
***Commonwealth of Virginia
Department of Medical
Assistance Services***

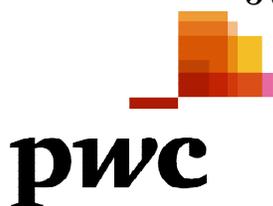
Program of All-Inclusive Care
for the Elderly (PACE)
Data Book and Capitation Rates
Fiscal Year 2014

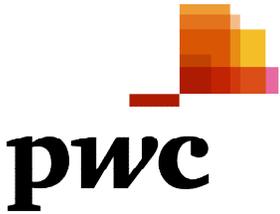
July 2013

Submitted by:

PricewaterhouseCoopers LLP
Three Embarcadero Center
San Francisco, CA 94111

July 30, 2013





Mr. William J. Lessard, Jr.
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

July 30, 2013

Dear Bill:

Re: PACE Data Book and Capitation Rates – FY 2014

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for Fiscal Year 2014, effective July 1, 2013 to June 30, 2014, for the Virginia Programs of All-Inclusive Care for the Elderly (PACE) that operate as a full PACE program. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services requirements that the capitation rates be developed under guidelines that rates do not exceed the Fee-for-Service Upper Payment Limit, the amount that would be paid by the Medicaid program in the absence of a PACE program, and are appropriate for the population covered by the program.

The development of these rates was overseen by Sandra Hunt, Partner, Susan Maerki, Project Manager, and Peter Davidson, Lead Actuary.

Please call us at 415/498-5365 if you have any questions regarding these capitation rates.

Very Truly Yours,

A handwritten signature in cursive script that reads "PricewaterhouseCoopers".

PricewaterhouseCoopers LLP

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***Program of All-Inclusive Care for the Elderly
Data Book and Capitation Rates
Fiscal Year 2014
Prepared by PricewaterhouseCoopers LLP
July 2013***

PricewaterhouseCoopers LLP (PwC) has revised the calculation of the capitation rates for the Virginia Medicaid Program of All-Inclusive Care for the Elderly (PACE) program for State Fiscal Year 2014 for rates effective July 1, 2013. This includes PACE rates for programs operational throughout the state. Rate setting for PACE programs is guided by regulations that limit payment to at or below the amount the Medicaid program would pay as a Fee-for-Service Equivalent (FFSE) cost in the absence of the PACE program; this is also referred to as the Upper Payment Limit (UPL). The methodology presented in this report meets the UPL guidelines and conforms to appropriate standards of practice promulgated from time to time by the Actuarial Standards Board. Rates based on UPL guidelines do not require actuarial certification.

The final rates will be established through signed contracts with the PACE plans, which will ensure that the plans concur that the rates paid will allow for contracting with sufficient numbers of providers to ensure appropriate access to health care and that they expect to remain financially sound throughout the contract period. Capitation rates are developed for a population aged 55 and over and vary by dual eligibility status (Medicaid/Medicare or Medicaid Only). The PACE rates are developed for five regions in the state will be paid to the six organizations that operate the twelve operating PACE sites. They will also be paid to the three expansion sites that are expected to become operational in FY 2014.

Medicaid PACE rates include funding for acute care as well as the long term care and personal care services under the Elderly or Disabled with Consumer Direction (EDCD) waiver. Total payments to PACE programs include separate payments from the Medicare program for dual eligibles.

I. *Background*

PACE programs provide an alternative to nursing home and home and community-based services care for individuals who are certified as nursing home eligible. Originally developed through the On-Lok program in San Francisco, PACE programs are seen as an option to allow nursing home eligible individuals to remain independent by providing a single source for all needed health and social services. To be eligible for PACE, an individual must be at least 55 years of age and certified by the state as eligible for nursing home services. Enrollment in the program is voluntary.

Medicaid programs pay PACE sites a capitated fee designed to cover the full cost of all services required by PACE enrollees that would otherwise be paid through the Medicaid fee-for-service system. A PACE program is capitated for both Medicaid and Medicare covered services. Medicare's contribution to PACE costs is currently set based on the Average Adjusted Per Capita Cost (AAPCC) for the geographic area in which the PACE program operates and is risk adjusted. PACE centers typically enroll 100 to 200 individuals although there are multi-site programs with larger centers. Consequently, it is important that the capitation rates paid for the program provide an accurate estimate of costs for the specific population that enrolls in the program, as there is little ability for PACE programs to accommodate significant variations in the level of health care need of individual participants through high volume.

Our analysis includes data for all individuals eligible to participate in PACE. This includes the nursing home eligible population, both those who are residents of nursing homes, as well as those who are enrolled in Home and Community Based Care waiver program. Those in the Home and Community Based Care waiver programs may either be in Medicaid Fee-for-Service or in the Medallion II managed care program. We have implicitly assumed that the distribution of enrollment in a PACE program will mirror the PACE-eligible population. In other words, if 60% of the PACE eligible population is currently residing in nursing homes, the UPLs reported here implicitly assume that 60% of the enrollees would otherwise have been nursing home residents for the base calculation. Virginia is currently contracting with six organizations to operate twelve PACE programs. The rates for these and any new PACE programs are assumed to have the same proportion of residents of nursing homes and Home and Community Based Service waiver programs as the eligible population statewide.

PACE capitation rates

Payments to managed care plans for PACE enrollees are subject to federal rules. As a Medicaid program, the state must comply with federal regulations set by CMS regarding payment levels. Specifically, full PACE programs are subject to rate setting under UPL guidelines. In addition, CMS must approve the payment rates made to each plan. The PACE capitation rates shown in this report are designed to comply with both the CMS definition of actuarial soundness and the UPL. In general, the methodological approach under either guideline can be similar.

Specifically, we have analyzed historical fee-for-service claims for the PACE-eligible population in each region. We then made adjustments to the historical data to reflect modifications of payment arrangements under the fee-for-service program and updated the payment rates to reflect the contract period covered by these rates. We also reviewed financial data provided by the contractor to assess comparability and the reasonableness of the distribution of medical and administrative costs. This financial review provided information used to adjust the fee-for-service results for expectations of managed care savings and an allowance for PACE plan administrative costs.

II. Data sources

PwC obtained detailed historical fee-for-service claims and eligibility data from the Department of Medical Assistance Services (DMAS) for services incurred and months of enrollment during State Fiscal Years 2011 through 2012 with claims paid through February 2013. The claims in the historical database include Medicaid paid amounts net of any third party insurance payments, which are primarily Medicare payments, and the amounts for which patients are personally responsible for the nursing facility and personal care services. Fee-for-service data are used to develop PACE rates because PACE rate setting guidelines do not permit direct use of encounter data from the contracting PACE plans. In any event, there is insufficient experience from the PACE organizations themselves to use as the basis for rate setting.

The work in this report builds on analyses performed in developing FY 2014 capitation rates for the Medallion II program. In the Medallion II program, special adjustments were made to the historical data to reflect changes in payment arrangements due to other programmatic and legislative adjustments. The amended Medallion II report, dated June 24, 2013, provides a detailed description of the process used for developing the adjustment factors; where applicable, these same adjustment factors are used in the development of the PACE rates.

The claims and eligibility information used in this report includes data for Medicaid recipients who are potentially eligible for the PACE program based on their age, eligibility category, and eligibility for nursing home services. Members eligible for PACE were identified through an indicator on each eligibility record that signifies that the member is in a nursing facility or a Home and Community Based Care waiver. A change in how duals were identified moved eligibles from Non-Dual to Dual status. Specifically, for those who became dual eligible in the middle of the Medicaid eligibility segment, the methodology was modified to separate the eligibility segment into non-dual and dual segments based on the date dual eligibility started. As a result, base period member months increased approximately by 5% for Duals and decreased by 3% for Non-Duals when compared to FY 2013 PACE rate setting.

All claims and eligibility data for members who are not eligible for the PACE program were excluded from the historical data used in these calculations. Members who incurred services indicated as “Nursing Facility/Mental Retardation” are not eligible to enroll in PACE, although they would otherwise qualify for PACE based on this indicator. Another category of members who would qualify for but are unlikely to enroll in PACE are those who receive a high level of special and complex services, such as ventilator assistance. All claims and eligibility periods for both of these groups were removed from the database prior to the calculations shown in this report.

PACE eligibles identified in the DMAS eligibility files were also matched to two other data sets. These are 1) costs associated with consumer-directed personal care services received under the EDCD waiver and 2) acute care costs for the Acute and Long Term Care (ALTC) population enrolled in managed care organizations who continue to receive acute services from their health plan and receive LTC services through Medicaid FFS. The costs for the ALTC population are added to the base for the non-dual PACE eligibles.

Claims and eligibility for retroactive periods (claims incurred prior to a determination of Medicaid eligibility that are ultimately paid by Medicaid) were also removed from the data before summarization because plans are not responsible for retroactive periods of coverage. Claims are limited to those services covered in the approved state plan.

The resulting historical claims and eligibility data were tabulated by service category for dual and non-dual eligibility status and region and are shown in Exhibits 1a - 1b, which are generally referred to as the “Data Book”. The regional data provide an adequate basis for rate setting and no data smoothing techniques are applied. These

exhibits in 1a – 1b show unadjusted historical data and are the basis of all future calculations described here. These exhibits show, for informational purposes:

- Member months for Fiscal Years 2011 and 2012,
- Medicaid payment amounts for the combined years,
- Patient payment amounts for the combined years¹,
- Costs per member per month (PMPM) for the combined years (a combination of Medicaid and patient payment amounts),
- Unadjusted units of service for Fiscal Years 2011 and 2012 (a definition of “units” for each category of service is provided in Exhibit 6),
- Annual units/1,000 members for the combined years, calculated as the total units of service divided by the appropriate member months, multiplied by 1,000, multiplied by 12, and
- Cost per unit of service.

III. Capitation rate calculations

The capitation rates for Fiscal Year 2014 are calculated based on the historical data shown in Exhibits 1a – 1b adjusted to reflect changes in payment rates and covered services. Each of the adjustments to the historical data is described in the following section. The adjustments are applied to the historical data and the resulting capitation rates are calculated in Exhibits 4a – 4b.

The steps used for calculating the capitation rates are as follows:

1. The historical data for each Medicare eligibility status and region are brought forward to Exhibits 4a and 4b from the corresponding cell in Exhibits 1a and 1b.² This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Legislature or by changes to the Medicaid State Plan. Several of these adjustments were described in the Medallion II report and applied to the PACE calculations; additional adjustments that apply to the PACE eligible group have been incorporated into these calculations. These adjustments are described in greater detail in Section IV.
3. The claims data are adjusted to update to the FY 2014 contract period; these trend adjustments are described in Section V. The resulting claims are shown in Exhibits 4a and 4b under the column “Completed & Trended Claims”.
4. The data are further adjusted to reflect expected managed care savings, which is applied to the UPL PMPM and results in the PACE PMPM.
5. The managed care adjusted claims from Step 4 are divided by the count of member months for each rate cell (from Exhibits 1a and 1b) to arrive at preliminary PMPM costs by service category. These PMPM costs are summarized for each dual eligibility status and region. Claims are summed to calculate health care cost components for PACE.
6. The final step is adding an allowance for PACE plan administrative costs. The rates shown in Exhibit 5a and 5c include only the Medicaid portion of the payment. The PACE program will also receive a capitation payment from the federal government for the Medicare component of services for dual eligibles.
7. The PACE rates are compared to the estimated Upper Payment Limit cost to confirm that FY 2014 PACE rates meet federal rate setting guidelines.

¹ Patient payment amounts are primarily for nursing home and personal care services.

² Patient payment amounts for adult day care, consumer directed, nursing home, and personal care services are carried forward to the capitation rate calculations in Exhibits 4a and 4b.

IV. Programmatic and legislative adjustments

Prescription drug adjustment

Under the guideline of actuarial soundness for managed care programs, States are no longer required to reduce the outpatient prescription drug payments by the amount of state drug rebates. However, the PACE rate-setting checklist requires that UPLs be developed based on the FFS equivalent cost. The prescription drug adjustment was based upon a combination of analysis of the DMAS FFS pharmacy payments, including rebate amounts, unit cost, utilization rates, dispensing fees, and application of co-payments.

For the Dual Demonstration population, the majority of prescriptions are covered under the Medicare Part D drug benefit. The Virginia Medicaid program continues to cover the prescription drugs for which federal matching funds remain available but which are specifically excluded by law from Medicare Part D and to cover specific DMAS approved over-the-counter (OTC) drugs, which are also excluded from Part D. For the Medicare Part B covered drugs, DMAS continues to pay for coinsurance and deductibles. Effective January 1, 2013, Medicare Part D began to cover benzodiazepines with no restrictions and barbiturates when used in the treatment of epilepsy, cancer or chronic mental disorders and are no longer paid by Virginia Medicaid. No adjustment is made for the change in drug coverage because historically the costs are very low for the mostly low cost generic drugs.

The DMAS dispensing fee during the data period of FY 2011 and FY 2012 was \$3.75 per script. Dispensing fees during the base period were reported as \$3.75 or as \$0.00 because no dispensing fee is paid if the same prescription is filled more than one time in a month. Therefore the data period dispensing fee average is less than \$3.75. The resulting FY 2014 average dispensing fees are \$2.95 for duals and \$3.03 for the non-dual population.

DMAS Medicaid prescription co-payments on brand name drugs are set at \$3.00 and the co-payment for generic drugs is \$1.00. As mandated by Federal law, co-payments are not imposed on recipients in nursing homes or in community based waivers, although a small amount of co-payment were reported in the FFS data. Because PACE members are certified as nursing home eligible, we have not calculated or applied any further co-payment adjustment.

The DMAS discounts, rebates, and dispensing fees, are applied for the non-dual population, but different adjustments are applied for the dual eligible population. As mandated by Federal law, co-payments are not imposed on recipients in nursing homes or in community-based waivers, although a small amount of co-payment was reported in the FFS data.

The prescription drugs covered by Medicaid for the dual eligible population contains a different mix of drugs than that used by the non-dual population; it includes a higher proportion of over-the-counter (OTC) and specialized drugs that do not receive the same discounts and rebates as other Medicaid covered drugs. We re-weighted the total FFS rebate percentage for the higher percent of OTC drugs in the PACE-eligible dual population post-Part D implementation and the higher percentage of brand name drugs used by the PACE-eligible non-dual population. Based on analysis of the more recent non-dual claims, we kept the same level of assumed savings from future expected improvements in the Brand-Generic mix.

These adjustments are calculated in Exhibit 2a and applied to the total historical claims data in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Non-emergency transportation adjustment

Non-emergency transportation (NET) services were contracted to a broker during the historical data period under a capitated payment methodology and services are not captured in the DMAS FFS claims. The non-emergency transportation adjustment is based on the service cost component (excluding the administrative cost) of the accepted bid for the ABAD nursing home population, a statewide rate at \$27.38 PMPM for FY 2014. This is in addition to the value of claims for emergency transportation services that were extracted from the DMAS FFS data. The per member per month value is shown in Exhibit 2b and the adjustment is applied in the total UPL column in Exhibits 4a and 4b.

Emergency transportation adjustment

The value of claims for emergency transportation services were extracted from the DMAS FFS data and are displayed in Exhibits 1a-b. The Virginia General Assembly increased Medicaid emergency transportation rates in FY 2013 to 40% of the applicable Virginia Medicare Ambulance Fee Schedule. Using payments reported for FY 2011, DMAS estimated the current emergency transportation fee schedule at approximately 29% of the Medicare rates. Based on a comparison of historical payments and the estimated dollars needed to increase the rate to 40% of the CY 2012 Medicare ambulance fee schedule, DMAS calculated a 38.4% increase over current DMAS rates. The full value is applied to the dual eligible population. For the non-dual population, the proportion of claims for the ALTC population currently covered by Medallion II MCOs receives the 0.4% increase based on the Medallion II ABAD estimate, resulting in a weighted adjustment of 22.0%. These values are shown in Exhibit 2c and are applied in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Home and community-based care fee adjustment

This adjustment incorporates and replaces the Consumer Directed and the Personal Care Services adjustments from the FY 2012 PACE rate setting. The Virginia General Assembly reduced the home and community based care (HCBC) waiver services fees by 1% effective FY 2012. This reduction applied to personal care provided by agencies and under consumer direction. Personal care services include personal care, respite care, companion care, and service facilitation provided through the waivers. Effective FY 2013, personal care services were increased by 1%. The result is a small increase for Consumer Directed Services and Personal Care Services categories and a slight decrease for Adult Day Care. The calculation is shown in Exhibit 2d, and the adjustment is applied in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Adult day care fee adjustment

This adjustment incorporates a fee increase of \$10 per day effective July 1, 2013. Northern Virginia rates are higher than the rest of the state; therefore the value of the increase is calculated separately. The calculation is shown in Exhibit 2e, and the adjustment is applied in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Hospital inpatient adjustment

There are a number of changes in DMAS hospital inpatient payment policy between the base period and the FY 2014 rate year. The hospital inpatient base period incorporates a FY 2012 capital reimbursement rate reduction from 75% to 71% of cost (applied to half of the CY 2011 base data). The reduction is applied to the percentage of total inpatient claims that represent the capital component estimated at 9.7%. No hospitals are exempt and adjustments were applied to both inpatient medical/surgical and inpatient psychiatric hospitals.

For the projection period, the hospital inpatient adjustment includes a 2.6% allowance for a cost per unit increase authorized by the Virginia General Assembly effective FY 2013. While there was no explicit unit cost increase for FY 2014, hospital reimbursement rates were rebased resulting in a weighted average cost per unit change of 4.7% for inpatient medical/surgical and -7.4% for inpatient psychiatric. Both years of unit cost changes are applied to the operating cost component. As a result of these adjustments, the contract period trend will be based solely on utilization.

