

# **Commonwealth Coordinated Care CY 2016 Final Rate Report January 28, 2016**

The Commonwealth of Virginia, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the Medicaid and Medicare components of the CY 2016 rates for the Commonwealth Coordinated Care program.

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract between CMS, the Commonwealth of Virginia, and the Participating Plans (Medicare-Medicaid Plans). The components of the capitation rates are based on estimates of what Medicare and Medicaid would have spent on behalf of the enrollees absent the Demonstration, with the agreed upon savings percentage subsequently applied.

Included in this report are final Medicaid rates and Medicare county base rates for calendar year 2016.

## **I. Components of the Capitation Rate**

CMS and Virginia will each contribute to the global capitation payment. CMS and Virginia will each make monthly payments to Participating Plans for their components of the capitated rate. Participating Plans will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services and a third amount from Virginia reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the prevailing Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. To adjust the Medicaid component, Virginia's methodology assigns each enrollee to a rating category (RC) according to the individual enrollee's nursing facility level of care status, age, and region.

Section II of this document includes information on the Medicaid component of the rate. Section III includes information on the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withholds.

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## II. Virginia Medicaid Component of the Rate – CY 2016

This section presents the development of the capitation rates for the Medicaid portion of the Virginia Medicare-Medicaid Financial Alignment Demonstration (Dual Demonstration) for Calendar Year 2016 effective January 1, 2016 prepared by the Virginia Department of Medical Assistance Services (DMAS). This content includes description of historical base data production details, adjustments applied to the historical base data, and trend factors used to project historical base data forward to the contract period.

The full report titled “Commonwealth of Virginia Department of Medical Assistance Services Dual Demonstration Data Book and Capitation Rates: Medicaid Component Calendar Year 2016 is available for download on the DMAS website for Integrated Care for Medicare-Medicaid Enrollees at [http://www.dmas.virginia.gov/content\\_pgs/capitation.aspx](http://www.dmas.virginia.gov/content_pgs/capitation.aspx).

Medicaid capitation rate cells for the Dual Demonstration are as follows:

- **Nursing Home Eligible (NHE) Age 21-64.** Single rate cell for all enrollees age 21-64 meeting Nursing Facility Level of Care criteria and enrolled in the EDCD waiver or residing in a nursing facility for 20 or more consecutive days; rates will vary for the five CCC Demonstration regions. Rates are developed separately for subpopulations in nursing home institutions (NHE-I) and HCBS waivers (NHE-W) and the final NHE rate blends the rates for the two subpopulations.
- **Nursing Home Eligible (NHE) Age 65 and over.** Single rate cell for all enrollees age 65 and over meeting Nursing Facility Level of Care criteria and enrolled in the EDCD waiver or residing in a nursing facility for 20 or more consecutive days; rates will vary for the five CCC Demonstration regions. Rates are developed separately for subpopulations in nursing home institutions (NHE-I) and HCBS waivers (NHE-W) and the final NHE rate blends the rates for the two subpopulations.
- **Community Well (CW) Age 21-64.** Enrollees age 21-64 who do not meet Nursing Facility Level of Care criteria; rates will vary for the five CCC Demonstration regions.
- **Community Well (CW) Age 65 and over.** Enrollees age 65 and over that do not meet Nursing Facility Level of Care criteria; rates will vary for the five CCC Demonstration regions.

### **Data Sources**

Detailed Medicaid historical fee-for-service claims and eligibility data from DMAS’ Medicaid Management Information System (MMIS) for services incurred and months of enrollment during state fiscal years 2013 and 2014 with claims paid through July 2015. 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 nursing facility and home and community base care services, termed the *patient pay amount*.

Individuals in the base data eligible for the CCC were matched to two other data sets. These are 1) mental and behavioral health costs managed by Magellan under an administrative services

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arrangement that began December 1, 2013, and 2) claims associated with consumer-directed personal care services received under the EDCD waiver that are paid through a separate vendor.

All claims, non-claims payment data, and eligibility data for members who are not eligible for the Demonstration were excluded from the historical data used in these calculations. Individuals who meet at least one of the criteria listed below are excluded from the CCC:

- Required to “spend down” in order to meet Medicaid eligibility requirements;
- In aid categories which Virginia only pays a limited amount each month toward their cost of care, including non-full benefit Medicaid beneficiaries such as Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs) or Qualifying Individuals (QIs);
- Inpatients in state mental hospitals;
- Residents of State Hospitals, , State Veterans Nursing Facilities, ICF/MR facilities, Residential Treatment Facilities, or long stay hospitals;
- Participate in federal Home and Community Based Services waivers other than the EDCD Waiver, such as Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology Assisted Waiver, and Alzheimer’s Assisted Living waivers;
- Enrolled in a hospice program;
- Receive the end stage renal disease (ESRD) Medicare benefit prior to enrollment into the Demonstration;
- Have other comprehensive group or individual health insurance coverage, other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);
- Have a Medicare supplemental policy to cover traditional Medicare deductible and copayment requirements;
- Have a Medicaid eligibility period that is only retroactive;
- Enrolled in the Virginia Birth-Related Neurological Injury Compensation Program;
- Enrolled in the Money Follows the Person (MFP) Program;
- Reside outside of the CCC Demonstration areas;
- Enrolled in a Program of All-Inclusive Care for the Elderly (PACE)<sup>1</sup>;
- Participate in the CMS Independence at Home (IAH) demonstration identified in the CMS/Infocrossing files.

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<sup>1</sup> Individuals enrolled in a PACE program may voluntarily elect to disenroll from PACE and enroll in the Demonstration, but they will not be passively enrolled.

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Claims are limited to those services covered in the approved State Plan and EDCD waiver services. The following is the list of services not covered in the State Plan or EDCD waiver:

- Abortions, induced
- Case management services for participants of Auxiliary Grants
- Case management services for the elderly
- Chiropractic services
- Christian Science nurses and Christian Science Sanatoria
- Dental
- Experimental and investigational procedures
- Regular assisted living services provided to residents of assisted living families

The following services are in the State Plan but carved out of the CCC Demonstration or are covered in waivers that are not part of the Demonstration:

- Community Mental Retardation Services
- Hospice Care
- Inpatient mental health services rendered in a state psychiatric hospital
- Private duty nursing
- Targeted case management

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## ***Programmatic and Legislative Adjustments***

As outlined in the Memorandum of Understanding (MOU), rates have been developed based on expected costs for the eligible population had the CCC Demonstration not been implemented. If a member opts out of the CCC program, he returns to the FFS program. The rate setting methodology for this time period (January to December 2016) uses the expected costs for the FFS program. A number of changes in covered services and payment levels have been mandated by the Virginia Legislature or by changes to the Medicaid State Plan or waivers. The adjustments included below have been made to the historical base data to reflect the benefits and costs that will apply in CY 2016 to fee-for-service dual eligible individuals.

The following table summarizes the adjustment percentages applied to the base data by major service category for each sub-population, with the exception of the administrative adjustment. A more detailed description of each adjustment and the accompanying adjustment value are provided below. As noted below, any adjustments related to changes in SFY 2017 may cause the CY16 CCC Duals rates to be revised adjustments for SFY 2017 effective July 1, 2016 may be included based on actions by the General Assembly in the upcoming 2016 session.

