Commonwealth of Virginia Department of Medical Assistance Services

Program of All-Inclusive Care for the Elderly (PACE) Data Book and Capitation Rates Fiscal Year 2018

June 2017

Submitted by:

PricewaterhouseCoopers LLP

Three Embarcadero Center

San Francisco, CA 94111

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

June 30, 2017

Dear Bill:

Re: PACE Data Book and Capitation Rates – FY 2018

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for Fiscal Year 2018, effective July 1, 2017 to June 30, 2018, 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 Equivalent 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,

PricewaterhouseCoopers

PricewaterhouseCoopers LLP

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Program of All-Inclusive Care for the Elderly Data Book and Capitation Rates Fiscal Year 2018 Prepared by PricewaterhouseCoopers LLP

June 2017

PricewaterhouseCoopers LLP (PwC) has developed the capitation rates for the Virginia Medicaid Program of All-Inclusive Care for the Elderly (PACE) for State Fiscal Year 2018 for rates effective July 1, 2017. 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 and will be paid to current PACE operators as well as to any expansion sites.

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, and costs for PACE enrollees are not permitted to be used in PACE rate setting.

Our analysis includes data for most 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. For the base period, those in the Home and Community Based Care waiver programs were in either Medicaid Fee-for-Service or in the Medallion 3.0 managed care program. As of December 1, 2014, all people in the Elderly or Disabled with Community Direction (EDCD) Home and Community Based Services (HCBS) waiver are in Medallion 3.0 for their acute care services. All long term care and HCBS are provided through the Medicaid FFS system.

PACE UPL and capitation rate development

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 the CMS requirement that PACE capitation rates be less than the UPL.

We 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 obtained data from DMAS to incorporate the Commonwealth's administrative costs associated with providing services to the PACE eligible population into the UPL calculation. PACE capitation rates were calculated by applying a savings percentage to the UPLs. Finally, we adjusted the rates to reflect changes in the average risk of the PACE eligible population and the expected mix of nursing home and non-nursing home service delivery during the contract period.

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 2015 through 2016 with claims paid through December 2016. 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 UPLs and capitation rates because PACE rate setting guidelines do not permit direct use of encounter data from the contracting PACE plans.

The work in this report builds on analyses performed in developing CY 2018 capitation rates for the Medallion 3.0 program. In the Medallion 3.0 program, special adjustments are made to the historical data to reflect changes in payment arrangements due to other programmatic and legislative adjustments. Where applicable, these same adjustment methodology and 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 are identified by an indicator on each eligibility record that signifies that the member is in a nursing facility or a Home and Community Based Care waiver, primarily those in the Elderly or Disabled with Consumer Direction (EDCD) waiver. There is one exception to the potentially eligible for PACE criteria. We excluded PACE eligibles who enrolled in the Commonwealth Coordinated Care (CCC) Duals Financial Alignment Demonstration and met the criteria for Nursing Home Eligible–Institution or Nursing Home Eligible–Waiver. Once these eligibles are enrolled in CCC, the acute and LTC service costs are the responsibility of the CCC health plan. Because voluntary enrollment in CCC began March 2014 and the first auto-assignment was not until July 2014, the CCC exclusion for the Dual Eligible PACE population impacted the historical base data, including the evaluation of trend factors and changes in risk mix.

All claims and eligibility data for members who are not eligible for the PACE program or are unlikely to enroll 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. A 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 these groups were removed from the database prior to the calculations shown in this report.

Additional costs for PACE eligibles were identified by matching to three other data sets. These are 1) mental and behavioral health encounter data for services managed by Magellan under an administrative services arrangement that began November 1, 2013, 2) FFS data for services associated with consumer-directed personal care services received under the EDCD waiver and 3) managed care encounter data for the Health and Acute Care Program (HAP) population enrolled in managed care organizations who continue to receive acute care services from their health plan and receive LTC services through Medicaid FFS. The costs for the HAP 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 2015 and 2016,
- Medicaid payment amounts for the combined years,

- Patient payment amounts for the combined years[1],
- 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 2015 and 2016 (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. UPL calculations

The UPLs for Fiscal Year 2018 are 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 UPLs are calculated in Exhibits 4a – 4b.

The steps used for calculating the UPLs 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 UPL 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 CY 2018 Medallion 3.0 report and applied to the PACE calculations. Additional adjustments that apply to the PACE eligible group are incorporated into these calculations. These adjustments are described in greater detail in Section IV.
3. The claims data are trended to the FY 2018 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 adjusted claims from Step 3 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 by dual eligibility status and region.
5. The DMAS FFS administrative cost is added.
6. Finally, a savings percentage is applied to the PACE UPLs to produce the PACE capitation rates, ensuring that the capitation rates paid to PACE plans are less than the expected FFS cost in the absence of the PACE program.

IV. Programmatic and legislative adjustments

Prescription drug adjustment

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.

[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.

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. Prescription drug costs for the non-dual population are covered by the Medicaid program and there is no adjustment to those costs in Exhibit 1b.

The DMAS dispensing fee during the data period of FY 2015 and FY 2016 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 2018 average dispensing fees are $3.23 for duals and $3.13 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. Therefore, the majority of the pharmacy claims report $0 copayment. 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. The prescription drugs covered by Medicaid for the dual eligible population contain a different mix of drugs than that used by the non-dual population; the dual mix 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. This mix was considered in calculating the total FFS rebate percentage for the PACE-eligible 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”.

Adult day care fee adjustment

Effective July 1, 2016, there is a 2.5% rate Adult Day Care rate increases across all regions for procedure code S5102. The calculation is shown in Exhibit 2b, and the adjustment is applied in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Hospital inpatient adjustment

The hospital capital percentage averaged 8.9% during the FY 2014- FY 2015 period. The percentage was decreased to 8.5% in FY 2016 and is expected to remain at that value in FY 2018.

There are no unit cost adjustments for either FY 2015 or FY 2016. The Virginia General Assembly authorized a unit cost adjustment for FY 2017 equal to half the regulatory inflation of 2.1%, a value of 1.05%. No further unit cost adjustment was authorized for FY 2018.

Hospital inpatient reimbursements rates were rebased for FY 2017 and an adjustment is applied because this is outside of the base data. For inpatient medical/surgical, the FFS rebasing is a negative adjustment of 7.25%. For inpatient psychiatric in acute care hospitals, the FFS rebasing is a positive adjustment of 27.00%. No further rebasing was applied for FY 2018.

For inpatient medical/surgical, the total adjustment is a negative 5.7%. For inpatient psychiatric in acute care hospitals, the total adjustment is a positive 25.7%. The inpatient psychiatric factor is applied to mental health claims.

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

Outpatient hospital adjustment

There are three adjustments to outpatient hospital for FY 2017. DMAS used to pay outpatient hospital as a percent of cost and rate setting used the outpatient hospital trend based on the historical trend. As of January 1, 2014, DMAS FFS started reimbursing outpatient hospital using Enhanced Ambulatory Patient Groups (EAPGs). Inflation adjustments will now be applied to outpatient hospital rates in the same manner as inpatient hospital. FY 2017 is the first year that outpatient hospital inflation has been modified. Outpatient hospital rates are going to be adjusted by 50% of inflation, a 1.05% unit cost increase.

The outpatient hospital adjustment is structured similarly to the inpatient hospital adjustment. There also is a small FFS outpatient hospital rebasing adjustment of 0.1%.

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

Nursing facility adjustment

Effective FY 2015, DMAS implemented a fully prospective nursing facility payment. The prospective per diem amount includes adjustments for cost settlement, unit cost inflation, capital and operating cost factors, occupancy requirement changes, and any policy changes. The move to prospective payment is now fully reflected in the base data. The hospital capital percentage average 9.5% during the FY 2017 period and is expected to remain at that value in FY 2018.

A 0.9% nursing facility fee increase was applied to the full FY 2015 – FY 2016 base period to project the costs to FY 2017. Effective July 1, 2017, there is an additional 3.1% nursing facility increase..

The FY 2018 nursing facility rebasing adjustment is a negative 0.85%.

The calculation is shown in Exhibit 2e, and the positive 2.9% adjustment is applied in Exhibits 4a to 4c under the column labelled “Policy and Program Adjustments”.

Incontinence Supplies adjustment

DMAS solicited bids for the cost of high volume incontinence supplies, primarily adult diapers and protection pads. When compared to current DMAS payment rates, the bid prices were estimated to produce nearly $2.7 million in savings, or 33% of the cost of the mix of those supplies. These reductions were implemented effective July 1, 2015 for FY 2016. DMAS provided a list of DME incontinence supplies HCPCS codes subject to the bid program and the bid rate for the items. These were used to calculate the dollar cost savings per unit and a savings percentage per affected DME code. This information was applied to the historical FY15 claims to determine the proportion of DME claims subject to the incontinence supplies fee reduction and the average savings percentage based on the mix of DME codes subject to the savings. The historical FY16 claims already reflect the bid prices for high volume incontinence supplies. Overall, about 30.3% of duals and 1.9% of non-duals DME claims costs were for incontinence supply codes subject to the reduction. Savings on this subset are 26.6% and 25.1%, respectively for dual and non-dual eligibles.

This results in adjustment factor reductions of 8.1% and 0.5% as shown in Exhibit 2f. The adjustment is added in Exhibits 4a to 4b under the column labeled “Policy and Program Adjustments.”

ER Triage adjustment

The 2015 General Assembly final Budget conference report eliminated emergency room (ER) triage for physician services effective for FY 2016. Prior DMAS FFS policy applied ER Triage review only to Level III ER claims. If a case was determined to have insufficient documentation of medical necessity for an emergency, DMAS could reduce the physician payment to an all-inclusive rate of $22.06 for the code 99283 instead of paying the physician fee of $43.65 plus ancillaries. Eliminating the ER Triage review increases the Level III ER payment to physicians by the difference in the 99283 physician fee plus the average amount of ancillary services billed on those claims.

The ER Triage adjustment reflects the additional amount estimated to cover the cost of discontinuing Level III Triage review and paying such claims at the average fee for CPT code 99283, plus the average of the ancillary payments that are associated with the claim. The historical base FFS data was analyzed in order to identify the number of Level III ER claims paid at the ER Triage level and was re-priced to reflect DMAS FFS average cost of a Level III professional claim paid in full at $43.65. For Level III claims for non-dual eligibles, this is approximately $5,000 based on the FY 2015 number of claims.

The calculation of the additional cost is presented in Exhibit 2g. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

RBRVS rebasing adjustment

Each year DMAS adjusts physician rates consistent with the Medicare RBRVS update in a budget neutral manner based on funding. Up until recently, the update was based solely on DMAS FFS data. Managed care plans reported that the rebasing is not cost neutral to their operations and that the impact on them varies. Therefore, the analysis was revised and the DMAS update now uses both FFS and MCO data. The FY 2018 DMAS analysis used FFS and the MCO data, as repriced to the DMAS physician fee schedule. Claims covered all professional providers, including physicians, nurse practitioners, psychologists, therapists, opticians, and federally qualified health centers and the full range of CPT codes from 10000 to 99499. The new physician rates for FY18 result in a 0.71% increase to the FFS unit costs. Other codes, such as J codes for drugs administered in an office setting and anaesthesia-related codes that are grouped in the professional service categories, are excluded from the adjustment.

The calculation of the RBRVS adjustment is shown in Exhibit 2h. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

Personal Care and Respite Care adjustment

The 2015 Virginia Appropriation Act increases personal care and respite care rates by 2% effective July 1, 2015. Under the contract, the plans are required to pay at least the Medicaid personal care and respite care rates. As a result, this FY 2016 effective fee change applies to relevant consumer directed services and personal care services claims.

Effective July 1, 2016, there is an additional 2% rate increase to personal care and respite care rates. This is applied to the full base period, excluding overtime payment claims that occurred for six months beginning January 2016.

Codes for personal care and respite care services were also found in the Physician-IP and OP Mental Health categories. Those claims were added to the personal care service line for this adjustment. This results in a cumulative positive adjustment of 2.9% to consumer directed services and a positive adjustment of 3.4% to personal care services.

The calculation of the Personal Care and Respite Care adjustment is shown in Exhibit 2l. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

Consumer Directed Respite Care Overtime adjustment

Effective January 1, 2016, states were required to pay time and a half for hours in excess of 8 hours a day for home care workers providing select home and community based services under the Elderly and Disables with Consumer Direction (EDCD) waiver. This was effective in Virginia for only six months and ended by June 30, 2016. No overtime payments are expected for FY 2018, so the historical claims data was adjusted to carve out excess payment amounts due to overtime during the January 2016 to June 2016 period. The adjustment is broken out by Northern Virginia and Rest of State, since home and community based services in NOVA are paid based on a slightly higher FFS fee schedule. During the six months that overtime was allowed, a negative adjustment of 5.4% and 4.7% was applied to Northern Virginia and Rest of State, respectively.

The calculation of the Consumer Directed Respite Care Overtime adjustment is shown in Exhibit 2j. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

Home Health and Rehab adjustment

Effective July 1, 2016, there was an increase to the fee schedule for home health care and outpatient rehabilitation agencies. The inflation adjustments are a 1.7% to home health care and a 2.1% to outpatient rehabilitative agency. Effective July 1, 2017, additional increases were implemented based on 50% of the FY18 inflation rates; the adjustment reflects a 1.15% fee change to home health care and 1.35% fee change to outpatient rehabilitation agencies. DMAS provided a list of outpatient rehabilitative procedure codes and provider class subject to the fee schedule inflation adjustment. The identified claims are under physician – other practitioner service line.

The calculation of the Home Health and Rehab adjustment is shown in Exhibit 2k. The adjustment is added in Exhibits 4a to 4b under the column labeled "Policy and Program Adjustments."

Non-emergency transportation adjustment

For the populations currently enrolled in fee-for-service, Non-emergency transportation (NET) services were contracted to a broker during the historical data period under a capitated payment methodology, and utilization is not captured in the DMAS FFS claims. The non-emergency transportation adjustment is based on the full cost, including both the service and administrative costs, of the accepted transportation vendor bid that was effective January 1, 2016. The non-emergency transportation adjustment is calculated separately for the CCC Plus populations. The adjustment is based on the service cost component (including the administrative cost) of the current payment rates.

The non-emergency transportation adjustment is based on the service cost component (including the administrative cost) of the accepted bid for the ABAD nursing home population, a statewide rate of $82.46 PMPM for FY 2018 effective January 2016. The PMPM value is shown in Exhibit 2l, and the adjustment is applied in the total UPL column in Exhibits 4a and 4b.

Other adjustments

DMAS Administrative Cost Adjustment

The CMS regulations permit administrative costs directly related to the provision of Medicaid State Plan approved services to be incorporated into the rate-setting process. DMAS estimates that its administrative costs to provide service to the PACE eligible population are 2.0%. This percentage is added to the UPL calculations and to the PACE per capita cost rate development.

This adjustment is shown in Exhibit 2m. 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.

UPL Savings Adjustment

An adjustment is made to reflect savings relative to the FFS system as required under PACE rate setting rules.

These PACE capitation rates reflect 3.5% savings relative to the projected UPL. The savings adjustment was not applied to prescription drugs or non-emergency transportation[3]. A small brand-generic improvement factor for prescription drugs for the non-dual population is incorporated in the Prescription Drug Adjustment described earlier and the non-emergency transportation adjustment is added as the contracted FY 2017 value.

The UPL savings adjustment factor is shown in Exhibit 2m and is applied in Exhibits 4a and 4b under the column labeled “UPL Savings Adjustment”.

V. Trend adjustments

The data used for the IBNR and trend calculations reflect experience for the period FY 2014 through FY 2016. Data for FY 2015 to FY 2016 is used to evaluate the base period trend and an additional year of data, FY 2014 through FY 2016, is used to develop contract period projected trend.

The data must be adjusted to reflect the contract period of FY 2018 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

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

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 estimated through actuarial models.

Trend and IBNR adjustment factors were developed using historical Virginia Medicaid FFS expenditures for FY 2014 to FY 2016 and are calculated separately for the dual and the non-dual populations. We used paid claims information with run out through December 2016 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 PwC 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, Personal Care, Consumer Directed Services, 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.

