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

FAMIS and FAMIS Moms  
Data Book and Capitation Rates  
Fiscal Year 2016

Rates Effective July 1, 2015

May 2015

**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

May 29, 2015

Dear Bill:

**Re: Revised FY 2016 FAMIS and FAMIS MOMS Data Book and Capitation Rates**

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for the Virginia Medicaid FAMIS and FAMIS MOMS programs for FY 2016. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services and State Children's Health Insurance Program requirements.

Please call Sandi Hunt at 415/498-5365 or Susan Maerki at 415/498-5394 if you have any questions regarding these capitation rates.

Very Truly Yours,

PricewaterhouseCoopers LLP

A handwritten signature in black ink that reads "Sandra S. Hunt".

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By: Sandra S. Hunt, M.P.A.  
Principal

A handwritten signature in black ink that reads "Susan C. Maerki".

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Susan Maerki, M.H.S.A., M.A.E.  
Director

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***FAMIS and FAMIS MOMS  
Data Book and Capitation Rates  
Fiscal Year 2016  
Prepared by PricewaterhouseCoopers LLP  
May 2015***

PricewaterhouseCoopers LLP (PwC) has calculated capitation rates for the Virginia Family Access to Medical Insurance Security (FAMIS) program and for the FAMIS MOMS program, for State Fiscal Year 2016. We used data submitted by the contracting health plans to estimate the cost of providing services. The development of these rates is discussed in this report and shown in the attached exhibits.

The methodology used is consistent with the actuarial soundness requirements for Medicaid managed care and is similar to the steps described in the Medallion 3.0 Data Book and Capitation Rates Fiscal Year 2016 (the "Medallion 3.0 report"). Please refer to that document for a complete description of the methodology. We have included in the report for the FAMIS and FAMIS MOMS Data Book and Capitation Rates Fiscal Year 2016 only information specific to the FAMIS and FAMIS MOMS programs and rate setting. However, the exhibits accompanying the report are complete.

## ***I. FAMIS program rate development***

### ***I.A. Introduction***

Title XXI of the Social Security Act through the Balanced Budget Act of 1997 does not impose specific rate setting requirements on states. Consequently, unlike Medicaid Managed Care programs that operate under Title XIX, states have significant flexibility in their approach to determining appropriate payment rates. Similar to most states, Virginia has chosen to mirror the Medicaid rate setting methodology for FAMIS, with appropriate adjustments to recognize differences in the covered population and the goals of the program. The FAMIS per member per month (PMPM) calculation relies on the analysis of health plan data submissions for this enrolled population with adjustments that would meet the test of actuarial soundness.

The development of the FAMIS rates is shown in the attached spreadsheets, with base capitation rates shown in Exhibit I.5a and the associated member months as of March 2015 in Exhibit I.5c. Capitation rate cells for FAMIS are statewide and vary based on the following criteria:

- **Age/Gender.** Capitation rates are paid separately for the following age/gender groups: Under 1, 1-5, 6-14, 15-18 Female, and 15-18 Male.
- **Income Level.** FAMIS includes member co-payment requirements based on income level. There are separate rates for those under and over 150% of the Federal Poverty Level.

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## *I.B. FAMIS program description*

The State Children's Health Insurance Program (SCHIP) was promulgated under Title XXI of the Social Security Act through the Balanced Budget Act of 1997. This federal legislation authorized states to expand child health insurance to uninsured, low-income children through either or both a Medicaid expansion and a commercial-like health plan with comprehensive benefits. The 2009 federal reauthorization legislation changed the name to Children's Health Insurance Program (CHIP).

Virginia chose to cover children with income under 133% of the federal poverty level not already eligible for Medicaid (children ages 6-18 with income between 100% and 133% of the federal poverty level) in its Medicaid program. Virginia covered children above 133% of the federal poverty level in a separate state program. Virginia began its program, called Children's Medical Security Insurance Plan (CMSIP), in October 1998 modeled on the Medicaid FFS program. The program covered eligible children from birth through age 18 in families with income between the maximum Medicaid income eligibility level (133% of the federal poverty level) and 185% of the federal poverty level. State Legislation was passed in 2000 to change CMSIP to a more commercially-based model.

The program transitioned to the Family Access to Medical Insurance Security (FAMIS) in August 2001 with health plan enrollment beginning in December 2001.

The FAMIS program covers eligible children from birth through age 18 in families with income at or below 200% of the Federal Poverty Level who are not otherwise eligible for Medicaid. Both a centralized eligibility processing unit and Local Departments of Social Services work together to create a "no wrong door" process that simplifies eligibility determination, resulting in a streamlined and shorter application process. A 12-month waiting period for persons who voluntarily dropped health insurance was ultimately reduced to 4 months. Health care services are delivered through managed health care insurance and FFS programs.

There were limited changes in the program until the past year.

As of January 1, 2014, the Affordable Care Act (ACA) required state Medicaid agencies to expand Medicaid eligibility to legal resident children up to 138% of the Federal Poverty Level. The child eligibility expansion is required even if the state does not expand Medicaid eligibility to low income adults. This results in a shift of children with incomes between 133% and 138% of FPL from FAMIS into Medicaid. Starting October 2013, DMAS began to implement this change by evaluating eligibility applications under the new standard. And beginning March 2014, DMAS began to move FAMIS children into the Medallion 3.0 program. As a result, the number of FAMIS children <150% FPL has dropped about 40% since January 2014 and is now less than 15% of the total FAMIS population.

The decision to halt new enrollment in the FAMIS MOMS program as of December 31, 2013 also affected the FAMIS population distribution. DMAS policy is that infants born to FAMIS MOMS are eligible for FAMIS for the first year of life, and may be eligible for Medicaid under Medallion 3.0. We observe a decrease in the FAMIS Under 1 age category as the number of FAMIS MOMS births has decreased. The FAMIS MOMS program was reinstated effective December 1, 2014.