<b>Table 1. Summary of Programmatic and Legislative Adjustments to Medicaid Base Year Expenditures</b>			
<b>Category of Service</b>	<b>NHE - Institutional</b>	<b>NHE - Waiver</b>	<b>Community Well</b>
Inpatient	2.1%	2.1%	1.9%
Outpatient/ER	0.0%	0.0%	0.0%
Physician/Professional	0.6%	0.5%	0.9%
Pharmacy	-3.8%	-3.8%	-4.0%
Nursing Facility	10.5%	10.5%	10.5%
HCBS/Home Health Care	5.2%	--	7.1%
HCBS/Home Health Care – CD Only	--	9.5%	--
HCBS/Home Health Care – without CD	--	2.2%	--
Mental Health/ Substance Abuse	-10.5%	0.5%	-2.0%
Ancillary/Other	-9.4%	-19.9%	-16.9%
Medicare Crossover	0.0%	0.0%	0.0%
<b>Weighted Average</b>	<b>10.2%</b>	<b>1.5%</b>	<b>0.0%</b>

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## Prescription drug co-pay adjustment

This adjustment is developed to take into consideration differences in pharmacy payment policy for FFS Medicaid and the dual eligible population. Effective January 1, 2013, Medicare Part D began to cover benzodiazepines with no restrictions and barbiturates when used in the treatment of epilepsy, cancer or chronic mental disorders and therefore they are no longer paid by Virginia Medicaid. These drugs are removed from the base data for the CCC population, which primarily affects cost and utilization in the period July 1 to December 31, 2012. A 4% rebate that reflects the high proportion of generic and over the counter medicines that are paid by DMAS was applied. As mandated by Federal law, co-payments are not imposed on recipients in nursing homes or in community-based waivers, although a small amount of co-payment was reported in the FFS data and is included in the adjustment for the NHE population. The Demonstration imposes limited cost-sharing for pharmacy services on the CW population. These copayments are excluded from the CW pharmacy base data and there is not any further co-payment adjustment.

This produces an adjustment of -3.8% for the NHE population and -4.0% for the CW population and is applied to the pharmacy claims.

## Non-emergency transportation adjustment

Non-emergency transportation (NET) services were contracted to a broker during the historical data period under a capitated payment methodology, and 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 October 1, 2014.

The ABAD nursing home population statewide non-emergency transportation rate of \$47.22 PMPM is used for the NHE value and the Other ABAD Age 21 and over rate of \$31.50 PMPM is used for the Community Well value. These rates are added to the overall cost for each sub-population.

## Adult day care fee adjustment

This adjustment incorporates a fee increase of \$10 per day effective July 1, 2013, the beginning of FY2014. Northern Virginia rates are higher than the rest of the state, therefore the value of the increase is calculated separately for that region.

The calculation results in a 7.2% adjustment for Northern Virginia and a 10.7% adjustment for the other regions and is applied to adult day care claims.

## Hospital inpatient adjustment

There are a number of changes in DMAS hospital inpatient payment policy between the FY 2013 and FY 2014 base period and the CY 2016 rate year.

Effective FY 2014, there was no explicit unit cost increase, but hospital reimbursement rates were rebased resulting in a weighted average cost per unit change of 4.7% for inpatient medical/surgical and -7.4% for inpatient psychiatric. FY 2014 unit cost change is applied to the operating cost component.

For both FY 2015 and FY 2016, the Virginia General Assembly did not provide a budget regulatory increase so there is no unit cost increase.

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For inpatient medical/surgical, the positive adjustment is 2.1%. For inpatient psychiatric in acute care hospitals, the negative adjustment is 1.1%. The inpatient psychiatric factor is applied to Inpatient-Psych service line.

### *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 and any policy changes. This nursing facility reimbursement change produced a substantial increase in the unit cost amount in the claims run out beginning July 2014 compared to the FY 2013 – FY 2014 base period. Because of the change to the prospective rate, the nursing facility adjustment is revised. The FY 2013 to FY 2015 capital and operating cost factor changes and the FY 2014 occupancy requirement change are incorporated in the prospective rate. The revised nursing facility adjustment is a unit cost adjustment that increases the CY 2013-CY2014 base period nursing facility unit cost to the FY 2015 nursing facility prospective unit cost.

The adjustment increase of 10.5% is equal to the ratio of the average of the prospective payment unit cost in the last six months of historical data in FY 2015 (January to June 2015) to the base data FY2013 and FY2014. There is no nursing facility fee increase for FY2016.

The calculation results in a positive 10.5% adjustment is applied to nursing facility claims.

### *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, the FY 2016 fee change applies to relevant claims in the consumer directed services and personal care services categories.

The calculation results in adjustment factors of 1.63% on the NHE-I, 1.98% on NHE-W and 2.00% on CW applied to consumer directed services claims and 1.98% on the NHE-I, 1.99% on NHE-W and 1.99% on CW applied to personal care services claims

### *Mental health skill-building services adjustment*

DMAS implemented a new policy for Mental Health Skill-Building Services (MHSS) effective December 1, 2013. This is described in the October 31, 2013 DMAS Medicaid Memo to Providers. Because of this policy change, DMAS expected an overall 20% reduction in utilization among the FFS population for Mental Health Skill Building Services. Members enrolled in CCC now receive MH services through the Medicare Medicaid Plans. Review of the DMAS FFS and the Magellan data after the new policy was implemented showed different levels of reduction across the CCC subpopulations.

The adjustments are: -20% for NHE-I, no savings for NHE-W and -3.9% for CW. These reductions are applied to service code H0046 (Mental Health Services, not otherwise specified). The H0046 code was 55% of the NHE I OP Mental Health base dollars, 62.4% of the NHE-W OP Mental Health and 51.8% of the CW OP Mental Health base dollars.

The MHSS adjustment is -11.1% on the NHE-I, 0.0% on NHE-W and -2.0% on CW and is applied to the Physician – OP Mental Health service.

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## Durable medical equipment fee adjustment

The 2014 General Assembly session reduced Medicaid fees for the products covered under the Medicare DME competitive bid program to a level based on the average of the competitive bid prices in the three areas of the state in the Medicare DME competitive bid program effective July 1, 2014. This was estimated to result in \$4.9 million in total savings. DMAS estimated that the Medicare competitive bid rates for the targeted DME services are 33% lower than the DMAS FFS Medicaid rates. DMAS provided a list of DME HCPCS codes subject to the Medicare competitive bid program and the average Medicare bid payment rate for the three areas in Virginia that participate in the program. 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 claims to determine the proportion of DME claims subject to the fee reduction and the average savings percentage based on the mix of DME codes subject to the savings. Overall, 8.7% of NHE-W and 6.2% of CW DME claims dollars were for codes subject to the reduction. Savings on this subset are 33.4% and 31.2% respectively.

This results in adjustment factor reduction of 2.9% for NHE-W and 1.9% for CW.