For inpatient medical/surgical, the positive adjustment is 6.4%. For inpatient psychiatric in acute care hospitals, the negative adjustment is 4.9%. The inpatient psychiatric factor is applied to mental health claims.

These adjustment factors are shown in Exhibit 2f and applied to all hospital inpatient service categories in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Hospital outpatient adjustment

The Virginia General Assembly reduced the cost basis for reimbursement of outpatient hospital services from 80% to 77% for FY 2011 (eventually this was limited only to the period from July 1, 2010 through September 30, 2010) and then to 76% for FY 2012, a decrease of 5.0% from the original 80% base. This is applied to all outpatient services except for triage fees paid in an Emergency Department. DMAS estimates that 6% of outpatient hospital payments are for the triage fees. The impact of the triage exemption is calculated relative to the proportion of Emergency Room and Related outpatient payments, which varies by eligibility category. Because the reduction is incorporated in one year of the base data, the exemption produces a 2.4% reduction for dual eligibles and a 1.5% reduction for non-dual eligibles. A 2.3% to 2.4% reduction is applied to the Outpatient-Other services line by eligibility categories.

These adjustment factors are shown in Exhibit 2g and applied to all hospital outpatient service categories in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Nursing facility adjustment

Nursing facility payment can include adjustments to the operating and/or the capital component of the rate. The operating component includes two sub-components; the direct operating rate and the indirect operating rate. The Virginia General Assembly authorized a 2.2% inflation increase for the operating component of the rates in FY13 and FY14 and an additional 1% increase in in FY13, for a net increase of 2.8% in FY13 and 3.9% in FY14

DMAS estimates that 9.7% of the total nursing facility payment is for the capital rent. The Virginia General Assembly reduced the nursing facility capital rental rate from 9% in FY 2010 and FY 2011 (except for three months in FY 2011 from July to September where it was 8.75%) to 8.0% for FY 2012 and 8.5% for FY 2013 and FY 2014, a net decrease of 5.6% from the base period. There is an additional change to the minimum occupancy requirements from 90% to 88% that affects the indirect operating rate and the capital rate components of nursing facility reimbursement. DMAS estimated an increase in reimbursement of \$1.8 million FY14.

DMAS provided information on supplemental payments to nursing facilities that are based upon DMAS reconciliation to nursing home submitted cost reports and which are not included in the historical claims databases. An adjustment for the supplemental payments is calculated against the total remitted claims. The 4.5% cost settlement percentage was provided by DMAS and is applied to the DMAS paid amount on the Nursing Facility service line

Nursing facility patient payments do not receive any of the adjustments.

The calculation is shown in Exhibit 2h, and the adjustment is applied in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Other adjustments

Managed Care Utilization Adjustment

A further adjustment is made to recognize utilization efficiencies under managed care relative to the FFS system.

Because of the limited number of PACE programs, the voluntary nature of the programs and the small enrollment in each program, there are few estimates of managed care savings based upon actual utilization. Those that are available report net Medicaid savings on the order of 15 percent or more. We also reviewed administrative financial data provided by the contracting PACE plans and conducted discussions with DMAS staff.

The actual level of managed care savings that can be realized depends upon a number of factors. Consequently, there is a range of reasonable savings assumptions. We have assumed that PACE plan utilization management and cost controls will result in reductions in overall costs of 18.4%. Prescription drugs and non-emergency transportation are exempt from the adjustment³. A small brand-generic improvement factor for prescription drugs for the non-dual population is incorporated as a managed care savings in the Prescription Drug Adjustment described earlier and the non-emergency transportation adjustment is added as the contracted FY 2014 value. The managed care adjustment factor is shown in Exhibit 2i and is applied in Exhibits 4a and 4b under the column labeled “Managed Care Utilization Adjustment”. The managed care adjustment must be considered in conjunction with the administrative cost adjustment described below, to arrive at the expectation of net Medicaid savings.

Administrative Cost Adjustment

The CMS regulations require that administrative costs directly related to the provision of Medicaid State Plan approved services be incorporated into the rate-setting process. The PACE plans provided revenue and administrative cost data for FY 2011 and/or FY 2012 as downloads from their financial reporting systems. These were evaluated to assist in determining an appropriate administrative factor.

The data submitted by the plans included overhead and allocation charges from the integrated delivery system operations that can be classified as medical costs. Because a number of the PACE programs are new and have small enrollment, there was wide variation in reported administrative cost. The administrative cost percentage is expected to decline as full operations are established and enrollment grows. A 15% administrative cost factor is applied to the total adjusted and trended claims amount for each rate payment category. This adjustment is shown in Exhibit 2i. This adjustment factor is applied in the final step of the per capita cost calculations at the bottom of each rate cell worksheet in Exhibits 4a and 4b.

V. *Trend adjustments*

The data used for the IBNR and trend calculations reflect experience for the period FY 2010 through FY 2012. Data for FY 2011 to FY 2012 is used to evaluate the base period trend and an additional year of data, FY 2010 through FY 2012, is used to develop contract period projected trend.

³ The small amount of non-dual Medicare crossover services is also exempt from the managed care utilization adjustment.

The data must be adjusted to reflect the contract period of FY 2014 through the application of trend rates that reflect changes in payment levels and utilization rates between the data period and the contract period. In addition, the claims data are not 100% “complete” in that some cost information is not available in the claims databases provided. Incomplete data result from the time lag between when services are provided and claims are fully paid. The amount of incomplete claims is referred to as Incurred but Not Reported (IBNR) and can be measured through actuarial models.

Trend and IBNR adjustment factors were developed using historical Virginia Medicaid FFS expenditures for FY 2010 to FY 2012 and are calculated separately for the dual and the non-dual populations. We also had paid claims information with run out through February 2013 and took into consideration the actual experience and information from DMAS on projected utilization and fee increases in budget estimates.

The historical data were evaluated using a PricewaterhouseCoopers model that estimates IBNR amounts using a variety of actuarially accepted methods, and trend using a least-squares regression methodology. Trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psych, Outpatient Hospital, Practitioner, Prescription Drug, and Other. The Other category includes Lab/X-Ray services, DME and transportation. IBNR factors and trend rates for the Medicare crossover service categories for the dual population, which are combined across all services, and long term care services, including Nursing Facility, Adult Day Care, and Personal Care were developed from analysis of the historical data. A combined trend was calculated for agency and consumer directed personal care services.

Annual trend rates must be applied to move the historical data from the midpoint of the data period (7/1/2011) to the midpoint of the contract period (1/1/2014), or two and a half years (30 months). Each category of service in Exhibits 3a and 3b shows a Data Period and a Contract Period trend. Data Period trends are applied from the midpoint of the data period to the end of the data period, and were developed from the historical regression analyses and budget work described above. The Contract Period trends are applied from the end of the data period to the midpoint of the contract period. For services with fee increases reflected in the adjustments in 2a through 2h, the contract period trend is in conjunction with the planned cost per unit increase.

Trend rates represent a combination of cost and utilization increases over time. The trend rates used reflect utilization and standard rate increases when additional legislative cost increases or decreases have been applied and represent PMPM increases otherwise. Specifically, the trend models are adjusted for the fee increases or decreases that occurred during the historical base period that are presented as adjustments in Exhibits 2a to 2h. A number greater than 1.0 reflects an increase to the underlying data while a number less than 1.0 represents a decrease. Adjustments to the historical data before the analysis of trend were applied to both the dual and the non-dual trend and are presented in the following table.

**Table 1
Summary of Adjustments to Trend**

Service	Time Period	PACE Adjustment
Nursing Facility	Jul 2009 – Jun 2010 Oct 2010 – Jun 2011	0.989
	Jul 2010 – Sep 2010	1.018
	Jul 2012 – Feb 2013	0.969
Personal Care with Consumer Directed PC	Jul 2009 – Jun 2010 Oct 2010 – Jun 2011 Jul 2012 – Feb 2013	0.990
	Jul 2010 - Sep 2010	1.040
Inpatient - Med/Surg	Jul 2009 – Jun 2010 Oct 2010 – Jun 2011	0.995
	Jul 2010 – Sep 2010	1.026
	Jul 2012 – Feb 2013	0.977
Inpatient - Psych	Jul 2009 – Jun 2010 Oct 2010 – Jun 2011	0.995
	Jul 2010 – Sep 2010	1.023
	Jul 2012 – Feb 2013	0.977
Outpatient Hospital	Jul 2009 – Jun 2010 Oct 2010 – Jun 2011	Dual 0.950 Non-Dual 0.953
	Jul 2010 – Sep 2010	Dual 0.986 Non-Dual 0.953
Practitioner	Jul 2010 - Sep 2010	1.024
Pharmacy	Jul 2010 - Sep 2010	Dual 1.021 Non-Dual 1.004
Other	Jul 2009 - Jan 2010	0.968
	Feb 2010 - Jun 2010	0.976

Agency personal care services have had a modest growth rate while Consumer Directed Personal Care (CDPC) services payments continue to rapidly increase⁴. The evaluation of nursing home and personal care services trend included both DMAS and patient payment amounts. Trend evaluation for the Home and Community Based Care services includes both dual and non-dual experience. Adult Day Health was evaluated as an independent service and CDPC and personal care services were combined. Past home health services cost per unit fee reductions are reflected in the base data, so contract period trend is applied based on analysis of PMPM trend.

⁴ The CDPC increase is primarily a utilization trend, rather than a cost trend, effect. There has been an increase in both the proportion of eligibles that elect consumer direction and the approved CDPC level of care (hours per week).

The total trend rates shown in Exhibits 3a and 3b represent the combination of Data Period and Contract Period trends, and are calculated using compound interest calculations. These trend/IBNR factors are applied to the historical data in Exhibits 4a and 4b by applicable service category in Exhibits 4a and 4b.

VI. Summary capitation rates

The historical data presented in Exhibits 1a and 1b is adjusted by the factors shown in Exhibits 2a through 2i and the Trend and IBNR factors in Exhibits 3a and 3b. These are applied in Exhibits 4a and 4b to determine the rates. This exhibit also presents the UPL rate summary.

A column is added to Exhibits 4a and 4b to show the comparative Upper Payment Limit (UPL) calculation. For most of the service lines, the value of the UPL PMPM is equal to the base period Medicaid payment, the completion factor adjustment, applicable policy and program adjustments, and trend. UPL is before the application of the managed care adjustment. For prescription drug and non-emergency transportation, the projected PMPM value is the same in the UPL and the FY 2014 PACE rates. The 2% administrative factor is the estimated cost of DMAS staff and monitoring activities for the existing FFS programs. The managed care adjustment and health plan administrative factor are applied to the UPL values to produce the PACE rates shown in Exhibit 5a. Averages are weighted by the distribution of member months for the historical FY 2011 to FY 2012 time period. Overall, the PACE rates are approximately 9.6% below the Upper Payment Limit and therefore meet CMS PACE rate setting checklist requirements. Weighting by PACE enrollees as of February 2013 results in a slightly lower statewide total PMPM but PACE rates are 9.6% below the Upper Payment Limit.

Analysis of the PACE eligible population by region indicates variation in the relative proportion of the eligible population that is in nursing homes and the proportion that is supported by home and community based services. The statewide proportion of the PACE eligible population in nursing homes has been decreasing over time. In the FY 2008 to FY 2009 base period used for the FY 2011 PACE rate setting, 68.2% of the dual eligible population and 51.1% of the non-dual population was in nursing homes. This dropped to 62.1% of Dual and 46.7% of Non-Dual in the FY 2010 to FY 2011 base period used for the FY 2013 PACE rates. It drops further for the FY 2011 to FY 2012 base period used in this year's PACE rate setting; 59.0% of the dual eligible population and 45.8% of the non-dual population was in nursing homes. These proportions, as reflected in member month counts for the historical data period, are shown in Table 2.

**Table 2
Nursing Home vs. Non-Nursing Home Blending Factor**

	Dual Population			Non-Dual Population		
	Member Months			Member Months		
Region	NH	Non-NH	%NH	NH	Non-NH	%NH
Northern Virginia	53,432	45,580	54.0%	4,627	5,342	46.4%
Other MSA	89,126	40,630	68.7%	4,147	3,767	52.4%
Richmond/Charlottesville	76,176	56,134	57.6%	4,409	6,884	39.0%
Rural	111,154	84,780	56.7%	5,174	7,158	42.0%
Tidewater	76,223	54,535	58.3%	6,963	6,787	50.6%
Statewide-PACE	406,112	281,659	59.0%	25,321	29,939	45.8%

PACE rates are benchmarked to the statewide average proportion of the eligible population that is in nursing homes. Therefore, the rates in Exhibit 5a are re-weighted to reflect a dual population that is 59.0% in nursing homes and a non-dual population with 45.8% in nursing homes. This is used in conjunction with cost factors that are the ratio of the average PMPM for those in nursing homes and those in community based care relative to the regional average PMPM. The relative cost factors and the resulting blending factors are presented in Exhibit 5b.

A comparison of the rates before and after the blending is shown in Exhibit 5c. PACE capitation rates for FY 2014 after the re-weighting are presented in Exhibit 5d. All averages are weighted by the distribution of member months for the historical FY 2011 to FY 2012 time period.

A comparison of FY 2014 PACE rates to FY 2013 rates in Exhibit 5e shows a 0.2% increase in the dual PACE rates and a 3.3% increase in the non-dual PACE rates, resulting in an overall decrease of 0.6%. The composite year-to-year change by region ranges from a 0.4% decrease to a 1.2% increase. If the regional rates are weighted by the PACE enrollee population as of February 2013, there is a 0.2% decrease in the dual population rates, a 1.9% increase in the non-dual PACE rates, and an overall weighted year to year change of 0.0%.