The FAMIS benefit package is designed to be equivalent to the benefit package offered to Virginia State employees and therefore does not cover all of the services offered to children in the Medicaid program.

The following services, which are covered under Medicaid, are not covered under FAMIS:

1. EPSDT services – Early and Period Screening Diagnosis and Treatment services, is not a covered service under FAMIS. However, many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS’ well child and immunization benefits.
2. Psychiatric Treatment in free standing facilities is not covered (but is covered when provided in a psychiatric unit of an acute hospital).
3. Routine transportation to and from medical appointments is not covered. Emergency transportation is covered.
4. Enrollees share in the cost of certain services through limited co-payments similar to commercial health plan practices. The following table shows the schedule of co-payments for children in families above and below 150% federal poverty level.

**Table I.1**

**FAMIS cost sharing requirements by service**

Service	Cost sharing	
	>150% FPL	<=150% FPL
Office Visit Copay	\$ 5.00	\$ 2.00
Specialist Copay	\$ 5.00	\$ 2.00
IP Copay/Admit	\$ 25.00	\$ 15.00
Rx	\$ 5.00	\$ 2.00
Annual Co-payment Maximum	\$ 350.00	\$ 180.00

Note: Individual plans may set copayment amounts at a lower dollar amount.

As required by Title XXI, cost sharing will not exceed 5% of a family’s gross income for families with incomes from 150% to 200% of poverty. Cost sharing will not exceed 2.5% of gross income for families with incomes below 150% of poverty.

***I.C. Data book***

The data available to PwC for developing the capitation rates, the process used for selecting the claims and the individuals that are included in the rate development process is similar to the process described in the Medallion 3.0 report. In addition, processing and adjustments that are made to the data in the early stages of the rate development process are similar.

The rate developed is a statewide rate based upon MCO encounter data for FY 2013 and FY 2014 and data used to evaluate contract period trend is MCO encounter data for July 1, 2011 to December 31, 2014 with run out through

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February 2015. The FY 2012 data excludes the FAMIS population in the Far Southwest region that moved to managed care in FY 2013. Any new FAMIS enrollees throughout the state will be paid the rates described in this report.

In the FAMIS rate setting process, historical claims data for the total population, both the  $\leq 150\%$  FPL and the  $> 150\%$  FPL, are combined, adjusted, and trended. We first present the MCO FAMIS encounter summary in Exhibits I.1. A change in policy effective July 1, 2010 altered the enrollment of FAMIS newborn. Since then, babies born to mothers enrolled in FAMIS MOMS are deemed eligible for FAMIS without having to file an application. All data used in the FY 2016 rate setting for the Under Age 1 rate cell reflects enrollment under this policy.

The final adjustment in the rate development reflects the difference in the co-payment schedules for the two income groups and then an administrative cost factor is applied.

### *I.D. Capitation rate calculations*

The capitation rates for FY 2016 are calculated based on the historical data shown in Exhibits I.1 adjusted to reflect changes in payment rates and covered services. Each adjustment to the historical data is described in the following section. The adjustments are applied to the historical data and resulting capitation rates are presented in Exhibits I.5a and I.5b.

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

1. The combined FY 2013 and FY 2014 historical data for each age-gender rate cell and service category are brought forward to Exhibit I.4 from the corresponding rate cell in Exhibit I.1. This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Virginia General Assembly. Each of these adjustments, as well as adjustments for other services not included in the source data, is described in detail below under Section I.E, and is shown in Exhibits I.2a to I.2h.
3. The claims data are adjusted to reflect the expected value of Incurred But Not Reported (IBNR) claims and to update the data to the FY 2016 contract period. These adjustments are described in Section I.F and are shown in Exhibit I.3. The resulting claims are shown in Exhibit I.4 under the column “Completed & Trended Claims.”
4. The adjusted claims costs from Step 3 are divided by the count of member months for each rate cell (from Exhibit I.1) to arrive at preliminary PMPM costs by service category.
5. The PMPM costs are summarized by rate cell across all service categories to arrive at the cost for each rate cell.
6. An adjustment is made to reflect the differences in the co-payment schedule applicable to FAMIS members below and above 150% of the Federal Poverty Level in Exhibit I.5a. Co-payment adjustments are made for major service categories; they are not added across all individual claims as health plans may require different collection of co-payments.
7. An adjustment is also made in Exhibit I.5a to reflect average health plan administrative costs plus a 1.5% contribution to reserves. The derivation of this value is included in the Adjustments described in Section I.E.

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8. An adjustment for projected high cost member drug reinsurance is presented in Exhibit I.6.
  9. The drug reinsurance adjustment is subtracted from rates presented in Exhibit I.5a and the final FY 2016 FAMIS rates are shown in Exhibit I.7.

### *I.E. FAMIS legislative and program adjustments*

Legislation and policy changes in the FAMIS program for FY 2013 and FY 2014 must be reflected in the development of per capita rates, as the data used to develop rates do not fully include the effect of those changes.

The historical data presented in Exhibit I.1 is adjusted by the policy and program factors described in this section (Exhibits I.2a to I.2h) and the Trend and IBNR factors (Exhibit I.3).

In general, the methodology for FAMIS adjustments is similar to the adjustments in the Medallion 3.0 report. Actual adjustment values may differ where the adjustment is developed using FAMIS encounter data instead of Medallion 3.0 encounter or DMAS FFS data. These adjustments based on FAMIS encounter data are applied to the MCO historical costs in Exhibit I.1. All of these adjustments are reflected in the column “Policy and Program Adjustments” in Exhibit I.4 except for the Provider Incentive and Administrative Cost Adjustments.