## Incontinence supplies fee adjustment

DMAS solicited bids for the cost of high volume incontinence supplies, primarily adult diapers and protection pads. The prices offered by the winning bidder were implemented January 1, 2014. When compared to prior DMAS payment rates, the new prices were estimated to produce nearly \$2.7 million in savings, or 33% of the cost of the mix of those supplies. 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 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. Overall, 21.6% of NHE-I and over half of the NHE-W and CW DME claims dollars were for incontinence supply codes subject to the reduction. Savings on this subset are 30.4% to 33.8%%

This results in adjustment factor reduction that ranges from 6.6% to 17.0%.

## Lab fee adjustment

The Virginia General Assembly approved budget includes a 12% reduction to lab fees (\$2.1 million in FFS savings) effective July 1, 2014. The 12% reduction was chosen to match the payment rates already in place for the Medallion 3.0 plans. Therefore, this adjustment is applied to any rates based on FFS claims data, including the CCC dual population.

## ER Triage adjustment

The 2015 General Assembly final Budget conference report eliminated ER triage for physician services. Current DMAS FFS policy applies ER Triage review only to Level III ER claims. If a case is 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 \$43.57 plus ancillaries. Eliminating the ER Triage review will increase the Level III ER payment to physicians by the difference in the triage amount and the physician fee for 99283 plus the average amount of ancillary services billed on those claims.

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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 \$43.57. Triage claims repriced to Level III claims for CW is approximately \$12,691. There were very few triage claims for NHE-W and NHE-I. When repriced to Level III, the estimated increase is \$1,100. The adjustment is very small because Medicare is the primary payer for the vast majority of ER claims.

The ER Triage adjustment is 0.07% on the NHE-I, 0.01% on NHE-W and 0.45% on CW and is applied to the Physician – Other Practitioner, Physician - .PCP, and Physician – Specialist claims.

### 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 last year, the update was based solely on DMAS FFS data. Plans reported that the rebasing is not cost neutral to their operations and that the impact on them varies. Last year the DMAS update used both FFS and MCO data. The FY 2016 DMAS analysis also used both 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 FY 2016 result in a -0.2% reduction to the MCO experience and a 0.5% increase to the FFS experience. Other codes, such as J codes for drugs administered in an office setting and anesthesia-related codes that are grouped in the professional service categories, are excluded from the adjustment.

The FFS professional fee adjustment is approximately 0.5% for NHE-I, NHE-W and CW.

### Elderly and Disabled with Consumer Direction overtime payment adjustment

Effective November 12 2015, states will be required to pay time and a half for hours in excess of 8 hours a day for home care workers providing home and community based services under the Elderly and Disabled with Consumer Direction (EDCD) waiver. In response to the Department of Labor regulatory requirement, DMAS analyzed the recent history of consumer directed payments to the home care workers, including the frequency and amount of time that would qualify for the overtime payment. That analysis estimated a 7.5% increase in Consumer Directed Services payments for all Medicaid beneficiaries in the EDCD waiver and includes the payments to the caregivers and employer taxes, but excludes the vendor administrative fees. Review of the DMAS analysis showed that PMPM payments for all EDCD eligibles is similar to the PMPM payment for the CCC Duals NHE-W population. The adjustment has the greatest impact on the NHE-W population where EDCD service payments are approximately 25% of the historical base data. There is a very minor impact on the NHE-I and the CW populations.

This adjustment is 7.5% for NHE-I, NHE-W and CW and is applied to the Consumer Directed Services claims.

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## DMAS FFS administrative adjustment

The 0.49% administrative factor is the estimated cost of DMAS staff and monitoring activities for the existing FFS programs that will be transferred to the participating health plans. The percentage is based on the estimated percentage cost of Medicare claims processing included in the Medicare standardized FFS county rates as a proxy for DMAS claims processing costs and the DMAS estimate of Medicaid administrative cost for prior authorizations attributed to the dual eligibles who will participate in the Demonstration. Because Demonstration requirements mandate that only current Medicaid expenditures related to the eligible population may be included in the capitation payments, there is no adjustment for costs related to administrative functions that the health plans will perform but are not currently performed by DMAS.

## ***Trend Adjustments***

The data used for the incurred by not reported (IBNR) and trend calculations reflect experience for the period FY 2012 through FY 2014. Data for FY 2013 to FY 2014 are used to evaluate the base period trend and an additional year of data, FY 2012 with run out through FY 2015, are used to develop contract period projected trend.

For services with fee increases reflected in the adjustments described in the previous section, the contract period trend is in addition to the planned cost per unit increase. The trend rates used reflect utilization and rate increases when additional legislative cost increases or decreases have been applied and represent PMPM increases otherwise. Specifically, the trend models are adjusted for the fee increases or decreases that occurred during the historical base period. Adjustments to the historical data before the analysis of trend were applied to both the Nursing Home Eligible and the Community Well trends and are presented in the following table.

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<b>Table 2. Summary of Adjustments to Trend</b>		
<b>Category of Service</b>	<b>Time Period</b>	<b>Adjustment</b>
HCBS	Jul 2012 – Jun 2013	0.990 ALL
	Jul 2013 – Jul 2015	0.990 NHE-I 0.987 NHE-W 0.990 CW
Mental Health / Substance Abuse	Dec 2013 – Jul 2015	1.239 NHE-I 1.000 NHE-W 1.043 CW
Ancillary/Other	Jul 2012 – Dec 2013	0.988 NHE-I 1.000 NHE-W 0.996 CW
	Jan 2014 – June 2014	1.038 NHE-I 1.273 NHE-W 1.264 CW
	Jul 2014 – Jul 2015	1.072 NHE-I 1.303 NHE-W 1.295 CW

Annual trend rates must be applied to move the historical data from the midpoint of the data period (July 1, 2013) to the midpoint of the contract period (June 30, 2016), for a total trend of 36 months.

The following tables show the IBNR and trend factors that have been applied to the adjusted historical base data for the two phases and separately for each sub-population. Calculation of applied trend incorporates patient payments for nursing facility and HCBS services. The cost and utilization of drugs that are now covered under Medicare Part D were removed from the pharmacy contract period trend development. Review of the residual Medicaid only Inpatient, Outpatient/ER, showed substantial fluctuation on a small utilization base for all the sub-populations. These Medicaid only data and contract period trends have been set to equal the trends developed for the ABAD population in the Medallion 3.0 program. All other data period and contract period trend values use the CCC Duals data.

