP) is computed from a formula that takes into account the average per capita income for each State relative to the national average. By law, the FMAP cannot be less than 50%.

¹³ The multiplier is based on the FMAP. For every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year.