#### *Pharmacy adjustment*

The outpatient prescription drug adjustment is based on FAMIS health plan data, taking into consideration aspects of pharmacy management reported by the health plans. The calculation uses health plan data, with factors for rebates, and Pharmacy Benefit Management (PBM) fees, to determine an adjusted PMPM amount.

The Federal Affordable Care Act (ACA) signed in March 2010 extended Medicaid FFS pharmacy rebates to Medicaid managed care plans. MCOs are required to submit pharmacy data to the State Medicaid agency, which will then submit the information to the pharmaceutical manufacturers to claim the rebate. PBM contracts with the MCOs have been modified to reduce the rebates historically available to the MCOs for their Medicaid managed care populations to offset these Medicaid agency rebates.

The same pharmacy rebates are not available to the state for the FAMIS program. However, the size and drug utilization of the FAMIS population is not, by itself, considered sufficient to allow the plans to negotiate comparable levels of rebate that were contracted for the Medicaid managed care population. Based on plan submitted data, we estimate the effective pharmacy rebate will not change from the amount projected by the health plans, or 1.7%.

The final pharmacy adjustment factors are shown in Exhibit I.2a.

#### *Exempt infant formula carveout adjustment*

DMAS policy regarding reimbursement of selected formula for infants with diseases of inborn errors of metabolism requires direct billing for those services. Historically, the health plans referred members to the Woman, Infants, and Children (WIC) program for these services, but pay for services after the WIC benefit maximum is reached. This adjustment removes the amount that the health plans paid for selected formulas after children up to age 19

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have met the WIC cap. The exempt formula adjustment is applied to all children up to age 19. DMAS provided a list of HCPCS codes to identify the exempt formula services.

The value of these services has been removed and is shown in Exhibit I.2b. The adjustment is applied to the DME/Supplies service line in Exhibit I.4 under the column labeled “Policy and Program Adjustments.”

### *Hospital inpatient adjustments*

The hospital inpatient adjustment includes a 2.6% allowance for a cost per unit increase authorized by the Virginia General Assembly effective FY 2013 (applied to FY 2012 of the base data for trend). While there was no explicit unit cost increase for FY 2014, hospital reimbursement rates were rebased resulting in a weighted average cost per unit change of 4.7% for inpatient medical/surgical and -7.4% for inpatient psychiatric.

The Virginia General Assembly has not authorized any further unit cost increases and there are no inpatient hospital adjustments for FY 2015 or FY 2016.

For FAMIS inpatient medical/surgical, the positive adjustment is 2.1%. For inpatient psychiatric in acute care hospitals, the negative adjustment is 3.4%. The inpatient psychiatric factor is applied to mental health claims that are submitted with FFS payment detail and the allocated inpatient mental health subcapitation dollars.

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

### *Durable Medical Equipment fee adjustment*

The FY 2014 General Assembly approved a proposal to reduce Medicaid fees for the DME products covered under the Medicare competitive bid program to a level based on the average of the competitive bid prices in the three areas of the state that are included in the Medicare competitive bid program. This was estimated to result in \$4.9 million in total savings, and \$1.6 million in MCO savings. DMAS estimated that the rates are 33% lower than the current FFS Medicaid rates for these DME services.

DMAS provided a list of DME HCPCS codes subject to the Medicare competitive budget program, the cost savings per unit and a calculated savings percentage per affected DME code. This information was used 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, 5.0% of FAMIS DME claims dollars were for codes subject to the reduction, with an estimated savings of 27.3%.

This results in adjustment factor reduction of 1.4%. It is shown in Exhibit I.2d and added in Exhibit I.4 under the column labeled “Policy and Program Adjustments.”

### *Provider incentive adjustment*

The Provider Incentive Payment Adjustment takes into consideration the various ways that health plans provide incentive payments to providers for coordinating care and ensuring access. Depending on the plan, this can be done through an increase in provider fee schedules, payment of case management fees, and/or provider incentive

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programs. To the extent that it has been used to increase professional fee schedules, the amount is already included in the claims and encounter data. Some plans reported the case management and incentive amounts as capitation payments. To avoid double counting, we did not include the value of the capitation amounts that plans reported as representing those payments in the base data. Their value has been incorporated into the Provider Incentive Payment Adjustment.

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS incentive is \$0.86 PMPM. This translates to 0.7% of the weighted average PMPM medical cost. This percentage is shown in Exhibit I.2e and is presented as the dollar value applicable to the rate cell in the service line labeled Provider Incentive Payment Adjustment in Exhibit I.4.

### *Hepatitis C treatment adjustment*

With the recent approval of breakthrough drugs for the treatment of Hepatitis C and clinical trials that are expected to result in additional drug approvals in the next few years, standards of treatment for Hepatitis C are evolving rapidly. The most recent drugs, Sovaldi, Olysio, Harvoni, and Viekira Pak have fewer adverse side effects, are predicted to attain the desired sustained virological response levels in 90% of patients, and are much more expensive.

Analysis of the historical data indicated that approximately 0.3% of the FAMIS population was tested for the disease, approximately 0.02%, or 20 FAMIS children, have a diagnosis of Hepatitis C, and of those, only 1 individual has undergone drug therapy. The Hepatitis C Drug treatment adjustment is developed by applying estimates of increases in Hepatitis C testing, identification of new cases, and increases in the frequency of drug treatment using the new drug regimens. The cost of the new Hepatitis C drug therapy is estimated to average \$90,000 per person, or \$30,000 more than the average cost of drug therapy at the end of the base data period.

The calculation of the additional cost of Hepatitis C treatment is presented in Exhibit I.2f. The increase is converted to a percentage adjustment to total claims in the pharmacy service category, and is 0.5% for FAMIS. The adjustment is added in Exhibit I.4 under the column labeled “Policy and Program Adjustments.”

### *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 may reduce the physician payment to an all-inclusive rate of \$22.06 for the code 99283 instead of paying the physician fee of \$43.54 plus ancillaries. Eliminating the ER Triage review would increase the Level III ER payment to physicians by the difference in the physician fee plus the average amount of ancillary services billed on those claims.