Annual trend rates are applied to move the historical data from the midpoint of the data period (7/1/2015) to the midpoint of the contract period (1/1/2018), 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 2m 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.

No trend adjustments were applied to nursing home. Nursing home utilization has been observed to decline consistently during the base period. This negative trend is attributed to a consistent shift in mix between enrollees who receive services in nursing homes and those who receive services in the community. Rather than apply this shift as a trend adjustment, we developed and applied a nursing home mix adjustment as described in a later section.

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. The historical data uses FY 2014 as the base year and applies trend adjustments to FY2014 – FY 2016 data as needed.

Table 1 Summary of Adjustments to Trend		
Service	**Time Period**	**PACE Adjustment**
Nursing Facility	Jul 2014 – Jun 2016	0.909
	Jul 2016 – Mar 2017	0.902
Personal Care with Consumer Directed PC*	Jul 2015 – Jun 2016	0.980
	Jul 2016 – Mar 2017	0.961
Inpatient - Med/Surg	Jul 2014 – Jun 2016	1.000
	Jul 2016 – Mar 2017	1.061
Inpatient – Psych	Jul 2014 – Jun 2016	1.000
	Jul 2016 – Mar 2017	0.780
Professional Care	Jul 2015 – Jun 2016	0.986
	Jul 2016 – Mar 2017	0.970
Adult Day Care	Jul 2014 - Jun 2016	1.000
	Jul 2016 - Mar 2017	0.977
Other	Jul 2014 - Jun 2015	Dual 1.019
	Jul 2015 - Mar 2017	Dual 1.046
	Jul 2014 - Mar 2017	Non-Dual 1.034
*Excludes adjustments made for the NH vs HCBS population mix		

The evaluation of nursing home (including Medicare crossover), adult day care, consumer directed services, and personal care services trend included both DMAS and patient payment amounts. Consumer Direction and Personal Care were evaluated as a combined service. 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. For these rates, a number of the dual and non-dual data period trend are negative. Contract period service category trend that is negative in the models is set to 0.0%. The result is that overall Medicaid data period trend is relatively flat and the contract period trend is slightly positive for both dual and non-dual. 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. PACE capitation rates

The UPL savings adjustment is applied to the UPL values to produce the unadjusted PACE capitation rates shown in Exhibit 5a. Averages are weighted by the distribution of eligible member months for the March 2017. Overall, the PACE rates are approximately 3.4% below the Upper Payment Limit, and therefore meet CMS PACE rate setting checklist requirements.

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 percentage of the PACE eligible population in nursing homes has been decreasing over time. It was 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. Five years later, for base period of FY 2015 to FY 2016 used in FY 2018 PACE rate setting, 49.4% of the dual eligible population and 35.3% of the non-dual population was in nursing homes.

Recent data indicates a continuing decline in the proportion of PACE eligibles in nursing facilities. As of March 2017, the proportion of the Dual PACE eligibles in nursing homes was 47.7% and the proportion of non-Dual eligibles in nursing homes was 32.3%. At the same time, the proportion of PACE eligibles using Home and community based services increased. The decrease in the proportion in nursing home over the past five rate setting periods is shown in Table 2.

Table 2
% in Nursing Home
Based upon Distribution of Historical PACE MM

Rate Period	Duals	% Change	Non-Duals	% Change
FY 2013	62.1%		46.7%	
FY 2014	59.0%	-5.0%	45.8%	-1.9%
FY 2015	56.5%	-4.2%	42.5%	-7.2%
FY 2016	54.5%	-3.5%	40.0%	-5.9%
FY 2017	52.2%	-4.2%	37.5%	-6.3%
FY 2018*	49.4%	-5.3%	35.3%	-5.8%
March 2017	47.7%	-3.4%	32.3%	-8.5%
Cumulative FY13-FY18		-20.4%		-24.4%
CAGR FY13 -FY18		-4.5%		-5.8%

* Change includes impact of CCC Duals implementation

To adjust for the differences in nursing home mix between the base data period and the contract period, we developed a Nursing Home Mix Factors for each region. The March 2017 mix was used to estimate the proportion of PACE eligibles in nursing homes for the FY 2018 rate period.

Exhibit 5b presents the Nursing Home vs Non Nursing Home Mix Factor that was first applied in the FY 2017 PACE rate development. This differs from the methodology in past PACE rate development that used the Statewide Nursing Home vs Non Nursing Home Mix Factor that are shown in Table 2. The revised factors compared the base period regional average and project to a more recent period, the "snapshot" month of March 2017. Although all regions have shown a pattern of decreasing use of nursing facilities, the change was made to reflect the different mix of nursing home and HCBS resources in each region.

The FY 2015 – FY 2016 historical PMPM base costs are shown in the first three columns of Exhibit 5b. The nursing home percentage for the historical period is shown for information purposes and then the percentage in nursing home for March 2017. The Nursing Home vs Non Nursing Home Mix Factor is calculated by reweighting the historical PMPMs by the percentage of eligibles in nursing home and non-nursing home by region in the snapshot month and comparing that weighted average PMPM to the average over the base period.

DMAS began phase-in of Commonwealth Coordinated Care, a Dual Demonstration managed care program in July 2014, coinciding with the start of the first year of the FY 2018 base period. Over a number of months, approximately 20% of the Dual PACE eligibles in nursing homes and with home and community based service waivers were moved to the CCC managed care plans.

An analysis of average cost PMPM pre and post CCC phase in by region indicated that PACE Dual eligibles who were in nursing homes and who opt-out of CCC and therefore remained in FFS were more expensive than the

average cost PMPM of the PACE Dual eligibles in nursing homes prior to the phase in. PACE Dual eligibles who were in the EDCD waiver were either similar or only slightly higher cost PMPM after the CCC Dual phase-in. The Post CCC Dual risk adjustment factor was developed by taking the ratio of the pre and post CCC Dual phase in PMPM and pro-rating for the months in the base period prior to CCC Dual phase in for the region. Tidewater, the first region to rollout the CCC phase in, is not risk adjusted because the base data fully encompasses their post CCC phase in experience. Rural, Richmond/Charlottesville and Other MSA were the next regions to phase in. Their risk adjustment factors are representative of only a few months pre-CCC phase in during the base period. The last region to roll out the CCC program was Norther Virginia, and as such have approximately 12 months of pre-rollout experience in the base period. The dual eligible risk adjustment factors by region are shown in Exhibit 5c.

Exhibit 5d applies the adjustment factors in Exhibits 5b and 5c to the historical base and the UPL rates in Exhibit 5a and weights them by the March 2017 PACE eligible member month distribution. The FY 2018 PACE adjusted capitation rates are 3.4% lower than the UPL.

A comparison of FY 2018 PACE rates to FY 2017 rates in Exhibit 5e for the PACE eligible population shows a 3.90% overall increase in the dual PACE capitation rates and an 7.41% increase in the non-dual PACE capitation rates - resulting in an overall increase of 4.49%. The composite year-to-year change by region ranges from a 2.9% to 6.3% increase. The regional percentage difference is primarily driven by the change to use of the regional proportion of nursing home percentage rather than the statewide average proportion of nursing home.

When the regional rates are weighted by the March 2017 PACE enrollee population, there is a 4.23% increase in the dual population rates, an 8.19% increase in the non-dual PACE rates, and an overall weighted year to year increase of 4.57%.

PACE programs will also receive a capitation payment from the federal government for the Medicare component of services for dual eligibles.

VIRGINIA MEDICAID

Exhibit 1a

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Northern Virginia	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	122,479						
Service Type							
Adult Day Care	$10,038,157	$24,766	$10,062,923	$82.16	447,719	43,866	$22.48
Ambulatory Surgery Center	$1,703	$0	$1,703	$0.01	3	0	$567.58
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$31,183,553	$398,318	$31,581,872	$257.86	2,416,296	236,739	$13.07
DME/Supplies	$2,726,200	$585	$2,726,785	$22.26	36,130	3,540	$75.47
Emergency	$22,464	$0	$22,464	$0.18	27	3	$832.01
FQHC	$96	$0	$96	$0.00	2	0	$48.24
Home Health Services	$14,732	$0	$14,732	$0.12	22	2	$669.66
Inpatient - Medical/Surgical	$9,286,254	$182,388	$9,468,642	$77.31	1,115	109	$8,492.06
Inpatient - Psych	$400,536	$20,342	$420,878	$3.44	769	75	$547.31
Lab and X-ray Services	$9,009	$0	$9,009	$0.07	766	75	$11.76
Medicare Xover - IP	$2,837,633	($0)	$2,837,633	$23.17	2,401	235	$1,181.85
Medicare Xover - Nursing Facility	$1,510,783	$22,616	$1,533,399	$12.52	96,154	9,421	$15.95
Medicare Xover - OP	$1,586,415	$483	$1,586,898	$12.96	16,103	1,578	$98.55
Medicare Xover - Other	$653,977	$8,784	$662,761	$5.41	38,421	3,764	$17.25
Medicare Xover - Physician	$4,264,847	$894	$4,265,741	$34.83	146,577	14,361	$29.10
Nursing Facility	$222,957,171	$48,896,390	$271,853,561	$2,219.60	1,281,857	125,591	$212.08
Outpatient - Other	$1,228,154	$0	$1,228,154	$10.03	436	43	$2,816.87
Outpatient - Psychological	$4,999	$885	$5,884	$0.05	5	0	$1,176.74
Personal Care Services	$172,091,199	$787,296	$172,878,495	$1,411.50	11,297,785	1,106,914	$15.30
Physician - Clinic	$34,131	$0	$34,131	$0.28	17,738	1,738	$1.92
Physician - IP Mental Health	$16	$0	$16	$0.00	1	0	$15.88
Physician - OP Mental Health	$25,669,605	$14,646	$25,684,251	$209.70	1,637,187	160,405	$15.69
Physician - Other Practitioner	$644,131	$225	$644,356	$5.26	8,361	819	$77.07
Physician - PCP	$99,965	$3,366	$103,331	$0.84	2,160	212	$47.84
Physician - Specialist	$60,658	$1,909	$62,566	$0.51	1,829	179	$34.21
Pharmacy	$923,577	$0	$923,577	$7.54	135,532	13,279	$6.81
Transportation - Emergency	$3,889	$0	$3,889	$0.03	42	4	$92.60
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$488,253,856	$50,363,891	$538,617,747	$4,397.64	17,585,438		

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

Exhibit 1a

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Other MSA	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	128,326						
Service Type							
Adult Day Care	$351,998	$6,724	$358,723	$2.80	6,460	604	$55.53
Ambulatory Surgery Center	$2,097	$0	$2,097	$0.02	4	0	$524.24
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$44,924,339	$660,072	$45,584,411	$355.22	4,490,648	419,928	$10.15
DME/Supplies	$2,012,666	$241	$2,012,907	$15.69	32,438	3,033	$62.05
Emergency	$8,270	$0	$8,270	$0.06	19	2	$435.27
FQHC	$2,029	$848	$2,877	$0.02	37	3	$77.77
Home Health Services	$6,366	$0	$6,366	$0.05	43	4	$148.04
Inpatient - Medical/Surgical	$2,238,437	$150,148	$2,388,585	$18.61	614	57	$3,890.20
Inpatient - Psych	$2,689,848	$166,253	$2,856,101	$22.26	5,648	528	$505.68
Lab and X-ray Services	$16,310	$0	$16,310	$0.13	1,326	124	$12.30
Medicare Xover - IP	$3,678,040	($0)	$3,678,040	$28.66	3,278	307	$1,122.04
Medicare Xover - Nursing Facility	$2,334,580	$106,600	$2,441,181	$19.02	149,809	14,009	$16.30
Medicare Xover - OP	$1,512,664	$619	$1,513,282	$11.79	19,257	1,801	$78.58
Medicare Xover - Other	$1,172,407	$437	$1,172,844	$9.14	59,833	5,595	$19.60
Medicare Xover - Physician	$4,495,444	$1,075	$4,496,519	$35.04	178,835	16,723	$25.14
Nursing Facility	$295,667,369	$67,936,321	$363,603,689	$2,833.43	2,040,426	190,804	$178.20
Outpatient - Other	$137,810	$0	$137,810	$1.07	397	37	$347.13
Outpatient - Psychological	$142	$0	$142	$0.00	5	0	$28.49
Personal Care Services	$32,084,021	$448,057	$32,532,078	$253.51	2,498,107	233,602	$13.02
Physician - Clinic	$29,524	$0	$29,524	$0.23	14,001	1,309	$2.11
Physician - IP Mental Health	$0	$0	$0	$0.00	0	0	$0.00
Physician - OP Mental Health	$8,053,726	$5,565	$8,059,291	$62.80	423,231	39,577	$19.04
Physician - Other Practitioner	$1,453,780	$234	$1,454,014	$11.33	22,543	2,108	$64.50
Physician - PCP	$44,877	$1,480	$46,357	$0.36	1,102	103	$42.07
Physician - Specialist	$56,371	$1,791	$58,163	$0.45	2,030	190	$28.65
Pharmacy	$1,101,949	$0	$1,101,949	$8.59	168,458	15,753	$6.54
Transportation - Emergency	$14,332	$0	$14,332	$0.11	150	14	$95.55
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$404,089,395	$69,486,467	$473,575,862	$3,690.41	10,118,699		

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

Exhibit 1a

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	108,451						
Service Type							
Adult Day Care	$2,471,151	$101,291	$2,572,442	$23.72	53,157	5,882	$48.39
Ambulatory Surgery Center	$1,016	$0	$1,016	$0.01	2	0	$507.96
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$56,804,052	$1,114,305	$57,918,358	$534.05	5,668,868	627,254	$10.22
DME/Supplies	$2,491,752	$600	$2,492,352	$22.98	33,658	3,724	$74.05
Emergency	$11,813	$0	$11,813	$0.11	23	3	$513.61
FQHC	$2,638	$0	$2,638	$0.02	30	3	$87.93
Home Health Services	$4,888	$0	$4,888	$0.05	20	2	$244.41
Inpatient - Medical/Surgical	$2,284,657	$126,902	$2,411,559	$22.24	636	70	$3,791.76
Inpatient - Psych	$1,335,956	$51,848	$1,387,804	$12.80	2,739	303	$506.68
Lab and X-ray Services	$11,825	$0	$11,825	$0.11	876	97	$13.50
Medicare Xover - IP	$3,209,624	$1,975	$3,211,598	$29.61	2,973	329	$1,080.26
Medicare Xover - Nursing Facility	$1,506,704	$23,054	$1,529,758	$14.11	101,108	11,187	$15.13
Medicare Xover - OP	$1,446,979	$575	$1,447,555	$13.35	20,399	2,257	$70.96
Medicare Xover - Other	$795,038	$421	$795,459	$7.33	46,697	5,167	$17.03
Medicare Xover - Physician	$4,539,681	$1,283	$4,540,964	$41.87	151,864	16,804	$29.90
Nursing Facility	$204,489,493	$53,817,594	$258,307,087	$2,381.78	1,416,910	156,779	$182.30
Outpatient - Other	$134,567	$0	$134,567	$1.24	213	24	$631.77
Outpatient - Psychological	$2,215	$0	$2,215	$0.02	3	0	$738.39
Personal Care Services	$39,684,374	$519,330	$40,203,703	$370.71	3,129,300	346,254	$12.85
Physician - Clinic	$48,824	$0	$48,824	$0.45	19,081	2,111	$2.56
Physician - IP Mental Health	$1,802	$0	$1,802	$0.02	138	15	$13.06
Physician - OP Mental Health	$7,935,380	$6,531	$7,941,911	$73.23	464,251	51,369	$17.11
Physician - Other Practitioner	$1,866,006	$1,441	$1,867,448	$17.22	31,489	3,484	$59.30
Physician - PCP	$58,702	$629	$59,332	$0.55	1,150	127	$51.59
Physician - Specialist	$57,302	$1,027	$58,328	$0.54	2,231	247	$26.14
Pharmacy	$830,592	$0	$830,592	$7.66	124,611	13,788	$6.67
Transportation - Emergency	$5,714	$0	$5,714	$0.05	64	7	$89.28
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$332,032,745	$55,768,806	$387,801,551	$3,575.82	11,272,491		