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<b>Table 3. Summary of IBNR Adjustments</b>			
<b>Category of Service</b>	<b>NHE - Institutional</b>	<b>NHE - Waiver</b>	<b>Community Well</b>
Inpatient	0.1%	0.0%	0.3%
Outpatient/ER	0.0%	0.0%	0.5%
Physician/Professional	0.0%	0.0%	0.0%
Pharmacy	0.0%	0.0%	0.0%
Nursing Facility	0.0%	0.0%	0.0%
HCBS/Home Health Care	0.0%	n/a	0.0%
HCBS/Home Health Care – CD Only	n/a	0.0%	n/a
HCBS/Home Health Care - without CD	n/a	0.0%	n/a
Mental Health/ Substance Abuse	0.0%	0.0%	0.0%
Ancillary/Other	0.0%	0.0%	0.0%
Medicare Crossover	-0.2%	0.0%	0.0%
<b>Weighted Average</b>	<b>0.0%</b>	<b>0.0%</b>	<b>0.0%</b>

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<b>Table 4. Summary of Trend Adjustments</b>			
<b>Category of Service</b>	<b>NHE - Institutional</b>	<b>NHE - Waiver</b>	<b>Community Well</b>
	Total Trend Factor	Total Trend Factor	Total Trend Factor
Inpatient	1.0949	1.0949	1.0949
Outpatient/ER	1.0699	1.0699	1.0699
Physician/ Professional	1.2391	1.4152	0.8480
Pharmacy	0.9390	0.9610	0.8640
Nursing Facility	1.0074	1.0074	0.9590
HCBS/ Home Health Care	1.1223	n/a	0.9357
HCBS/Home Health Care – CD only	n/a	1.4879	n/a
HCBS/Home Health Care - without CD	n/a	0.9890	n/a
Mental Health/ Substance Abuse	0.9710	1.2181	1.1270
Ancillary/Other	0.8810	1.0660	1.1288
Medicare Crossover	1.0513	1.0115	1.1659
<b>Weighted Average</b>	<b>1.0081</b>	<b>1.1158</b>	<b>1.1054</b>

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### ***Blended Nursing Home Eligible Medicaid Capitation Rates and the Member Enrollment Mix Adjustment***

The NHE population is a combination of the NHE-Institutional and the NHE-Waiver populations. The adjusted and trended rates for these two populations are blended using the eligible member month distribution for July 2015 of 40% NHE-I and 60% NHE-W.

Table 5 presents the NHE blended rates. The blended NHE rates will be revised over the period of the Demonstration to pay health plan specific rates within each region that reflect the actual proportion of NHE-I and NHE-W members enrolled in each plan. This Member Enrollment Mix Adjustment (MEMA) adjustment is intended to minimize the risk due to actual plan enrollment that diverges from the Demonstration population average mix for any one plan and to adjust to the changes in enrollment mix over the course of the Demonstration. DMAS has adopted the MEMA policy recommendations described in a memo dated September 30, 2013. It is available on the DMAS website at [http://www.dmas.virginia.gov/Content\\_atchs/altc/cntct-mmfa\\_cr3.pdf](http://www.dmas.virginia.gov/Content_atchs/altc/cntct-mmfa_cr3.pdf).

<b>Table 5. CY 2016 Blended Nursing Home Eligible-Institutional and Nursing Home Eligible-Waiver</b>							
<b>Sub-Population</b>	<b>Age Group</b>						<b>CY 2016 Average</b>
		Central Virginia	Northern Virginia	Southwest/Roanoke	Tidewater	Western/Charlottesville	
Nursing Home Eligible-Institutional	Age 21-64	\$5,050.82	\$6,276.29	\$5,178.56	\$5,087.59	\$4,594.88	\$5,268.67
	Age 65+	\$5,117.34	\$6,152.11	\$4,928.38	\$4,934.45	\$4,959.16	\$5,182.28
Nursing Home Eligible-Waiver	Age 21-64	\$2,627.25	\$3,379.44	\$2,489.91	\$2,612.05	\$2,571.45	\$2,678.65
	Age 65+	\$2,456.17	\$3,395.46	\$2,272.07	\$2,419.01	\$2,202.09	\$2,677.78
<b>Nursing Home Eligible</b>	Age 21-64	\$3,180.00	\$4,333.02	\$3,102.04	\$3,158.90	\$3,020.47	\$3,297.81
	Age 65+	\$3,727.80	\$4,257.52	\$3,885.56	\$3,514.40	\$3,684.50	\$3,827.94
	<b>Average</b>	\$3,598.85	\$4,268.05	\$3,697.86	\$3,425.77	\$3,537.22	\$3,712.32

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### **Base Medicaid Capitation Rates**

The CY16 base capitation rates for the blended NHE and CW prior to the second year savings adjustment are presented in Table 6.

<b>Table 6. CY 2016 Dual Demonstration Base Capitation Rates Prior to 2% MOU Savings</b>							
<b>Sub-Population</b>	<b>Age Group</b>						<b>CY 2016 Average</b>
		Central Virginia	Northern Virginia	Southwest/ Roanoke	Tidewater	Western/ Charlottesville	
Nursing Home Eligible*	Age 21-64	\$3,180.00	\$4,333.02	\$3,102.04	\$3,158.90	\$3,020.47	\$3,297.81
	Age 65+	\$3,727.80	\$4,257.52	\$3,885.56	\$3,514.40	\$3,684.50	\$3,827.94
	<b>Average</b>	\$3,598.85	\$4,268.05	\$3,697.86	\$3,425.77	\$3,537.22	\$3,712.32
Community Well	Age 21-64	\$403.77	\$331.51	\$418.09	\$337.58	\$262.27	\$367.07
	Age 65+	\$232.27	\$148.72	\$285.27	\$215.21	\$230.06	\$197.29
	<b>Average</b>	\$321.27	\$181.66	\$364.14	\$277.47	\$246.98	\$268.96
<b>Weighted Average</b>		<b>\$1,714.42</b>	<b>\$1,356.06</b>	<b>\$1,807.34</b>	<b>\$1,465.19</b>	<b>\$1,647.65</b>	<b>\$1,572.25</b>

Note: \*NHE rates will be adjusted by MEMA calculations over the time period of the Demonstration.

### **MOU Savings Adjustment**

The MOU signed by the Commonwealth of Virginia and the Centers for Medicare and Medicaid Services establishes annual savings assumptions for the Virginia Medicare-Medicaid Financial Alignment Demonstration. First year savings, to cover the period CY 2014 and CY 2015, are 1%. The original MOU established CY 2016 savings at 2% and CY 2017 savings at 4%. However, DMAS submitted a request to CMS that the CY 2016 savings adjustment remain at 1% rather than increase to 2%, as in the terms of the original MOU. In early January 2016, CMS notified DMAS that it approved the reduction to the savings adjustment. As a result, the CY 2016 savings adjustment will remain at 1% and will increase to 2% during CY 2017.

The second year MOU savings of 1% is included in the Medicaid component of the capitation rates.

### **Quality Withhold adjustment**

The actual rates paid monthly to the health plans equal the final rates minus a quality withhold. Plans may earn back the “withheld” amount if they fully meet the quality criteria. There are two additional exhibits to reflect the quality withhold adjustment and the monthly rates that will actually be paid to the MMPs. The quality withhold was 1% in Demonstration Year One (2014-2015), 2% in Demonstration Year Two (2016) and 3% in Demonstration Year Three (2017).

The quality withhold adjustment for 2016 of 2% is included in the Medicaid component of the capitation rates

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### **Summary Capitation Rates**

The resulting Medicaid capitation rates for CY 2016 are presented in Table 7. These incorporate the 1% second year savings and the 2% quality withhold. All averages are weighted by the distribution of member months in July 2015.