Actuarially sound rates should fall within a range of several percentage points, taking into consideration the technical calculations performed, PACE plan projected revenue requirements, known changes in provider contracting arrangements, and other factors. Final rates for each plan are negotiated between DMAS and the PACE plan representatives.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Northern Virginia	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1000 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	99,012						
Service Type							
Adult Day Care	\$4,238,307	\$43,716	\$4,282,023	\$43.25	200,903	24,349	\$21.31
Ambulatory Surgery Center	\$3,082	\$0	\$3,082	\$0.03	42	5	\$73.39
Case Management Services	\$11,008	\$0	\$11,008	\$0.11	3,356	407	\$3.28
Consumer Directed Services	\$27,165,909	\$300,858	\$27,466,767	\$277.41	2,181,037	264,335	\$12.59
DME/Supplies	\$2,253,166	\$3,476	\$2,256,642	\$22.79	26,240	3,180	\$86.00
Emergency	\$1,886	\$0	\$1,886	\$0.02	4	0	\$471.41
FQHC	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Home Health Services	\$49,468	\$0	\$49,468	\$0.50	79	10	\$626.18
Inpatient - Medical/Surgical	\$6,578,920	\$157,647	\$6,736,567	\$68.04	1,033	125	\$6,521.36
Inpatient - Psych	\$70,580	\$4,290	\$74,870	\$0.76	150	18	\$499.13
Lab and X-ray Services	\$11,728	\$0	\$11,728	\$0.12	941	114	\$12.46
Medicare Xover - IP	\$2,092,112	\$0	\$2,092,112	\$21.13	2,091	253	\$1,000.53
Medicare Xover - Nursing Facility	\$1,476,877	\$15,277	\$1,492,154	\$15.07	90,519	10,971	\$16.48
Medicare Xover - OP	\$1,043,363	\$223	\$1,043,585	\$10.54	9,899	1,200	\$105.42
Medicare Xover - Other	\$692,788	\$372	\$693,160	\$7.00	32,367	3,923	\$21.42
Medicare Xover - Physician	\$2,535,997	\$51	\$2,536,048	\$25.61	73,349	8,890	\$34.58
Nursing Facility	\$212,411,206	\$45,944,143	\$258,355,349	\$2,609.33	1,406,372	170,448	\$183.70
Outpatient - Other	\$757,756	\$0	\$757,756	\$7.65	234	28	\$3,238.27
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$76,186,144	\$376,124	\$76,562,269	\$773.26	773,497	93,746	\$98.98
Physician - Clinic	\$39,067	\$0	\$39,067	\$0.39	23,302	2,824	\$1.68
Physician - IP Mental Health	\$327	\$0	\$327	\$0.00	1	0	\$326.50
Physician - OP Mental Health	\$15,506,533	\$15,731	\$15,522,264	\$156.77	1,007,481	122,104	\$15.41
Physician - Other Practitioner	\$700,422	\$82	\$700,504	\$7.07	9,950	1,206	\$70.40
Physician - PCP	\$114,244	\$908	\$115,152	\$1.16	1,930	234	\$59.66
Physician - Specialist	\$62,494	\$758	\$63,252	\$0.64	2,591	314	\$24.41
Pharmacy	\$1,115,333	\$0	\$1,115,333	\$11.26	165,988	20,117	\$6.72
Transportation - Emergency	\$5,010	\$0	\$5,010	\$0.05	97	12	\$51.65
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$355,123,725	\$46,863,656	\$401,987,380	\$4,059.98	6,013,453		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Other MSA	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1000 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	129,756						
Service Type							
Adult Day Care	\$584,121	\$12,935	\$597,056	\$4.60	13,184	1,219	\$45.29
Ambulatory Surgery Center	\$846	\$0	\$846	\$0.01	1	0	\$846.37
Case Management Services	\$3,506	\$0	\$3,506	\$0.03	1,053	97	\$3.33
Consumer Directed Services	\$24,855,979	\$331,212	\$25,187,190	\$194.11	2,571,232	237,791	\$9.80
DME/Supplies	\$1,992,974	\$5,351	\$1,998,326	\$15.40	32,599	3,015	\$61.30
Emergency	\$4,195	\$0	\$4,195	\$0.03	9	1	\$466.07
FQHC	\$420	\$68	\$487	\$0.00	8	1	\$60.90
Home Health Services	\$13,175	\$0	\$13,175	\$0.10	75	7	\$175.66
Inpatient - Medical/Surgical	\$2,146,177	\$146,962	\$2,293,139	\$17.67	665	62	\$3,448.33
Inpatient - Psych	\$527,339	\$22,896	\$550,235	\$4.24	1,088	101	\$505.73
Lab and X-ray Services	\$19,118	\$0	\$19,118	\$0.15	1,390	129	\$13.75
Medicare Xover - IP	\$3,083,023	\$0	\$3,083,023	\$23.76	3,096	286	\$995.81
Medicare Xover - Nursing Facility	\$1,752,672	\$59,060	\$1,811,731	\$13.96	125,309	11,589	\$14.46
Medicare Xover - OP	\$1,335,934	\$2	\$1,335,936	\$10.30	10,957	1,013	\$121.93
Medicare Xover - Other	\$1,006,364	\$253	\$1,006,617	\$7.76	54,018	4,996	\$18.63
Medicare Xover - Physician	\$2,963,207	\$163	\$2,963,370	\$22.84	135,802	12,559	\$21.82
Nursing Facility	\$292,689,160	\$69,353,696	\$362,042,856	\$2,790.18	2,384,813	220,550	\$151.81
Outpatient - Other	\$146,204	\$0	\$146,204	\$1.13	484	45	\$302.07
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$31,800,664	\$261,730	\$32,062,394	\$247.10	549,390	50,808	\$58.36
Physician - Clinic	\$88	\$0	\$88	\$0.00	7	1	\$12.58
Physician - IP Mental Health	\$214	\$0	\$214	\$0.00	2	0	\$106.82
Physician - OP Mental Health	\$8,313,228	\$1,753	\$8,314,981	\$64.08	541,971	50,122	\$15.34
Physician - Other Practitioner	\$835,973	\$119	\$836,092	\$6.44	13,896	1,285	\$60.17
Physician - PCP	\$61,877	\$454	\$62,331	\$0.48	1,414	131	\$44.08
Physician - Specialist	\$39,384	\$922	\$40,306	\$0.31	1,128	104	\$35.73
Pharmacy	\$2,032,430	\$0	\$2,032,430	\$15.66	308,041	28,488	\$6.60
Transportation - Emergency	\$15,940	\$0	\$15,940	\$0.12	284	26	\$56.13
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$376,224,212	\$70,197,575	\$446,421,787	\$3,440.47	6,751,916		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1000 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	132,311						
Service Type							
Adult Day Care	\$3,355,075	\$72,704	\$3,427,779	\$25.91	77,129	6,995	\$44.44
Ambulatory Surgery Center	\$1,731	\$0	\$1,731	\$0.01	3	0	\$576.87
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$30,565,967	\$490,954	\$31,056,921	\$234.73	3,163,245	286,893	\$9.82
DME/Supplies	\$3,520,002	\$2,151	\$3,522,154	\$26.62	45,536	4,130	\$77.35
Emergency	\$9,004	\$0	\$9,004	\$0.07	14	1	\$643.16
FQHC	\$2,336	\$0	\$2,336	\$0.02	26	2	\$89.83
Home Health Services	\$21,201	\$0	\$21,201	\$0.16	60	5	\$353.35
Inpatient - Medical/Surgical	\$2,064,122	\$140,832	\$2,204,954	\$16.66	701	64	\$3,145.44
Inpatient - Psych	\$20,705	\$0	\$20,705	\$0.16	41	4	\$505.00
Lab and X-ray Services	\$18,799	\$0	\$18,799	\$0.14	1,118	101	\$16.81
Medicare Xover - IP	\$3,717,805	\$0	\$3,717,805	\$28.10	3,913	355	\$950.12
Medicare Xover - Nursing Facility	\$2,165,462	\$57,585	\$2,223,047	\$16.80	148,215	13,442	\$15.00
Medicare Xover - OP	\$1,322,226	\$0	\$1,322,226	\$9.99	14,152	1,284	\$93.43
Medicare Xover - Other	\$1,207,380	\$267	\$1,207,647	\$9.13	61,077	5,539	\$19.77
Medicare Xover - Physician	\$3,396,215	\$122	\$3,396,337	\$25.67	140,129	12,709	\$24.24
Nursing Facility	\$252,832,778	\$66,141,700	\$318,974,479	\$2,410.80	2,022,461	183,429	\$157.72
Outpatient - Other	\$221,138	\$0	\$221,138	\$1.67	152	14	\$1,454.86
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$59,619,335	\$759,990	\$60,379,324	\$456.35	898,108	81,455	\$67.23
Physician - Clinic	\$23,833	\$0	\$23,833	\$0.18	12,014	1,090	\$1.98
Physician - IP Mental Health	\$452	\$0	\$452	\$0.00	25	2	\$18.07
Physician - OP Mental Health	\$12,906,942	\$3,145	\$12,910,087	\$97.57	938,362	85,105	\$13.76
Physician - Other Practitioner	\$935,143	\$315	\$935,457	\$7.07	15,741	1,428	\$59.43
Physician - PCP	\$82,985	\$501	\$83,486	\$0.63	1,822	165	\$45.82
Physician - Specialist	\$54,488	\$322	\$54,810	\$0.41	1,510	137	\$36.30
Pharmacy	\$1,445,996	\$0	\$1,445,996	\$10.93	210,741	19,113	\$6.86
Transportation - Emergency	\$29,458	\$0	\$29,458	\$0.22	547	50	\$53.85
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$379,540,579	\$67,670,587	\$447,211,166	\$3,380.01	7,756,842		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Rural	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1000 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	195,934						
Service Type							
Adult Day Care	\$679,170	\$7,369	\$686,539	\$3.50	15,086	924	\$45.51
Ambulatory Surgery Center	\$3,192	\$0	\$3,192	\$0.02	5	0	\$638.39
Case Management Services	\$65,043	\$0	\$65,043	\$0.33	19,626	1,202	\$3.31
Consumer Directed Services	\$49,325,862	\$610,032	\$49,935,894	\$254.86	5,102,507	312,503	\$9.79
DME/Supplies	\$4,301,875	\$4,181	\$4,306,056	\$21.98	66,971	4,102	\$64.30
Emergency	\$18,006	\$0	\$18,006	\$0.09	46	3	\$391.44
FQHC	\$3,984	\$192	\$4,176	\$0.02	55	3	\$75.93
Home Health Services	\$45,658	\$0	\$45,658	\$0.23	153	9	\$298.42
Inpatient - Medical/Surgical	\$3,479,203	\$176,758	\$3,655,960	\$18.66	959	59	\$3,812.26
Inpatient - Psych	\$128,434	\$9,568	\$138,002	\$0.70	268	16	\$514.93
Lab and X-ray Services	\$28,488	\$0	\$28,488	\$0.15	2,306	141	\$12.35
Medicare Xover - IP	\$5,256,161	\$4,528	\$5,260,689	\$26.85	5,365	329	\$980.56
Medicare Xover - Nursing Facility	\$3,596,220	\$60,427	\$3,656,647	\$18.66	243,457	14,911	\$15.02
Medicare Xover - OP	\$2,725,902	\$414	\$2,726,316	\$13.91	26,718	1,636	\$102.04
Medicare Xover - Other	\$2,131,174	\$542	\$2,131,715	\$10.88	109,713	6,719	\$19.43
Medicare Xover - Physician	\$4,807,929	\$502	\$4,808,431	\$24.54	228,554	13,998	\$21.04
Nursing Facility	\$329,400,851	\$70,696,705	\$400,097,556	\$2,042.00	2,856,108	174,923	\$140.08
Outpatient - Other	\$92,238	\$0	\$92,238	\$0.47	770	47	\$119.79
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$71,862,663	\$832,373	\$72,695,036	\$371.02	1,314,213	80,489	\$55.31
Physician - Clinic	\$20,411	\$0	\$20,411	\$0.10	6,211	380	\$3.29
Physician - IP Mental Health	\$140	\$0	\$140	\$0.00	2	0	\$70.02
Physician - OP Mental Health	\$15,971,610	\$930	\$15,972,540	\$81.52	1,129,312	69,165	\$14.14
Physician - Other Practitioner	\$1,638,790	\$1,781	\$1,640,571	\$8.37	27,573	1,689	\$59.50
Physician - PCP	\$82,338	\$1,884	\$84,222	\$0.43	2,418	148	\$34.83
Physician - Specialist	\$74,906	\$2,641	\$77,546	\$0.40	2,181	134	\$35.56
Pharmacy	\$2,723,584	\$0	\$2,723,584	\$13.90	381,602	23,371	\$7.14
Transportation - Emergency	\$30,746	\$0	\$30,746	\$0.16	338	21	\$90.96
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$498,494,579	\$72,410,825	\$570,905,404	\$2,913.76	11,542,517		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Tidewater	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1000 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	130,758						
Service Type							
Adult Day Care	\$377,234	\$4,548	\$381,782	\$2.92	8,416	772	\$45.36
Ambulatory Surgery Center	\$4,207	\$2,696	\$6,903	\$0.05	12	1	\$575.23
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$13,108,712	\$204,440	\$13,313,152	\$101.81	1,358,091	124,635	\$9.80
DME/Supplies	\$3,704,008	\$5,230	\$3,709,237	\$28.37	45,107	4,140	\$82.23
Emergency	\$7,888	\$0	\$7,888	\$0.06	25	2	\$315.51
FQHC	\$915	\$272	\$1,187	\$0.01	15	1	\$79.12
Home Health Services	\$17,415	\$0	\$17,415	\$0.13	45	4	\$386.99
Inpatient - Medical/Surgical	\$2,808,729	\$132,611	\$2,941,340	\$22.49	834	77	\$3,526.79
Inpatient - Psych	\$7,760	\$0	\$7,760	\$0.06	16	1	\$485.00
Lab and X-ray Services	\$21,829	\$0	\$21,829	\$0.17	1,917	176	\$11.39
Medicare Xover - IP	\$3,269,361	\$0	\$3,269,361	\$25.00	3,113	286	\$1,050.23
Medicare Xover - Nursing Facility	\$1,671,344	\$109,898	\$1,781,242	\$13.62	110,656	10,155	\$16.10
Medicare Xover - OP	\$1,296,927	\$153	\$1,297,080	\$9.92	14,120	1,296	\$91.86
Medicare Xover - Other	\$1,271,878	\$333	\$1,272,211	\$9.73	60,264	5,531	\$21.11
Medicare Xover - Physician	\$4,031,196	\$186	\$4,031,382	\$30.83	172,062	15,791	\$23.43
Nursing Facility	\$235,846,870	\$69,317,181	\$305,164,051	\$2,333.80	2,042,811	187,473	\$149.38
Outpatient - Other	\$174,717	\$0	\$174,717	\$1.34	143	13	\$1,221.80
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$81,118,129	\$646,367	\$81,764,496	\$625.31	1,198,966	110,032	\$68.20
Physician - Clinic	\$25,780	\$0	\$25,780	\$0.20	11,129	1,021	\$2.32
Physician - IP Mental Health	\$687	\$0	\$687	\$0.01	17	2	\$40.39
Physician - OP Mental Health	\$19,827,132	\$5,902	\$19,833,034	\$151.68	1,511,459	138,710	\$13.12
Physician - Other Practitioner	\$575,871	\$594	\$576,465	\$4.41	11,734	1,077	\$49.13
Physician - PCP	\$50,134	\$2,854	\$52,989	\$0.41	1,414	130	\$37.47
Physician - Specialist	\$53,584	\$2,405	\$55,989	\$0.43	1,700	156	\$32.93
Pharmacy	\$1,693,304	\$0	\$1,693,304	\$12.95	229,818	21,091	\$7.37
Transportation - Emergency	\$14,386	\$0	\$14,386	\$0.11	311	29	\$46.26
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$370,979,996	\$70,435,670	\$441,415,666	\$3,375.81	6,784,195		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
All Regions	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1000 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	687,771						
Service Type							
Adult Day Care	\$9,233,907	\$141,272	\$9,375,179	\$13.63	314,718	5,491	\$29.79
Ambulatory Surgery Center	\$13,058	\$2,696	\$15,754	\$0.02	63	1	\$250.07
Case Management Services	\$79,557	\$0	\$79,557	\$0.12	24,035	419	\$3.31
Consumer Directed Services	\$145,022,428	\$1,937,496	\$146,959,924	\$213.68	14,376,112	250,829	\$10.22
DME/Supplies	\$15,772,026	\$20,389	\$15,792,415	\$22.96	216,453	3,777	\$72.96
Emergency	\$40,978	\$0	\$40,978	\$0.06	98	2	\$418.15
FQHC	\$7,654	\$532	\$8,186	\$0.01	104	2	\$78.71
Home Health Services	\$146,917	\$0	\$146,917	\$0.21	412	7	\$356.59
Inpatient - Medical/Surgical	\$17,077,150	\$754,809	\$17,831,960	\$25.93	4,192	73	\$4,253.81
Inpatient - Psych	\$754,818	\$36,754	\$791,572	\$1.15	1,563	27	\$506.44
Lab and X-ray Services	\$99,962	\$0	\$99,962	\$0.15	7,672	134	\$13.03
Medicare Xover - IP	\$17,418,463	\$4,528	\$17,422,991	\$25.33	17,578	307	\$991.18
Medicare Xover - Nursing Facility	\$10,662,575	\$302,246	\$10,964,821	\$15.94	718,156	12,530	\$15.27
Medicare Xover - OP	\$7,724,352	\$792	\$7,725,144	\$11.23	75,846	1,323	\$101.85
Medicare Xover - Other	\$6,309,583	\$1,767	\$6,311,350	\$9.18	317,439	5,539	\$19.88
Medicare Xover - Physician	\$17,734,544	\$1,024	\$17,735,568	\$25.79	749,896	13,084	\$23.65
Nursing Facility	\$1,323,180,866	\$321,453,425	\$1,644,634,291	\$2,391.25	10,712,565	186,909	\$153.52
Outpatient - Other	\$1,392,053	\$0	\$1,392,053	\$2.02	1,783	31	\$780.74
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$320,586,935	\$2,876,584	\$323,463,519	\$470.31	4,734,174	82,600	\$68.33
Physician - Clinic	\$109,180	\$0	\$109,180	\$0.16	52,663	919	\$2.07
Physician - IP Mental Health	\$1,818	\$0	\$1,818	\$0.00	47	1	\$38.69
Physician - OP Mental Health	\$72,525,446	\$27,461	\$72,552,907	\$105.49	5,128,585	89,482	\$14.15
Physician - Other Practitioner	\$4,686,199	\$2,891	\$4,689,089	\$6.82	78,894	1,377	\$59.44
Physician - PCP	\$391,578	\$6,601	\$398,179	\$0.58	8,998	157	\$44.25
Physician - Specialist	\$284,856	\$7,048	\$291,904	\$0.42	9,110	159	\$32.04
Pharmacy	\$9,010,646	\$0	\$9,010,646	\$13.10	1,296,190	22,615	\$6.95
Transportation - Emergency	\$95,539	\$0	\$95,539	\$0.14	1,577	28	\$60.58
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$1,980,363,090	\$327,578,314	\$2,307,941,403	\$3,355.68	38,848,923		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Northern Virginia	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1100 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	9,969						
Service Type							
Adult Day Care	\$63,835	\$0	\$63,835	\$6.40	2,146	2,583	\$29.75
Ambulatory Surgery Center	\$9,177	\$0	\$9,177	\$0.92	13	16	\$705.89
Case Management Services	\$100	\$0	\$100	\$0.01	31	37	\$3.23
Consumer Directed Services	\$4,189,092	\$12,229	\$4,201,320	\$421.44	336,479	405,034	\$12.49
DME/Supplies	\$844,355	\$30	\$844,385	\$84.70	7,850	9,449	\$107.56
Emergency	\$530,893	\$0	\$530,893	\$53.25	756	910	\$702.24
FQHC	\$8,077	\$0	\$8,077	\$0.81	147	177	\$54.95
Home Health Services	\$468,428	\$0	\$468,428	\$46.99	1,039	1,251	\$450.85
Inpatient - Medical/Surgical	\$7,974,438	\$7,214	\$7,981,652	\$800.65	715	861	\$11,163.15
Inpatient - Psych	\$18,194	\$0	\$18,194	\$1.83	20	24	\$909.68
Lab and X-ray Services	\$333,872	\$0	\$333,872	\$33.49	22,574	27,173	\$14.79
Medicare Xover - IP	\$1,132	\$0	\$1,132	\$0.11	1	1	\$1,132.00
Medicare Xover - Nursing Facility	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - OP	\$65	\$0	\$65	\$0.01	1	1	\$65.00
Medicare Xover - Other	\$301	\$0	\$301	\$0.03	10	12	\$30.07
Medicare Xover - Physician	\$7	\$0	\$7	\$0.00	1	1	\$7.30
Nursing Facility	\$22,444,824	\$1,589,282	\$24,034,106	\$2,410.90	132,643	159,668	\$181.19
Outpatient - Other	\$1,501,804	\$0	\$1,501,804	\$150.65	1,769	2,129	\$848.96
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$8,221,885	\$16,597	\$8,238,482	\$826.42	83,289	100,258	\$98.91
Physician - Clinic	\$914,221	\$0	\$914,221	\$91.71	177,851	214,086	\$5.14
Physician - IP Mental Health	\$154	\$0	\$154	\$0.02	2	2	\$76.96
Physician - OP Mental Health	\$2,076,261	\$91	\$2,076,352	\$208.28	125,766	151,390	\$16.51
Physician - Other Practitioner	\$404,511	\$148	\$404,659	\$40.59	7,197	8,663	\$56.23
Physician - PCP	\$1,055,933	\$42	\$1,055,975	\$105.93	15,829	19,054	\$66.71
Physician - Specialist	\$773,531	\$64	\$773,595	\$77.60	21,801	26,243	\$35.48
Pharmacy	\$5,801,778	\$0	\$5,801,778	\$581.99	94,931	114,272	\$61.12
Transportation - Emergency	\$86,871	\$0	\$86,871	\$8.71	1,503	1,809	\$57.80
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$57,723,737	\$1,625,697	\$59,349,434	\$5,953.44	1,034,364		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Other MSA	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1100 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	7,915						
Service Type							
Adult Day Care	\$45,485	\$0	\$45,485	\$5.75	1,002	1,519	\$45.39
Ambulatory Surgery Center	\$13,064	\$0	\$13,064	\$1.65	20	30	\$653.22
Case Management Services	\$47	\$0	\$47	\$0.01	14	21	\$3.33
Consumer Directed Services	\$2,290,742	\$3,815	\$2,294,557	\$289.91	236,457	358,508	\$9.70
DME/Supplies	\$768,277	\$79	\$768,355	\$97.08	7,584	11,499	\$101.31
Emergency	\$322,092	\$0	\$322,092	\$40.70	721	1,093	\$446.73
FQHC	\$51,537	\$3	\$51,540	\$6.51	631	957	\$81.68
Home Health Services	\$455,728	\$0	\$455,728	\$57.58	1,446	2,192	\$315.16
Inpatient - Medical/Surgical	\$7,875,507	\$1,782	\$7,877,289	\$995.27	770	1,167	\$10,230.25
Inpatient - Psych	\$35,012	\$0	\$35,012	\$4.42	49	74	\$714.52
Lab and X-ray Services	\$317,967	\$0	\$317,967	\$40.17	21,701	32,902	\$14.65
Medicare Xover - IP	\$653	\$0	\$653	\$0.08	1	2	\$652.66
Medicare Xover - Nursing Facility	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - OP	\$252	\$0	\$252	\$0.03	3	5	\$84.07
Medicare Xover - Other	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Physician	\$536	\$0	\$536	\$0.07	27	41	\$19.85
Nursing Facility	\$17,157,254	\$827,650	\$17,984,904	\$2,272.34	119,733	181,535	\$150.21
Outpatient - Other	\$1,628,415	\$0	\$1,628,415	\$205.75	2,092	3,172	\$778.40
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$2,533,359	\$6,134	\$2,539,493	\$320.86	43,560	66,044	\$58.30
Physician - Clinic	\$395,173	\$0	\$395,173	\$49.93	43,227	65,539	\$9.14
Physician - IP Mental Health	\$2,312	\$0	\$2,312	\$0.29	32	49	\$72.26
Physician - OP Mental Health	\$1,121,250	\$87	\$1,121,337	\$141.68	43,619	66,134	\$25.71
Physician - Other Practitioner	\$384,221	\$3	\$384,224	\$48.55	8,301	12,586	\$46.29
Physician - PCP	\$847,391	(\$26)	\$847,365	\$107.06	22,091	33,494	\$38.36
Physician - Specialist	\$605,159	\$77	\$605,236	\$76.47	13,150	19,938	\$46.03
Pharmacy	\$5,062,582	\$0	\$5,062,582	\$639.64	99,926	151,505	\$50.66
Transportation - Emergency	\$183,313	\$0	\$183,313	\$23.16	3,164	4,797	\$57.94
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$42,097,327	\$839,603	\$42,936,930	\$5,424.96	669,321		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1100 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	11,293						
Service Type							
Adult Day Care	\$418,183	\$6,152	\$424,335	\$37.57	9,441	10,032	\$44.95
Ambulatory Surgery Center	\$22,237	\$0	\$22,237	\$1.97	38	40	\$585.18
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$4,391,663	\$3,181	\$4,394,844	\$389.15	454,716	483,163	\$9.67
DME/Supplies	\$1,525,573	\$118	\$1,525,691	\$135.10	12,493	13,275	\$122.12
Emergency	\$667,666	\$121	\$667,787	\$59.13	1,012	1,075	\$659.87
FQHC	\$76,990	\$45	\$77,035	\$6.82	748	795	\$102.99
Home Health Services	\$541,200	\$0	\$541,200	\$47.92	2,152	2,287	\$251.49
Inpatient - Medical/Surgical	\$10,475,733	\$1,804	\$10,477,537	\$927.75	937	996	\$11,182.00
Inpatient - Psych	\$40,318	\$0	\$40,318	\$3.57	50	53	\$806.36
Lab and X-ray Services	\$382,589	\$0	\$382,589	\$33.88	22,172	23,559	\$17.26
Medicare Xover - IP	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Nursing Facility	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - OP	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Other	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Physician	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Nursing Facility	\$18,870,669	\$1,035,349	\$19,906,018	\$1,762.61	128,783	136,840	\$154.57
Outpatient - Other	\$2,978,493	\$0	\$2,978,493	\$263.74	4,276	4,544	\$696.56
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$5,825,600	\$18,857	\$5,844,458	\$517.51	91,842	97,588	\$63.64
Physician - Clinic	\$901,785	\$0	\$901,785	\$79.85	158,965	168,910	\$5.67
Physician - IP Mental Health	\$498	\$0	\$498	\$0.04	10	11	\$49.78
Physician - OP Mental Health	\$2,044,744	\$1,001	\$2,045,745	\$181.14	107,374	114,091	\$19.05
Physician - Other Practitioner	\$899,801	\$556	\$900,357	\$79.72	10,090	10,721	\$89.23
Physician - PCP	\$889,689	\$20	\$889,709	\$78.78	14,962	15,898	\$59.46
Physician - Specialist	\$798,868	\$3	\$798,871	\$70.74	14,249	15,140	\$56.07
Pharmacy	\$5,389,322	\$0	\$5,389,322	\$477.21	105,760	112,376	\$50.96
Transportation - Emergency	\$203,231	\$0	\$203,231	\$18.00	3,484	3,702	\$58.33
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$57,344,850	\$1,067,208	\$58,412,058	\$5,172.20	1,143,554		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Rural	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1100 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	12,332						
Service Type							
Adult Day Care	\$18,551	\$0	\$18,551	\$1.50	406	395	\$45.69
Ambulatory Surgery Center	\$27,616	\$0	\$27,616	\$2.24	47	46	\$587.56
Case Management Services	\$5,558	\$0	\$5,558	\$0.45	1,669	1,624	\$3.33
Consumer Directed Services	\$4,651,545	\$14,494	\$4,666,039	\$378.38	479,631	466,730	\$9.73
DME/Supplies	\$1,598,577	\$1,156	\$1,599,733	\$129.73	14,937	14,535	\$107.10
Emergency	\$652,397	\$0	\$652,397	\$52.90	1,553	1,511	\$420.09
FQHC	\$252,878	\$323	\$253,201	\$20.53	3,472	3,379	\$72.93
Home Health Services	\$895,851	\$201	\$896,052	\$72.66	2,389	2,325	\$375.07
Inpatient - Medical/Surgical	\$11,089,691	\$843	\$11,090,534	\$899.35	1,140	1,109	\$9,728.54
Inpatient - Psych	\$21,624	\$0	\$21,624	\$1.75	32	31	\$675.76
Lab and X-ray Services	\$488,589	\$0	\$488,589	\$39.62	33,274	32,379	\$14.68
Medicare Xover - IP	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Nursing Facility	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - OP	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Other	\$14	\$0	\$14	\$0.00	1	1	\$14.38
Medicare Xover - Physician	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Nursing Facility	\$20,050,786	\$557,629	\$20,608,415	\$1,671.17	148,958	144,951	\$138.35
Outpatient - Other	\$2,486,643	\$9	\$2,486,652	\$201.65	4,098	3,988	\$606.80
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$5,320,197	\$15,865	\$5,336,062	\$432.71	99,801	97,116	\$53.47
Physician - Clinic	\$640,183	\$0	\$640,183	\$51.91	111,342	108,347	\$5.75
Physician - IP Mental Health	\$2,321	\$0	\$2,321	\$0.19	32	31	\$72.53
Physician - OP Mental Health	\$1,882,666	\$244	\$1,882,910	\$152.69	96,557	93,960	\$19.50
Physician - Other Practitioner	\$460,700	\$145	\$460,844	\$37.37	9,022	8,779	\$51.08
Physician - PCP	\$1,415,942	\$138	\$1,416,080	\$114.83	28,548	27,780	\$49.60
Physician - Specialist	\$903,336	\$245	\$903,581	\$73.27	18,474	17,977	\$48.91
Pharmacy	\$8,529,836	\$0	\$8,529,836	\$691.70	148,833	144,830	\$57.31
Transportation - Emergency	\$301,373	\$0	\$301,373	\$24.44	3,823	3,720	\$78.83
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$61,696,874	\$591,293	\$62,288,168	\$5,051.06	1,208,039		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Tidewater	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1100 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	13,751						
Service Type							
Adult Day Care	\$14,610	\$0	\$14,610	\$1.06	323	282	\$45.23
Ambulatory Surgery Center	\$21,119	\$0	\$21,119	\$1.54	29	25	\$728.26
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$1,257,102	\$4,281	\$1,261,383	\$91.73	128,718	112,330	\$9.80
DME/Supplies	\$1,546,026	\$35	\$1,546,061	\$112.43	12,827	11,194	\$120.53
Emergency	\$768,518	\$0	\$768,518	\$55.89	1,366	1,192	\$562.60
FQHC	\$35,440	\$32	\$35,472	\$2.58	453	395	\$78.30
Home Health Services	\$834,535	\$0	\$834,535	\$60.69	2,587	2,258	\$322.59
Inpatient - Medical/Surgical	\$11,476,407	\$3,282	\$11,479,689	\$834.84	1,072	936	\$10,708.66
Inpatient - Psych	\$25,368	\$0	\$25,368	\$1.84	36	31	\$704.66
Lab and X-ray Services	\$477,527	\$0	\$477,527	\$34.73	33,369	29,121	\$14.31
Medicare Xover - IP	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Nursing Facility	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - OP	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - Other	\$21	\$0	\$21	\$0.00	2	2	\$10.35
Medicare Xover - Physician	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Nursing Facility	\$28,355,422	\$2,103,688	\$30,459,110	\$2,215.09	203,065	177,211	\$150.00
Outpatient - Other	\$2,367,576	\$0	\$2,367,576	\$172.18	3,274	2,857	\$723.14
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$9,979,733	\$36,699	\$10,016,431	\$728.43	147,765	128,952	\$67.79
Physician - Clinic	\$1,351,590	\$0	\$1,351,590	\$98.29	327,650	285,934	\$4.13
Physician - IP Mental Health	\$1,701	\$0	\$1,701	\$0.12	24	21	\$70.88
Physician - OP Mental Health	\$3,274,814	\$134	\$3,274,948	\$238.17	216,740	189,145	\$15.11
Physician - Other Practitioner	\$869,763	\$29	\$869,792	\$63.25	11,326	9,884	\$76.80
Physician - PCP	\$1,559,740	\$184	\$1,559,924	\$113.44	33,076	28,865	\$47.16
Physician - Specialist	\$1,056,263	\$185	\$1,056,448	\$76.83	24,406	21,299	\$43.29
Pharmacy	\$8,237,678	\$0	\$8,237,678	\$599.07	135,702	118,425	\$60.70
Transportation - Emergency	\$202,866	\$0	\$202,866	\$14.75	3,542	3,091	\$57.27
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$73,713,818	\$2,148,547	\$75,862,365	\$5,516.97	1,287,352		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2014 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
All Regions	Medicaid Payments FY11 - FY12	Patient Payments FY11 - FY12	Total Payments FY11 - FY12	Unadjusted PMPM	Units FY11 - FY12	Units/1100 FY11 - FY12	Cost/Unit FY11 - FY12
Member Months	55,260						
Service Type							
Adult Day Care	\$560,664	\$6,152	\$566,816	\$10.26	13,318	2,892	\$42.56
Ambulatory Surgery Center	\$93,213	\$0	\$93,213	\$1.69	147	32	\$634.10
Case Management Services	\$5,704	\$0	\$5,704	\$0.10	1,714	372	\$3.33
Consumer Directed Services	\$16,780,144	\$37,999	\$16,818,144	\$304.35	1,636,001	355,269	\$10.28
DME/Supplies	\$6,282,808	\$1,418	\$6,284,226	\$113.72	55,691	12,094	\$112.84
Emergency	\$2,941,565	\$121	\$2,941,686	\$53.23	5,408	1,174	\$543.95
FQHC	\$424,922	\$402	\$425,324	\$7.70	5,451	1,184	\$78.03
Home Health Services	\$3,195,743	\$201	\$3,195,944	\$57.84	9,613	2,088	\$332.46
Inpatient - Medical/Surgical	\$48,891,776	\$14,925	\$48,906,701	\$885.04	4,634	1,006	\$10,553.88
Inpatient - Psych	\$140,515	\$0	\$140,515	\$2.54	187	41	\$751.42
Lab and X-ray Services	\$2,000,543	\$0	\$2,000,543	\$36.20	133,090	28,901	\$15.03
Medicare Xover - IP	\$1,785	\$0	\$1,785	\$0.03	2	0	\$892.33
Medicare Xover - Nursing Facility	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Medicare Xover - OP	\$317	\$0	\$317	\$0.01	4	1	\$79.31
Medicare Xover - Other	\$336	\$0	\$336	\$0.01	13	3	\$25.83
Medicare Xover - Physician	\$543	\$0	\$543	\$0.01	28	6	\$19.40
Nursing Facility	\$106,878,955	\$6,113,598	\$112,992,553	\$2,044.76	733,182	159,216	\$154.11
Outpatient - Other	\$10,962,930	\$9	\$10,962,939	\$198.39	15,509	3,368	\$706.88
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$31,880,774	\$94,152	\$31,974,926	\$578.63	466,257	101,251	\$68.58
Physician - Clinic	\$4,202,953	\$0	\$4,202,953	\$76.06	819,035	177,859	\$5.13
Physician - IP Mental Health	\$6,986	\$0	\$6,986	\$0.13	100	22	\$69.86
Physician - OP Mental Health	\$10,399,734	\$1,557	\$10,401,291	\$188.23	590,056	128,135	\$17.63
Physician - Other Practitioner	\$3,018,995	\$881	\$3,019,875	\$54.65	45,936	9,975	\$65.74
Physician - PCP	\$5,768,695	\$358	\$5,769,053	\$104.40	114,506	24,866	\$50.38
Physician - Specialist	\$4,137,157	\$574	\$4,137,731	\$74.88	92,080	19,996	\$44.94
Pharmacy	\$33,021,195	\$0	\$33,021,195	\$597.57	585,152	127,070	\$56.43
Transportation - Emergency	\$977,654	\$0	\$977,654	\$17.69	15,516	3,369	\$63.01
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$292,576,607	\$6,272,348	\$298,848,954	\$5,408.10	5,342,630		