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

Exhibit 1a

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Rural	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	201,662						
Service Type							
Adult Day Care	$611,950	$2,077	$614,028	$3.04	11,125	662	$55.19
Ambulatory Surgery Center	$6,111	$0	$6,111	$0.03	10	1	$611.08
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$99,009,414	$1,381,807	$100,391,221	$497.82	9,829,146	584,888	$10.21
DME/Supplies	$3,938,759	$2,853	$3,941,612	$19.55	63,822	3,798	$61.76
Emergency	$13,111	$0	$13,111	$0.07	40	2	$327.77
FQHC	$3,348	$307	$3,655	$0.02	49	3	$74.59
Home Health Services	$22,136	$0	$22,136	$0.11	62	4	$357.03
Inpatient - Medical/Surgical	$2,874,588	$201,440	$3,076,029	$15.25	938	56	$3,279.35
Inpatient - Psych	$1,018,027	$35,589	$1,053,616	$5.22	2,060	123	$511.46
Lab and X-ray Services	$24,620	$0	$24,620	$0.12	1,835	109	$13.42
Medicare Xover - IP	$5,711,935	$795	$5,712,729	$28.33	5,113	304	$1,117.30
Medicare Xover - Nursing Facility	$3,891,599	$77,827	$3,969,427	$19.68	264,098	15,715	$15.03
Medicare Xover - OP	$2,859,951	$139	$2,860,090	$14.18	38,099	2,267	$75.07
Medicare Xover - Other	$2,209,336	$360	$2,209,696	$10.96	106,506	6,338	$20.75
Medicare Xover - Physician	$6,473,399	$6,640	$6,480,039	$32.13	282,092	16,786	$22.97
Nursing Facility	$344,144,994	$79,987,800	$424,132,794	$2,103.18	2,622,188	156,034	$161.75
Outpatient - Other	$144,276	$0	$144,276	$0.72	396	24	$364.33
Outpatient - Psychological	$1,002	$0	$1,002	$0.00	5	0	$200.36
Personal Care Services	$60,944,999	$725,611	$61,670,610	$305.81	4,734,160	281,708	$13.03
Physician - Clinic	$23,100	$0	$23,100	$0.11	9,688	576	$2.38
Physician - IP Mental Health	$1,304	$0	$1,304	$0.01	31	2	$42.07
Physician - OP Mental Health	$12,593,653	$6,270	$12,599,923	$62.48	768,835	45,750	$16.39
Physician - Other Practitioner	$3,115,572	$2,847	$3,118,419	$15.46	49,350	2,937	$63.19
Physician - PCP	$89,791	$1,843	$91,635	$0.45	5,988	356	$15.30
Physician - Specialist	$69,264	$1,625	$70,889	$0.35	2,069	123	$34.26
Pharmacy	$1,447,832	$0	$1,447,832	$7.18	229,010	13,627	$6.32
Transportation - Emergency	$12,428	$0	$12,428	$0.06	96	6	$129.46
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$551,256,500	$82,435,832	$633,692,332	$3,142.35	19,026,811		

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

Exhibit 1a

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
Tidewater	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	107,054						
Service Type							
Adult Day Care	$241,231	$83	$241,314	$2.25	4,940	554	$48.85
Ambulatory Surgery Center	$2,958	$731	$3,689	$0.03	9	1	$409.91
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$19,704,053	$333,679	$20,037,732	$187.17	1,954,998	219,141	$10.25
DME/Supplies	$2,785,666	$753	$2,786,419	$26.03	37,200	4,170	$74.90
Emergency	$11,853	$0	$11,853	$0.11	21	2	$564.44
FQHC	$3,427	$0	$3,427	$0.03	33	4	$103.86
Home Health Services	$21,599	$0	$21,599	$0.20	54	6	$399.97
Inpatient - Medical/Surgical	$2,255,045	$131,906	$2,386,951	$22.30	548	61	$4,355.75
Inpatient - Psych	$97,773	$4,557	$102,329	$0.96	190	21	$538.58
Lab and X-ray Services	$6,781	$0	$6,781	$0.06	341	38	$19.88
Medicare Xover - IP	$2,877,540	($0)	$2,877,540	$26.88	2,470	277	$1,165.00
Medicare Xover - Nursing Facility	$1,025,016	$34,621	$1,059,637	$9.90	69,500	7,790	$15.25
Medicare Xover - OP	$1,429,623	$0	$1,429,623	$13.35	19,973	2,239	$71.58
Medicare Xover - Other	$942,113	$374	$942,487	$8.80	50,489	5,659	$18.67
Medicare Xover - Physician	$4,838,097	$1,120	$4,839,217	$45.20	168,972	18,941	$28.64
Nursing Facility	$190,549,037	$53,706,971	$244,256,009	$2,281.61	1,379,947	154,682	$177.00
Outpatient - Other	$295,870	$2,731	$298,601	$2.79	274	31	$1,089.78
Outpatient - Psychological	$2,964	$0	$2,964	$0.03	6	1	$494.08
Personal Care Services	$83,615,728	$906,859	$84,522,587	$789.53	6,565,102	735,900	$12.87
Physician - Clinic	$656	$0	$656	$0.01	365	41	$1.80
Physician - IP Mental Health	$374	$0	$374	$0.00	14	2	$26.71
Physician - OP Mental Health	$17,871,627	$27,564	$17,899,190	$167.20	1,288,762	144,461	$13.89
Physician - Other Practitioner	$760,675	$439	$761,115	$7.11	11,616	1,302	$65.52
Physician - PCP	$62,615	$1,103	$63,718	$0.60	1,848	207	$34.48
Physician - Specialist	$54,348	$293	$54,641	$0.51	1,563	175	$34.96
Pharmacy	$710,722	$0	$710,722	$6.64	98,713	11,065	$7.20
Transportation - Emergency	$10,438	$0	$10,438	$0.10	142	16	$73.51
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$330,177,829	$55,153,784	$385,331,612	$3,599.40	11,658,090		

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

Exhibit 1a

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Age 55 and Over							
All Regions	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	667,973						
Service Type							
Adult Day Care	$13,714,488	$134,941	$13,849,429	$20.73	523,401	9,403	$26.46
Ambulatory Surgery Center	$13,885	$731	$14,616	$0.02	28	1	$521.99
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$251,625,412	$3,888,181	$255,513,594	$382.52	24,359,956	437,622	$10.49
DME/Supplies	$13,955,043	$5,032	$13,960,076	$20.90	203,248	3,651	$68.68
Emergency	$67,512	$0	$67,512	$0.10	130	2	$519.32
FQHC	$11,538	$1,155	$12,694	$0.02	151	3	$84.06
Home Health Services	$69,721	$0	$69,721	$0.10	201	4	$346.87
Inpatient - Medical/Surgical	$18,938,981	$792,785	$19,731,766	$29.54	3,851	69	$5,123.80
Inpatient - Psych	$5,542,140	$278,588	$5,820,728	$8.71	11,406	205	$510.32
Lab and X-ray Services	$68,545	$0	$68,545	$0.10	5,144	92	$13.33
Medicare Xover - IP	$18,314,771	$2,770	$18,317,541	$27.42	16,235	292	$1,128.27
Medicare Xover - Nursing Facility	$10,268,682	$264,719	$10,533,401	$15.77	680,669	12,228	$15.48
Medicare Xover - OP	$8,835,633	$1,816	$8,837,449	$13.23	113,831	2,045	$77.64
Medicare Xover - Other	$5,772,872	$10,376	$5,783,248	$8.66	301,946	5,424	$19.15
Medicare Xover - Physician	$24,611,468	$11,012	$24,622,480	$36.86	928,340	16,677	$26.52
Nursing Facility	$1,257,808,063	$304,345,076	$1,562,153,140	$2,338.65	8,741,328	157,036	$178.71
Outpatient - Other	$1,940,676	$2,731	$1,943,407	$2.91	1,716	31	$1,132.52
Outpatient - Psychological	$11,323	$885	$12,208	$0.02	24	0	$508.65
Personal Care Services	$388,420,321	$3,387,153	$391,807,473	$586.56	28,224,454	507,047	$13.88
Physician - Clinic	$136,235	$0	$136,235	$0.20	60,873	1,094	$2.24
Physician - IP Mental Health	$3,496	$0	$3,496	$0.01	184	3	$19.00
Physician - OP Mental Health	$72,123,990	$60,576	$72,184,566	$108.07	4,582,266	82,320	$15.75
Physician - Other Practitioner	$7,840,165	$5,186	$7,845,351	$11.75	123,359	2,216	$63.60
Physician - PCP	$355,951	$8,422	$364,372	$0.55	12,248	220	$29.75
Physician - Specialist	$297,943	$6,645	$304,587	$0.46	9,722	175	$31.33
Pharmacy	$5,014,672	$0	$5,014,672	$7.51	756,324	13,587	$6.63
Transportation - Emergency	$46,801	$0	$46,801	$0.07	494	9	$94.74
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$2,105,810,325	$313,208,779	$2,419,019,104	$3,621.43	69,661,529		

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

Exhibit 1b

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Northern Virginia	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	15,037						
Service Type							
Adult Day Care	$150,149	$0	$150,149	$9.99	5,179	4,133	$28.99
Ambulatory Surgery Center	$6,739	$0	$6,739	$0.45	14	11	$481.39
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$6,261,933	$6,771	$6,268,704	$416.88	483,934	386,185	$12.95
DME/Supplies	$745,201	$18	$745,219	$49.56	8,084	6,451	$92.18
Emergency	$835,050	$0	$835,050	$55.53	1,390	1,109	$600.76
FQHC	$13,098	$0	$13,098	$0.87	171	136	$76.60
Home Health Services	$446,786	$0	$446,786	$29.71	1,250	998	$357.43
Inpatient - Medical/Surgical	$15,633,740	$150	$15,633,889	$1,039.67	989	789	$15,807.77
Inpatient - Psych	$109,652	$0	$109,652	$7.29	143	114	$766.80
Lab and X-ray Services	$413,678	$0	$413,678	$27.51	18,548	14,802	$22.30
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	$29,649,055	$1,516,928	$31,165,983	$2,072.57	152,726	121,877	$204.06
Outpatient - Other	$3,147,891	$0	$3,147,891	$209.34	5,241	4,182	$600.63
Outpatient - Psychological	$12,538	$0	$12,538	$0.83	62	49	$202.22
Personal Care Services	$19,449,925	$12,225	$19,462,150	$1,294.25	1,284,235	1,024,835	$15.15
Physician - Clinic	$1,913,203	$0	$1,913,203	$127.23	234,148	186,853	$8.17
Physician - IP Mental Health	$400	$0	$400	$0.03	4	3	$99.98
Physician - OP Mental Health	$3,239,951	$904	$3,240,856	$215.52	194,489	155,205	$16.66
Physician - Other Practitioner	$1,160,754	$43	$1,160,797	$77.19	14,377	11,473	$80.74
Physician - PCP	$1,005,951	$4	$1,005,955	$66.90	16,672	13,304	$60.34
Physician - Specialist	$1,062,137	$5	$1,062,142	$70.63	17,568	14,019	$60.46
Pharmacy	$8,355,887	$0	$8,355,887	$555.67	123,946	98,910	$67.42
Transportation - Emergency	$292,377	$0	$292,377	$19.44	3,881	3,097	$75.34
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$93,906,095	$1,537,048	$95,443,142	$6,347.06	2,567,051		

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

Exhibit 1b

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Other MSA	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	11,063						
Service Type							
Adult Day Care	$68,338	$0	$68,338	$6.18	1,228	1,332	$55.65
Ambulatory Surgery Center	$4,136	$0	$4,136	$0.37	10	11	$413.57
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$6,613,341	$5,628	$6,618,969	$598.29	658,487	714,253	$10.05
DME/Supplies	$887,091	$87	$887,178	$80.19	10,548	11,441	$84.11
Emergency	$599,328	$0	$599,328	$54.17	1,190	1,291	$503.64
FQHC	$29,259	$0	$29,259	$2.64	612	664	$47.81
Home Health Services	$377,310	$0	$377,310	$34.11	1,148	1,245	$328.67
Inpatient - Medical/Surgical	$10,567,731	$607	$10,568,338	$955.28	847	919	$12,477.38
Inpatient - Psych	$294,287	$0	$294,287	$26.60	474	514	$620.86
Lab and X-ray Services	$374,361	$0	$374,361	$33.84	19,185	20,810	$19.51
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	$20,865,018	$579,219	$21,444,237	$1,938.36	124,656	135,213	$172.03
Outpatient - Other	$2,261,515	$832	$2,262,347	$204.50	5,222	5,664	$433.23
Outpatient - Psychological	$8,309	$0	$8,309	$0.75	71	77	$117.04
Personal Care Services	$3,047,839	$7,788	$3,055,627	$276.20	233,984	253,800	$13.06
Physician - Clinic	$938,130	$0	$938,130	$84.80	53,476	58,005	$17.54
Physician - IP Mental Health	$544	$0	$544	$0.05	6	7	$90.60
Physician - OP Mental Health	$1,255,372	$452	$1,255,824	$113.51	44,621	48,400	$28.14
Physician - Other Practitioner	$717,840	$3	$717,843	$64.89	11,878	12,884	$60.43
Physician - PCP	$664,384	$81	$664,465	$60.06	15,610	16,932	$42.57
Physician - Specialist	$659,938	$524	$660,462	$59.70	12,100	13,125	$54.58
Pharmacy	$7,162,768	$0	$7,162,768	$647.45	116,813	126,706	$61.32
Transportation - Emergency	$443,680	$0	$443,680	$40.10	7,700	8,352	$57.62
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$57,840,521	$595,220	$58,435,740	$5,282.05	1,319,866		

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

Exhibit 1b

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	17,707						
Service Type							
Adult Day Care	$525,990	$2,049	$528,040	$29.82	10,015	6,787	$52.72
Ambulatory Surgery Center	$12,189	$0	$12,189	$0.69	17	12	$717.01
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$15,274,000	$28,965	$15,302,965	$864.21	1,521,335	1,030,983	$10.06
DME/Supplies	$1,402,728	$5	$1,402,733	$79.22	11,957	8,103	$117.31
Emergency	$1,035,517	$0	$1,035,517	$58.48	1,801	1,221	$574.97
FQHC	$57,635	$0	$57,635	$3.25	917	621	$62.85
Home Health Services	$398,149	$0	$398,149	$22.48	1,177	798	$338.27
Inpatient - Medical/Surgical	$14,286,370	$0	$14,286,370	$806.80	1,083	734	$13,191.48
Inpatient - Psych	$250,257	$0	$250,257	$14.13	297	201	$842.62
Lab and X-ray Services	$391,753	$0	$391,753	$22.12	19,438	13,173	$20.15
Medicare Xover - IP	$1,550	$0	$1,550	$0.09	2	1	$774.97
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$18	$0	$18	$0.00	1	1	$17.95
Medicare Xover - Other	$350	$0	$350	$0.02	12	8	$29.18
Medicare Xover - Physician	$201	$0	$201	$0.01	18	12	$11.17
Nursing Facility	$26,721,408	$1,004,453	$27,725,861	$1,565.78	159,265	107,931	$174.09
Outpatient - Other	$4,376,705	$702	$4,377,407	$247.21	8,663	5,871	$505.30
Outpatient - Psychological	$20,040	$0	$20,040	$1.13	68	46	$294.71
Personal Care Services	$5,709,896	$10,255	$5,720,150	$323.04	438,742	297,328	$13.04
Physician - Clinic	$1,617,323	$0	$1,617,323	$91.34	113,836	77,145	$14.21
Physician - IP Mental Health	$1,554	$0	$1,554	$0.09	31	21	$50.13
Physician - OP Mental Health	$2,836,013	$443	$2,836,455	$160.18	87,607	59,370	$32.38
Physician - Other Practitioner	$1,442,341	$0	$1,442,341	$81.45	20,784	14,085	$69.40
Physician - PCP	$887,708	$1	$887,709	$50.13	18,785	12,730	$47.26
Physician - Specialist	$921,662	$6	$921,668	$52.05	17,185	11,646	$53.63
Pharmacy	$10,318,951	$0	$10,318,951	$582.75	148,633	100,726	$69.43
Transportation - Emergency	$389,446	$0	$389,446	$21.99	10,196	6,910	$38.20
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$88,879,754	$1,046,879	$89,926,633	$5,078.48	2,591,865		