The NHE Age 21-64 and Age 65 and Over regional blended rates will be revised during the year. DMAS will apply the MEMA as measured by enrollment effective January 2016. These MEMA adjustments will be health plan specific by region.

A new MEMA will be done effective July 2016 for all regions and establish rates for the remainder of the calendar year based on enrollment mix for each plan at the beginning of July. There will be further member enrollment mix adjustments to NHE rates over the final year of the Demonstration.

<b>Table 7. CY 2016 Dual Demonstration Capitation Rates with 1% Savings and 2% Quality Withhold</b>							
<b>Sub-Population</b>	<b>Age Group</b>						<b>CY 2016 Average</b>
		Central Virginia	Northern Virginia	Southwest/Roanoke	Tidewater	Western/Charlottesville	
Nursing Home Eligible*	Age 21-64	\$3,085.24	\$4,203.90	\$3,009.60	\$3,064.77	\$2,930.46	\$3,199.53
	Age 65+	\$3,616.72	\$4,130.65	\$3,769.77	\$3,409.67	\$3,574.70	\$3,713.87
	<b>Average</b>	\$3,491.61	\$4,140.86	\$3,587.67	\$3,323.68	\$3,431.81	\$3,601.69
Community Well	Age 21-64	\$391.74	\$321.63	\$405.63	\$327.52	\$254.45	\$356.13
	Age 65+	\$225.35	\$144.29	\$276.77	\$208.80	\$223.20	\$191.42
	<b>Average</b>	\$311.69	\$176.25	\$353.29	\$269.20	\$239.62	\$260.94
<b>Weighted Average</b>		<b>\$1,663.33</b>	<b>\$1,315.65</b>	<b>\$1,753.48</b>	<b>\$1,421.53</b>	<b>\$1,598.55</b>	<b>\$1,525.40</b>

Note: \*NHE rates will be adjusted by MEMA calculations over the time period of the Demonstration.

A list of the Demonstration counties by region follows in Table 8.

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<b>Table 8. Dual Demonstration County Listing by Region</b>				
<b>Phase</b>	<b>Region</b>	<b>County</b>		
Phase I	Central Virginia	Amelia County	Greensville County	Northumberland County
		Brunswick County	Hanover County	Nottoway County
		Caroline County	Henrico County	Petersburg City
		Charles City County	Hopewell City	Powhatan County Prince
		Chesterfield County	King George County	Edward County Prince
		Colonial Heights City	King William County	George County
		Cumberland County	King and Queen	Richmond City Richmond
		Dinwiddie County	County	County Southampton
		Emporia City	Lancaster County	County Spotsylvania
		Essex County	Lunenburg County	County Stafford County
		Franklin City	Mecklenburg County	Surry County Sussex
		Fredericksburg City	Middlesex County	County Westmoreland
	Goochland County	New Kent County	County	
	Tidewater	Accomack County	Matthews County	Suffolk City
Chesapeake City		Newport News City	Virginia Beach City	
Gloucester County		Norfolk City	Williamsburg City	
Hampton City		Northampton County	York County	
Isle of Wight County		Poquoson City		
James City County		Portsmouth City		
Phase II	Northern Virginia	Alexandria City	Fairfax County	Manassas City
		Arlington County	Falls Church City	Manassas Park City
		Culpeper County	Fauquier County	Prince William County
		Fairfax City	Loudoun County	
	Southwest/ Roanoke	Alleghany County	Floyd County	Patrick County
		Bath County	Franklin County	Pulaski County
		Bedford City	Giles County	Radford City
		Bedford County	Henry County	Roanoke City
		Botetourt County	Highland County	Roanoke County
		Buena Vista City	Lexington City	Rockbridge County
		Covington City	Martinsville City	Salem City
		Craig County	Montgomery County	Wythe County
	Western/ Charlottesville	Albemarle County	Greene County	Orange County
		Augusta County	Harrisonburg City	Rockingham County
		Buckingham County	Louisa County	Staunton City
Charlottesville City		Madison County	Waynesboro City	
Fluvanna County		Nelson County		

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## III. Medicare Components of the Rate – CY 2016

### *Medicare A/B Services*

CMS has developed baseline spending (costs absent the Demonstration) for Medicare A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the Demonstration. With the exception of specific subsets of enrollees as noted below, the Medicare baseline for A/B services is a blend of the Medicare Fee-for-Service (FFS) Standardized County Rates, as adjusted below, and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

Both baseline spending and payment rates under the Demonstration for Medicare A/B services are calculated as PMPM standardized amounts for each Demonstration county. Except as otherwise noted, the Medicare A/B portion of the baseline is updated annually based on the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage and Part D rate announcement, and Medicare Advantage bids (for the applicable year or for prior years trended forward to the applicable year) for products in which potential Demonstration enrollees would be enrolled absent the Demonstration.

*Medicare A/B Baseline Incorporating Medicare A/B FFS Baseline and Medicare Advantage Component:* CY 2016 Medicare A/B Baseline County rates are provided below.

The rates represent the weighted average of the CY 2016 FFS Standardized County Rates, updated to incorporate the adjustments noted below, and the Medicare Advantage projected payment rates for CY 2016, based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration start at the county level. The rates weight the FFS and Medicare Advantage components at the same weighting as used to set 2014-2015 rates. The Medicare Advantage component of the 2015 rate has been updated for CY 2016 based on Medicare Advantage trends.

The FFS component of the CY 2016 Medicare A/B baseline rate has been updated to better align Commonwealth Coordinated Care program Plan payments with Medicare fee-for-service costs, by offsetting underprediction in the CMS-HCC risk adjustment model for full benefit dual eligible beneficiaries. This 6.76% upward adjustment applies to the Medicare A/B FFS rate component for CY 2016 only.

*Applying the Savings Percentage:* The savings percentage (1% in Demonstration Year Two) described in Section IV is applied to the final Medicare A/B baseline (blending the final Medicare A/B FFS baseline and the Medicare Advantage rate components).

*Medicare A/B Component Payments:* CY 2016 Medicare A/B Baseline County rates are provided below.

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The FFS component of the CY 2016 Medicare A/B baseline rate has been updated to reflect a 1.84% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration). This 1.84% adjustment applies for CY 2016 and will be updated for subsequent years of the Demonstration.

*Coding Intensity Adjustment:* CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for CY 2016 in Medicare Advantage is 5.41%. For 2016, CMS has applied the full prevailing Medicare Advantage coding intensity adjustment and there is no upward adjustment to the Medicare A/B baseline rates to offset this reduction in the risk scores.

*Impact of Sequestration:* Under sequestration, for services beginning April 1, 2013, Medicare payments to providers for individual services under Medicare Parts A and B, and non-exempt portions of capitated payments to Part C Medicare Advantage Plans and Part D Medicare Prescription Drug Plans are reduced by 2%. These reductions are also applied to the Medicare components of the integrated rate. Therefore, under this Demonstration CMS will reduce non-exempt portions of the Medicare components of the integrated rate by 2%, as noted in the sections below.