PwC prepared an estimate of the payment increase based upon review of historical Level III ER claims paid at the ER Triage rate.

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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 data was analyzed by health plan to identify the number of Level III ER claims paid at the ER Triage level and was re-priced to reflect each plan's average cost of a Level III professional claim paid in full. For Level III claims for FAMIS, this is approximately \$83,000 per year. Plan payment of the physician fee varied and the average of \$44.67 is slightly higher than the DMAS Medicaid fee schedule.

Approximately 4.8% of the Level III claims paid as ER Triage were for services to the FAMIS population. The paid amount of these claims is increased to the weighted average of the plan professional fee payment and then calculated as a percentage of the Professional Evaluation and Management service line. The calculation of the additional cost is presented in Exhibit I.2g. The adjustment is added in Exhibit I.4 under the column labeled "Policy and Program Adjustments."<sup>1</sup>

### *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 have 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 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 -0.24 percent reduction to the FAMIS and FAMIS MOMS. Other codes, such as J codes for drugs administered in an office setting, that are grouped in the professional service categories, are excluded from the adjustment.

The managed care professional fee adjustment is -0.23% for FAMIS. The calculation of the RBRVS adjustment is shown in Exhibit I.2h. The adjustment is added in Exhibit I.4 under the column labeled "Policy and Program Adjustments."

### *Plan administration adjustment*

The FAMIS plan administrative adjustment is calculated using the same methodology described for the LIFC and ABAD populations in the Medallion 3.0 report. The FAMIS program is included when the CY 2014 average administrative dollar PMPM is apportioned across the eligibility groups enrolled in the Virginia DMAS managed care programs and described in Medallion 3.0, Section II under the same subheading.

The resulting CY 2014 administrative cost of \$8.17 PMPM for FAMIS is the sum of lines 1 and 2 of the administrative adjustment exhibit. Trending the separate administrative expense and salary components increases the value to \$8.41 PMPM. To reflect an estimate of administrative activity rather than just differences in base costs,

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<sup>1</sup> Level III adjustment for FAMIS is estimated at \$83,000 annualized value and at \$1.55 million across all program, including AA/FC, ALTC/HAP and FAMIS.

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the administrative dollars PMPM were reallocated based on weighting by claims volume PMPM for each eligibility group on line 5b. The \$11.20 PMPM reallocated administrative costs are compared to the weighted average of the medical component of the FY 2016 FAMIS base rates to determine separate administrative allowances as a percentage of the base capitation rate.

This percentage is then increased by a 1.50% contribution to reserves. The allowance for a contribution to reserve is the same as in last year's rate setting. The trended value of the administrative factor is 9.8% for FAMIS.

As for LIFC and ABAD, a rate adjustment for the health insurance premium excise tax is not included in the administrative cost adjustment presented here. An aggregated retrospective adjustment process will be used to pay the health insurer fee adjustment for the FY 2016 rates in the fall of that year.

The administrative cost factor is applied to the total adjusted and trended claims amount for each rate payment category. This adjustment factor is applied in the final step of the per capita cost calculations after the application of the co-payment adjustment in Exhibit I.5a.

### *I.F. FAMIS Trend and IBNR Adjustments*

Trend and IBNR adjustment factors use FAMIS encounter data and apply the same methodology described in the Medallion 3.0 report. We used the monthly historical health plan expenditures for FY 2013 and FY 2014 with run-out through October 2014 to develop the historical data period trend and monthly historical health plan expenditures from July 2011, the beginning of FY 2012, through December 2014 with run-out through February 2015 to develop the contract period trend. The FY 2012 Far Southwest FFS data was excluded from the contract trend model.

We observed age-gender mix changes in the FAMIS population. Up through the first quarter of FY 2014, there was an increase in the proportion of higher cost FAMIS children, particularly the Under Age 1, likely due to the policy change which made children born to FAMIS MOMS eligible for FAMIS without an application. This has been followed by a decrease in the number and proportion of Under 1. This change is consistent with the end of new enrollment in FAMIS MOMS, the major source of newborns for the FAMIS program, at the end of 2013. At the same time, we observe an increase in both the male and females Age 15 to 20 rate cells.

Because of the changes in the Under Age 1, they were excluded from the trend development and the calculation of the age-gender adjustment.

Analysis of the period evaluated for data trend shows an age-gender overall risk mix for all services was unchanged from July 2012 to June 2014. Analysis of the period evaluated for contract trend shows an age-gender increase of 0.6% for inpatient hospital. There was negative impact on outpatient hospital and the professional services categories, although pharmacy increased by 2.3%. Overall, the risk mix for all services combined was unchanged from July 2011 to December 2014. The age gender adjustment factors applied to the contract period service trend models is shown in Table I.2.

**Table I.2.****Estimated Change in Age-Gender Mix : July 2011 to February 2015**

<b>AID Group</b>	<b>IP Med/Surg &amp; Psych</b>	<b>OP/HH</b>	<b>Prof</b>	<b>Pharmacy</b>	<b>Other</b>	<b>All Services</b>
FAMIS	0.6%	-0.9%	-1.0%	2.3%	0.2%	0.0%

In addition to the age-gender adjustments, the trend models apply an adjustment to remove the impact of increases or decreases to services that are already reflected in the adjustment Exhibits I.2a to I.2h. For FY 2016, the adjustment is applied to inpatient hospital and is the same values as for LIFC Child, LIFC Adult and ABAD. It is presented in the following table.