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

Exhibit 1b

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Rural	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	19,535						
Service Type							
Adult Day Care	$6,233	$0	$6,233	$0.32	112	69	$55.65
Ambulatory Surgery Center	$15,532	$0	$15,532	$0.80	34	21	$456.83
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$13,442,922	$26,920	$13,469,842	$689.52	1,324,805	813,803	$10.17
DME/Supplies	$1,695,592	$1	$1,695,593	$86.80	18,423	11,317	$92.04
Emergency	$1,393,372	$0	$1,393,372	$71.33	2,772	1,703	$502.66
FQHC	$162,787	$0	$162,787	$8.33	2,533	1,556	$64.27
Home Health Services	$778,517	$0	$778,517	$39.85	2,137	1,313	$364.30
Inpatient - Medical/Surgical	$17,617,099	$2,264	$17,619,364	$901.94	1,582	972	$11,137.40
Inpatient - Psych	$321,822	$0	$321,822	$16.47	467	287	$689.13
Lab and X-ray Services	$565,622	$0	$565,622	$28.95	27,362	16,808	$20.67
Medicare Xover - IP	$1,216	$0	$1,216	$0.06	1	1	$1,216.00
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	$30,825,206	$895,931	$31,721,137	$1,623.81	191,869	117,862	$165.33
Outpatient - Other	$6,106,620	$0	$6,106,620	$312.60	11,824	7,263	$516.46
Outpatient - Psychological	$13,605	$0	$13,605	$0.70	151	93	$90.10
Personal Care Services	$6,472,496	$13,383	$6,485,879	$332.01	497,520	305,617	$13.04
Physician - Clinic	$1,754,487	$0	$1,754,487	$89.81	100,886	61,972	$17.39
Physician - IP Mental Health	$5,058	$0	$5,058	$0.26	135	83	$37.47
Physician - OP Mental Health	$2,136,509	$614	$2,137,123	$109.40	91,686	56,321	$23.31
Physician - Other Practitioner	$1,536,359	$175	$1,536,534	$78.66	21,587	13,260	$71.18
Physician - PCP	$1,057,352	$79	$1,057,431	$54.13	21,908	13,458	$48.27
Physician - Specialist	$1,307,614	$3	$1,307,617	$66.94	21,344	13,111	$61.26
Pharmacy	$12,915,511	$0	$12,915,511	$661.15	205,466	126,214	$62.86
Transportation - Emergency	$915,359	$0	$915,359	$46.86	11,885	7,301	$77.02
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$101,046,890	$939,370	$101,986,260	$5,220.69	2,556,489		

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

Exhibit 1b

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
Tidewater	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	19,702						
Service Type							
Adult Day Care	$10,073	$0	$10,073	$0.51	181	110	$55.65
Ambulatory Surgery Center	$15,087	$0	$15,087	$0.77	24	15	$628.62
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$3,942,333	$1,833	$3,944,166	$200.19	388,069	236,360	$10.16
DME/Supplies	$1,712,554	$0	$1,712,554	$86.92	15,105	9,200	$113.38
Emergency	$1,617,010	$0	$1,617,010	$82.07	2,545	1,550	$635.37
FQHC	$249,172	$0	$249,172	$12.65	2,620	1,596	$95.10
Home Health Services	$636,988	$0	$636,988	$32.33	1,679	1,023	$379.39
Inpatient - Medical/Surgical	$20,138,444	$5,314	$20,143,758	$1,022.41	1,435	874	$14,037.46
Inpatient - Psych	$213,290	$0	$213,290	$10.83	249	152	$856.59
Lab and X-ray Services	$493,606	$0	$493,606	$25.05	22,599	13,764	$21.84
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	$35,602,783	$1,747,787	$37,350,570	$1,895.75	213,498	130,035	$174.95
Outpatient - Other	$4,832,785	$0	$4,832,785	$245.29	9,787	5,961	$493.80
Outpatient - Psychological	$17,435	$0	$17,435	$0.88	63	38	$276.75
Personal Care Services	$18,807,620	$37,254	$18,844,875	$956.48	1,482,031	902,658	$12.72
Physician - Clinic	$2,403,282	$0	$2,403,282	$121.98	233,711	142,346	$10.28
Physician - IP Mental Health	$1,179	$0	$1,179	$0.06	20	12	$58.94
Physician - OP Mental Health	$6,055,144	$243	$6,055,387	$307.35	347,185	211,459	$17.44
Physician - Other Practitioner	$2,412,321	$1	$2,412,322	$122.44	19,950	12,151	$120.92
Physician - PCP	$1,372,858	$312	$1,373,170	$69.70	56,881	34,644	$24.14
Physician - Specialist	$1,336,669	$266	$1,336,935	$67.86	22,599	13,764	$59.16
Pharmacy	$12,651,975	$0	$12,651,975	$642.16	170,482	103,835	$74.21
Transportation - Emergency	$562,469	$0	$562,469	$28.55	9,307	5,669	$60.44
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$115,085,076	$1,793,010	$116,878,087	$5,932.23	3,000,020		

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

Exhibit 1b

FY 2018 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Age 55 and Over							
All Regions	Medicaid Payments FY15 - FY16	Patient Payments FY15 - FY16	Total Payments FY15 - FY16	Unadjusted PMPM	Units FY15 - FY16	Units/1000 FY15 - FY16	Cost/Unit FY15 - FY16
Member Months	83,045						
Service Type							
Adult Day Care	$760,783	$2,049	$762,832	$9.19	16,715	2,415	$45.64
Ambulatory Surgery Center	$53,683	$0	$53,683	$0.65	99	14	$542.26
Case Management Services	$0	$0	$0	$0.00	0	0	$0.00
Consumer Directed Services	$45,534,530	$70,116	$45,604,646	$549.16	4,376,630	632,422	$10.42
DME/Supplies	$6,443,166	$111	$6,443,277	$77.59	64,117	9,265	$100.49
Emergency	$5,480,276	$0	$5,480,276	$65.99	9,698	1,401	$565.09
FQHC	$511,951	$0	$511,951	$6.16	6,853	990	$74.70
Home Health Services	$2,637,750	$0	$2,637,750	$31.76	7,391	1,068	$356.89
Inpatient - Medical/Surgical	$78,243,385	$8,335	$78,251,720	$942.28	5,936	858	$13,182.57
Inpatient - Psych	$1,189,309	$0	$1,189,309	$14.32	1,630	236	$729.64
Lab and X-ray Services	$2,239,019	$0	$2,239,019	$26.96	107,132	15,481	$20.90
Medicare Xover - IP	$2,766	$0	$2,766	$0.03	3	0	$921.98
Medicare Xover - Nursing Facility	$0	$0	$0	$0.00	0	0	$0.00
Medicare Xover - OP	$18	$0	$18	$0.00	1	0	$17.95
Medicare Xover - Other	$350	$0	$350	$0.00	12	2	$29.18
Medicare Xover - Physician	$201	$0	$201	$0.00	18	3	$11.17
Nursing Facility	$143,663,470	$5,744,318	$149,407,788	$1,799.12	842,014	121,671	$177.44
Outpatient - Other	$20,725,516	$1,534	$20,727,050	$249.59	40,737	5,886	$508.80
Outpatient - Psychological	$71,927	$0	$71,927	$0.87	415	60	$173.32
Personal Care Services	$53,487,776	$80,904	$53,568,680	$645.06	3,936,512	568,825	$13.61
Physician - Clinic	$8,626,425	$0	$8,626,425	$103.88	736,057	106,360	$11.72
Physician - IP Mental Health	$8,735	$0	$8,735	$0.11	196	28	$44.56
Physician - OP Mental Health	$15,522,989	$2,657	$15,525,646	$186.95	765,588	110,627	$20.28
Physician - Other Practitioner	$7,269,615	$222	$7,269,837	$87.54	88,576	12,799	$82.07
Physician - PCP	$4,988,253	$477	$4,988,730	$60.07	129,856	18,764	$38.42
Physician - Specialist	$5,288,020	$804	$5,288,824	$63.69	90,796	13,120	$58.25
Pharmacy	$51,405,092	$0	$51,405,092	$619.00	765,340	110,591	$67.17
Transportation - Emergency	$2,603,331	$0	$2,603,331	$31.35	42,969	6,209	$60.59
Transportation - Non-Emergency	$0	$0	$0	$0.00	0	0	$0.00
Total	$456,758,336	$5,911,527	$462,669,863	$5,571.31	12,035,291		

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 2018 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	$7.44	$616.83	FY15-FY16 FFS Invoices
2.	Fee-for-Service Net Cost per Script	$6.63	$67.18	FY15-FY16 FFS Invoices
3.	Average Fee-for-Service Copayment per Script	$0.02	$0.02	FY15-FY16 FFS Invoices
4.	Fee-for-Service Gross Cost per Script	$6.65	$67.21	= (2.) + (3.)
5.	Average Fee-for-Service Dispensing Fees	$3.23	$3.13	FY15-FY16 FFS Invoices
6.	Fee-for-Service Ingredient Cost per Script	$3.42	$64.07	= (4.) - (5.)
7.	Average Fee-for-Service Rebate	7%	36%	Provided by DMAS
8.	Fee-for-Service Cost per Script with Rebate	$3.17	$40.84	= (6.) * (1 - (7.))
9.	Brand-Generic Improvement Adjustment	1.000	0.995	VA Claims Analysis
10.	Adjusted Cost PMPM with Brand-Generic Improvement Adjustment	$3.17	$40.63	= (8.) * (9.)
11.	Average Fee-for-Service Dispensing Fees	$3.23	$3.13	= (5.)
12.	Adjusted Cost per Script	$6.41	$43.77	= (10.) + (11.)
13.	Adjusted Cost PMPM	$7.19	$401.84	= (12.) * scripts / MM
14.	**Pharmacy Adjustment Factor**	**-3.3%**	**-34.9%**	= (13.) / (1.) -1

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Adult Day Care Adjustment

Exhibit 2b

		Adjustment Value	Source
1.	Total Claims in Adult Day Care	$14,475,271	FY15-FY16 FFS Invoices
2.	FY17 Fee Change	2.5%	Provided by DMAS
3a.	Claims Associated with Procedure Code S5102	$13,880,773	FY15-FY16 FFS Invoices
3b.	Dollar Change	$347,019	= (3a.) * (2.)
4.	**Adult Day Care Adjustment**	**2.4%**	= (3b.) / (1.)

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Hospital Inpatient Adjustment

Exhibit 2c

	Inpatient - Medical/Surgical	Inpatient - Psych	Source
1a. FY15 Claims in IP Service Categories	$45,622,265	$3,901,945	FY15 FFS Invoices
1b. FY16 Claims in IP Service Categories	$51,560,101	$2,829,504	FY16 FFS Invoices
2a. FY15 Hospital Capital Percentage	8.9%	8.9%	Provided by DMAS
2b. FY16 Hospital Capital Percentage	8.5%	8.5%	Provided by DMAS
3a. FY16 Capital Reimbursement Decrease	-4.5%	-4.5%	= ((2b.) - (2a.)) / (2a.)
3b. FY17 Capital Reimbursement Decrease	-0.8%	-0.8%	= ((4a.) - (2b.)) / (2b.)
3c. FY18 Capital Reimbursement Decrease	0.0%	0.0%	= ((4a.) - (4a.)) / (4a.)
4a. FY17 & FY18 Hospital Capital Percentage	8.43%	8.43%	Provided by DMAS
5a. FY17 Hospital Rate Change - Unit Cost	1.05%	1.05%	Provided by DMAS
5b. FY18 Hospital Rate Change - Unit Cost	0.00%	0.00%	Provided by DMAS
5c. Dollar Change	$934,394	$64,722	= ((1a.) + (1b.)) * (1-(4a.)) * ((1+(5a.))*(1+(5b.))-1)
6a. FY17 Hospital Rate Change - Rebasing	-7.25%	27.00%	Provided by DMAS
6b. FY18 Hospital Rate Change - Rebasing	0.00%	0.00%	Provided by DMAS
6c. Dollar Change	($6,451,767)	$1,664,277	= ((1a.) + (1b.)) * (1-(4a.)) * ((1+(6a.))*(1+(6b.))-1)
7. Hospital Inpatient Adjustment	**-5.7%**	**25.7%**	= ((5c.) + (6c.)) / ((1a.) + (1b.))

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Hospital Outpatient Adjustment

Exhibit 2d

		Outpatient - Other	Source
1a.	FY15 Total Claims in OP Service Categories	$10,707,294	FY15 FFS Invoices
1b.	FY16 Total Claims in OP Service Categories	$11,958,897	FY16 FFS Invoices
2a.	FY17 Hospital Rate Change - Unit Cost	1.05%	Provided by DMAS
2b.	FY18 Hospital Rate Change - Unit Cost	0.00%	Provided by DMAS
2c.	Dollar Change	$237,995	= ((1a.)+(1b.)) * ((1+(2a.))*(1+(2b.))-1)
3a.	FY17 Hospital Rate Change - Rebasing	0.1%	Provided by DMAS
3b.	FY18 Hospital Rate Change - Rebasing	0.0%	Provided by DMAS
3c.	Dollar Change	$22,666	= ((1a.)+(1b.)) * ((1+(3a.))*(1+(3b.))-1)
4.	**Hospital Outpatient Adjustment**	**1.1%**	= ((2c.) + (3c.)) / ((1a.) + (1b.))

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Nursing Facility Adjustment

Exhibit 2e

	Adjustment Value	Source
1a. FY15 Claims in Nursing Facility Service Category	$859,570,341	FY15 FFS Invoices
1b. FY16 Claims in Nursing Facility Service Category	$851,990,587	FY16 FFS Invoices
2. FY18 Nursing Facility Capital Percentage	9.5%	Provided by DMAS
3a. FY17 Nursing Facility Operating Rate Increase	0.9%	Provided by DMAS
3b. FY18 Nursing Facility Operating Rate Increase	3.1%	Provided by DMAS
3c. Dollar Change	$62,390,666	= [((1a.) +(1b.))* (1-(2.))]* ((1+(3a.)*(1+(3b.))-1)
4a. FY18 Nursing Facility Rate Change - Rebasing	-0.85%	Provided by DMAS
4b. Dollar Change	($13,166,182)	= [((1a.) +(1b.))* (1-(2.))]* (4a.)
5. Nursing Facility Adjustment	**2.9%**	= ((3c.) + (4b.)) / ((1a.) +(1b.))

Virginia Medicaid

FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Incontinence Supplies Adjustment

Exhibit 2f

		Dual Eligibles	Non-Dual Eligibles	Source
1.	FY15-FY16 Claims in DME Supplies	$13,955,043	$6,443,166	FY15-FY16 FFS Invoice
2.	Proportion of Claims Associated with Incontinence Supplies	$4,231,594	$120,924	FY15 FFS Invoices
3a.	FY16 Average Incontinence Supplies Rate Change	-26.6%	-25.1%	Provided by DMAS- Rates Effective FY16
3b.	Dollar Change	($1,127,346)	($30,412)	= (2.) * (3a.)
4.	**Incontinence Supplies Adjustment Factor**	**-8.1%**	**-0.5%**	= (3b.) / (1.)

Virginia Medicaid

FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Emergency Room Triage Adjustment

Exhibit 2g

		Non-Dual Eligibles	Source
1.	FY15-FY16 Claims in Physician - Other Practitioner, PCP, Special	$17,545,889	FY15-16 FFS Invoices
2	FY15 Number of Claims in ER Triage Level 3	139	FY15 FFS Invoices
3.	ER Cost No Triage Level 3	$43.65	Provided by DMAS
4.	ER Triage Cost	$22.06	Provided by DMAS
5.	Dollar Change	$3,001	= (2.) * ((3.) - (4.))
6.	**FY18 ER Triage Adjustment**	**0.02%**	= (5.) / (1.)