*Default Rate:* The default rate will be paid when a beneficiary's address on record is outside of the service area. The default rate is specific to each Participating Plan and is calculated using an enrollment-weighted average of the rates for each county in which the Demonstration Plan participates.

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<b>2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County <sup>1</sup></b>							
<b>County</b>	<b>2016 Published FFS Standardized County Rate</b>	<b>2016 Initial Medicare A/B FFS Baseline</b>  (increased to reflect CY 2016 risk adjustment model update)	<b>2016 Updated Medicare A/B FFS Baseline</b>  (updated by CY 2016 bad debt adjustment)	<b>2016 Final Medicare A/B FFS Baseline</b>  (increased to offset application of coding intensity adjustment factor in 2016)	<b>2016 Final Medicare A/B Baseline</b>  (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	<b>2016 Medicare A/B Baseline PMPM, Savings Percentage Applied</b>  (after application of 1% savings percentage)	<b>2016 Final Medicare A/B PMPM Payment</b>  (2% sequestration reduction applied and prior to quality withhold)
Albemarle	677.82	723.62	736.94	736.94	737.28	729.91	715.31
Alexandria City	776.45	828.92	844.17	844.17	843.51	835.08	818.38
Alleghany	688.62	735.15	748.68	748.68	748.74	741.25	726.43
Amelia	787.81	841.05	856.52	856.52	854.74	846.20	829.28
Arlington	696.02	743.05	756.73	756.73	756.93	749.36	734.37
Augusta	669.31	714.54	727.69	727.69	729.45	722.16	707.72
Bath	954.82	1019.34	1038.10	1038.10	1038.10	1027.72	1007.17
Bedford City	625.02	667.26	679.53	679.53	679.55	672.75	659.30
Bedford	663.67	708.52	721.55	721.55	721.42	714.21	699.93
Botetourt	658.56	703.06	716.00	716.00	719.27	712.08	697.84
Brunswick	717.92	766.43	780.54	780.54	780.34	772.54	757.09
Buckingham	677.29	723.06	736.36	736.36	736.71	729.34	714.75
Buena Vista City	639.09	682.28	694.83	694.83	695.48	688.53	674.76
Caroline	766.72	818.53	833.59	833.59	833.59	825.26	808.75
Charles City	650.14	694.07	706.84	706.84	710.55	703.44	689.37
Charlottesville City	663.60	708.44	721.48	721.48	721.76	714.54	700.25
Chesapeake City	719.15	767.75	781.87	781.87	783.47	775.64	760.13
Chesterfield	737.72	787.57	802.06	802.06	798.89	790.90	775.08
Colonial Heights City	732.73	782.24	796.64	796.64	796.05	788.09	772.33
Covington City	662.42	707.18	720.20	720.20	720.20	713.00	698.74
Craig	694.05	740.95	754.58	754.58	754.58	747.03	732.09
Culpeper	751.45	802.23	816.99	816.99	816.99	808.82	792.64

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<b>2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County <sup>1</sup></b>							
<b>County</b>	<b>2016 Published FFS Standardized County Rate</b>	<b>2016 Initial Medicare A/B FFS Baseline</b>  (increased to reflect CY 2016 risk adjustment model update)	<b>2016 Updated Medicare A/B FFS Baseline</b>  (updated by CY 2016 bad debt adjustment)	<b>2016 Final Medicare A/B FFS Baseline</b>  (increased to offset application of coding intensity adjustment factor in 2016)	<b>2016 Final Medicare A/B Baseline</b>  (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	<b>2016 Medicare A/B Baseline PMPM, Savings Percentage Applied</b>  (after application of 1% savings percentage)	<b>2016 Final Medicare A/B PMPM Payment</b>  (2% sequestration reduction applied and prior to quality withhold)
Cumberland	705.47	753.14	767.00	767.00	770.13	762.44	747.19
Dinwiddie	746.31	796.74	811.40	811.40	811.53	803.42	787.35
Emporia City	681.42	727.47	740.85	740.85	741.24	733.83	719.15
Essex	724.61	773.58	787.81	787.81	787.71	779.84	764.24
Fairfax City	700.34	747.67	761.42	761.42	761.42	753.80	738.72
Fairfax	720.35	769.03	783.18	783.18	783.35	775.52	760.01
Falls Church City	820.87	876.34	892.46	892.46	889.74	880.84	863.22
Fauquier	746.09	796.51	811.16	811.16	811.16	803.05	786.99
Floyd	657.68	702.12	715.04	715.04	716.07	708.91	694.73
Fluvanna	682.35	728.46	741.86	741.86	741.64	734.22	719.54
Franklin City	713.84	762.08	776.10	776.10	776.22	768.45	753.08
Franklin	702.56	750.04	763.84	763.84	766.93	759.26	744.07
Fredericksburg City	895.53	956.05	973.64	973.64	973.64	963.90	944.62
Giles	660.06	704.66	717.63	717.63	717.63	710.45	696.24
Gloucester	656.27	700.62	713.51	713.51	717.96	710.78	696.56
Goochland	733.81	783.40	797.81	797.81	797.75	789.77	773.97
Greene	685.92	732.27	745.74	745.74	746.41	738.95	724.17
Greensville	706.64	754.39	768.27	768.27	773.54	765.80	750.48
Hampton City	725.77	774.81	789.07	789.07	792.25	784.33	768.64
Hanover	740.33	790.36	804.90	804.90	801.75	793.73	777.86
Harrisonburg City	611.18	652.48	664.49	664.49	665.23	658.57	645.40
Henrico	749.95	800.63	815.36	815.36	812.61	804.48	788.39

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<b>2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County <sup>1</sup></b>							
<b>County</b>	<b>2016 Published FFS Standardized County Rate</b>	<b>2016 Initial Medicare A/B FFS Baseline</b>  (increased to reflect CY 2016 risk adjustment model update)	<b>2016 Updated Medicare A/B FFS Baseline</b>  (updated by CY 2016 bad debt adjustment)	<b>2016 Final Medicare A/B FFS Baseline</b>  (increased to offset application of coding intensity adjustment factor in 2016)	<b>2016 Final Medicare A/B Baseline</b>  (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	<b>2016 Medicare A/B Baseline PMPM, Savings Percentage Applied</b>  (after application of 1% savings percentage)	<b>2016 Final Medicare A/B PMPM Payment</b>  (2% sequestration reduction applied and prior to quality withhold)
Henry	680.71	726.71	740.08	740.08	742.69	735.25	720.55
Highland	713.68	761.91	775.93	775.93	775.93	768.17	752.81
Hopewell City	765.08	816.78	831.81	831.81	827.50	819.23	802.85
Isle of Wight	706.19	753.91	767.78	767.78	774.47	766.73	751.40
James City	693.17	740.01	753.63	753.63	755.18	747.63	732.68
King and Queen	698.19	745.37	759.08	759.08	759.08	751.49	736.46
King George	816.55	871.73	887.77	887.77	887.77	878.89	861.31
King William	750.99	801.74	816.49	816.49	816.54	808.38	792.21
Lancaster	645.21	688.81	701.48	701.48	702.90	695.87	681.95
Lexington City	615.98	657.60	669.70	669.70	669.70	663.01	649.75
Loudoun	713.15	761.34	775.35	775.35	775.55	767.79	752.43
Louisa	699.41	746.67	760.41	760.41	762.68	755.06	739.96
Lunenburg	695.52	742.52	756.18	756.18	756.18	748.62	733.65
Madison	696.01	743.04	756.71	756.71	756.71	749.14	734.16
Martinsville City	643.30	686.77	699.41	699.41	705.30	698.24	684.28
Manassas City	672.79	718.25	731.47	731.47	731.47	724.15	709.67
Manassas Park City	787.01	840.19	855.65	855.65	855.65	847.09	830.15
Mathews	681.66	727.72	741.11	741.11	745.08	737.63	722.88
Mecklenburg	682.32	728.43	741.83	741.83	743.13	735.70	720.99
Middlesex	666.76	711.82	724.91	724.91	726.11	718.85	704.47
Montgomery	682.87	729.01	742.43	742.43	742.19	734.77	720.07
Nelson	701.97	749.41	763.19	763.19	762.42	754.80	739.70