**Table I.3****Summary of Adjustments to Trend**

<b>Service</b>	<b>Time Period</b>	<b>Adjustment</b>
Inpatient Hospital	July 2012 – June 2013	0.975
	July 2013 – June 2014	0.931

Incurred But Not Reported (IBNR) completion factors in the first column of Exhibit I.3 are based on the FAMIS historical data and are applied to the total claims in the first column of Exhibit I.4, with the dollar value of the IBNR completion factors shown in the second column of that exhibit. The data used in this analysis has run-out through October 2014 or four months past the end of the data period, and the resulting IBNR factors are generally small. IBNR factors for Outpatient Hospital, Inpatient Psychiatric, Inpatient Hospital, Practitioner, Prescription Drug and Other services are all calculated to be 1.0% or less. The second column of Exhibit I.3 provides information on the cumulative impact of the policy and program adjustments in Exhibits I.2a - I.2h. This is for informational purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. Overall, the data period trend, using the adjusted FAMIS trend factors and weighted by the service distribution in the FAMIS population, has a weighted average of -4.1%. The contract period trend is positive with a weighted average of 2.0%. The pharmacy contract period trend is calculated after removal of Hepatitis C drug therapies, and a negative contract period trend for inpatient psychiatric services has been set to 0%.

The resulting trend factors are shown in Exhibit I.3. These trend and IBNR factors are applied to the historical data in Exhibit I.4 by applicable service category. The Exhibit I.4 includes an additional column "Base Claims Redistribution FY13-14" which represents the redistributed value of individual annual inpatient claims costs above \$250,000. Approximately \$737,000, or 3.0% of the inpatient dollars, was redistributed across the inpatient hospital service lines. IBNR is applied to the Total Base Claims excluding the redistributed dollars.

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## *I.G. Capitation rates for FAMIS*

### *Adjustment for FAMIS co-payment schedule*

The FAMIS benefit package includes member co-payments for inpatient admissions, physician office visits, and outpatient pharmacy services. FAMIS copayments have not changed over time. Using this information, the historical data for each plan was increased separately for the under and over 150% FPL populations by the value of the co-payments. The total value of the co-payments was added to the historical claims base in Exhibit 1 to arrive at a total cost of services. The co-payment adjustment is applied for major service categories. There are some differences among plan co-payment schedules, such as variation between medical supplies and DME co-payments, which are not applied because of insufficient information or lack of claims detail. FFS FAMIS copayments were blended with the reported MCO copayment amounts.

The final step in developing the capitation rates for FAMIS is to adjust the combined base rates for the under 150% FPL and over 150% FPL. This was done through a factor that valued the differences in the co-payment amount for separate categories relative to the average utilization of the entire FAMIS population. The separate under 150% FPL and over 150% FPL co-payment adjustment values for medical services for each age-gender cell is shown under the columns Copay Value FAMIS  $\leq$  150% and Copay Value FAMIS  $>$  150% in Exhibit I.5a. The co-payment adjustments for FY 2016 are similar to those that were applied to the FY 2015 FAMIS rate setting for both those under 150% and those over 150% FPL. These values are subtracted from the medical component of the base rate.

The administrative factor is then applied to the medical component of the capitation rate to produce the statewide FAMIS rates. The resulting values are shown in the last two columns of Exhibit I.5a.

Exhibit I.5b is the summary comparison of FY 2015 and FY 2016 FAMIS rates. Compared to those rates, average statewide FAMIS  $\leq$  150% FPL rates decrease 13.20% and average state wide FAMIS  $>$  150% FPL rates decrease 13.15% with a weighted average decrease of 13.15%. This comparison uses the FAMIS member months as of March 2015 which are shown in Exhibit I.5c.

### *Drug reinsurance adjustment*

The drug reinsurance adjustment was calculated for the populations similarly to the process described for Medallion 3.0.

Exhibit I.6 presents the steps in the reinsurance calculation and information on the number of people who met the threshold in each of the base years. For FY 2013, the dollars above the discounted threshold amounts were trended 36 months at 12% (three years to the midpoint of the FY 2016 period ended June 30, 2016). This amount is reduced by \$150,000 per person plus the additional 10% of risk that will be retained by the health plans. This is the estimate of the 90% reinsurance pool for that year. The calculation is repeated for the FY 2014 dollars above the discounted threshold amount, which is trended at 12% for 24 months (two years to the midpoint of the FY 2016 period ended June 30, 2016). The average of the two year base period reinsurance pool is divided by the historical members in the aid category to develop each reinsurance amount PMPM.

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The reinsurance amount is \$2.27 PMPM for FAMIS. This amount will be subtracted from the health plan capitation payment for each rate cell to fund a drug reinsurance pool.

### *Performance Incentive Award*

As with the Medallion 3.0 program, beginning FY 2016, the FAMIS program will be included in the DMAS Performance Incentive Award (PIA) program. This builds upon a pilot program established in FY 2015 and will be based upon criteria established by DMAS using three HEDIS [2016](#) measures and three [FY 2016](#) administrative measures designed to measure managed care quality. The Performance Incentive Award, or penalty, will be relative to performance among the contracting health plans. The maximum amount at risk for each Contractor is 0.15% of the PMPM capitation rate and the maximum award is 0.15% of the PMPM capitation rate. Total awards for all Contractors will equal total penalties for all Contractors.

The structure of the PIA follows the HEDIS reporting year time frame. HEDIS 2016, for instance, reflects services provided in the calendar year 2015. The three administrative measures are based on the monthly reporting deliverables received by the Department from July 1 to June 31 of each measurement year.

DMAS anticipates that report cards for each health plan will be completed by December 31, 2016 for FY 2016. Payment or penalties pursuant to the PIA will be distributed by March 2017. This process and the schedule will recur in the following years.

The value of the 0.15% maximum Performance Incentive award or penalty is not reflected in the FY 2016 capitation rates because total awards for all Contractors will equal total penalties for all Contractors.

The adjusted FAMIS rates, net of drug reinsurance, are presented in Exhibit I.7.