Note:

Patient Payments are included here for all services but are only carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.

Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Prescription Drug Adjustment

Exhibit 2a

	Dual Eligibles	Non-Dual Eligibles	Source
1. Fee-for-Service Net Cost PMPM	\$13.10	\$597.57	DMAS FY11-FY12 FFS Invoices
2. Fee-for-Service Net Cost per Script	\$6.95	\$56.43	DMAS FY11-FY12 FFS Invoices
3. Average Fee-for-Service Copayment per Script	\$0.02	\$0.05	DMAS FY11-FY12 FFS Invoices
4. Fee-for-Service Gross Cost per Script	\$6.97	\$56.48	= (2.) + (3.)
5. Average Fee-for-Service Dispensing Fees	\$2.95	\$3.03	DMAS FY11-FY12 FFS Invoices
6. Fee-for-Service Ingredient Cost per Script	\$4.02	\$53.45	= (4.) - (5.)
7. Average Fee-for-Service Rebate	10%	36%	Provided by DMAS
8. Fee-for-Service Cost per Script with Rebate	\$3.62	\$34.14	= (6.) * (1 - (7.))
9. Brand-Generic Improvement Adjustment	1.000	0.995	VA Claims Analysis
10. Adjusted Cost PMPM with Brand-Generic Improvement Adjustment	\$3.62	\$33.97	= (8.) * (9.)
11. Average Fee-for-Service Dispensing Fees	\$2.95	\$3.03	= (5.)
12. Adjusted Cost per Script	\$6.57	\$37.00	= (10.) + (11.)
13. Adjusted Cost PMPM	\$12.38	\$391.81	= (12.) * scripts / MM
14. Pharmacy Adjustment Factor	-5.5%	-34.4%	= (13.) / (1.) -1

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Non-Emergency Transportation Adjustment**

Exhibit 2b

	Adjustment Values	Source
Non-ER Transportation Rate	\$27.38	Non-Emergency Transportation Rate - Service Cost Component Only

**Virginia Medicaid
 FY 2014 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Emergency Transportation Adjustment**

Exhibit 2c

	Dual Eligibles	Non-Dual Eligibles	Source
1. Total claims in Transportation - Emergency Service Category	\$95,539	\$977,654	DMAS FY11-FY12 FFS Invoices
2a. % FFS Claims	100%	57%	DMAS FY11-FY12 FFS Invoices
2b. % MCO Claims	0%	43%	FY11-FY12 ALTC Health Plan Encounter Data
3a. FFS Increase to 40% of Medicare	38.4%	38.4%	Provided by DMAS
3b. MCO Increase to 40% of Medicare	0.4%	0.4%	Estimate based on Medallion II ABAD population
4. Emergency Transportation Adjustment	38.4%	22.0%	$= ((1.) * (2a.) * (3a.) + (1.) * (2b.) * (3b.)) / (1.)$

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Home and Community-Based Care Fee Adjustment

Exhibit 2d

		Adjustment Value	Source
1.	Total Claims in Service Categories		
	a. Adult Day Care	\$9,794,571	DMAS FY11-FY12 FFS Invoices
	b. Consumer Directed Services	\$161,802,572	
	c. Personal Care Services	\$352,467,709	
2a.	FY12 Fee Decrease	1.0%	Provided by DMAS
2b.	FY13 Fee Increase	1.0%	Provided by DMAS
3.	Claims associated with FY12 Fee Decrease		
	a. Adult Day Care	\$4,755,691	DMAS FY11 FFS Invoices
	b. Consumer Directed Services	\$76,096,003	
	c. Personal Care Services	\$166,515,679	
4.	Claims associated with FY13 Fee Increase		
	a. Adult Day Care	\$0	DMAS FY11-FY12 FFS Invoices
	b. Consumer Directed Services	\$161,755,998	
	c. Personal Care Services	\$352,467,709	
5.	HCBC Fee Adjustment		
	a. Adult Day Care	-0.5%	= ((3.) * (-2a.) + (4.) * (2b.)) / (1.)
	b. Consumer Directed Services	0.5%	
	c. Personal Care Services	0.5%	

**Virginia Medicaid
 FY 2014 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Adult Day Care Adjustment**

Exhibit 2e

	Northern Virginia	Rest of State	Source
1. Total Claims in Adult Day Care	\$4,302,141	\$5,492,429	DMAS FY11-FY12 FFS Invoices
2a. Rates Effective Prior to 7/1/2013	\$50.10	\$45.65	Provided by DMAS
2b. Rates Effective FY14	\$60.10	\$55.65	Provided by DMAS
2c. % Change in rates	20.0%	21.9%	= (2b.) / (2a.) - 1
3a. Claims Associated with Procedure Code S5102	\$4,067,818	\$5,490,197	DMAS FY11-FY12 FFS Invoices
3b. Dollar Change	\$811,939.67	\$1,202,671.93	= (3a.) * (2c.)
4. Adult Day Care Adjustment	18.9%	21.9%	= (3b.) / (1.)