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<b>2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County <sup>1</sup></b>							
<b>County</b>	<b>2016 Published FFS Standardized County Rate</b>	<b>2016 Initial Medicare A/B FFS Baseline</b>  (increased to reflect CY 2016 risk adjustment model update)	<b>2016 Updated Medicare A/B FFS Baseline</b>  (updated by CY 2016 bad debt adjustment)	<b>2016 Final Medicare A/B FFS Baseline</b>  (increased to offset application of coding intensity adjustment factor in 2016)	<b>2016 Final Medicare A/B Baseline</b>  (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	<b>2016 Medicare A/B Baseline PMPM, Savings Percentage Applied</b>  (after application of 1% savings percentage)	<b>2016 Final Medicare A/B PMPM Payment</b>  (2% sequestration reduction applied and prior to quality withhold)
New Kent	763.41	815.00	829.99	829.99	825.88	817.62	801.27
Newport News City	723.68	772.58	786.80	786.80	790.21	782.32	766.67
Norfolk City	708.19	756.05	769.96	769.96	774.34	766.60	751.27
Northampton	699.21	746.46	760.19	760.19	760.70	753.10	738.04
Northumberland	684.52	730.78	744.22	744.22	744.69	737.25	722.51
Nottoway	693.66	740.53	754.16	754.16	755.33	747.77	732.81
Orange	730.13	779.47	793.81	793.81	792.87	784.94	769.24
Patrick	725.99	775.05	789.31	789.31	788.73	780.84	765.22
Petersburg City	722.48	771.30	785.49	785.49	786.26	778.40	762.83
Portsmouth City	677.98	723.79	737.11	737.11	742.08	734.66	719.97
Poquoson City	675.07	720.69	733.95	733.95	734.66	727.31	712.76
Powhatan	756.74	807.88	822.74	822.74	821.46	813.24	796.98
Prince Edward	731.67	781.11	795.48	795.48	794.21	786.27	770.54
Prince George	772.31	824.50	839.67	839.67	839.67	831.27	814.64
Prince William	736.22	785.97	800.43	800.43	800.87	792.86	777.00
Pulaski	724.64	773.61	787.84	787.84	787.54	779.67	764.08
Radford City	666.87	711.93	725.03	725.03	725.58	718.33	703.96
Richmond	667.57	712.68	725.79	725.79	728.33	721.05	706.63
Richmond City	704.27	751.86	765.70	765.70	768.63	760.94	745.72
Roanoke	675.08	720.70	733.96	733.96	736.98	729.61	715.02
Roanoke City	675.85	721.52	734.80	734.80	738.40	731.02	716.40
Rockbridge	665.31	710.27	723.34	723.34	723.34	716.11	701.79

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<b>2016 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County <sup>1</sup></b>							
<b>County</b>	<b>2016 Published FFS Standardized County Rate</b>	<b>2016 Initial Medicare A/B FFS Baseline</b>  (increased to reflect CY 2016 risk adjustment model update)	<b>2016 Updated Medicare A/B FFS Baseline</b>  (updated by CY 2016 bad debt adjustment)	<b>2016 Final Medicare A/B FFS Baseline</b>  (increased to offset application of coding intensity adjustment factor in 2016)	<b>2016 Final Medicare A/B Baseline</b>  (incorporating Final Medicare A/B FFS baseline and Medicare Advantage component)	<b>2016 Medicare A/B Baseline PMPM, Savings Percentage Applied</b>  (after application of 1% savings percentage)	<b>2016 Final Medicare A/B PMPM Payment</b>  (2% sequestration reduction applied and prior to quality withhold)
Rockingham	654.42	698.64	711.50	711.50	712.59	705.47	691.36
Salem City	644.77	688.34	701.01	701.01	703.12	696.10	682.18
Southampton	690.15	736.79	750.34	750.34	752.44	744.92	730.02
Spotsylvania	796.75	850.59	866.24	866.24	865.11	856.46	839.33
Stafford	802.12	856.32	872.08	872.08	870.68	861.97	844.73
Staunton City	661.13	705.81	718.79	718.79	720.05	712.85	698.59
Suffolk City	725.00	773.99	788.23	788.23	793.03	785.10	769.40
Surry	724.79	773.77	788.00	788.00	781.55	773.74	758.27
Sussex	719.97	768.62	782.76	782.76	782.76	774.94	759.44
Virginia Beach City	727.24	776.38	790.67	790.67	793.60	785.67	769.96
Waynesboro City	644.92	688.50	701.17	701.17	703.82	696.78	682.84
Westmoreland	755.19	806.22	821.06	821.06	821.06	812.85	796.59
Williamsburg City	697.98	745.15	758.86	758.86	758.86	751.27	736.24
Wythe	705.87	753.57	767.43	767.43	766.99	759.31	744.12
York	704.97	752.61	766.46	766.46	769.50	761.81	746.57

<sup>1</sup> Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

Note: For CY 2016 CMS has applied the full prevailing Medicare Advantage coding intensity adjustment of 5.41%.

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The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the prevailing CMS-HCC risk adjustment model.

*Beneficiaries with End-Stage Renal Disease (ESRD):* Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment are excluded from the Demonstration; however, an individual who develops ESRD while enrolled in the Demonstration will remain in the Demonstration, unless he/she opts out.

Separate Medicare A/B baselines and risk adjustment models apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD vary by the enrollee's ESRD status: dialysis, transplant, and functioning graft, as follows:

- **Dialysis:** For enrollees in the dialysis status phase, the Medicare A/B baseline is the CY 2016 Virginia ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for Virginia is \$6,672.86 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$6,539.40 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.
- **Transplant:** For enrollees in the transplant status phase (inclusive of the 3-months starting with the transplant), the Medicare A/B baseline is the CY 2016 Virginia ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2016 ESRD dialysis state rate for Virginia is \$6,672.86 PMPM; the updated CY 2016 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is \$6,539.40 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.
- **Functioning Graft:** For enrollees in the functioning graft status phase (beginning at 4 months post-transplant) the Medicare A/B baseline is the Medicare Advantage 3.5% bonus county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the prevailing HCC-ESRD functioning graft risk adjustment model.