## ***II. FAMIS MOMS program rate development***

### ***II.A. Introduction***

Title XXI does not impose specific rate setting requirements on states. Similar to most states, Virginia has chosen to mirror the Medicaid rate setting methodology for FAMIS MOMS, with appropriate adjustments to recognize differences in the covered population and the goals of the program. The FAMIS MOMS PMPM calculation relies on the analysis of health plan data submissions for this enrolled population with adjustments that would meet the test of actuarial soundness. There is a single statewide rate for FAMIS MOMS.

### ***II.B. FAMIS MOMS program description***

The 2004-2005 Virginia General Assembly budgeted funding for a program “to expand prenatal care, pregnancy-related services, and 60 days of post-partum care under FAMIS to an annual estimated 380 pregnant women who are 19 or older with annual family income less than or equal to 150 percent of the federal poverty level.

FAMIS MOMS provides full Medicaid benefits for pregnant women to the covered Federal Poverty Level (FPL) through the CHIP program. Full Medicaid benefits for pregnant women include all services, except dental, and include non-emergency transportation, which is not a covered benefit for FAMIS children. Pregnant women who are under age 21 are also eligible for EPSDT-related services. The provision of full Medicaid benefits also means that, in contrast to the FAMIS program for children, there are no co-payments for services.

Since the program was established there have been eligibility income expansions in the FAMIS MOMS program and it now covers pregnant women up to 200% of FPL. The schedule of the income expansions was:

<b>Table II.1 FAMIS MOMS income eligibility</b>	
<b>Federal poverty level</b>	<b>Effective date</b>
133-150% FPL	August 1, 2005
133-166% FPL	September 1, 2007
133-185% FPL	July 1, 2008
133-200% FPL	July 1, 2009
New Enrollment Discontinued	December 31, 2013
133- 200% FPL	December 1, 2014

The FAMIS MOMS program was discontinued for most of CY 2014. DMAS halted new enrollment into the FAMIS MOMS program on December 31, 2013. This decision by the General Assembly was based on the assumption that these higher income pregnant women are eligible to enroll in the Qualified Health Plans that are available through the Federal Health Benefits Exchange. The program was reinstated with the first FAMIS MOMS enrollment

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effective December 1, 2014 for pregnant women up to 200% of the Federal Poverty Level, an annual income up to \$23,340 for a single person.

Eligibility begins with a determination of pregnancy and income verification and continues through the month of delivery, plus an additional two months. One important difference between Medicaid for pregnant women (under either FFS or Medallion 3.0) and FAMIS MOMS is that Medicaid offers up to three months of retroactive coverage while the FAMIS MOMS' effective date of coverage is the first of the month that the signed application was received. There is no retroactive coverage for FAMIS MOMS enrollees. Based on a policy change effective July 1, 2010, babies born to FAMIS MOMS are automatically covered for the birth month plus two additional months but not beyond the first three months. The baby is eligible for additional coverage through the first year of life, and may be determined eligible for either FAMIS or the Medicaid Medallion 3.0 program, FAMIS Plus.

Eligible women are enrolled in managed care plans wherever possible. If a woman's FFS OB-GYN participates with one of the available managed care organizations, DMAS will transition her into that MCO to provide continuity of care. However, similar to Medicaid rules, a woman can opt out of an MCO if she is in her last trimester and her regular OB-GYN does not participate with the MCO.

Beginning March 1, 2015, pregnant women enrolled in FAMIS MOMS will receive dental benefits during the pregnancy and for 60 days following the birth of the child. However, services are administered through the Smiles For Children program rather than through MCOs. Services include: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials and dentures, tooth extractions and other oral surgeries, and other appropriate services.

## *II.C. Data book*

### *Approach to rate setting for FAMIS MOMS*

The FY 2016 FAMIS MOMS rate setting uses MCO data for FY 2013 and FY 2014, the period from July 1, 2012 to June 30, 2014. In developing proposed capitation rates, a key consideration is the method by which women will be enrolled in the health plan and the potential variation in the length of plan enrollment. A very small difference in the average length of plan enrollment can have a material difference in the capitation rate, since most of the cost is incurred at the time of delivery and is not evenly spread over the entire pregnancy and eligibility period.

Originally, PwC used the available MCO health plan encounter and claims data for a similar LIFC population, program category PD-91, in conjunction with the available FAMIS MOMS data, to develop rates for FAMIS MOMS. Analysis showed that while there is small enrollment and some unexpected anomalies in the data, the results are sufficiently stable to allow development of the capitation rate directly from the population that is covered by the program. Since FY 2012, we use only FAMIS MOMS data, both for base data and trend development in the rate setting. Although DMAS discontinued FAMIS MOMS enrollment as of December 31, 2013, those enrolled prior to December 31, 2013 continued to be eligible for services until three months after the last of these eligibles completed her pregnancy. As a result, FAMIS MOMS rates for FY15 were increased to reflect the higher proportion of delivery

costs. With the reinstatement of the program, we believe that the costs will return to levels similar to those seen in the program in recent years.

Development of the Data Book for FAMIS MOMS rate setting follows the same methodology described in the Medallion 3.0 report, including use of the DMAS capitation payment file to determine eligibility, claims matching, and inclusion of sub capitated services.

### ***II.D. FAMIS MOMS legislative and program adjustments***

In general, the methodology for FAMIS MOMS adjustments is similar to the adjustments in the Medallion 3.0 report. Actual adjustment values may differ where the adjustment is developed using FAMIS MOMS encounter data instead of Medallion 3.0 encounter data. All of these adjustment are reflected in the column “Policy and Program Adjustments” in Exhibit II.4 except for the Provider Incentive and Administrative Cost Adjustments.

The historical data presented in Exhibit II.1 is adjusted by the policy and program factors summarized in the table (Exhibits II.2a to II.2g) and the Trend and IBNR factors (Exhibit II.3).