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Hospital Inpatient Adjustment

Exhibit 2f

	Inpatient Medical/Surgical	Inpatient - Psych	Source
1a FY11 Claims in IP Service Categories	\$31,476,922	\$668,011	DMAS FY11 FFS Invoices
1b FY12 Claims in IP Service Categories	\$34,492,005	\$227,322	DMAS FY12 FFS Invoices
2. FY11-12 Hospital Capital Percentage*	9.7%	9.7%	Provided by DMAS
3a. FY12 Capital Reimbursement Reduction	5.3%	5.3%	Provided by DMAS
3b. Dollar Change	(\$162,849)	(\$3,456)	= - (1a.) * (2.) * (3a.)
4a. FY13 Hospital Rate Increase	2.6%	2.6%	Provided by DMAS
4b. Dollar Change	\$1,548,810	\$21,021	= ((1a.) + (1b.)) * (1 - (2.)) * (4a.)
5a. FY14 Hospital Rate Change	4.7%	-7.4%	Provided by DMAS
5b. Dollar Change	\$2,853,515	(\$61,111)	= ((1a.) + (1b.)) * (1 - (2.)) * (1 + (4a.)) * (5a.)
6. Hospital Inpatient Adjustment	6.4%	-4.9%	= ((3b.) + (4b.) + (5b.)) / ((1a.) + (1b.))

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Hospital Outpatient Adjustment

Exhibit 2g

		Dual Eligibles	Non-Dual Eligibles	Source	
1.	Claims Associated with FY11 Outpatient Services	a. Emergency b. Outpatient - Other	\$20,029 \$656,286	\$1,252,962 \$5,022,703	DMAS FY11 FFS Invoices
2.	Claims Associated with FY12 Outpatient Services	a. Emergency b. Outpatient - Other	\$20,950 \$735,767	\$1,688,603 \$5,940,227	DMAS FY12 FFS Invoices
3.	% ER Triage of Total Outpatient		0.0%	6.0%	Provided by DMAS
4.	% FY11 OP - Emergency of Total Outpatient		3.0%	20.0%	= (1a.) / ((1a.) + (1b.))
5.	% FY11 Claims Exempt from Fee Reduction		0.0%	30.1%	= (3.) / (4.)
6.	FY12 Hospital Rate Reduction		5.0%	5.0%	Provided by DMAS
7.	Dollar Decrease	a. Emergency b. Outpatient - Other	\$1,001 \$32,814	\$43,821 \$251,135	= (1a.) * (1 - (5.)) * (6.) = (1b.) * (6.)
8.	Hospital Outpatient Adjustment	a. Emergency b. Outpatient - Other	-2.4% -2.4%	-1.5% -2.3%	= (7a.) / ((1a.) + (2a.)) = (7b.) / ((1b.) + (2b.))

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Nursing Facility Adjustment

Exhibit 2h

	Adjustment Value	Source
1a. FY11 Claims in Nursing Facility Service Category	\$871,108,522	DMAS FY11 FFS Invoices
1b. FY12 Claims in Nursing Facility Service Category	\$886,518,323	DMAS FY12 FFS Invoices
2. FY12 Nursing Facility Capital Rental Rate Percentage	9.7%	Provided by DMAS
3a. FY12 Nursing Facility Capital Rental Rate Reduction	10.5%	Provided by DMAS
3b. FY13 Nursing Facility Capital Rental Rate Increase	6.3%	Provided by DMAS
3c. Dollar Change	\$1,238,275	= (1a.) * (2.) * ((1 - (3a.)) * (1 + (3b.)) - 1) + (1b.) * (2.) * (3b.)
4a. FY13 Nursing Facility Operating Rate Increase	2.8%	Provided by DMAS
4b. FY14 Nursing Facility Operating Rate Increase	1.1%	Provided by DMAS
4c. Dollar Change	\$61,898,345	= ((1a.) + (1b.)) * (1 - (2.)) * ((1 + (4a.)) * (1 + (4b.)) - 1)
5a. FY14 Occupancy Requirement Change Impact	0.17%	Provided by DMAS
5b. Dollar Change	\$3,095,298	= ((1a.) + (1b.) + (3c.) + (4c.)) * (5a.)
6a. Nursing Facility Cost Settlement Adjustment	4.5%	Provided by DMAS
6b. Dollar Change	\$82,073,644	= ((1a.) + (1b.) + (3c.) + (4c.) + (5b.)) * (6a.)
7. Nursing Facility Adjustment	8.4%	= ((3c.) + (4c.) + (5b.) + (6b.)) / ((1a.) + (1b.))

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Other Adjustments**

Exhibit 2i

	Adjustment Values	Source
1. Managed Care Utilization Savings	-18.4%	American Academy of Actuaries
2. Administrative Cost	15.0%	Provided by DMAS

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
IBNR, Policy/Program, and Trend Adjustments for Dual Population**

Exhibit 3a

Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Nursing Facility	0.0%	8.4%	8.4%	1.0%	-4.0%	-3.0%	0.0%	0.9697
Adult Day Care	0.0%	20.3%	20.3%	1.4%	2.1%	3.6%	0.9%	1.0497
Personal Care	0.0%	0.5%	0.5%	0.9%	6.1%	7.1%	9.3%	1.2240
Consumer Directed Services	0.0%	0.5%	0.6%	0.9%	6.1%	7.1%	9.3%	1.2240
IP Medical/Surgical - DRG Services	0.4%	6.4%	6.9%	-11.2%	15.3%	2.4%	0.0%	1.0243
IP Psych - Per Diem Services	0.0%	-4.9%	-4.9%	-11.2%	15.3%	2.4%	0.0%	1.0243
Outpatient Hospital	0.0%	-2.1%	-2.1%	25.6%	-9.8%	13.3%	0.0%	1.1330
Practitioner	0.0%	0.0%	0.0%	8.6%	-25.7%	-19.3%	0.0%	0.8066
Prescription Drug	0.0%	-5.5%	-5.5%	-6.9%	-5.6%	-12.1%	0.0%	0.8792
Other	0.1%	0.2%	0.3%	2.0%	4.9%	7.0%	2.4%	1.1094
Weighted Average*	0.0%	6.5%	6.5%	1.1%	-2.5%	-1.4%	1.9%	1.0137
Medicare Crossovers								
Inpatient	-0.1%	0.0%	-0.1%	-2.7%	1.3%	-1.5%	0.0%	0.9850
Nursing Facility	-0.1%	0.0%	-0.1%	-2.7%	1.3%	-1.5%	0.0%	0.9850
Outpatient	-0.1%	0.0%	-0.1%	-2.7%	1.3%	-1.5%	0.0%	0.9850
Professional	-0.1%	0.0%	-0.1%	-2.7%	1.3%	-1.5%	0.0%	0.9850
Other	-0.1%	0.0%	-0.1%	-2.7%	1.3%	-1.5%	0.0%	0.9850
Weighted Average*	-0.1%	0.0%	-0.1%	-2.7%	1.3%	-1.5%	0.0%	0.9850
Months of Trend Applied:				12	12	12	18	

Notes:

Trend rates are calculated based on regression studies of historical Virginia fee-for-service data. Contract period trend for Nursing Home, Adult Day Care, and Personal Care categories also considers DMAS budget projections.

Trend rates have been calculated separately for the broad service categories shown above.

Regressions were based on PMPM costs. Trends for Long Term Care Services were developed from historical data and DMAS budget information.

Data period trend are applied from the midpoint of the data period to the end of the data period using compound interest calculations. Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest.

Total Trend & IBNR = [(1 + Data Period Trend) ^ (months/12) * (1+ Contract Period Utilization Trend) ^ (months/12) * (1 + IBNR Adjustment)]

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2011-2012 Claims)

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
IBNR, Policy/Program, and Trend Adjustments for Non-Dual Population**

Exhibit 3b

Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Nursing Facility	0.0%	8.4%	8.5%	0.9%	-7.0%	-6.2%	0.0%	0.9385
Adult Day Care	0.0%	21.3%	21.3%	1.4%	2.1%	3.6%	0.9%	1.0497
Personal Care	0.0%	0.5%	0.5%	0.9%	6.1%	7.1%	9.3%	1.2240
Consumer Directed Services	0.0%	0.5%	0.5%	0.9%	6.1%	7.1%	9.3%	1.2240
IP Medical/Surgical - DRG Services	0.1%	6.4%	6.5%	-0.1%	1.7%	1.6%	0.0%	1.0157
IP Psych - Per Diem Services	0.0%	-4.9%	-4.9%	-0.1%	1.7%	1.6%	0.0%	1.0157
Outpatient Hospital	0.3%	-1.7%	-1.5%	4.3%	3.5%	8.0%	9.5%	1.2376
Practitioner	0.1%	0.0%	0.1%	36.1%	-32.9%	-8.6%	2.1%	0.9430
Prescription Drug	0.0%	-34.4%	-34.4%	1.7%	-2.5%	-0.9%	0.2%	0.9948
Other	0.1%	2.3%	2.4%	0.6%	2.5%	3.1%	3.8%	1.0901
Weighted Average*	0.0%	1.6%	1.6%	4.2%	-4.5%	-1.4%	2.4%	1.0214
Months of Trend Applied:				12	12	12	18	

Notes:

Trend rates are calculated based on regression studies of historical Virginia fee-for-service data. Contract period trend for Nursing Home, Adult Day Care, and Personal Care categories also considers DMAS budget projections. Trend rates have been calculated separately for the broad service categories shown above. Regressions were based on PMPM costs. Trends for Long Term Care Services were developed from historical data and DMAS budget information.

Data period trend are applied from the midpoint of the data period to the end of the data period using compound interest calculations. Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest.

Total Trend & IBNR = [(1 + Data Period Trend) ^ (months/12) * (1+ Contract Period Utilization Trend) ^ (months/12) * (1 + IBNR Adjustment)]

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2011-2012 Claims)

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Northern Virginia	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$4,238,307	\$166	\$43,716	\$787,382	\$5,069,571	1.050	\$5,321,734	\$53.75	0.82	\$43.86
Ambulatory Surgery Center	\$3,082	\$1			\$3,084	0.807	\$2,488	\$0.03	0.82	\$0.02
Case Management Services	\$11,008	\$5			\$11,013	0.807	\$8,883	\$0.09	0.82	\$0.07
Consumer Directed Services	\$27,165,909	\$4,116	\$300,858	\$145,434	\$27,616,317	1.224	\$33,803,258	\$341.40	0.82	\$278.59
DME/Supplies	\$2,253,166	\$1,316			\$2,254,482	1.109	\$2,501,212	\$25.26	0.82	\$20.61
Emergency	\$1,886	\$1		(\$46)	\$1,840	1.133	\$2,085	\$0.02	0.82	\$0.02
FQHC	\$0	\$0			\$0	0.807	\$0	\$0.00	0.82	\$0.00
Home Health Services	\$49,468	\$17			\$49,485	1.133	\$56,064	\$0.57	0.82	\$0.46
Inpatient - Medical/Surgical	\$6,578,920	\$29,271		\$424,674	\$7,032,864	1.024	\$7,203,428	\$72.75	0.82	\$59.37
Inpatient - Psych	\$70,580	\$0		(\$3,433)	\$67,147	1.024	\$68,776	\$0.69	0.82	\$0.57
Lab and X-ray Services	\$11,728	\$7			\$11,735	1.109	\$13,019	\$0.13	0.82	\$0.11
Medicare Xover - IP	\$2,092,112	(\$2,791)			\$2,089,321	0.985	\$2,057,981	\$20.79	0.82	\$16.96
Medicare Xover - Nursing Facility	\$1,476,877	(\$1,970)	\$15,277		\$1,490,184	0.985	\$1,467,831	\$14.82	0.82	\$12.10
Medicare Xover - OP	\$1,043,363	(\$1,392)			\$1,041,971	0.985	\$1,026,341	\$10.37	0.82	\$8.46
Medicare Xover - Other	\$692,788	(\$924)			\$691,863	0.985	\$681,485	\$6.88	0.82	\$5.62
Medicare Xover - Physician	\$2,535,997	(\$3,383)			\$2,532,614	0.985	\$2,494,625	\$25.20	0.82	\$20.56
Nursing Facility	\$212,411,206	(\$25,973)	\$45,944,143	\$17,920,704	\$276,250,081	0.970	\$267,888,008	\$2,705.60	0.82	\$2,207.77
Outpatient - Other	\$757,756	\$258		(\$17,868)	\$740,145	1.133	\$838,551	\$8.47	0.82	\$6.91
Outpatient - Psychological	\$0	\$0			\$0	1.133	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$76,186,144	\$11,543	376124.32	\$403,982	\$76,977,794	1.224	\$94,223,290	\$951.63	0.82	\$776.53
Physician - Clinic	\$39,067	\$18			\$39,085	0.807	\$31,527	\$0.32	0.82	\$0.26
Physician - IP Mental Health	\$327	\$0			\$327	0.807	\$263	\$0.00	0.82	\$0.00
Physician - OP Mental Health	\$15,506,533	\$7,322			\$15,513,855	0.807	\$12,513,861	\$126.39	0.82	\$103.13
Physician - Other Practitioner	\$700,422	\$331			\$700,753	0.807	\$565,244	\$5.71	0.82	\$4.66
Physician - PCP	\$114,244	\$54			\$114,298	0.807	\$92,195	\$0.93	0.82	\$0.76
Physician - Specialist	\$62,494	\$30			\$62,523	0.807	\$50,433	\$0.51	0.82	\$0.42
Pharmacy	\$1,115,333	\$29		(\$61,428)	\$1,053,934	0.879	\$926,601	\$9.36	1.00	\$9.36
Transportation - Emergency	\$5,010	\$3		\$1,927	\$6,940	1.109	\$7,699	\$0.08	0.82	\$0.06
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$355,123,725	\$18,053	\$46,680,119	\$19,601,328	\$421,423,224			\$4,409.13		\$3,604.61
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$4,499.11		\$4,240.72