A savings percentage will not be applied to the Medicare A/B baseline for enrollees with ESRD (inclusive of those enrollees in the dialysis, transplant and functioning graft status phases)

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<b>2016 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County</b>		
<b>County</b>	<b>2016 3.5% Bonus County Rate (Benchmark)</b>	<b>2016 Sequestration-Adjusted Medicare A/B Baseline</b>  (after application of 2% Sequestration reduction)
Albemarle	758.43	743.26
Alexandria City	803.63	787.56
Alleghany	764.37	749.08
Amelia	844.93	828.03
Arlington	798.68	782.71
Augusta	766.98	751.64
Bath	940.50	921.69
Bedford City	747.16	732.22
Bedford	776.18	760.66
Botetourt	793.50	777.63
Brunswick	769.59	754.20
Buckingham	758.46	743.29
Buena Vista City	757.32	742.17
Caroline	793.56	777.69
Charles City	785.49	769.78
Charlottesville City	759.06	743.88
Chesapeake City	825.22	808.72
Chesterfield	825.91	809.39
Colonial Heights City	813.33	797.06
Covington City	778.28	762.71
Craig	828.91	812.33
Culpeper	834.11	817.43
Cumberland	839.76	822.96
Dinwiddie	856.39	839.26
Emporia City	773.78	758.30
Essex	778.55	762.98
Fairfax City	834.89	818.19
Fairfax	809.71	793.52
Falls Church City	808.56	792.39
Fauquier	833.63	816.96
Floyd	778.11	762.55
Fluvanna	758.23	743.07
Franklin City	780.48	764.87
Franklin	837.01	820.27
Fredericksburg City	882.10	864.46
Giles	777.60	762.05

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<b>County</b>	<b>2016 3.5% Bonus County Rate (Benchmark)</b>	<b>2016 Sequestration-Adjusted Medicare A/B Baseline</b>  (after application of 2% Sequestration reduction)
Gloucester	791.82	775.98
Goochland	845.46	828.55
Greene	758.08	742.92
Greensville	842.62	825.77
Hampton City	860.57	843.36
Hanover	821.77	805.33
Harrisonburg City	724.25	709.77
Henrico	837.57	820.82
Henry	776.98	761.44
Highland	766.60	751.27
Hopewell City	803.71	787.64
Isle of Wight	841.03	824.21
James City	828.22	811.66
King and Queen	801.17	785.15
King George	831.45	814.82
King William	833.60	816.93
Lancaster	764.57	749.28
Lexington City	729.94	715.34
Loudoun	791.60	775.77
Louisa	830.99	814.37
Lunenburg	773.26	757.79
Madison	757.64	742.49
Martinsville City	762.31	747.06
Manassas City	797.26	781.31
Manassas Park City	919.14	900.76
Mathews	816.75	800.42
Mecklenburg	771.97	756.53
Middlesex	779.18	763.60
Montgomery	772.43	756.98
Nelson	757.37	742.22
New Kent	825.77	809.25
Newport News City	857.88	840.72
Norfolk City	839.21	822.43
Northampton	780.91	765.29
Northumberland	779.72	764.13
Nottoway	778.75	763.18
Orange	760.23	745.03

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<b>2016 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County</b>		
<b>County</b>	<b>2016 3.5% Bonus County Rate (Benchmark)</b>	<b>2016 Sequestration-Adjusted Medicare A/B Baseline</b>  (after application of 2% Sequestration reduction)
Patrick	772.48	757.03
Petersburg City	811.86	795.62
Portsmouth City	803.41	787.34
Poquoson City	810.12	793.92
Powhatan	843.46	826.59
Prince Edward	774.71	759.22
Prince George	833.92	817.24
Prince William	817.20	800.86
Pulaski	779.02	763.44
Radford City	779.45	763.86
Richmond	781.42	765.79
Richmond City	838.26	821.49
Roanoke	809.86	793.66
Roanoke City	810.62	794.41
Rockbridge	769.36	753.97
Rockingham	774.54	759.05
Salem City	780.58	764.97
Southampton	779.37	763.78
Spotsylvania	831.26	814.63
Stafford	836.03	819.31
Staunton City	770.64	755.23
Suffolk City	859.12	841.94
Surry	804.52	788.43
Sussex	832.18	815.54
Virginia Beach City	861.78	844.54
Waynesboro City	764.23	748.95
Westmoreland	781.93	766.29
Williamsburg City	832.92	816.26
Wythe	778.58	763.01
York	839.81	823.01

*Beneficiaries Electing the Medicare Hospice Benefit:* If an enrollee elects to receive the Medicare hospice benefit, the enrollee will be disenrolled from the Demonstration

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## *Medicare Part D Services*

The Part D plan payment is the risk adjusted Part D national average monthly bid amount (NAMBA) for the payment year, adjusted for payment reductions resulting from sequestration applied to the non-premium portion of the NAMBA. The non-premium portion is determined by subtracting the applicable regional Low-Income Premium Subsidy Amount from the risk adjusted NAMBA. To illustrate, the NAMBA for CY 2016 is \$64.66 and the CY 2016 Low-Income Premium Subsidy Amount for Virginia is \$32.78. Thus, the updated Virginia Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2016 is \$64.02. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

CMS will pay an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be 100% cost reconciled after the payment year has ended. These prospective payments will be the same for all counties, and are shown below.

- Virginia low income cost-sharing: \$170.34 PMPM
- Virginia reinsurance: \$87.37 PMPM

The low-income cost sharing and reinsurance subsidy amounts are exempt from mandatory payment reductions under sequestration.

A savings percentage will not be applied to the Part D component of the rate. Part D payments will not be subject to a quality withhold.

**Additional Information:** More information on the Medicare components of the rate under the Demonstration may be found online at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>

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## IV. Savings Percentages and Quality Withholds

### *Savings Percentages*

One of the components of the capitated financial alignment model is the application of aggregate savings percentages to reflect savings achievable through the coordination of services across Medicare and Medicaid. This is reflected in the rates through the application of aggregate savings percentages to both the Medicaid and Medicare A/B components of the rates.

CMS and Virginia established composite savings percentages for each year of the Demonstration, as shown in the table below. The savings percentage will be applied to the Medicaid and Medicare A/B components of the rates, uniformly to all population groups, unless otherwise noted in this report. The savings percentage will not be applied to the Part D component of the joint rate.

Year	Calendar dates	Savings percentage
Demonstration Year 1	April 1, 2014 – December 31, 2015	1%
Demonstration Year 2	January 1 – December 31, 2016	1%
Demonstration Year 3	January 1 – December 31, 2017	2%

### *Quality Withhold*

In Demonstration Year 2, a 2% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. The quality withhold will increase to 3% in Demonstration Year 3. More information about the quality withhold methodology for Demonstration Year 1 is available at: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf> Updates to reflect any changes for Demonstration Year 2 are forthcoming.