<b>Table II.2</b>		
<b>Medallion 3.0 Adjustment Methodology Used in FAMIS MOMS Rates</b>		
<b>Medallion Exhibit Number and Adjustment Name</b>	<b>FAMIS MOMS Exhibits</b>	<b>FAMIS MOMS values</b>
2a Pharmacy Adjustment	2a	2a: -0.6% applied to pharmacy services
2b Exempt Infant Formula Carveout	Not applicable	Applies only to children
2c Hospital Inpatient Adjustments	2b	2b: 2.2% Inpatient Medical/Surgical, -5.5% Inpatient Psychiatric
2d Freestanding Psychiatric Hospital	Not applicable	Not a covered FAMIS MOMS service
2e DME Fee Adjustment	2c	2c: -1.0% applied to DME services
2g Provider Incentive	2d	2d: \$0.66 PMPM and 0.1% of the weighted average PMPM medical cost
2f Hepatitis C Adjustment	2e	2e: 0.1% applied to Pharmacy
2h ER Triage Adjustment	2f	2f: 0.3% applied to Professional Evaluation and Management
2i RBRVS Adjustment	2g	2g: -0.24% applied to professional services
2j Administrative Cost	2h	2h: \$36.25 PMPM based on reallocation weighted by claims, or 4.8% of base capitation rate with contribution to reserves

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### *Pharmacy adjustment*

The size and drug utilization of the FAMIS MOMS population is not sufficient to allow the plans to negotiate levels of rebate that were contracted for the Medicaid managed care population. Based on plan submitted data, we do not expect additional reductions to the managed care rebate and use the health plan projection of 1.7%.

The final pharmacy adjustment factors are shown in Exhibit II.2a. The PBM factor is a reduction of 0.6%.

### *Hospital Inpatient adjustment*

While there was no explicit unit cost increase for FY 2014, hospital reimbursement rates were rebased resulting in a weighted average cost per unit change of 4.7% for inpatient medical/surgical and -7.4% for inpatient psychiatric.

The Virginia General Assembly has not authorized any further unit cost increases and there are no inpatient hospital adjustments for FY 2015 or FY 2016.

For FAMIS MOMS inpatient medical/surgical, the positive adjustment is 2.2%. For inpatient psychiatric in acute care hospitals, the negative adjustment is 5.5%. The inpatient psychiatric factor is applied to mental health claims that are submitted with FFS payment detail and the allocated inpatient mental health subcapitation dollars, but exclude payments to freestanding psychiatric hospitals.

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

### *Durable Medical Equipment fee adjustment*

This is calculated in the same way as in the Medallion 3.0 and FAMIS program and uses the FAMIS MOMS experience. Overall, 4.5% of FAMIS MOMS DME claims dollars were for codes subject to the reduction and the expected savings on this subset averaged 22.0%.

This results in adjustment factor reduction of -1.0%. It is shown in Exhibit II.2c and added in Exhibit II.4 under the column labeled “Policy and Program Adjustments.”

### *Hepatitis C treatment adjustment*

The Hepatitis C Drug treatment adjustment is developed by applying estimates of increases in Hepatitis C testing, identification of new cases, and increases in the frequency of drug treatment using the new drug regimens. The cost of the new Hepatitis C drug therapy is estimated to average \$90,000 per person, or \$40,000 more than the average cost of drug therapy in the base data. Analysis of the historical data indicated that approximately 2.0% of the FAMIS MOMS population was tested for the disease, approximately 0.25%, or 13 FAMIS MOMS, had a diagnosis of Hepatitis C, and of those, none have undergone drug therapy.

The calculation of the additional cost of Hepatitis C treatment is presented in Exhibit II.2e. The increase is converted to a percentage adjustment to total claims in the pharmacy service category, and is 0.1% for FAMIS MOMS. The adjustment is added in Exhibit II.4 under the column labeled “Policy and Program Adjustments.”

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## 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 may reduce the physician payment to an all-inclusive rate of \$22.06 for the code 99283 instead of paying the physician fee of \$43.54 plus ancillaries. Eliminating the ER Triage review would increase the Level III ER payment to physicians by the difference in the physician fee plus the average amount of ancillary services billed on those claims.

PwC prepared an estimate of the payment increase based upon review of historical Level III ER claims paid at the ER Triage rate. 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 data was analyzed by health plan to identify the number of Level III ER claims paid at the ER Triage level and was re-priced to reflect each plan's average cost of a Level III professional claim paid in full. For Level III claims for FAMIS MOMS, this is approximately \$5,000 per year. Plan payment of the physician fee varied and the average of \$44.67 is slightly higher than the DMAS Medicaid fee schedule.

Approximately 0.1% of the Level III claims paid as ER Triage were for services to the FAMIS MOMS population. The paid amount of these claims is increased to the weighted average of the plan professional fee payment and then calculated as a percentage of the Outpatient Hospital – Emergency Room and Related service line. The calculation of the additional cost is presented in Exhibit II.2f. The adjustment is added in Exhibit II.4 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 last year, the update was based solely on DMAS FFS data. Plans have 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 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 FY16 result in a -0.24 percent reduction to the FAMIS and FAMIS MOMS experience. Other codes, such as J codes for drugs administered in an office setting, that are grouped in the professional service categories, are excluded from the adjustment.

The managed care professional fee adjustment is -0.23% for FAMIS MOMS. The calculation of the RBRVS adjustment is shown in Exhibit II.2g. The adjustment is added in Exhibit II.4 under the column labeled “Policy and Program Adjustments.”

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## *Plan administration adjustment*

The administrative allowance for FAMIS MOMS is calculated using the same revised approach that was used to develop the administrative allowance for the Medallion 3.0 and FAMIS programs. These administrative dollars were based upon trended CY 2014 costs PMPM that were then reallocated based on weighting by claims volume PMPM for each eligibility group. The CY 2014 base of \$70.53 PMPM value is trended. The reallocation decreases the FAMIS MOMS administrative cost adjustment from \$72.61 PMPM to \$36.25 PMPM.