Virginia Medicaid

FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Resource Based Relative Value Scale Adjustment

Exhibit 2h

		Adjustment Value	Source
1.	Professional Fee Adjustment - Effective FY18	0.71%	Provided by DMAS
2.	Proportion of claims subject to fee adjustment	99%	FY15-16 FFS Invoices
3.	**Final Professional Fee Adjustment**	**0.7%**	= (1.) * (2.)

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Personal Care and Respite Care Adjustment

Exhibit 2i

			Adjustment Value	Source
1.	FY15-16 Claims in Service Categories	a. Consumer Directed Services	$297,159,942	FY15-16 FFS Invoices
		b. Personal Care Services	$441,908,097	FY15-16 FFS Invoices
2.	FY15 Claims Associated with Fee Change	a. Consumer Directed Services	$133,711,763	FY15 FFS Invoices
		b. Personal Care Services	$243,493,174	FY15 FFS Invoices
3.	FY16 Claims Associated with Fee Change	a. Consumer Directed Services	$159,220,997	FY16 FFS Invoices
		b. Personal Care Services	$268,535,090	FY16 FFS Invoices
4a.	FY16 Fee Change (CDLTC, Personal Care)		2.0%	Provided by DMAS
4b.	FY17 Fee Change (CDLTC, Personal Care)		2.0%	Provided by DMAS
5.	Dollar Change	a. Consumer Directed Services	$8,586,375	= (2a.) * ((1 + (4a.)) * (1 + (4b.)) - 1) + (3a.) * (4b.)
		b. Personal Care Services	$15,207,826	= (2b.) * ((1 + (4a.)) * (1 + (4b.)) - 1) + (3b.) * (4b.)
6.	**Personal Care and Respite Care Adjustment**	**a.** Consumer Directed Services	**2.9%**	= (5a.) / (1a.)
		b. Personal Care Services	**3.4%**	= (5b.) / (1b.)

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Consumer Directed Respite Care Overtime Adjustment

Exhibit 2j

		Northern Virginia	Rest of State	Source
1.	FY15-16 Claims in Consumer Directed Services	$37,445,486	$259,714,456	FY15-16 FFS Invoices
2.	Claims Associated with Overtime Period	$9,659,104	$73,060,855	January 2016 - June 2016 FFS Invoices
3.	FY16 Fee Change (CDLTC)	-5.4%	-4.7%	Provided by DMAS
4.	Dollar Change	($521,551)	($3,448,272)	= (2.) * (3.)
5.	**Consumer Directed Respite Care Overtime Adjustment**	**-1.4%**	**-1.3%**	= (4.) / (1.)

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Home Health and Rehab Adjustment

Exhibit 2k

			Adjustment Value	Source
1.	FY15-16 Claims in Service Categories	a. Home Health Services	$2,707,470	FY15-16 FFS Invoices
		b. Physician - Other Practitioner	$15,109,780	FY15-16 FFS Invoices
2.	FY15-16 Claims Associated with Fee Change	a. Home Health	$555,445	FY15-16 FFS Invoices
		b. Physician - Other Practitioner	$100,749	FY15-16 FFS Invoices
3.	FY17 Fee Change	a. Home Health Inflation	1.7%	Provided by DMAS
		b. OP Rehab Inflation	2.1%	Provided by DMAS
4.	FY18 Fee Change	a. 50% of Home Health Inflation	1.15%	Provided by DMAS
		b. 50% of OP Rehab Inflation	1.35%	Provided by DMAS
5.	Dollar Change	a. Home Health Services	$15,939	= ((2a.) * ((1+(3a.))*(1+(4a.))-1)
		b. Physician - Other Practitioner	$3,504	= ((2b.) * ((1+(3b.))*(1+(4b.))-1)
6.	**Home Health and Rehab Adjustment**	a. Home Health Services	**0.59%**	= (5a.) / (1a.)
		b. Physician - Other Practitioner	**0.02%**	= (5b.) / (1b.)

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Non-Emergency Transportation Adjustment

Exhibit 2l

	Adjustment Value	Source
Non-ER Transportation Rate	**$82.46**	From DMAS - Rates Effective January 1, 2016 - Present

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Other Adjustments

Exhibit 2m

		Adjustment Values	Source
1.	**DMAS Fee-For-Service Admin Cost**	**2.0%**	Provided by DMAS
2.	**Saving below UPL Rates**	**-3.5%**	Provided by DMAS

Virginia Medicaid

Exhibit 3a

FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
IBNR, Policy/Program, and Trend Adjustments for Dual Population

	Completion and Policy/Program Adjustments			Data Period Trend				
Category of Service	**IBNR**	**Policy/ Program**	**Total Base Data Adjustments**	**Cost Trend**	**Utilization Trend**	**Cost and Utilization Trend**	**Contract Period Cost and Utilization Trend**	**Total Trend Factor**
Nursing Facility	0.1%	2.9%	2.9%	0.0%	0.0%	0.0%	0.0%	1.0000
Adult Day Care	0.0%	2.4%	2.4%	-3.7%	17.1%	12.8%	12.3%	1.3416
Personal Care	0.0%	3.5%	3.5%	-0.5%	3.5%	2.9%	3.8%	1.0889
Consumer Directed Services	0.0%	1.6%	1.6%	-0.5%	3.5%	2.9%	3.8%	1.0889
IP Medical/Surgical - DRG Services	0.9%	-5.7%	-4.8%	8.1%	-1.7%	6.2%	1.5%	1.0862
IP Psych - Per Diem Services	0.0%	25.7%	25.7%	8.1%	-1.7%	6.2%	1.5%	1.0862
Outpatient Hospital	-0.1%	1.1%	1.0%	26.0%	-8.4%	15.4%	8.2%	1.2986
Practitioner	0.1%	0.7%	0.8%	5.2%	-3.1%	2.0%	4.7%	1.0927
Prescription Drug	0.0%	-3.3%	-3.3%	-1.7%	-16.1%	-17.5%	0.0%	0.8252
Other	0.2%	-8.0%	-7.9%	0.9%	6.7%	7.7%	3.6%	1.1353
Weighted Average*	0.1%	2.7%	2.8%	0.1%	0.9%	1.0%	1.3%	1.0306
Medicare Crossovers								
Inpatient	0.1%	0.0%	0.1%	-2.9%	5.2%	2.2%	3.0%	1.0684
Nursing Facility	0.1%	0.0%	0.1%	-2.9%	5.2%	2.2%	3.0%	1.0684
Outpatient	0.1%	0.0%	0.1%	-2.9%	5.2%	2.2%	3.0%	1.0684
Professional	0.1%	0.0%	0.1%	-2.9%	5.2%	2.2%	3.0%	1.0684
Other	0.1%	0.0%	0.1%	-2.9%	5.2%	2.2%	3.0%	1.0684
Weighted Average*	0.1%	0.0%	0.1%	-2.9%	5.2%	2.2%	3.0%	1.0684
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.
The following categories include patient payments: Nursing Facility, Adult Day Care, Personal Care, Consumer Directed Services, and Medicare Crossover - Nursing Facility.

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 2014-2015 Claims)

Virginia Medicaid

Exhibit 3b

FY 2018 PACE Capitation Rate Development
Historical Fee-for-Service Claims
IBNR, Policy/Program, and Trend Adjustments for Non-Dual Population

	Completion and Policy/Program Adjustments			Data Period Trend				
Category of Service	**IBNR**	**Policy/ Program**	**Total Base Data Adjustments**	**Cost Trend**	**Utilization Trend**	**Cost and Utilization Trend**	**Contract Period Cost and Utilization Trend**	**Total Trend Factor**
Nursing Facility	0.1%	2.9%	3.0%	0.0%	0.0%	0.0%	0.0%	1.0000
Adult Day Care	0.0%	2.4%	2.4%	-3.7%	17.1%	5.2%	12.3%	1.2513
Personal Care	0.0%	3.4%	3.5%	-0.5%	3.5%	2.9%	3.8%	1.0889
Consumer Directed Services	0.0%	1.6%	1.6%	-0.5%	3.5%	2.9%	3.8%	1.0889
IP Medical/Surgical - DRG Services	0.3%	-5.7%	-5.4%	11.6%	-10.9%	-0.5%	3.4%	1.0461
IP Psych - Per Diem Services	0.0%	25.7%	25.7%	11.6%	-10.9%	-0.5%	3.4%	1.0461
Outpatient Hospital	0.3%	0.9%	1.2%	0.7%	-2.5%	-1.7%	0.0%	0.9826
Practitioner	0.2%	0.7%	0.9%	12.8%	-9.9%	1.6%	0.5%	1.0238
Prescription Drug	0.0%	-34.9%	-34.8%	7.9%	-1.0%	6.8%	4.2%	1.1362
Other	0.2%	-0.3%	-0.1%	9.3%	3.2%	12.7%	1.6%	1.1539
Weighted Average*	0.1%	-1.8%	-1.7%	3.9%	-2.1%	1.5%	1.9%	1.0433
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.
The following categories include patient payments: Nursing Facility, Adult Day Care, Personal Care, Consumer Directed Services, and Medicare Crossover - Nursing Facility.

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 2014-2015 Claims)

Virginia Medicaid

FY 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Northern Virginia	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$10,038,157	$525	$24,766	$241,254	$10,304,702	1.342	$13,825,278	$112.88	0.965	$108.93
Ambulatory Surgery Center	$1,703	$1			$1,704	1.093	$1,862	$0.02	0.965	$0.01
Case Management Services	$0	$0			$0	1.093	$0	$0.00	0.965	$0.00
Consumer Directed Services	$31,183,553	$5,956	$398,318	$472,760	$32,060,588	1.089	$34,909,551	$285.03	0.965	$275.05
DME/Supplies	$2,726,200	$4,101		($220,565)	$2,509,736	1.135	$2,849,384	$23.26	0.965	$22.45
Emergency	$22,464	($30)			$22,434	1.299	$29,134	$0.24	0.965	$0.23
FQHC	$96	$0			$97	1.093	$105	$0.00	0.965	$0.00
Home Health Services	$14,732	($20)		$87	$14,799	1.299	$19,219	$0.16	0.965	$0.15
Inpatient - Medical/Surgical	$9,286,254	$86,372		($532,116)	$8,840,511	1.086	$9,602,862	$78.40	0.965	$75.66
Inpatient - Psych	$400,536	$0		$102,879	$503,416	1.086	$546,827	$4.46	0.965	$4.31
Lab and X-ray Services	$9,009	$14			$9,023	1.135	$10,244	$0.08	0.965	$0.08
Medicare Xover - IP	$2,837,633	$2,948			$2,840,581	1.068	$3,034,769	$24.78	0.965	$23.91
Medicare Xover - Nursing Facility	$1,510,783	$1,570	$22,616		$1,534,968	1.068	$1,639,902	$13.39	0.965	$12.92
Medicare Xover - OP	$1,586,415	$1,648			$1,588,064	1.068	$1,696,627	$13.85	0.965	$13.37
Medicare Xover - Other	$653,977	$679			$654,656	1.068	$699,410	$5.71	0.965	$5.51
Medicare Xover - Physician	$4,264,847	$4,431			$4,269,277	1.068	$4,561,133	$37.24	0.965	$35.94
Nursing Facility	$222,957,171	$147,848	$48,896,390	$6,416,499	$278,417,908	1.000	$278,417,908	$2,273.19	0.965	$2,193.63
Outpatient - Other	$1,228,154	($1,635)		$14,105	$1,240,624	1.299	$1,611,116	$13.15	0.965	$12.69
Outpatient - Psychological	$4,999	($7)			$4,992	1.299	$6,483	$0.05	0.965	$0.05
Personal Care Services	$172,091,199	$52,643	$787,296	$5,951,252	$178,882,390	1.089	$194,778,210	$1,590.30	0.965	$1,534.64
Physician - Clinic	$34,131	$20		$240	$34,391	1.093	$37,578	$0.31	0.965	$0.30
Physician - IP Mental Health	$16	$0		$0	$16	1.093	$17	$0.00	0.965	$0.00
Physician - OP Mental Health	$25,669,605	$14,860		$180,873	$25,865,338	1.093	$28,262,028	$230.75	0.965	$222.67
Physician - Other Practitioner	$644,131	$373		$4,688	$649,192	1.093	$709,347	$5.79	0.965	$5.59
Physician - PCP	$99,965	$58		$704	$100,727	1.093	$110,061	$0.90	0.965	$0.87
Physician - Specialist	$60,658	$35		$427	$61,120	1.093	$66,784	$0.55	0.965	$0.53
Pharmacy	$923,577	$110		($30,527)	$893,159	0.825	$737,068	$6.02	1.000	$6.02
Transportation - Emergency	$3,889	$6			$3,895	1.135	$4,422	$0.04	0.965	$0.03
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$488,253,856	$322,506	$50,129,386	$12,602,562	$551,308,309			$4,803.01		$4,638.00
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$4,899.35		$4,730.97

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Other MSA	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$351,998	$18	$6,724	$8,600	$367,341	1.342	$492,843	$3.84	0.965	$3.71
Ambulatory Surgery Center	$2,097	$1			$2,098	1.093	$2,293	$0.02	0.965	$0.02
Case Management Services	$0	$0			$0	1.093	$0	$0.00	0.965	$0.00
Consumer Directed Services	$44,924,339	$8,581	$660,072	$712,054	$46,305,047	1.089	$50,419,799	$392.90	0.965	$379.15
DME/Supplies	$2,012,666	$3,027		($162,836)	$1,852,857	1.135	$2,103,609	$16.39	0.965	$15.82
Emergency	$8,270	($11)			$8,259	1.299	$10,726	$0.08	0.965	$0.08
FQHC	$2,029	$1			$2,030	1.093	$2,219	$0.02	0.965	$0.02
Home Health Services	$6,366	($8)		$37	$6,395	1.299	$8,304	$0.06	0.965	$0.06
Inpatient - Medical/Surgical	$2,238,437	$20,820		($128,266)	$2,130,991	1.086	$2,314,754	$18.04	0.965	$17.41
Inpatient - Psych	$2,689,848	$0		$690,898	$3,380,746	1.086	$3,672,281	$28.62	0.965	$27.62
Lab and X-ray Services	$16,310	$25			$16,334	1.135	$18,545	$0.14	0.965	$0.14
Medicare Xover - IP	$3,678,040	$3,821			$3,681,861	1.068	$3,933,560	$30.65	0.965	$29.58
Medicare Xover - Nursing Facility	$2,334,580	$2,425	$106,600		$2,443,606	1.068	$2,610,656	$20.34	0.965	$19.63
Medicare Xover - OP	$1,512,664	$1,572			$1,514,235	1.068	$1,617,751	$12.61	0.965	$12.17
Medicare Xover - Other	$1,172,407	$1,218			$1,173,625	1.068	$1,253,856	$9.77	0.965	$9.43
Medicare Xover - Physician	$4,495,444	$4,670			$4,500,115	1.068	$4,807,751	$37.47	0.965	$36.15
Nursing Facility	$295,667,369	$196,064	$67,936,321	$8,509,031	$372,308,784	1.000	$372,308,784	$2,901.27	0.965	$2,799.72
Outpatient - Other	$137,810	($183)		$1,583	$139,209	1.299	$180,781	$1.41	0.965	$1.36
Outpatient - Psychological	$142	($0)			$142	1.299	$185	$0.00	0.965	$0.00
Personal Care Services	$32,084,021	$9,814	$448,057	$1,119,897	$33,661,789	1.089	$36,653,038	$285.62	0.965	$275.63
Physician - Clinic	$29,524	$17		$208	$29,749	1.093	$32,505	$0.25	0.965	$0.24
Physician - IP Mental Health	$0	$0			$0	1.093	$0	$0.00	0.965	$0.00
Physician - OP Mental Health	$8,053,726	$4,662		$56,748	$8,115,136	1.093	$8,867,087	$69.10	0.965	$66.68
Physician - Other Practitioner	$1,453,780	$842		$10,581	$1,465,202	1.093	$1,600,968	$12.48	0.965	$12.04
Physician - PCP	$44,877	$26		$316	$45,219	1.093	$49,409	$0.39	0.965	$0.37
Physician - Specialist	$56,371	$33		$397	$56,801	1.093	$62,064	$0.48	0.965	$0.47
Pharmacy	$1,101,949	$131		($36,423)	$1,065,657	0.825	$879,420	$6.85	1.000	$6.85
Transportation - Emergency	$14,332	$22			$14,354	1.135	$16,296	$0.13	0.965	$0.12
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$404,089,395	$257,588	$69,157,775	$10,782,826	$484,287,584			$3,931.40		$3,796.92
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$4,009.95		$3,872.73