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services. Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Other MSA	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$584,121	\$23	\$12,935	\$127,843	\$724,921	1.050	\$760,979	\$5.86	0.82	\$4.79
Ambulatory Surgery Center	\$846	\$0			\$847	0.807	\$683	\$0.01	0.82	\$0.00
Case Management Services	\$3,506	\$2			\$3,508	0.807	\$2,830	\$0.02	0.82	\$0.02
Consumer Directed Services	\$24,855,979	\$3,766	\$331,212	\$133,364	\$25,324,320	1.224	\$30,997,780	\$238.89	0.82	\$194.94
DME/Supplies	\$1,992,974	\$1,164			\$1,994,138	1.109	\$2,212,376	\$17.05	0.82	\$13.91
Emergency	\$4,195	\$1		(\$103)	\$4,094	1.133	\$4,638	\$0.04	0.82	\$0.03
FQHC	\$420	\$0			\$420	0.807	\$339	\$0.00	0.82	\$0.00
Home Health Services	\$13,175	\$4			\$13,179	1.133	\$14,932	\$0.12	0.82	\$0.09
Inpatient - Medical/Surgical	\$2,146,177	\$9,549		\$138,537	\$2,294,263	1.024	\$2,349,904	\$18.11	0.82	\$14.78
Inpatient - Psych	\$527,339	\$0		(\$25,649)	\$501,691	1.024	\$513,858	\$3.96	0.82	\$3.23
Lab and X-ray Services	\$19,118	\$11			\$19,130	1.109	\$21,223	\$0.16	0.82	\$0.13
Medicare Xover - IP	\$3,083,023	(\$4,113)			\$3,078,910	0.985	\$3,032,726	\$23.37	0.82	\$19.07
Medicare Xover - Nursing Facility	\$1,752,672	(\$2,338)	\$59,060		\$1,809,393	0.985	\$1,782,252	\$13.74	0.82	\$11.21
Medicare Xover - OP	\$1,335,934	(\$1,782)			\$1,334,152	0.985	\$1,314,140	\$10.13	0.82	\$8.26
Medicare Xover - Other	\$1,006,364	(\$1,343)			\$1,005,021	0.985	\$989,946	\$7.63	0.82	\$6.23
Medicare Xover - Physician	\$2,963,207	(\$3,953)			\$2,959,253	0.985	\$2,914,865	\$22.46	0.82	\$18.33
Nursing Facility	\$292,689,160	(\$35,789)	\$69,353,696	\$24,693,593	\$386,700,660	0.970	\$374,995,256	\$2,890.00	0.82	\$2,358.24
Outpatient - Other	\$146,204	\$50		(\$3,448)	\$142,806	1.133	\$161,793	\$1.25	0.82	\$1.02
Outpatient - Psychological	\$0	\$0			\$0	1.133	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$31,800,664	\$4,818	261729.89	\$169,178	\$32,236,390	1.224	\$39,458,375	\$304.10	0.82	\$248.14
Physician - Clinic	\$88	\$0			\$88	0.807	\$71	\$0.00	0.82	\$0.00
Physician - IP Mental Health	\$214	\$0			\$214	0.807	\$172	\$0.00	0.82	\$0.00
Physician - OP Mental Health	\$8,313,228	\$3,925			\$8,317,153	0.807	\$6,708,822	\$51.70	0.82	\$42.19
Physician - Other Practitioner	\$835,973	\$395			\$836,367	0.807	\$674,635	\$5.20	0.82	\$4.24
Physician - PCP	\$61,877	\$29			\$61,906	0.807	\$49,935	\$0.38	0.82	\$0.31
Physician - Specialist	\$39,384	\$19			\$39,403	0.807	\$31,783	\$0.24	0.82	\$0.20
Pharmacy	\$2,032,430	\$53		(\$111,938)	\$1,920,545	0.879	\$1,688,511	\$13.01	1.00	\$13.01
Transportation - Emergency	\$15,940	\$9		\$6,131	\$22,080	1.109	\$24,496	\$0.19	0.82	\$0.15
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$376,224,212	(\$25,500)	\$70,018,632	\$25,127,509	\$471,344,853			\$3,655.01		\$2,989.92
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,729.60		\$3,517.56

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services. Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$3,355,075	\$131	\$72,704	\$733,962	\$4,161,873	1.050	\$4,368,887	\$33.02	0.82	\$26.94
Ambulatory Surgery Center	\$1,731	\$1			\$1,731	0.807	\$1,397	\$0.01	0.82	\$0.01
Case Management Services	\$0	\$0			\$0	0.807	\$0	\$0.00	0.82	\$0.00
Consumer Directed Services	\$30,565,967	\$4,631	\$490,954	\$164,443	\$31,225,996	1.224	\$38,221,621	\$288.88	0.82	\$235.72
DME/Supplies	\$3,520,002	\$2,056			\$3,522,058	1.109	\$3,907,511	\$29.53	0.82	\$24.10
Emergency	\$9,004	\$3		(\$220)	\$8,787	1.133	\$9,955	\$0.08	0.82	\$0.06
FQHC	\$2,336	\$1			\$2,337	0.807	\$1,885	\$0.01	0.82	\$0.01
Home Health Services	\$21,201	\$7			\$21,208	1.133	\$24,028	\$0.18	0.82	\$0.15
Inpatient - Medical/Surgical	\$2,064,122	\$9,184		\$133,240	\$2,206,547	1.024	\$2,260,060	\$17.08	0.82	\$13.94
Inpatient - Psych	\$20,705	\$0		(\$1,007)	\$19,698	1.024	\$20,176	\$0.15	0.82	\$0.12
Lab and X-ray Services	\$18,799	\$11			\$18,810	1.109	\$20,868	\$0.16	0.82	\$0.13
Medicare Xover - IP	\$3,717,805	(\$4,960)			\$3,712,845	0.985	\$3,657,152	\$27.64	0.82	\$22.55
Medicare Xover - Nursing Facility	\$2,165,462	(\$2,889)	\$57,585		\$2,220,158	0.985	\$2,186,855	\$16.53	0.82	\$13.49
Medicare Xover - OP	\$1,322,226	(\$1,764)			\$1,320,462	0.985	\$1,300,655	\$9.83	0.82	\$8.02
Medicare Xover - Other	\$1,207,380	(\$1,611)			\$1,205,769	0.985	\$1,187,682	\$8.98	0.82	\$7.32
Medicare Xover - Physician	\$3,396,215	(\$4,531)			\$3,391,684	0.985	\$3,340,809	\$25.25	0.82	\$20.60
Nursing Facility	\$252,832,778	(\$30,916)	\$66,141,700	\$21,330,991	\$340,274,554	0.970	\$329,974,465	\$2,493.94	0.82	\$2,035.05
Outpatient - Other	\$221,138	\$75		(\$5,215)	\$215,999	1.133	\$244,717	\$1.85	0.82	\$1.51
Outpatient - Psychological	\$0	\$0			\$0	1.133	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$59,619,335	\$9,033	759989.54	\$318,592	\$60,706,949	1.224	\$74,307,254	\$561.61	0.82	\$458.28
Physician - Clinic	\$23,833	\$11			\$23,845	0.807	\$19,234	\$0.15	0.82	\$0.12
Physician - IP Mental Health	\$452	\$0			\$452	0.807	\$365	\$0.00	0.82	\$0.00
Physician - OP Mental Health	\$12,906,942	\$6,094			\$12,913,037	0.807	\$10,415,976	\$78.72	0.82	\$64.24
Physician - Other Practitioner	\$935,143	\$442			\$935,584	0.807	\$754,665	\$5.70	0.82	\$4.65
Physician - PCP	\$82,985	\$39			\$83,024	0.807	\$66,970	\$0.51	0.82	\$0.41
Physician - Specialist	\$54,488	\$26			\$54,514	0.807	\$43,972	\$0.33	0.82	\$0.27
Pharmacy	\$1,445,996	\$38		(\$79,639)	\$1,366,394	0.879	\$1,201,311	\$9.08	1.00	\$9.08
Transportation - Emergency	\$29,458	\$17		\$11,330	\$40,804	1.109	\$45,270	\$0.34	0.82	\$0.28
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$379,540,579	(\$14,870)	\$67,522,933	\$22,606,477	\$469,655,119			\$3,636.95		\$2,974.46
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,711.17		\$3,499.36

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services. Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Rural	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$679,170	\$27	\$7,369	\$147,003	\$833,569	1.050	\$875,031	\$4.47	0.82	\$3.64
Ambulatory Surgery Center	\$3,192	\$2			\$3,193	0.807	\$2,576	\$0.01	0.82	\$0.01
Case Management Services	\$65,043	\$31			\$65,074	0.807	\$52,490	\$0.27	0.82	\$0.22
Consumer Directed Services	\$49,325,862	\$7,474	\$610,032	\$264,405	\$50,207,773	1.224	\$61,455,925	\$313.66	0.82	\$255.94
DME/Supplies	\$4,301,875	\$2,513			\$4,304,388	1.109	\$4,775,459	\$24.37	0.82	\$19.89
Emergency	\$18,006	\$6		(\$440)	\$17,572	1.133	\$19,908	\$0.10	0.82	\$0.08
FQHC	\$3,984	\$2			\$3,986	0.807	\$3,215	\$0.02	0.82	\$0.01
Home Health Services	\$45,658	\$16			\$45,674	1.133	\$51,746	\$0.26	0.82	\$0.22
Inpatient - Medical/Surgical	\$3,479,203	\$15,480		\$224,585	\$3,719,267	1.024	\$3,809,468	\$19.44	0.82	\$15.87
Inpatient - Psych	\$128,434	\$0		(\$6,247)	\$122,187	1.024	\$125,151	\$0.64	0.82	\$0.52
Lab and X-ray Services	\$28,488	\$17			\$28,505	1.109	\$31,624	\$0.16	0.82	\$0.13
Medicare Xover - IP	\$5,256,161	(\$7,012)			\$5,249,149	0.985	\$5,170,412	\$26.39	0.82	\$21.53
Medicare Xover - Nursing Facility	\$3,596,220	(\$4,798)	\$60,427		\$3,651,849	0.985	\$3,597,071	\$18.36	0.82	\$14.98
Medicare Xover - OP	\$2,725,902	(\$3,637)			\$2,722,266	0.985	\$2,681,432	\$13.69	0.82	\$11.17
Medicare Xover - Other	\$2,131,174	(\$2,843)			\$2,128,330	0.985	\$2,096,405	\$10.70	0.82	\$8.73
Medicare Xover - Physician	\$4,807,929	(\$6,414)			\$4,801,514	0.985	\$4,729,492	\$24.14	0.82	\$19.70
Nursing Facility	\$329,400,851	(\$40,278)	\$70,696,705	\$27,790,885	\$427,848,163	0.970	\$414,897,226	\$2,117.53	0.82	\$1,727.91
Outpatient - Other	\$92,238	\$31		(\$2,175)	\$90,095	1.133	\$102,073	\$0.52	0.82	\$0.43
Outpatient - Psychological	\$0	\$0			\$0	1.133	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$71,862,663	\$10,888	832372.9	\$383,576	\$73,089,500	1.224	\$89,463,894	\$456.60	0.82	\$372.59
Physician - Clinic	\$20,411	\$10			\$20,421	0.807	\$16,472	\$0.08	0.82	\$0.07
Physician - IP Mental Health	\$140	\$0			\$140	0.807	\$113	\$0.00	0.82	\$0.00
Physician - OP Mental Health	\$15,971,610	\$7,541			\$15,979,152	0.807	\$12,889,180	\$65.78	0.82	\$53.68
Physician - Other Practitioner	\$1,638,790	\$774			\$1,639,564	0.807	\$1,322,513	\$6.75	0.82	\$5.51
Physician - PCP	\$82,338	\$39			\$82,377	0.807	\$66,447	\$0.34	0.82	\$0.28
Physician - Specialist	\$74,906	\$35			\$74,941	0.807	\$60,449	\$0.31	0.82	\$0.25
Pharmacy	\$2,723,584	\$71		(\$150,004)	\$2,573,651	0.879	\$2,262,710	\$11.55	1.00	\$11.55
Transportation - Emergency	\$30,746	\$18		\$11,825	\$42,589	1.109	\$47,250	\$0.24	0.82	\$0.20
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$498,494,579	(\$20,010)	\$72,206,906	\$28,663,414	\$599,344,888			\$3,143.76		\$2,572.47
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,207.92		\$3,026.44

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services. Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Tidewater	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$377,234	\$15	\$4,548	\$81,748	\$463,544	1.050	\$486,601	\$3.72	0.82	\$3.04
Ambulatory Surgery Center	\$4,207	\$2			\$4,209	0.807	\$3,395	\$0.03	0.82	\$0.02
Case Management Services	\$0	\$0			\$0	0.807	\$0	\$0.00	0.82	\$0.00
Consumer Directed Services	\$13,108,712	\$1,986	\$204,440	\$70,492	\$13,385,630	1.224	\$16,384,441	\$125.30	0.82	\$102.25
DME/Supplies	\$3,704,008	\$2,163			\$3,706,171	1.109	\$4,111,773	\$31.45	0.82	\$25.66
Emergency	\$7,888	\$3		(\$193)	\$7,698	1.133	\$8,721	\$0.07	0.82	\$0.05
FQHC	\$915	\$0			\$915	0.807	\$738	\$0.01	0.82	\$0.00
Home Health Services	\$17,415	\$6			\$17,420	1.133	\$19,737	\$0.15	0.82	\$0.12
Inpatient - Medical/Surgical	\$2,808,729	\$12,497		\$181,305	\$3,002,531	1.024	\$3,075,349	\$23.52	0.82	\$19.19
Inpatient - Psych	\$7,760	\$0		(\$377)	\$7,383	1.024	\$7,562	\$0.06	0.82	\$0.05
Lab and X-ray Services	\$21,829	\$13			\$21,842	1.109	\$24,232	\$0.19	0.82	\$0.15
Medicare Xover - IP	\$3,269,361	(\$4,362)			\$3,264,999	0.985	\$3,216,024	\$24.60	0.82	\$20.07
Medicare Xover - Nursing Facility	\$1,671,344	(\$2,230)	\$109,898		\$1,779,012	0.985	\$1,752,327	\$13.40	0.82	\$10.94
Medicare Xover - OP	\$1,296,927	(\$1,730)			\$1,295,197	0.985	\$1,275,769	\$9.76	0.82	\$7.96
Medicare Xover - Other	\$1,271,878	(\$1,697)			\$1,270,181	0.985	\$1,251,128	\$9.57	0.82	\$7.81
Medicare Xover - Physician	\$4,031,196	(\$5,378)			\$4,025,818	0.985	\$3,965,431	\$30.33	0.82	\$24.75
Nursing Facility	\$235,846,870	(\$28,839)	\$69,317,181	\$19,897,924	\$325,033,136	0.970	\$315,194,404	\$2,410.51	0.82	\$1,966.98
Outpatient - Other	\$174,717	\$59		(\$4,120)	\$170,657	1.133	\$193,346	\$1.48	0.82	\$1.21
Outpatient - Psychological	\$0	\$0			\$0	1.133	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$81,118,129	\$12,291	646367.19	\$431,431	\$82,208,218	1.224	\$100,625,497	\$769.55	0.82	\$627.96
Physician - Clinic	\$25,780	\$12			\$25,792	0.807	\$20,805	\$0.16	0.82	\$0.13
Physician - IP Mental Health	\$687	\$0			\$687	0.807	\$554	\$0.00	0.82	\$0.00
Physician - OP Mental Health	\$19,827,132	\$9,362			\$19,836,493	0.807	\$16,000,608	\$122.37	0.82	\$99.85
Physician - Other Practitioner	\$575,871	\$272			\$576,143	0.807	\$464,731	\$3.55	0.82	\$2.90
Physician - PCP	\$50,134	\$24			\$50,158	0.807	\$40,459	\$0.31	0.82	\$0.25
Physician - Specialist	\$53,584	\$25			\$53,609	0.807	\$43,243	\$0.33	0.82	\$0.27
Pharmacy	\$1,693,304	\$44		(\$93,260)	\$1,600,088	0.879	\$1,406,770	\$10.76	1.00	\$10.76
Transportation - Emergency	\$14,386	\$8		\$5,533	\$19,927	1.109	\$22,108	\$0.17	0.82	\$0.14
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$370,979,996	(\$5,453)	\$70,282,434	\$20,570,483	\$461,827,459			\$3,618.70		\$2,959.88
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,692.56		\$3,482.21

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services. Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
All Regions	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$9,233,907	\$361	\$141,272	\$1,877,938	\$11,253,478	1.050	\$11,813,232	\$17.18	0.82	\$14.02
Ambulatory Surgery Center	\$13,058	\$6			\$13,064	0.807	\$10,538	\$0.02	0.82	\$0.01
Case Management Services	\$79,557	\$38			\$79,594	0.807	\$64,203	\$0.09	0.82	\$0.08
Consumer Directed Services	\$145,022,428	\$21,973	\$1,937,496	\$778,138	\$147,760,035	1.224	\$180,863,025	\$262.97	0.82	\$214.58
DME/Supplies	\$15,772,026	\$9,212			\$15,781,238	1.109	\$17,508,331	\$25.46	0.82	\$20.77
Emergency	\$40,978	\$14		(\$1,002)	\$39,991	1.133	\$45,307	\$0.07	0.82	\$0.05
FQHC	\$7,654	\$4			\$7,658	0.807	\$6,177	\$0.01	0.82	\$0.01
Home Health Services	\$146,917	\$50			\$146,967	1.133	\$166,507	\$0.24	0.82	\$0.20
Inpatient - Medical/Surgical	\$17,077,150	\$75,980		\$1,102,341	\$18,255,472	1.024	\$18,698,210	\$27.19	0.82	\$22.18
Inpatient - Psych	\$754,818	\$0		(\$36,713)	\$718,106	1.024	\$735,521	\$1.07	0.82	\$0.87
Lab and X-ray Services	\$99,962	\$58			\$100,021	1.109	\$110,967	\$0.16	0.82	\$0.13
Medicare Xover - IP	\$17,418,463	(\$23,239)			\$17,395,224	0.985	\$17,134,296	\$24.91	0.82	\$20.33
Medicare Xover - Nursing Facility	\$10,662,575	(\$14,225)	\$302,246		\$10,950,596	0.985	\$10,786,337	\$15.68	0.82	\$12.80
Medicare Xover - OP	\$7,724,352	(\$10,305)			\$7,714,047	0.985	\$7,598,336	\$11.05	0.82	\$9.01
Medicare Xover - Other	\$6,309,583	(\$8,418)			\$6,301,165	0.985	\$6,206,648	\$9.02	0.82	\$7.36
Medicare Xover - Physician	\$17,734,544	(\$23,660)			\$17,710,884	0.985	\$17,445,221	\$25.36	0.82	\$20.70
Nursing Facility	\$1,323,180,866	(\$161,795)	\$321,453,425	\$111,634,097	\$1,756,106,594	0.970	\$1,702,949,358	\$2,476.04	0.82	\$2,020.45
Outpatient - Other	\$1,392,053	\$474		(\$32,825)	\$1,359,701	1.133	\$1,540,479	\$2.24	0.82	\$1.83
Outpatient - Psychological	\$0	\$0			\$0	1.133	\$0	\$0.00	1.00	\$0.00
Personal Care Services	\$320,586,935	\$48,574	\$2,876,584	\$1,706,759	\$325,218,851	1.224	\$398,078,311	\$578.79	0.82	\$472.30
Physician - Clinic	\$109,180	\$52			\$109,231	0.807	\$88,109	\$0.13	0.82	\$0.10
Physician - IP Mental Health	\$1,818	\$1			\$1,819	0.807	\$1,468	\$0.00	0.82	\$0.00
Physician - OP Mental Health	\$72,525,446	\$34,245			\$72,559,691	0.807	\$58,528,447	\$85.10	0.82	\$69.44
Physician - Other Practitioner	\$4,686,199	\$2,213			\$4,688,411	0.807	\$3,781,789	\$5.50	0.82	\$4.49
Physician - PCP	\$391,578	\$185			\$391,763	0.807	\$316,006	\$0.46	0.82	\$0.37
Physician - Specialist	\$284,856	\$135			\$284,991	0.807	\$229,880	\$0.33	0.82	\$0.27
Pharmacy	\$9,010,646	\$234		(\$496,269)	\$8,514,612	0.879	\$7,485,903	\$10.88	1.00	\$10.88
Transportation - Emergency	\$95,539	\$56		\$36,746	\$132,340	1.109	\$146,824	\$0.21	0.82	\$0.17
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$1,980,363,090	(\$47,780)	\$326,711,023	\$116,569,210	\$2,423,595,543			\$3,607.55		\$2,950.80
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,681.17		\$3,471.53