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

Exhibit 4a

FY 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Dual Population

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$2,471,151	$129	$101,291	$61,673	$2,634,244	1.342	$3,534,227	$32.59	0.965	$31.45
Ambulatory Surgery Center	$1,016	$1			$1,017	1.093	$1,111	$0.01	0.965	$0.01
Case Management Services	$0	$0			$0	1.093	$0	$0.00	0.965	$0.00
Consumer Directed Services	$56,804,052	$10,850	$1,114,305	$904,717	$58,833,925	1.089	$64,062,016	$590.70	0.965	$570.02
DME/Supplies	$2,491,752	$3,748		($201,597)	$2,293,903	1.135	$2,604,342	$24.01	0.965	$23.17
Emergency	$11,813	($16)			$11,797	1.299	$15,320	$0.14	0.965	$0.14
FQHC	$2,638	$2			$2,639	1.093	$2,884	$0.03	0.965	$0.03
Home Health Services	$4,888	($7)		$29	$4,910	1.299	$6,377	$0.06	0.965	$0.06
Inpatient - Medical/Surgical	$2,284,657	$21,250		($130,914)	$2,174,992	1.086	$2,362,551	$21.78	0.965	$21.02
Inpatient - Psych	$1,335,956	$0		$343,145	$1,679,101	1.086	$1,823,897	$16.82	0.965	$16.23
Lab and X-ray Services	$11,825	$18			$11,843	1.135	$13,446	$0.12	0.965	$0.12
Medicare Xover - IP	$3,209,624	$3,335			$3,212,958	1.068	$3,432,602	$31.65	0.965	$30.54
Medicare Xover - Nursing Facility	$1,506,704	$1,565	$23,054		$1,531,323	1.068	$1,636,008	$15.09	0.965	$14.56
Medicare Xover - OP	$1,446,979	$1,503			$1,448,483	1.068	$1,547,504	$14.27	0.965	$13.77
Medicare Xover - Other	$795,038	$826			$795,864	1.068	$850,271	$7.84	0.965	$7.57
Medicare Xover - Physician	$4,539,681	$4,716			$4,544,397	1.068	$4,855,061	$44.77	0.965	$43.20
Nursing Facility	$204,489,493	$135,602	$53,817,594	$5,885,017	$264,327,706	1.000	$264,327,706	$2,437.30	0.965	$2,351.99
Outpatient - Other	$134,567	($179)		$1,545	$135,933	1.299	$176,527	$1.63	0.965	$1.57
Outpatient - Psychological	$2,215	($3)			$2,212	1.299	$2,873	$0.03	0.965	$0.03
Personal Care Services	$39,684,374	$12,139	$519,330	$1,383,988	$41,599,831	1.089	$45,296,469	$417.67	0.965	$403.05
Physician - Clinic	$48,824	$28		$344	$49,196	1.093	$53,755	$0.50	0.965	$0.48
Physician - IP Mental Health	$1,802	$1		$13	$1,815	1.093	$1,984	$0.02	0.965	$0.02
Physician - OP Mental Health	$7,935,380	$4,594		$55,914	$7,995,888	1.093	$8,736,790	$80.56	0.965	$77.74
Physician - Other Practitioner	$1,866,006	$1,080		$13,581	$1,880,668	1.093	$2,054,931	$18.95	0.965	$18.28
Physician - PCP	$58,702	$34		$414	$59,150	1.093	$64,631	$0.60	0.965	$0.58
Physician - Specialist	$57,302	$33		$404	$57,739	1.093	$63,089	$0.58	0.965	$0.56
Pharmacy	$830,592	$99		($27,454)	$803,237	0.825	$662,861	$6.11	1.000	$6.11
Transportation - Emergency	$5,714	$9			$5,723	1.135	$6,497	$0.06	0.965	$0.06
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$332,032,745	$201,357	$55,575,574	$8,290,819	$396,100,496			$3,846.33		$3,714.80
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$3,923.14		$3,788.93

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Rural	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$611,950	$32	$2,077	$14,721	$628,781	1.342	$843,602	$4.18	0.965	$4.04
Ambulatory Surgery Center	$6,111	$4			$6,114	1.093	$6,681	$0.03	0.965	$0.03
Case Management Services	$0	$0			$0	1.093	$0	$0.00	0.965	$0.00
Consumer Directed Services	$99,009,414	$18,912	$1,381,807	$1,568,168	$101,978,301	1.089	$111,040,282	$550.63	0.965	$531.35
DME/Supplies	$3,938,759	$5,925		($318,668)	$3,626,016	1.135	$4,116,733	$20.41	0.965	$19.70
Emergency	$13,111	($17)			$13,093	1.299	$17,003	$0.08	0.965	$0.08
FQHC	$3,348	$2			$3,350	1.093	$3,660	$0.02	0.965	$0.02
Home Health Services	$22,136	($29)		$130	$22,237	1.299	$28,877	$0.14	0.965	$0.14
Inpatient - Medical/Surgical	$2,874,588	$26,737		($164,718)	$2,736,607	1.086	$2,972,595	$14.74	0.965	$14.22
Inpatient - Psych	$1,018,027	$0		$261,484	$1,279,511	1.086	$1,389,848	$6.89	0.965	$6.65
Lab and X-ray Services	$24,620	$37			$24,657	1.135	$27,994	$0.14	0.965	$0.13
Medicare Xover - IP	$5,711,935	$5,934			$5,717,869	1.068	$6,108,753	$30.29	0.965	$29.23
Medicare Xover - Nursing Facility	$3,891,599	$4,043	$77,827		$3,973,470	1.068	$4,245,103	$21.05	0.965	$20.31
Medicare Xover - OP	$2,859,951	$2,971			$2,862,923	1.068	$3,058,637	$15.17	0.965	$14.64
Medicare Xover - Other	$2,209,336	$2,295			$2,211,631	1.068	$2,362,822	$11.72	0.965	$11.31
Medicare Xover - Physician	$6,473,399	$6,725			$6,480,124	1.068	$6,923,118	$34.33	0.965	$33.13
Nursing Facility	$344,144,994	$228,211	$79,987,800	$9,904,172	$434,265,176	1.000	$434,265,176	$2,153.43	0.965	$2,078.06
Outpatient - Other	$144,276	($192)		$1,657	$145,741	1.299	$189,264	$0.94	0.965	$0.91
Outpatient - Psychological	$1,002	($1)			$1,000	1.299	$1,299	$0.01	0.965	$0.01
Personal Care Services	$60,944,999	$18,643	$725,611	$2,122,974	$63,812,227	1.089	$69,482,700	$344.55	0.965	$332.49
Physician - Clinic	$23,100	$13		$163	$23,277	1.093	$25,433	$0.13	0.965	$0.12
Physician - IP Mental Health	$1,304	$1		$9	$1,314	1.093	$1,436	$0.01	0.965	$0.01
Physician - OP Mental Health	$12,593,653	$7,290		$88,737	$12,689,681	1.093	$13,865,511	$68.76	0.965	$66.35
Physician - Other Practitioner	$3,115,572	$1,804		$22,676	$3,140,052	1.093	$3,431,010	$17.01	0.965	$16.42
Physician - PCP	$89,791	$52		$633	$90,476	1.093	$98,860	$0.49	0.965	$0.47
Physician - Specialist	$69,264	$40		$488	$69,793	1.093	$76,260	$0.38	0.965	$0.36
Pharmacy	$1,447,832	$172		($47,855)	$1,400,149	0.825	$1,155,455	$5.73	1.000	$5.73
Transportation - Emergency	$12,428	$19			$12,447	1.135	$14,131	$0.07	0.965	$0.07
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$551,256,500	$329,622	$82,175,123	$13,454,771	$647,216,016			$3,383.78		$3,268.44
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$3,451.16		$3,333.46

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
Tidewater	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$241,231	$13	$83	$5,785	$247,112	1.342	$331,537	$3.10	0.965	$2.99
Ambulatory Surgery Center	$2,958	$2			$2,960	1.093	$3,234	$0.03	0.965	$0.03
Case Management Services	$0	$0			$0	1.093	$0	$0.00	0.965	$0.00
Consumer Directed Services	$19,704,053	$3,764	$333,679	$313,001	$20,354,496	1.089	$22,163,235	$207.03	0.965	$199.78
DME/Supplies	$2,785,666	$4,190		($225,376)	$2,564,480	1.135	$2,911,537	$27.20	0.965	$26.24
Emergency	$11,853	($16)			$11,837	1.299	$15,372	$0.14	0.965	$0.14
FQHC	$3,427	$2			$3,429	1.093	$3,747	$0.04	0.965	$0.03
Home Health Services	$21,599	($29)		$127	$21,697	1.299	$28,176	$0.26	0.965	$0.25
Inpatient - Medical/Surgical	$2,255,045	$20,974		($129,217)	$2,146,802	1.086	$2,331,929	$21.78	0.965	$21.02
Inpatient - Psych	$97,773	$0		$25,113	$122,886	1.086	$133,483	$1.25	0.965	$1.20
Lab and X-ray Services	$6,781	$10			$6,791	1.135	$7,710	$0.07	0.965	$0.07
Medicare Xover - IP	$2,877,540	$2,990			$2,880,529	1.068	$3,077,448	$28.75	0.965	$27.74
Medicare Xover - Nursing Facility	$1,025,016	$1,065	$34,621		$1,060,702	1.068	$1,133,213	$10.59	0.965	$10.21
Medicare Xover - OP	$1,429,623	$1,485			$1,431,108	1.068	$1,528,941	$14.28	0.965	$13.78
Medicare Xover - Other	$942,113	$979			$943,092	1.068	$1,007,563	$9.41	0.965	$9.08
Medicare Xover - Physician	$4,838,097	$5,026			$4,843,124	1.068	$5,174,209	$48.33	0.965	$46.64
Nursing Facility	$190,549,037	$126,358	$53,706,971	$5,483,823	$249,866,190	1.000	$249,866,190	$2,334.01	0.965	$2,252.32
Outpatient - Other	$295,870	($394)		$3,398	$298,874	1.299	$388,127	$3.63	0.965	$3.50
Outpatient - Psychological	$2,964	($4)			$2,961	1.299	$3,845	$0.04	0.965	$0.03
Personal Care Services	$83,615,728	$25,578	$906,859	$2,909,641	$87,457,806	1.089	$95,229,468	$889.54	0.965	$858.41
Physician - Clinic	$656	$0		$5	$661	1.093	$722	$0.01	0.965	$0.01
Physician - IP Mental Health	$374	$0		$3	$377	1.093	$412	$0.00	0.965	$0.00
Physician - OP Mental Health	$17,871,627	$10,346		$125,927	$18,007,900	1.093	$19,676,517	$183.80	0.965	$177.37
Physician - Other Practitioner	$760,675	$440		$5,536	$766,652	1.093	$837,690	$7.82	0.965	$7.55
Physician - PCP	$62,615	$36		$441	$63,092	1.093	$68,939	$0.64	0.965	$0.62
Physician - Specialist	$54,348	$31		$383	$54,762	1.093	$59,836	$0.56	0.965	$0.54
Pharmacy	$710,722	$85		($23,492)	$687,315	0.825	$567,198	$5.30	1.000	$5.30
Transportation - Emergency	$10,438	$16			$10,454	1.135	$11,868	$0.11	0.965	$0.11
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$330,177,829	$202,947	$54,982,213	$8,495,098	$393,858,088			$3,880.18		$3,747.45
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$3,957.68		$3,822.24

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Dual Population

Exhibit 4a

Age 55 and Over										
All Regions	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$13,714,488	$717	$134,941	$332,033	$14,182,179	1.342	$19,027,486	$28.49	0.965	$27.49
Ambulatory Surgery Center	$13,885	$8			$13,893	1.093	$15,180	$0.02	0.965	$0.02
Case Management Services	$0	$0			$0	1.093	$0	$0.00	1.000	$0.00
Consumer Directed Services	$251,625,412	$48,064	$3,888,181	$3,970,700	$259,532,358	1.089	$282,594,883	$423.06	0.965	$408.26
DME/Supplies	$13,955,043	$20,991		($1,129,042)	$12,846,993	1.135	$14,585,605	$21.84	0.965	$21.07
Emergency	$67,512	($90)			$67,422	1.299	$87,556	$0.13	0.965	$0.13
FQHC	$11,538	$7			$11,545	1.093	$12,615	$0.02	0.965	$0.02
Home Health Services	$69,721	($93)		$410	$70,038	1.299	$90,954	$0.14	0.965	$0.13
Inpatient - Medical/Surgical	$18,938,981	$176,153		($1,085,231)	$18,029,903	1.086	$19,584,691	$29.32	0.965	$28.29
Inpatient - Psych	$5,542,140	$0		$1,423,520	$6,965,660	1.086	$7,566,336	$11.33	0.965	$10.93
Lab and X-ray Services	$68,545	$103			$68,648	1.135	$77,938	$0.12	0.965	$0.11
Medicare Xover - IP	$18,314,771	$19,027			$18,333,799	1.068	$19,587,132	$29.32	0.965	$28.30
Medicare Xover - Nursing Facility	$10,268,682	$10,668	$264,719		$10,544,069	1.068	$11,264,882	$16.86	0.965	$16.27
Medicare Xover - OP	$8,835,633	$9,179			$8,844,812	1.068	$9,449,460	$14.15	0.965	$13.65
Medicare Xover - Other	$5,772,872	$5,998			$5,778,869	1.068	$6,173,924	$9.24	0.965	$8.92
Medicare Xover - Physician	$24,611,468	$25,569			$24,637,037	1.068	$26,321,272	$39.40	0.965	$38.03
Nursing Facility	$1,257,808,063	$834,082	$304,345,076	$36,198,542	$1,599,185,764	1.000	$1,599,185,764	$2,394.09	0.965	$2,310.30
Outpatient - Other	$1,940,676	($2,583)		$22,288	$1,960,380	1.299	$2,545,816	$3.81	0.965	$3.68
Outpatient - Psychological	$11,323	($15)			$11,308	1.299	$14,685	$0.02	0.965	$0.02
Personal Care Services	$388,420,321	$118,818	$3,387,153	$13,487,752	$405,414,043	1.089	$441,439,884	$660.87	0.965	$637.73
Physician - Clinic	$136,235	$79		$960	$137,274	1.093	$149,994	$0.22	0.965	$0.22
Physician - IP Mental Health	$3,496	$2		$25	$3,522	1.093	$3,849	$0.01	0.965	$0.01
Physician - OP Mental Health	$72,123,990	$41,752		$508,200	$72,673,943	1.093	$79,407,933	$118.88	0.965	$114.72
Physician - Other Practitioner	$7,840,165	$4,539		$57,063	$7,901,766	1.093	$8,633,946	$12.93	0.965	$12.47
Physician - PCP	$355,951	$206		$2,508	$358,665	1.093	$391,899	$0.59	0.965	$0.57
Physician - Specialist	$297,943	$172		$2,099	$300,215	1.093	$328,032	$0.49	0.965	$0.47
Pharmacy	$5,014,672	$596		($165,750)	$4,849,518	0.825	$4,002,002	$5.99	1.000	$5.99
Transportation - Emergency	$46,801	$70			$46,872	1.135	$53,215	$0.08	0.965	$0.08
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$2,105,810,325	$1,314,020	$312,020,070	$53,626,077	$2,472,770,492			$3,903.87		$3,770.33
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$3,981.86		$3,845.59

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 Trend Adjustment application.

Virginia Medicaid

FY 2018 PACE Capitation Rate Development

UPL and Unadjusted Capitation Rate Calculations

Non-Dual Population

Exhibit 4b

Age 55 and Over										
Northern Virginia	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$150,149	$8		$3,600	$153,757	1.251	$192,394	$12.79	0.965	$12.35
Ambulatory Surgery Center	$6,739	$11			$6,751	1.024	$6,911	$0.46	0.965	$0.44
Case Management Services	$0	$0			$0	1.024	$0	$0.00	0.965	$0.00
Consumer Directed Services	$6,261,933	$1,196	$6,771	$93,839	$6,363,738	1.089	$6,929,232	$460.80	0.965	$444.67
DME/Supplies	$745,201	$1,164		($3,523)	$742,842	1.154	$857,186	$57.00	0.965	$55.01
Emergency	$835,050	$2,565			$837,615	0.983	$823,024	$54.73	0.965	$52.82
FQHC	$13,098	$22			$13,120	1.024	$13,432	$0.89	0.965	$0.86
Home Health Services	$446,786	$1,372		$2,638	$450,797	0.983	$442,944	$29.46	0.965	$28.43
Inpatient - Medical/Surgical	$15,633,740	$42,277		($889,981)	$14,786,036	1.046	$15,467,571	$1,028.61	0.965	$992.61
Inpatient - Psych	$109,652	$0		$28,165	$137,816	1.046	$144,169	$9.59	0.965	$9.25
Lab and X-ray Services	$413,678	$646			$414,324	1.154	$478,100	$31.79	0.965	$30.68
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Physician	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Nursing Facility	$29,649,055	$34,198	$1,516,928	$853,690	$32,053,871	1.000	$32,053,871	$2,131.61	0.965	$2,057.01
Outpatient - Other	$3,147,891	$9,670		$36,312	$3,193,873	0.983	$3,138,239	$208.70	0.965	$201.39
Outpatient - Psychological	$12,538	$39			$12,576	0.983	$12,357	$0.82	0.965	$0.79
Personal Care Services	$19,449,925	$5,950	$12,225	$669,975	$20,138,074	1.089	$21,927,581	$1,458.21	0.965	$1,407.17
Physician - Clinic	$1,913,203	$3,172		$13,495	$1,929,871	1.024	$1,975,809	$131.39	0.965	$126.79
Physician - IP Mental Health	$400	$1		$3	$403	1.024	$413	$0.03	0.965	$0.03
Physician - OP Mental Health	$3,239,951	$5,372		$22,854	$3,268,177	1.024	$3,345,972	$222.51	0.965	$214.72
Physician - Other Practitioner	$1,160,754	$1,924		$8,656	$1,171,335	1.024	$1,199,217	$79.75	0.965	$76.96
Physician - PCP	$1,005,951	$1,668		$7,268	$1,014,887	1.024	$1,039,045	$69.10	0.965	$66.68
Physician - Specialist	$1,062,137	$1,761		$7,674	$1,071,572	1.024	$1,097,080	$72.96	0.965	$70.40
Pharmacy	$8,355,887	$1,066		($2,912,811)	$5,444,142	1.136	$6,185,884	$411.37	1.000	$411.37
Transportation - Emergency	$292,377	$457			$292,833	1.154	$337,909	$22.47	0.965	$21.68
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$93,906,095	$114,537	$1,535,924	($2,058,145)	$93,498,410			$6,577.50		$6,364.57
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$6,710.05		$6,492.78

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 2018 PACE Capitation Rate Development

UPL and Unadjusted Capitation Rate Calculations

Non-Dual Population

Exhibit 4b

Age 55 and Over										
Other MSA	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$68,338	$4		$1,638	$69,980	1.251	$87,565	$7.92	0.965	$7.64
Ambulatory Surgery Center	$4,136	$7			$4,143	1.024	$4,241	$0.38	0.965	$0.37
Case Management Services	$0	$0			$0	1.024	$0	$0.00	0.965	$0.00
Consumer Directed Services	$6,613,341	$1,263	$5,628	$103,392	$6,723,625	1.089	$7,321,098	$661.76	0.965	$638.60
DME/Supplies	$887,091	$1,385		($4,194)	$884,283	1.154	$1,020,400	$92.23	0.965	$89.01
Emergency	$599,328	$1,841			$601,169	0.983	$590,697	$53.39	0.965	$51.52
FQHC	$29,259	$49			$29,307	1.024	$30,005	$2.71	0.965	$2.62
Home Health Services	$377,310	$1,159		$2,228	$380,697	0.983	$374,065	$33.81	0.965	$32.63
Inpatient - Medical/Surgical	$10,567,731	$28,578		($601,588)	$9,994,720	1.046	$10,455,409	$945.07	0.965	$911.99
Inpatient - Psych	$294,287	$0		$75,589	$369,876	1.046	$386,925	$34.97	0.965	$33.75
Lab and X-ray Services	$374,361	$585			$374,945	1.154	$432,660	$39.11	0.965	$37.74
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Physician	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Nursing Facility	$20,865,018	$24,066	$579,219	$600,770	$22,069,073	1.000	$22,069,073	$1,994.84	0.965	$1,925.02
Outpatient - Other	$2,261,515	$6,947		$26,087	$2,294,549	0.983	$2,254,580	$203.79	0.965	$196.66
Outpatient - Psychological	$8,309	$26			$8,335	0.983	$8,190	$0.74	0.965	$0.71
Personal Care Services	$3,047,839	$932	$7,788	$105,188	$3,161,747	1.089	$3,442,706	$311.19	0.965	$300.30
Physician - Clinic	$938,130	$1,555		$6,617	$946,303	1.024	$968,828	$87.57	0.965	$84.51
Physician - IP Mental Health	$544	$1		$4	$548	1.024	$561	$0.05	0.965	$0.05
Physician - OP Mental Health	$1,255,372	$2,081		$8,855	$1,266,309	1.024	$1,296,452	$117.19	0.965	$113.09
Physician - Other Practitioner	$717,840	$1,190		$5,353	$724,384	1.024	$741,627	$67.04	0.965	$64.69
Physician - PCP	$664,384	$1,101		$4,800	$670,286	1.024	$686,241	$62.03	0.965	$59.86
Physician - Specialist	$659,938	$1,094		$4,768	$665,801	1.024	$681,649	$61.61	0.965	$59.46
Pharmacy	$7,162,768	$914		($2,496,897)	$4,666,785	1.136	$5,302,615	$479.31	1.000	$479.31
Transportation - Emergency	$443,680	$693			$444,373	1.154	$512,775	$46.35	0.965	$44.73
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$57,840,521	$75,471	$592,634	($2,157,388)	$56,351,237			$5,385.53		$5,216.70
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$5,493.76		$5,321.48

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$525,990	$27	$2,049	$12,659	$540,727	1.251	$676,603	$38.21	0.965	$36.87
Ambulatory Surgery Center	$12,189	$20			$12,209	1.024	$12,500	$0.71	0.965	$0.68
Case Management Services	$0	$0			$0	1.024	$0	$0.00	0.965	$0.00
Consumer Directed Services	$15,274,000	$2,918	$28,965	$239,042	$15,544,924	1.089	$16,926,275	$955.89	0.965	$922.43
DME/Supplies	$1,402,728	$2,191		($6,631)	$1,398,287	1.154	$1,613,524	$91.12	0.965	$87.93
Emergency	$1,035,517	$3,181			$1,038,698	0.983	$1,020,605	$57.64	0.965	$55.62
FQHC	$57,635	$96			$57,731	1.024	$59,105	$3.34	0.965	$3.22
Home Health Services	$398,149	$1,223		$2,351	$401,723	0.983	$394,725	$22.29	0.965	$21.51
Inpatient - Medical/Surgical	$14,286,370	$38,634		($813,279)	$13,511,725	1.046	$14,134,523	$798.23	0.965	$770.29
Inpatient - Psych	$250,257	$0		$64,280	$314,537	1.046	$329,035	$18.58	0.965	$17.93
Lab and X-ray Services	$391,753	$612			$392,365	1.154	$452,761	$25.57	0.965	$24.67
Medicare Xover - IP	$1,550	$0			$1,550	1.000	$1,550	$0.09	1.000	$0.09
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - OP	$18	$0			$18	1.000	$18	$0.00	1.000	$0.00
Medicare Xover - Other	$350	$0			$350	1.000	$350	$0.02	1.000	$0.02
Medicare Xover - Physician	$201	$0			$201	1.000	$201	$0.01	1.000	$0.01
Nursing Facility	$26,721,408	$30,821	$1,004,453	$769,394	$28,526,076	1.000	$28,526,076	$1,610.97	0.965	$1,554.59
Outpatient - Other	$4,376,705	$13,444		$50,487	$4,440,636	0.983	$4,363,284	$246.41	0.965	$237.79
Outpatient - Psychological	$20,040	$62			$20,102	0.983	$19,752	$1.12	0.965	$1.08
Personal Care Services	$5,709,896	$1,747	$10,255	$196,913	$5,918,810	1.089	$6,444,767	$363.96	0.965	$351.22
Physician - Clinic	$1,617,323	$2,681		$11,408	$1,631,413	1.024	$1,670,246	$94.32	0.965	$91.02
Physician - IP Mental Health	$1,554	$3		$11	$1,568	1.024	$1,605	$0.09	0.965	$0.09
Physician - OP Mental Health	$2,836,013	$4,702		$20,005	$2,860,719	1.024	$2,928,815	$165.40	0.965	$159.61
Physician - Other Practitioner	$1,442,341	$2,391		$10,756	$1,455,489	1.024	$1,490,135	$84.15	0.965	$81.21
Physician - PCP	$887,708	$1,472		$6,414	$895,593	1.024	$916,912	$51.78	0.965	$49.97
Physician - Specialist	$921,662	$1,528		$6,659	$929,849	1.024	$951,983	$53.76	0.965	$51.88
Pharmacy	$10,318,951	$1,317		($3,597,123)	$6,723,145	1.136	$7,639,146	$431.41	1.000	$431.41
Transportation - Emergency	$389,446	$608			$390,054	1.154	$450,095	$25.42	0.965	$24.53
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$88,879,754	$109,676	$1,045,722	($3,026,655)	$87,008,498			$5,222.95		$5,058.13
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$5,327.85		$5,159.68

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Rural	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$6,233	$0		$149	$6,383	1.251	$7,986	$0.41	0.965	$0.39
Ambulatory Surgery Center	$15,532	$26			$15,558	1.024	$15,928	$0.82	0.965	$0.79
Case Management Services	$0	$0			$0	1.024	$0	$0.00	0.965	$0.00
Consumer Directed Services	$13,442,922	$2,568	$26,920	$210,407	$13,682,817	1.089	$14,898,697	$762.67	0.965	$735.97
DME/Supplies	$1,695,592	$2,648		($8,016)	$1,690,225	1.154	$1,950,399	$99.84	0.965	$96.35
Emergency	$1,393,372	$4,280			$1,397,652	0.983	$1,373,306	$70.30	0.965	$67.84
FQHC	$162,787	$270			$163,057	1.024	$166,939	$8.55	0.965	$8.25
Home Health Services	$778,517	$2,391		$4,597	$785,506	0.983	$771,823	$39.51	0.965	$38.13
Inpatient - Medical/Surgical	$17,617,099	$47,641		($1,002,887)	$16,661,853	1.046	$17,429,850	$892.24	0.965	$861.01
Inpatient - Psych	$321,822	$0		$82,661	$404,483	1.046	$423,127	$21.66	0.965	$20.90
Lab and X-ray Services	$565,622	$883			$566,505	1.154	$653,707	$33.46	0.965	$32.29
Medicare Xover - IP	$1,216	$0			$1,216	1.000	$1,216	$0.06	1.000	$0.06
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Physician	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Nursing Facility	$30,825,206	$35,554	$895,931	$887,555	$32,644,247	1.000	$32,644,247	$1,671.06	0.965	$1,612.58
Outpatient - Other	$6,106,620	$18,758		$70,442	$6,195,820	0.983	$6,087,895	$311.64	0.965	$300.73
Outpatient - Psychological	$13,605	$42			$13,646	0.983	$13,409	$0.69	0.965	$0.66
Personal Care Services	$6,472,496	$1,980	$13,383	$223,273	$6,711,133	1.089	$7,307,496	$374.07	0.965	$360.98
Physician - Clinic	$1,754,487	$2,909		$12,376	$1,769,771	1.024	$1,811,899	$92.75	0.965	$89.50
Physician - IP Mental Health	$5,058	$8		$36	$5,102	1.024	$5,223	$0.27	0.965	$0.26
Physician - OP Mental Health	$2,136,509	$3,542		$15,071	$2,155,121	1.024	$2,206,422	$112.95	0.965	$108.99
Physician - Other Practitioner	$1,536,359	$2,547		$11,457	$1,550,363	1.024	$1,587,268	$81.25	0.965	$78.41
Physician - PCP	$1,057,352	$1,753		$7,640	$1,066,745	1.024	$1,092,138	$55.91	0.965	$53.95
Physician - Specialist	$1,307,614	$2,168		$9,448	$1,319,229	1.024	$1,350,632	$69.14	0.965	$66.72
Pharmacy	$12,915,511	$1,648		($4,502,268)	$8,414,891	1.136	$9,561,385	$489.45	1.000	$489.45
Transportation - Emergency	$915,359	$1,430			$916,788	1.154	$1,057,908	$54.15	0.965	$52.26
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$101,046,890	$133,047	$936,234	($3,978,059)	$98,138,111			$5,325.29		$5,158.93
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$5,432.29		$5,262.53

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
Tidewater	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$10,073	$1		$241	$10,315	1.251	$12,907	$0.66	0.965	$0.63
Ambulatory Surgery Center	$15,087	$25			$15,112	1.024	$15,472	$0.79	0.965	$0.76
Case Management Services	$0	$0			$0	1.024	$0	$0.00	0.965	$0.00
Consumer Directed Services	$3,942,333	$753	$1,833	$61,610	$4,006,530	1.089	$4,362,557	$221.42	0.965	$213.67
DME/Supplies	$1,712,554	$2,675		($8,096)	$1,707,133	1.154	$1,969,910	$99.98	0.965	$96.48
Emergency	$1,617,010	$4,967			$1,621,977	0.983	$1,593,724	$80.89	0.965	$78.06
FQHC	$249,172	$413			$249,585	1.024	$255,526	$12.97	0.965	$12.52
Home Health Services	$636,988	$1,957		$3,761	$642,706	0.983	$631,511	$32.05	0.965	$30.93
Inpatient - Medical/Surgical	$20,138,444	$54,459		($1,146,420)	$19,046,483	1.046	$19,924,396	$1,011.28	0.965	$975.88
Inpatient - Psych	$213,290	$0		$54,784	$268,075	1.046	$280,431	$14.23	0.965	$13.74
Lab and X-ray Services	$493,606	$771			$494,377	1.154	$570,476	$28.95	0.965	$27.94
Medicare Xover - IP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - OP	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Other	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - Physician	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Nursing Facility	$35,602,783	$41,065	$1,747,787	$1,025,117	$38,416,751	1.000	$38,416,751	$1,949.87	0.965	$1,881.62
Outpatient - Other	$4,832,785	$14,845		$55,748	$4,903,378	0.983	$4,817,966	$244.54	0.965	$235.98
Outpatient - Psychological	$17,435	$54			$17,489	0.983	$17,184	$0.87	0.965	$0.84
Personal Care Services	$18,807,620	$5,753	$37,254	$648,726	$19,499,353	1.089	$21,232,102	$1,077.65	0.965	$1,039.93
Physician - Clinic	$2,403,282	$3,984		$16,952	$2,424,218	1.024	$2,481,924	$125.97	0.965	$121.56
Physician - IP Mental Health	$1,179	$2		$8	$1,189	1.024	$1,217	$0.06	0.965	$0.06
Physician - OP Mental Health	$6,055,144	$10,039		$42,712	$6,107,895	1.024	$6,253,287	$317.39	0.965	$306.28
Physician - Other Practitioner	$2,412,321	$3,999		$17,990	$2,434,310	1.024	$2,492,256	$126.50	0.965	$122.07
Physician - PCP	$1,372,858	$2,276		$9,919	$1,385,053	1.024	$1,418,023	$71.97	0.965	$69.45
Physician - Specialist	$1,336,669	$2,216		$9,658	$1,348,543	1.024	$1,380,643	$70.08	0.965	$67.62
Pharmacy	$12,651,975	$1,615		($4,410,401)	$8,243,189	1.136	$9,366,289	$475.39	1.000	$475.39
Transportation - Emergency	$562,469	$878			$563,347	1.154	$650,063	$32.99	0.965	$31.84
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$115,085,076	$152,747	$1,786,874	($3,617,690)	$113,407,007			$6,078.97		$5,885.73
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$6,201.35		$6,004.16