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services. Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Northern Virginia	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$63,835	\$2		\$11,738	\$75,575	1.050	\$79,335	\$7.96	0.82	\$6.49
Ambulatory Surgery Center	\$9,177	\$8			\$9,185	0.943	\$8,661	\$0.87	0.82	\$0.71
Case Management Services	\$100	\$0			\$100	0.943	\$94	\$0.01	0.82	\$0.01
Consumer Directed Services	\$4,189,092	\$635	\$12,229	\$22,246	\$4,224,201	1.224	\$5,170,557	\$518.67	0.82	\$423.23
DME/Supplies	\$844,355	\$429			\$844,784	1.090	\$920,940	\$92.38	0.82	\$75.38
Emergency	\$530,893	\$1,432		(\$7,930)	\$524,394	1.238	\$648,988	\$65.10	0.82	\$53.12
FQHC	\$8,077	\$7			\$8,084	0.943	\$7,624	\$0.76	0.82	\$0.62
Home Health Services	\$468,428	\$1,263			\$469,691	1.238	\$581,288	\$58.31	0.82	\$47.58
Inpatient - Medical/Surgical	\$7,974,438	\$4,126		\$512,740	\$8,491,304	1.016	\$8,624,394	\$865.13	0.82	\$705.94
Inpatient - Psych	\$18,194	\$0		(\$885)	\$17,309	1.016	\$17,580	\$1.76	0.82	\$1.44
Lab and X-ray Services	\$333,872	\$170			\$334,041	1.090	\$364,155	\$36.53	0.82	\$29.81
Medicare Xover - IP	\$1,132	\$0			\$1,132	1.000	\$1,132	\$0.11	1.00	\$0.11
Medicare Xover - Nursing Facility	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - OP	\$65	\$0			\$65	1.000	\$65	\$0.01	1.00	\$0.01
Medicare Xover - Other	\$301	\$0			\$301	1.000	\$301	\$0.03	1.00	\$0.03
Medicare Xover - Physician	\$7	\$0			\$7	1.000	\$7	\$0.00	1.00	\$0.00
Nursing Facility	\$22,444,824	\$4,284	\$1,589,282	\$1,894,218	\$25,932,608	0.938	\$24,337,305	\$2,441.32	0.82	\$1,992.11
Outpatient - Other	\$1,501,804	\$4,051		(\$34,496)	\$1,471,359	1.238	\$1,820,948	\$182.66	0.82	\$149.05
Outpatient - Psychological	\$0	\$0			\$0	1.238	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$8,221,885	\$1,246	16596.72	\$43,470	\$8,283,198	1.224	\$10,138,901	\$1,017.05	0.82	\$829.91
Physician - Clinic	\$914,221	\$817			\$915,038	0.943	\$862,897	\$86.56	0.82	\$70.63
Physician - IP Mental Health	\$154	\$0			\$154	0.943	\$145	\$0.01	0.82	\$0.01
Physician - OP Mental Health	\$2,076,261	\$1,855			\$2,078,116	0.943	\$1,959,700	\$196.58	0.82	\$160.41
Physician - Other Practitioner	\$404,511	\$361			\$404,872	0.943	\$381,802	\$38.30	0.82	\$31.25
Physician - PCP	\$1,055,933	\$943			\$1,056,877	0.943	\$996,653	\$99.98	0.82	\$81.58
Physician - Specialist	\$773,531	\$691			\$774,222	0.943	\$730,105	\$73.24	0.82	\$59.76
Pharmacy	\$5,801,778	\$95		(\$1,997,762)	\$3,804,111	0.995	\$3,784,232	\$379.60	1.00	\$379.60
Transportation - Emergency	\$86,871	\$44		\$19,094	\$106,009	1.090	\$115,566	\$11.59	0.82	\$9.46
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$57,723,737	\$22,459	\$1,618,107	\$462,434	\$59,826,737			\$6,201.91		\$5,135.67
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$6,328.47		\$6,041.96

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Other MSA	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$45,485	\$2		\$9,739	\$55,226	1.050	\$57,973	\$7.32	0.82	\$5.98
Ambulatory Surgery Center	\$13,064	\$12			\$13,076	0.943	\$12,331	\$1.56	0.82	\$1.27
Case Management Services	\$47	\$0			\$47	0.943	\$44	\$0.01	0.82	\$0.00
Consumer Directed Services	\$2,290,742	\$347	\$3,815	\$12,149	\$2,307,054	1.224	\$2,823,908	\$356.79	0.82	\$291.14
DME/Supplies	\$768,277	\$390			\$768,667	1.090	\$837,961	\$105.87	0.82	\$86.39
Emergency	\$322,092	\$869		(\$4,811)	\$318,149	1.238	\$393,740	\$49.75	0.82	\$40.59
FQHC	\$51,537	\$46			\$51,583	0.943	\$48,644	\$6.15	0.82	\$5.02
Home Health Services	\$455,728	\$1,229			\$456,957	1.238	\$565,528	\$71.45	0.82	\$58.31
Inpatient - Medical/Surgical	\$7,875,507	\$4,075		\$506,379	\$8,385,961	1.016	\$8,517,399	\$1,076.15	0.82	\$878.14
Inpatient - Psych	\$35,012	\$0		(\$1,703)	\$33,309	1.016	\$33,831	\$4.27	0.82	\$3.49
Lab and X-ray Services	\$317,967	\$161			\$318,129	1.090	\$346,808	\$43.82	0.82	\$35.76
Medicare Xover - IP	\$653	\$0			\$653	1.000	\$653	\$0.08	1.00	\$0.08
Medicare Xover - Nursing Facility	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - OP	\$252	\$0			\$252	1.000	\$252	\$0.03	1.00	\$0.03
Medicare Xover - Other	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Physician	\$536	\$0			\$536	1.000	\$536	\$0.07	1.00	\$0.07
Nursing Facility	\$17,157,254	\$3,275	\$827,650	\$1,447,976	\$19,436,155	0.938	\$18,240,496	\$2,304.64	0.82	\$1,880.58
Outpatient - Other	\$1,628,415	\$4,392		(\$37,404)	\$1,595,403	1.238	\$1,974,464	\$249.47	0.82	\$203.57
Outpatient - Psychological	\$0	\$0			\$0	1.238	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$2,533,359	\$384	6133.68	\$13,400	\$2,553,276	1.224	\$3,125,292	\$394.87	0.82	\$322.22
Physician - Clinic	\$395,173	\$353			\$395,527	0.943	\$372,989	\$47.13	0.82	\$38.45
Physician - IP Mental Health	\$2,312	\$2			\$2,314	0.943	\$2,182	\$0.28	0.82	\$0.23
Physician - OP Mental Health	\$1,121,250	\$1,002			\$1,122,252	0.943	\$1,058,303	\$133.71	0.82	\$109.11
Physician - Other Practitioner	\$384,221	\$343			\$384,564	0.943	\$362,651	\$45.82	0.82	\$37.39
Physician - PCP	\$847,391	\$757			\$848,148	0.943	\$799,819	\$101.05	0.82	\$82.46
Physician - Specialist	\$605,159	\$541			\$605,700	0.943	\$571,186	\$72.17	0.82	\$58.89
Pharmacy	\$5,062,582	\$82		(\$1,743,230)	\$3,319,434	0.995	\$3,302,088	\$417.21	1.00	\$417.21
Transportation - Emergency	\$183,313	\$93		\$40,292	\$223,698	1.090	\$243,864	\$30.81	0.82	\$25.14
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$42,097,327	\$18,355	\$837,598	\$242,789	\$43,196,069			\$5,547.86		\$4,608.90
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,661.09		\$5,422.23

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$418,183	\$16	\$6,152	\$90,859	\$515,211	1.050	\$540,837	\$47.89	0.82	\$39.08
Ambulatory Surgery Center	\$22,237	\$20			\$22,257	0.943	\$20,988	\$1.86	0.82	\$1.52
Case Management Services	\$0	\$0			\$0	0.943	\$0	\$0.00	0.82	\$0.00
Consumer Directed Services	\$4,391,663	\$665	\$3,181	\$23,270	\$4,418,780	1.224	\$5,408,729	\$478.93	0.82	\$390.80
DME/Supplies	\$1,525,573	\$775			\$1,526,348	1.090	\$1,663,947	\$147.34	0.82	\$120.23
Emergency	\$667,666	\$1,801		(\$9,973)	\$659,493	1.238	\$816,186	\$72.27	0.82	\$58.97
FQHC	\$76,990	\$69			\$77,059	0.943	\$72,668	\$6.43	0.82	\$5.25
Home Health Services	\$541,200	\$1,460			\$542,660	1.238	\$671,594	\$59.47	0.82	\$48.53
Inpatient - Medical/Surgical	\$10,475,733	\$5,420		\$673,568	\$11,154,722	1.016	\$11,329,556	\$1,003.20	0.82	\$818.61
Inpatient - Psych	\$40,318	\$0		(\$1,961)	\$38,357	1.016	\$38,958	\$3.45	0.82	\$2.81
Lab and X-ray Services	\$382,589	\$194			\$382,783	1.090	\$417,291	\$36.95	0.82	\$30.15
Medicare Xover - IP	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Nursing Facility	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - OP	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Other	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Physician	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Nursing Facility	\$18,870,669	\$3,602	\$1,035,349	\$1,592,579	\$21,502,198	0.938	\$20,179,442	\$1,786.82	0.82	\$1,458.05
Outpatient - Other	\$2,978,493	\$8,033		(\$68,414)	\$2,918,111	1.238	\$3,611,443	\$319.78	0.82	\$260.94
Outpatient - Psychological	\$0	\$0			\$0	1.238	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$5,825,600	\$883	18857.47	\$30,838	\$5,876,179	1.224	\$7,192,631	\$636.88	0.82	\$519.70
Physician - Clinic	\$901,785	\$806			\$902,590	0.943	\$851,159	\$75.37	0.82	\$61.50
Physician - IP Mental Health	\$498	\$0			\$498	0.943	\$470	\$0.04	0.82	\$0.03
Physician - OP Mental Health	\$2,044,744	\$1,827			\$2,046,571	0.943	\$1,929,953	\$170.89	0.82	\$139.45
Physician - Other Practitioner	\$899,801	\$804			\$900,604	0.943	\$849,286	\$75.20	0.82	\$61.36
Physician - PCP	\$889,689	\$795			\$890,484	0.943	\$839,742	\$74.36	0.82	\$60.67
Physician - Specialist	\$798,868	\$714			\$799,581	0.943	\$754,019	\$66.77	0.82	\$54.48
Pharmacy	\$5,389,322	\$88		(\$1,855,738)	\$3,533,672	0.995	\$3,515,206	\$311.26	1.00	\$311.26
Transportation - Emergency	\$203,231	\$103		\$44,670	\$248,005	1.090	\$270,362	\$23.94	0.82	\$19.53
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$57,344,850	\$28,074	\$1,063,540	\$519,699	\$58,956,163			\$5,426.47		\$4,490.31
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,537.22		\$5,282.72

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Rural	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$18,551	\$1		\$3,972	\$22,524	1.050	\$23,645	\$1.92	0.82	\$1.56
Ambulatory Surgery Center	\$27,616	\$25			\$27,640	0.943	\$26,065	\$2.11	0.82	\$1.72
Case Management Services	\$5,558	\$5			\$5,563	0.943	\$5,246	\$0.43	0.82	\$0.35
Consumer Directed Services	\$4,651,545	\$705	\$14,494	\$24,706	\$4,691,450	1.224	\$5,742,485	\$465.67	0.82	\$379.99
DME/Supplies	\$1,598,577	\$812			\$1,599,389	1.090	\$1,743,572	\$141.39	0.82	\$115.37
Emergency	\$652,397	\$1,760		(\$9,745)	\$644,412	1.238	\$797,521	\$64.67	0.82	\$52.77
FQHC	\$252,878	\$226			\$253,104	0.943	\$238,682	\$19.36	0.82	\$15.79
Home Health Services	\$895,851	\$2,416			\$898,267	1.238	\$1,111,692	\$90.15	0.82	\$73.56
Inpatient - Medical/Surgical	\$11,089,691	\$5,738		\$713,045	\$11,808,474	1.016	\$11,993,555	\$972.58	0.82	\$793.62
Inpatient - Psych	\$21,624	\$0		(\$1,052)	\$20,573	1.016	\$20,895	\$1.69	0.82	\$1.38
Lab and X-ray Services	\$488,589	\$248			\$488,837	1.090	\$532,906	\$43.21	0.82	\$35.26
Medicare Xover - IP	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Nursing Facility	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - OP	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Other	\$14	\$0			\$14	1.000	\$14	\$0.00	1.00	\$0.00
Medicare Xover - Physician	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Nursing Facility	\$20,050,786	\$3,827	\$557,629	\$1,692,174	\$22,304,416	0.938	\$20,932,310	\$1,697.44	0.82	\$1,385.11
Outpatient - Other	\$2,486,643	\$6,707		(\$57,117)	\$2,436,233	1.238	\$3,015,073	\$244.50	0.82	\$199.51
Outpatient - Psychological	\$0	\$0			\$0	1.238	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$5,320,197	\$806	15865.15	\$28,156	\$5,365,024	1.224	\$6,566,962	\$532.53	0.82	\$434.54
Physician - Clinic	\$640,183	\$572			\$640,755	0.943	\$604,244	\$49.00	0.82	\$39.98
Physician - IP Mental Health	\$2,321	\$2			\$2,323	0.943	\$2,191	\$0.18	0.82	\$0.14
Physician - OP Mental Health	\$1,882,666	\$1,682			\$1,884,348	0.943	\$1,776,974	\$144.10	0.82	\$117.58
Physician - Other Practitioner	\$460,700	\$412			\$461,111	0.943	\$434,836	\$35.26	0.82	\$28.77
Physician - PCP	\$1,415,942	\$1,265			\$1,417,207	0.943	\$1,336,452	\$108.38	0.82	\$88.43
Physician - Specialist	\$903,336	\$807			\$904,143	0.943	\$852,623	\$69.14	0.82	\$56.42
Pharmacy	\$8,529,836	\$139		(\$2,937,131)	\$5,592,845	0.995	\$5,563,619	\$451.16	1.00	\$451.16
Transportation - Emergency	\$301,373	\$153		\$66,242	\$367,768	1.090	\$400,922	\$32.51	0.82	\$26.53
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$61,696,874	\$28,306	\$587,989	(\$476,749)	\$61,836,420			\$5,194.75		\$4,326.97
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,300.76		\$5,090.55

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Tidewater	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$14,610	\$1		\$3,128	\$17,739	1.050	\$18,621	\$1.35	0.82	\$1.11
Ambulatory Surgery Center	\$21,119	\$19			\$21,138	0.943	\$19,934	\$1.45	0.82	\$1.18
Case Management Services	\$0	\$0			\$0	0.943	\$0	\$0.00	0.82	\$0.00
Consumer Directed Services	\$1,257,102	\$190	\$4,281	\$6,679	\$1,268,252	1.224	\$1,552,381	\$112.89	0.82	\$92.12
DME/Supplies	\$1,546,026	\$785			\$1,546,811	1.090	\$1,686,255	\$122.63	0.82	\$100.07
Emergency	\$768,518	\$2,073		(\$11,480)	\$759,111	1.238	\$939,473	\$68.32	0.82	\$55.75
FQHC	\$35,440	\$32			\$35,471	0.943	\$33,450	\$2.43	0.82	\$1.99
Home Health Services	\$834,535	\$2,251			\$836,786	1.238	\$1,035,603	\$75.31	0.82	\$61.46
Inpatient - Medical/Surgical	\$11,476,407	\$5,938		\$737,910	\$12,220,255	1.016	\$12,411,790	\$902.63	0.82	\$736.54
Inpatient - Psych	\$25,368	\$0		(\$1,234)	\$24,134	1.016	\$24,512	\$1.78	0.82	\$1.45
Lab and X-ray Services	\$477,527	\$243			\$477,769	1.090	\$520,840	\$37.88	0.82	\$30.91
Medicare Xover - IP	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Nursing Facility	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - OP	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - Other	\$21	\$0			\$21	1.000	\$21	\$0.00	1.00	\$0.00
Medicare Xover - Physician	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Nursing Facility	\$28,355,422	\$5,412	\$2,103,688	\$2,393,039	\$32,857,560	0.938	\$30,836,254	\$2,242.52	0.82	\$1,829.90
Outpatient - Other	\$2,367,576	\$6,386		(\$54,382)	\$2,319,579	1.238	\$2,870,702	\$208.77	0.82	\$170.35
Outpatient - Psychological	\$0	\$0			\$0	1.238	\$0	\$0.00	0.82	\$0.00
Personal Care Services	\$9,979,733	\$1,512	36698.53	\$52,852	\$10,070,795	1.224	\$12,326,976	\$896.46	0.82	\$731.51
Physician - Clinic	\$1,351,590	\$1,208			\$1,352,798	0.943	\$1,275,712	\$92.77	0.82	\$75.70
Physician - IP Mental Health	\$1,701	\$2			\$1,703	0.943	\$1,606	\$0.12	0.82	\$0.10
Physician - OP Mental Health	\$3,274,814	\$2,926			\$3,277,740	0.943	\$3,090,967	\$224.79	0.82	\$183.43
Physician - Other Practitioner	\$869,763	\$777			\$870,540	0.943	\$820,935	\$59.70	0.82	\$48.72
Physician - PCP	\$1,559,740	\$1,394			\$1,561,134	0.943	\$1,472,177	\$107.06	0.82	\$87.36
Physician - Specialist	\$1,056,263	\$944			\$1,057,207	0.943	\$996,965	\$72.50	0.82	\$59.16
Pharmacy	\$8,237,678	\$134		(\$2,836,530)	\$5,401,282	0.995	\$5,373,057	\$390.75	1.00	\$390.75
Transportation - Emergency	\$202,866	\$103		\$44,590	\$247,559	1.090	\$269,876	\$19.63	0.82	\$16.02
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$73,713,818	\$32,327	\$2,144,667	\$334,572	\$76,225,384			\$5,669.13		\$4,702.94
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,784.82		\$5,532.88