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 2018 PACE Capitation Rate Development
UPL and Unadjusted Capitation Rate Calculations
Non-Dual Population

Exhibit 4b

Age 55 and Over										
All Regions	Medicaid Payments FY15 - FY16	Completion Factor Adjustment	Patient Payments FY15 - FY16	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	FFSE PMPM FY18	Savings Factor	Unadjusted Capitation Rate FY18
Service Type										
Adult Day Care	$760,783	$40	$2,049	$18,289	$781,161	1.251	$977,454	$11.77	0.965	$11.36
Ambulatory Surgery Center	$53,683	$89			$53,772	1.024	$55,052	$0.66	0.965	$0.64
Case Management Services	$0	$0			$0	1.024	$0	$0.00	1.000	$0.00
Consumer Directed Services	$45,534,530	$8,698	$70,116	$708,290	$46,321,634	1.089	$50,437,860	$607.36	0.965	$586.10
DME/Supplies	$6,443,166	$10,063		($30,459)	$6,422,770	1.154	$7,411,420	$89.25	0.965	$86.12
Emergency	$5,480,276	$16,834			$5,497,110	0.983	$5,401,356	$65.04	0.965	$62.76
FQHC	$511,951	$849			$512,800	1.024	$525,007	$6.32	0.965	$6.10
Home Health Services	$2,637,750	$8,103		$15,576	$2,661,428	0.983	$2,615,069	$31.49	0.965	$30.39
Inpatient - Medical/Surgical	$78,243,385	$211,588		($4,454,156)	$74,000,817	1.046	$77,411,750	$932.17	0.965	$899.54
Inpatient - Psych	$1,189,309	$0		$305,479	$1,494,788	1.046	$1,563,687	$18.83	0.965	$18.17
Lab and X-ray Services	$2,239,019	$3,497			$2,242,516	1.154	$2,587,704	$31.16	0.965	$30.07
Medicare Xover - IP	$2,766	$0			$2,766	1.000	$2,766	$0.03	1.000	$0.03
Medicare Xover - Nursing Facility	$0	$0			$0	1.000	$0	$0.00	1.000	$0.00
Medicare Xover - OP	$18	$0			$18	1.000	$18	$0.00	1.000	$0.00
Medicare Xover - Other	$350	$0			$350	1.000	$350	$0.00	1.000	$0.00
Medicare Xover - Physician	$201	$0			$201	1.000	$201	$0.00	1.000	$0.00
Nursing Facility	$143,663,470	$165,703	$5,744,318	$4,136,526	$153,710,017	1.000	$153,710,017	$1,850.92	0.965	$1,786.14
Outpatient - Other	$20,725,516	$63,665		$239,076	$21,028,256	0.983	$20,661,964	$248.80	0.965	$240.10
Outpatient - Psychological	$71,927	$221			$72,148	0.983	$70,891	$0.85	0.965	$0.82
Personal Care Services	$53,487,776	$16,362	$80,904	$1,844,076	$55,429,118	1.089	$60,354,652	$726.77	0.965	$701.33
Physician - Clinic	$8,626,425	$14,302		$60,849	$8,701,576	1.024	$8,908,707	$107.28	0.965	$103.52
Physician - IP Mental Health	$8,735	$14		$62	$8,811	1.024	$9,020	$0.11	0.965	$0.10
Physician - OP Mental Health	$15,522,989	$25,736		$109,496	$15,658,221	1.024	$16,030,947	$193.04	0.965	$186.28
Physician - Other Practitioner	$7,269,615	$12,052		$54,213	$7,335,880	1.024	$7,510,502	$90.44	0.965	$87.27
Physician - PCP	$4,988,253	$8,270		$36,041	$5,032,564	1.024	$5,152,359	$62.04	0.965	$59.87
Physician - Specialist	$5,288,020	$8,767		$38,207	$5,334,994	1.024	$5,461,987	$65.77	0.965	$63.47
Pharmacy	$51,405,092	$6,560		($17,919,500)	$33,492,152	1.136	$38,055,320	$458.25	1.000	$458.25
Transportation - Emergency	$2,603,331	$4,066			$2,607,396	1.154	$3,008,750	$36.23	0.965	$34.96
Transportation - Non-Emergency	$0	$0			$0	1.000	$0	$82.46	1.000	$82.46
Total	$456,758,336	$585,478	$5,897,388	($14,837,937)	$448,403,264			$5,717.05		$5,535.88
DMAS Fee-For-Service Admin Cost								2.0%		2.0%
Total With Admin								$5,832.04		$5,647.17

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 2018 PACE Capitation Rate Development

Comparison of FY 2018 Unadjusted Capitation Rates and UPL

Exhibit 5a

Region	Dual Eligibles FY 2018	Non-Dual Eligibles FY 2018	Weighted Average FY 2018	Difference from UPL Rates
	PACE Unadjusted Capitation Rates			
Northern Virginia	$4,730.97	$6,492.78	$4,952.56	-3.4%
Other MSA	$3,872.73	$5,321.48	$4,001.41	-3.4%
Richmond/Charlottesville	$3,788.93	$5,159.68	$4,011.95	-3.4%
Rural	$3,333.46	$5,262.53	$3,532.15	-3.4%
Tidewater	$3,822.24	$6,004.16	$4,192.87	-3.4%
Statewide Average weighted by PACE Eligibles	$3,861.19	$5,654.59	$4,087.83	-3.4%

Region	Dual Eligibles FY 2018	Non-Dual Eligibles FY 2018	Weighted Average FY 2018
	FFSE / UPL		
Northern Virginia	$4,899.35	$6,710.05	$5,127.09
Other MSA	$4,009.95	$5,493.76	$4,141.74
Richmond/Charlottesville	$3,923.14	$5,327.85	$4,151.68
Rural	$3,451.16	$5,432.29	$3,655.21
Tidewater	$3,957.68	$6,201.35	$4,338.80
Statewide Average weighted by PACE Eligibles	$3,998.02	$5,839.76	$4,230.77

Note:
Percent change and weighted average by region based on March 2017 member months for PACE eligibles.

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Nursing Home vs Non-Nursing Home Mix Factor

Exhibit 5b

Dual Population

Region	Historical Cost PMPM (FY15-FY16)			NH Eligible % FY15-FY16	NH Eligible % March 2017*	Nursing Home Mix Factor with NH Eligible % March 2017
	NH	Non-NH	Total			
Northern Virginia	$5,867.14	$3,456.40	$4,397.65	39.0%	35.0%	0.978
Other MSA	$4,863.13	$1,903.77	$3,690.41	60.4%	59.5%	0.993
Richmond/Charlottesville	$5,035.34	$2,181.54	$3,575.82	48.9%	47.0%	0.985
Rural	$4,363.73	$1,931.13	$3,142.35	49.8%	49.3%	0.996
Tidewater	$4,862.22	$2,430.96	$3,599.41	48.1%	47.1%	0.993
Statewide	$4,884.17	$2,387.46	$3,621.44	49.4%	47.7%	

Non-Dual Population

Region	Historical Cost PMPM (FY15-FY16)			NH Eligible % FY15-FY16	NH Eligible % March 2017*	Nursing Home Mix Factor with NH Eligible % March 2017
	NH	Non-NH	Total			
Northern Virginia	$7,945.93	$5,443.75	$6,347.06	36.1%	30.0%	0.976
Other MSA	$7,096.73	$4,121.75	$5,282.05	39.0%	35.8%	0.982
Richmond/Charlottesville	$6,953.11	$4,245.26	$5,078.48	30.8%	30.0%	0.996
Rural	$6,955.17	$4,319.47	$5,220.69	34.2%	33.2%	0.995
Tidewater	$7,267.22	$5,123.56	$5,932.23	37.7%	34.4%	0.988
Statewide	$7,238.32	$4,662.31	$5,571.31	35.3%	32.3%	

Note:
NH Eligible % FY15-FY16 based on historical period FY15-FY16 PACE eligibles.
*NH Eligible % March 2017 based on March 2017 PACE eligibles with Duals floored at 35.0% and Nonduals floored at 30.0%.

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Post-CCC Dual Risk Adjustment Factor

Exhibit 5c

Dual Population

Region	Historical Cost PMPM (FY15-FY16)			NH Eligible % March 2017	Risk Adjustment Factor		Weighted Risk Adjustment Factor
	NH	Non-NH	Total reweighted to March 2017 Mix		NH	Non-NH	
Northern Virginia	$5,867.14	$3,456.40	$4,300.16	35.0%	1.006	1.044	**1.026**
Other MSA	$4,863.13	$1,903.77	$3,663.67	59.5%	1.001	1.000	**1.001**
Richmond/Charlottesville	$5,035.34	$2,181.54	$3,523.18	47.0%	1.004	1.000	**1.002**
Rural	$4,363.73	$1,931.13	$3,131.17	49.3%	1.000	1.000	**1.000**
Tidewater	$4,862.22	$2,430.96	$3,575.38	47.1%	1.000	1.000	**1.000**

Note:
Risk adjustment factor reflects the phase in of the CCC Dual program and is applied only to the months before CCC Dual Program implementation in base period (FY15-FY16).

Risk adjustment factor does not apply to Non-Dual population.

Weighted Risk Adjustment Factor =

{[NH Eligible %*NH PMPM*NH Risk Adjustment Factor]+[(1-NH Eligible %)*Non-NH PMPM*Non-NH Risk Adjustment Factor]}/Total Historical Cost reweighted to March 2017

Virginia Medicaid

Exhibit 5d

FY 2018 PACE Capitation Rate Development

Comparison of FY 2018 Adjusted Capitation Rates and UPL

Region	Dual Eligibles FY 2018	Non-Dual Eligibles FY 2018	Weighted Average FY 2018	Difference from UPL Rates
	PACE Adjusted Capitation Rates			
Northern Virginia	$4,744.13	$6,336.61	$4,944.42	-3.4%
Other MSA	$3,848.24	$5,225.45	$3,970.57	-3.4%
Richmond/Charlottesville	$3,742.39	$5,138.47	$3,969.53	-3.4%
Rural	$3,322.32	$5,237.29	$3,519.56	-3.4%
Tidewater	$3,796.73	$5,932.69	$4,159.55	-3.4%
Statewide Averageweighted by PACE Eligibles	$3,843.96	$5,585.19	$4,064.01	-3.4%
Statewide Averageweighted by PACE Enrollees*	$3,788.11	$5,613.68	$3,898.75	-3.4%

Region	Dual Eligibles FY 2018	Non-Dual Eligibles FY 2018	Weighted Average FY 2018
	FFSE / UPL		
Northern Virginia	$4,912.97	$6,548.66	$5,118.70
Other MSA	$3,984.59	$5,394.62	$4,109.83
Richmond/Charlottesville	$3,874.95	$5,305.96	$4,107.77
Rural	$3,439.63	$5,406.23	$3,642.18
Tidewater	$3,931.27	$6,127.52	$4,304.33
Statewide Averageweighted by PACE Eligibles	$3,980.18	$5,768.07	$4,206.13
Statewide Averageweighted by PACE Enrollees*	$3,922.32	$5,797.61	$4,035.97

Note:
Percent change and weighted average by region based on March 2017 member months for PACE eligibles.
*Statewide weighted average based on March 2017 PACE Enrollees.

Virginia Medicaid

FY 2018 PACE Capitation Rate Development
Comparison of FY 2017 and FY 2018 Capitation Rates

Exhibit 5e

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	FY 2017	FY 2018	% Change	FY 2017	FY 2018	% Change	FY 2017	FY 2018	% Change
	PACE Capitation Rates								
Northern Virginia	$4,626.04	$4,744.13	2.6%	$6,053.03	$6,336.61	4.7%	$4,805.52	$4,944.42	2.9%
Other MSA	$3,713.76	$3,848.24	3.6%	$5,056.24	$5,225.45	3.3%	$3,833.01	$3,970.57	3.6%
Richmond/Charlottesville	$3,592.37	$3,742.39	4.2%	$4,707.58	$5,138.47	9.2%	$3,773.81	$3,969.53	5.2%
Rural	$3,177.90	$3,322.32	4.5%	$4,876.72	$5,237.29	7.4%	$3,352.87	$3,519.56	5.0%
Tidewater	$3,617.01	$3,796.73	5.0%	$5,360.09	$5,932.69	10.7%	$3,913.10	$4,159.55	6.3%
Statewide Average weighted by PACE Eligibles	$3,699.82	$3,843.96	3.90%	$5,199.92	$5,585.19	7.41%	$3,889.40	$4,064.01	4.49%
Statewide Average weighted by PACE Enrollees*	$3,634.33	$3,788.11	4.23%	$5,188.65	$5,613.68	8.19%	$3,728.53	$3,898.75	4.57%

Note:
Percent change and weighted average by region based on March 2017 member months for PACE Eligibles.
*Statewide weighted average based on March 2017 PACE Enrollees.

Virginia Medicaid

FY 2018 PACE Capitation Rate Development
Member Months of Eligibles and Enrollees

Exhibit 5f

PACE Eligibles, March 2017

Region	Dual Eligibles	Non-Dual Eligibles	Total
	Member Months		
Northern Virginia	5,541	797	6,338
Other MSA	5,684	554	6,238
Richmond/Charlottesville	4,703	914	5,617
Rural	8,262	949	9,210
Tidewater	4,761	974	5,735
Statewide Average	28,951	4,188	33,139

PACE Enrollees, March 2017

Region	Dual Enrollees	Non-Dual Enrollees	Total
	Member Months		
Northern Virginia	115	12	127
Other MSA	214	9	223
Richmond/Charlottesville	312	23	335
Rural	242	11	253
Tidewater	450	31	481
Statewide Average	1,333	86	1,419

Virginia Medicaid
FY 2018 PACE Capitation Rate Development
Historical Fee-For-Service Claims
Description of Unit Counts

Exhibit 6
DRAFT

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 2018 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	Chesapeake City
Arlington County	Appomattox County	Amelia County	Alleghany County	Lunenburg County	Gloucester County
Clarke County	Bedford City	Caroline County	Augusta County	Madison County	Hampton City
Fairfax City	Bedford County	Charles City County	Bath County	Martinsville City	Isle of Wight County
Fairfax County	Botetourt County	Charlottesville City	Bland County	Mecklenburg County	James City County
Falls Church City	Bristol City	Chesterfield County	Brunswick County	Middlesex County	Mathews County
Fauquier County	Campbell County	Colonial Heights City	Buchanan County	Northampton County	Newport News City
Fredericksburg City	Craig County	Cumberland County	Buckingham County	Northumberland County	Norfolk City
Loudoun County	Danville City	Dinwiddie County	Buena Vista City	Norton City	Poquoson City
Manassas City	Franklin County	Fluvanna County	Carroll County	Nottoway County	Portsmouth City
Manassas Park City	Frederick County	Goochland County	Charlotte County	Orange County	Suffolk City
Prince William County	Giles County	Greene County	Clifton Forge City	Page County	Surry County
Spotsylvania County	Harrisonburg, City of	Hanover County	Covington City	Patrick County	Virginia Beach City
Stafford County	Lynchburg City	Henrico County	Culpeper County	Prince Edward County	Williamsburg City
Warren County	Montgomery County	Hopewell City	Dickenson County	Rappahannock County	York 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 3.0 rate setting, but is moved to Rural for PACE rate setting.
Bedford County is in Roanoke-Alleghany for Medallion 3.0 rate setting, but is retained in Other MSA for PACE rate setting.