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
All Regions	Medicaid Payments FY11 - FY12	Completion Factor Adjustment	Patient Payments FY11 - FY12	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY14	Managed Care Utilization Adjustment	PACE PMPM FY14
Service Type										
Adult Day Care	\$560,664	\$22	\$6,152	\$119,437	\$686,275	1.050	\$720,411	\$13.04	0.82	\$10.64
Ambulatory Surgery Center	\$93,213	\$83			\$93,296	0.943	\$87,980	\$1.59	0.82	\$1.30
Case Management Services	\$5,704	\$5			\$5,709	0.943	\$5,384	\$0.10	0.82	\$0.08
Consumer Directed Services	\$16,780,144	\$2,542	\$37,999	\$89,050	\$16,909,736	1.224	\$20,698,060	\$374.56	0.82	\$305.64
DME/Supplies	\$6,282,808	\$3,191			\$6,285,998	1.090	\$6,852,676	\$124.01	0.82	\$101.19
Emergency	\$2,941,565	\$7,934		(\$43,939)	\$2,905,559	1.238	\$3,595,909	\$65.07	0.82	\$53.10
FQHC	\$424,922	\$380			\$425,302	0.943	\$401,067	\$7.26	0.82	\$5.92
Home Health Services	\$3,195,743	\$8,619			\$3,204,362	1.238	\$3,965,706	\$71.77	0.82	\$58.56
Inpatient - Medical/Surgical	\$48,891,776	\$25,297		\$3,143,642	\$52,060,715	1.016	\$52,876,694	\$956.88	0.82	\$780.81
Inpatient - Psych	\$140,515	\$0		(\$6,834)	\$133,681	1.016	\$135,776	\$2.46	0.82	\$2.00
Lab and X-ray Services	\$2,000,543	\$1,016			\$2,001,559	1.090	\$2,181,998	\$39.49	0.82	\$32.22
Medicare Xover - IP	\$1,785	\$0			\$1,785	1.000	\$1,785	\$0.03	1.00	\$0.03
Medicare Xover - Nursing Facility	\$0	\$0			\$0	1.000	\$0	\$0.00	1.00	\$0.00
Medicare Xover - OP	\$317	\$0			\$317	1.000	\$317	\$0.01	1.00	\$0.01
Medicare Xover - Other	\$336	\$0			\$336	1.000	\$336	\$0.01	1.00	\$0.01
Medicare Xover - Physician	\$543	\$0			\$543	1.000	\$543	\$0.01	1.00	\$0.01
Nursing Facility	\$106,878,955	\$20,398	\$6,113,598	\$9,019,985	\$122,032,937	0.938	\$114,525,807	\$2,072.51	0.82	\$1,691.17
Outpatient - Other	\$10,962,930	\$29,568		(\$251,812)	\$10,740,686	1.238	\$13,292,630	\$240.55	0.82	\$196.29
Outpatient - Psychological	\$0	\$0			\$0	1.238	\$0	\$0.00	1.00	\$0.00
Personal Care Services	\$31,880,774	\$4,830	\$94,152	\$168,716	\$32,148,472	1.224	\$39,350,762	\$712.11	0.82	\$581.08
Physician - Clinic	\$4,202,953	\$3,755			\$4,206,708	0.943	\$3,967,001	\$71.79	0.82	\$58.58
Physician - IP Mental Health	\$6,986	\$6			\$6,992	0.943	\$6,594	\$0.12	0.82	\$0.10
Physician - OP Mental Health	\$10,399,734	\$9,292			\$10,409,026	0.943	\$9,815,897	\$177.63	0.82	\$144.95
Physician - Other Practitioner	\$3,018,995	\$2,697			\$3,021,692	0.943	\$2,849,510	\$51.57	0.82	\$42.08
Physician - PCP	\$5,768,695	\$5,154			\$5,773,849	0.943	\$5,444,843	\$98.53	0.82	\$80.40
Physician - Specialist	\$4,137,157	\$3,696			\$4,140,853	0.943	\$3,904,899	\$70.66	0.82	\$57.66
Pharmacy	\$33,021,195	\$538		(\$11,370,390)	\$21,651,344	0.995	\$21,538,202	\$389.76	1.00	\$389.76
Transportation - Emergency	\$977,654	\$497		\$214,888	\$1,193,039	1.090	\$1,300,590	\$23.54	0.82	\$19.21
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$292,576,607	\$129,521	\$6,251,901	\$1,082,744	\$300,040,773			\$5,592.42		\$4,640.18
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,706.55		\$5,459.03

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

**Virginia Medicaid
 FY 2014 PACE Capitation Rate Development
 Summary of FY 2014 Capitation Rates
 Before Nursing Home vs Non-Nursing Home Blending Factor Adjustment**

Region	Dual Eligibles FY 2014	Non-Dual Eligibles FY 2014	Weighted Average FY 2014	Difference from UPL Rates
PACE Rates				
Northern Virginia	\$4,240.72	\$6,041.96	\$4,405.48	-5.6%
Other MSA	\$3,517.56	\$5,422.23	\$3,627.06	-5.6%
Richmond/Charlottesville	\$3,499.36	\$5,282.72	\$3,639.61	-5.6%
Rural	\$3,026.44	\$5,090.55	\$3,148.66	-5.5%
Tidewater	\$3,482.21	\$5,532.88	\$3,677.34	-5.5%
Statewide Average weighted by PACE Eligibles	\$3,471.53	\$5,391.64	\$3,614.33	-5.6%

Region	Dual Eligibles FY 2014	Non-Dual Eligibles FY 2014	Weighted Average FY 2014
UPL			
Northern Virginia	\$4,499.11	\$6,328.47	\$4,666.45
Other MSA	\$3,729.60	\$5,661.09	\$3,840.65
Richmond/Charlottesville	\$3,711.17	\$5,537.22	\$3,854.78
Rural	\$3,207.92	\$5,300.76	\$3,331.84
Tidewater	\$3,692.56	\$5,784.82	\$3,891.64
Statewide Average weighted by PACE Eligibles	\$3,681.17	\$5,639.78	\$3,826.84

Note:
 Percent change and weighted average by region based on historical member months for PACE eligibles.

**Virginia Medicaid
 FY 2014 PACE Capitation Rate Development
 Historical Fee-For-Service Claims
 Nursing Home vs Non-Nursing Home Blending Factor**

Dual Population

Region	Cost		Statewide NH Blending	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.25	0.71	59.0%	1.0271
Other MSA	1.26	0.43	59.0%	0.9204
Richmond/Charlottesville	1.30	0.59	59.0%	1.0105
Rural	1.35	0.54	59.0%	1.0188
Tidewater	1.18	0.75	59.0%	1.0032

Non-Dual Population

Region	Cost		Statewide NH Blending	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.36	0.68	45.8%	0.9960
Other MSA	1.41	0.55	45.8%	0.9432
Richmond/Charlottesville	1.57	0.63	45.8%	1.0639
Rural	1.43	0.69	45.8%	1.0286
Tidewater	1.27	0.72	45.8%	0.9733

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Comparison of Capitation Rates
Before and After Blending Factor Adjustment**

Exhibit 5c

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change
PACE Rates									
Northern Virginia	\$4,240.72	\$4,355.78	2.7%	\$6,041.96	\$6,017.67	-0.4%	\$4,405.48	\$4,507.80	2.3%
Other MSA	\$3,517.56	\$3,237.49	-8.0%	\$5,422.23	\$5,114.21	-5.7%	\$3,627.06	\$3,345.38	-7.8%
Richmond/Charlottesville	\$3,499.36	\$3,536.16	1.1%	\$5,282.72	\$5,620.21	6.4%	\$3,639.61	\$3,700.06	1.7%
Rural	\$3,026.44	\$3,083.21	1.9%	\$5,090.55	\$5,235.91	2.9%	\$3,148.66	\$3,210.68	2.0%
Tidewater	\$3,482.21	\$3,493.32	0.3%	\$5,532.88	\$5,385.17	-2.7%	\$3,677.34	\$3,673.34	-0.1%
Statewide Average weighted by PACE Eligibles	\$3,471.53	\$3,460.62	-0.3%	\$5,391.64	\$5,475.19	1.5%	\$3,614.33	\$3,610.45	-0.1%
Statewide Average weighted by PACE Enrollees*	\$3,384.13	\$3,412.77	0.8%	\$5,391.64	\$5,453.67	1.2%	\$3,519.16	\$3,550.05	0.9%

Note:

Percent change and weighted average by region based on historical member months for PACE eligibles.

*Statewide weighted average based on February 2013 PACE Enrollees.

**Virginia Medicaid
 FY 2014 PACE Capitation Rate Development
 Summary of FY 2014 Capitation Rates
 After Nursing vs Non-Nursing Home Blending Factor Adjustment**

Region	Dual Eligibles FY 2014	Non-Dual Eligibles FY 2014	Weighted Average FY 2014	Difference from UPL Rates
PACE Rates				
Northern Virginia	\$4,355.78	\$6,017.67	\$4,507.80	-5.6%
Other MSA	\$3,237.49	\$5,114.21	\$3,345.38	-5.6%
Richmond/Charlottesville	\$3,536.16	\$5,620.21	\$3,700.06	-5.6%
Rural	\$3,083.21	\$5,235.91	\$3,210.68	-5.5%
Tidewater	\$3,493.32	\$5,385.17	\$3,673.34	-5.5%
Statewide Average weighted by PACE Eligibles	\$3,460.62	\$5,475.19	\$3,610.45	-5.5%
Statewide Average weighted by PACE Enrollees*	\$3,412.77	\$5,453.67	\$3,550.05	-5.6%

Region	Dual Eligibles FY 2014	Non-Dual Eligibles FY 2014	Weighted Average FY 2014
UPL			
Northern Virginia	\$4,621.19	\$6,303.03	\$4,775.03
Other MSA	\$3,432.65	\$5,339.50	\$3,542.28
Richmond/Charlottesville	\$3,750.20	\$5,890.96	\$3,918.56
Rural	\$3,268.10	\$5,452.12	\$3,397.42
Tidewater	\$3,704.33	\$5,630.39	\$3,887.61
Statewide Average weighted by PACE Eligibles	\$3,669.62	\$5,723.54	\$3,822.37
Statewide Average weighted by PACE Enrollees*	\$3,618.74	\$5,704.89	\$3,759.05

Note:
 Percent change and weighted average by region based on historical member months for PACE eligibles.
 *Statewide weighted average based on February 2013 PACE Enrollees.

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Comparison of FY 2013 and FY 2014 Capitation Rates

Exhibit 5e

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	FY 2013	FY 2014	% Change	FY 2013	FY 2014	% Change	FY 2013	FY 2014	% Change
PACE Rates									
Northern Virginia	\$4,329.77	\$4,355.78	0.6%	\$5,901.86	\$6,017.67	2.0%	\$4,473.57	\$4,507.80	0.8%
Other MSA	\$3,219.15	\$3,237.49	0.6%	\$4,696.49	\$5,114.21	8.9%	\$3,304.09	\$3,345.38	1.2%
Richmond/Charlottesville	\$3,516.09	\$3,536.16	0.6%	\$5,539.27	\$5,620.21	1.5%	\$3,675.20	\$3,700.06	0.7%
Rural	\$3,076.59	\$3,083.21	0.2%	\$4,977.70	\$5,235.91	5.2%	\$3,189.16	\$3,210.68	0.7%
Tidewater	\$3,519.10	\$3,493.32	-0.7%	\$5,302.03	\$5,385.17	1.6%	\$3,688.75	\$3,673.34	-0.4%
Statewide Average weighted by PACE Eligibles	\$3,452.57	\$3,460.62	0.2%	\$5,299.62	\$5,475.19	3.3%	\$3,589.94	\$3,610.45	0.6%
Statewide Average weighted by PACE Enrollees*	\$3,418.68	\$3,412.77	-0.2%	\$5,351.44	\$5,453.67	1.9%	\$3,548.68	\$3,550.05	0.0%

Note:

Percent change and weighted average by region based on historical member months for PACE eligibles.

*Statewide weighted average based on February 2013 PACE Enrollees.

**Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Member Months of Eligibles and Enrollees**

Exhibit 5f

PACE Eligibles, Historical Member Months FY 2011 - FY 2012

Region	Dual Eligibles	Non-Dual Eligibles	Total
Member Months			
Northern Virginia	99,012	9,969	108,981
Other MSA	129,756	7,915	137,671
Richmond/Charlottesville	132,311	11,293	143,604
Rural	195,934	12,332	208,266
Tidewater	130,758	13,751	144,509
Statewide Average	687,771	55,260	743,031

PACE Enrollees, February 2013

Region	Dual Enrollees	Non-Dual Enrollees	Total
Member Months			
Northern Virginia	1	0	1
Other MSA	0	0	0
Richmond/Charlottesville	165	16	181
Rural	139	5	144
Tidewater	305	23	328
Statewide Average	610	44	654

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-For-Service Claims
Description of Unit Counts

Exhibit 6

Service Type	Type of Units
Adult Day Care	Units
Ambulatory Surgery Center	Units
Case Management Services	Units
Consumer Directed Services	Hours
DME/Supplies	Claims
Emergency	Claims
FQHC	Units
Home Health Services	Claims
Inpatient - Medical/Surgical	Admits
Inpatient - Psych	Days
Lab and X-ray Services	Claims
Medicare Xover - IP	Admits
Medicare Xover - Nursing Facility	Days
Medicare Xover - OP	Claims
Medicare Xover - Other	Claims
Medicare Xover - Physician	Claims
Nursing Facility	Days
Outpatient - Other	Claims
Outpatient - Psychological	Claims
Personal Care Services	Units
Pharmacy	Scripts
Physician - Clinic	Units
Physician - IP Mental Health	Units
Physician - OP Mental Health	Units
Physician - Other Practitioner	Units
Physician - PCP	Units
Physician - Specialist	Units
Transportation - Emergency	Claims
Transportation - Non-Emergency	N/A

Virginia Medicaid
FY 2014 PACE Capitation Rate Development
Historical Fee-for-Service Claims
County Listing by Region

Exhibit 7

Northern Virginia	Other MSA	Richmond/Charlottesville	Rural	Tidewater
Alexandria City	Amherst County	Albemarle County	Accomack County	Lexington City
Arlington County	Appomattox County	Amelia County	Alleghany County	Lunenburg County
Clarke County	Bedford City	Caroline County	Augusta County	Madison County
Fairfax City	Bedford County	Charles City County	Bath County	Martinsville City
Fairfax County	Botetourt County	Charlottesville City	Bland County	Mecklenburg County
Falls Church City	Bristol City	Chesterfield County	Brunswick County	Middlesex County
Fauquier County	Campbell County	Colonial Heights City	Buchanan County	Northampton County
Fredericksburg City	Craig County	Cumberland County	Buckingham County	Northumberland County
Loudoun County	Danville City	Dinwiddie County	Buena Vista City	Norton City
Manassas City	Franklin County	Fluvanna County	Carroll County	Nottoway County
Manassas Park City	Frederick County	Goochland County	Charlotte County	Orange County
Prince William County	Giles County	Greene County	Clifton Forge City	Page County
Spotsylvania County	Harrisonburg, City of	Hanover County	Covington City	Patrick County
Stafford County	Lynchburg City	Henrico County	Culpeper County	Prince Edward County
Warren County	Montgomery County	Hopewell City	Dickenson County	Rappahannock County
	Pittsylvania County	King and Queen County	Emporia City	Richmond County
	Pulaski County	King William County	Essex County	Rockbridge County
	Radford, City of	Louisa County	Floyd County	Russell County
	Roanoke City	Nelson County	Franklin City	Shenandoah County
	Roanoke County	New Kent County	Galax City	Smyth County
	Rockingham County	Petersburg City	Grayson County	Southampton County
	Salem City	Powhatan County	Greensville County	Staunton City
	Washington County	Prince George County	Halifax County	Tazewell County
	Winchester, City of	Richmond City	Henry County	Waynesboro City
		Sussex County	Highland County	Westmoreland County
			Lancaster County	Wise County
			King George County	Wythe County
			Lee County	Scott County

Scott County is in Other MSA for Medallion II rate setting, but is moved to Rural for PACE rate setting.
 Bedford County is in Roanoke-Alleghany for Medallion II rate setting, but is retained in Other MSA for PACE rate setting.