The reallocated administrative cost is compared to the medical component of the FY 2016 base rate to determine administrative allowance as a percentage of the base capitation rate, a value of 3.3%. This percentage is then increased by a 1.50% contribution to reserves. The allowance for a contribution to reserve is the same as in last year's rate setting. With the contribution to reserves, the final administrative factor is 4.8% for FAMIS MOMS.

This adjustment factor is shown in Exhibit II.2h and is presented as the dollar value applicable to rate cell in the line labeled Admin Cost Adjustment in Exhibit II.4.

## *II.E. FAMIS MOMS trend and IBNR adjustments*

Trend and IBNR adjustment factors uses FAMIS MOMS encounter data and applies the same methodology described in the Medallion 3.0 report. This uses monthly historical health plan expenditures for FY 2013 and FY 2014 with run-out through October 2014 to develop the historical data period trend and the monthly health plan expenditures for FY 2012 through December 2014 with run-out through February 2015 to develop the contract period trend. Although FAMIS MOMS data is used to develop trend for the majority of the service categories, Inpatient Psychiatric is using the LIFC Adult values.

There is no age-gender adjustment for FAMIS MOMS and the Inpatient Hospital trend analysis incorporates the same adjustment as that used for FAMIS and presented in Table I.3.

IBNR completion factors in the first column of Exhibit II.3 are applied to the total claims in the first column of Exhibit II.4 and the dollar value of the IBNR completion factors are shown in the second column of that exhibit. Since the data used in this analysis has run-out through October 2014, or four months past the end of the data reporting period, the resulting IBNR factors are generally small. IBNR factors for Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient, Practitioner, Prescription Drug and Other services are all 0.9% or less. The second column of Exhibit II.3 is information on the cumulative impact of the policy and program adjustments in Exhibits II.2a to II.2g. This is for informational purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. The weighted average data period trend assigned is an increase of 8.0%, with substantial increases in inpatient hospital, outpatient hospital and professional services slightly offset by decreases in other services. Overall contract period trend is a weighted average increase of 3.6%. Any negative contract period trends have been set to 0%.

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The resulting trend factors are shown in Exhibit II.3. These trend and IBNR factors are applied to the historical data in Exhibit II.4 by applicable service category.

## *II.F. Capitation rates for FAMIS MOMS*

The historical data presented in Exhibit II.1 is adjusted by the factors shown in Exhibits II.2a through II.2h and the Trend and IBNR factors in Exhibit II.3. The administrative adjustment is then added to the completed and adjusted claims. The result of these calculations is shown in Exhibit II.4.

FY 2016 FAMIS MOMS base rate of \$1,102.79 is presented in Exhibit II.5. The comparison of FAMIS MOMS rates from FY 2015 and FY 2016 is also shown in Exhibit II.5 and is an increase of 11.7% compared to the FY 2015 FAMIS MOMS rate developed using the rate setting approach used in the FY 2016 rate development. It is a decrease of 16.4% compared to the FY 2015 rate that was developed to account for higher average PMPM cost anticipated when the FAMIS MOMS program was temporarily halted between January 1, 2014 and December 1, 2014.

The FAMIS program will be not be included in the DMAS Performance Incentive Award (PIA) program.

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development for the FAMIS Program**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Historical Eligibility, Claims, and Utilization Data**

**Section I**  
**Exhibit 1**

Age Under 1												
MCO Statewide	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	34,299	32,890										
<b>Service Type</b>												
DME/Supplies	\$100,020	\$98,725	\$0	\$0	\$2.92	\$3.00	1,708	1,536	598	560	\$58.56	\$64.27
FQHC / RHC	\$61,703	\$44,473	\$0	\$0	\$1.80	\$1.35	1,266	890	443	325	\$48.74	\$49.97
Home Health	\$27,657	\$5,449	\$0	\$0	\$0.81	\$0.17	55	27	19	10	\$502.86	\$201.81
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$6,739,511	\$5,789,983	\$0	\$0	\$196.49	\$176.04	2,093	1,621	732	591	\$3,220.02	\$3,571.86
IP - Other	\$679,213	\$1,057,406	\$0	\$0	\$19.80	\$32.15	348	120	122	44	\$1,951.76	\$8,811.71
IP - Psych	\$0	\$0	\$13,768	\$13,371	\$0.40	\$0.41	0	0	-	-	-	-
Lab	\$48,139	\$46,514	\$32,195	\$32,206	\$2.34	\$2.39	5,505	4,590	1,926	1,675	\$14.59	\$17.15
OP - Emergency Room & Related	\$425,317	\$318,596	\$0	\$0	\$12.40	\$9.69	2,381	2,116	833	772	\$178.63	\$150.57
OP - Other	\$541,478	\$483,385	\$0	\$0	\$15.79	\$14.70	1,948	2,082	682	760	\$277.97	\$232.17
Pharmacy	\$585,145	\$632,452	\$0	\$0	\$17.06	\$19.23	10,171	8,969	3,558	3,272	\$57.53	\$70.52
Prof - Anesthesia	\$44,980	\$33,757	\$0	\$0	\$1.31	\$1.03	222	189	78	69	\$202.61	\$178.61
Prof - Child EPSDT	\$749,479	\$723,045	\$0	\$0	\$21.85	\$21.98	17,988	17,839	6,293	6,509	\$41.67	\$40.53
Prof - Evaluation & Management	\$3,207,865	\$3,054,639	\$12,316	\$9,787	\$93.89	\$93.17	39,455	37,705	13,804	13,757	\$81.62	\$81.27
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$1,757,811	\$1,810,220	\$3,248	\$2,828	\$51.34	\$55.12	32,047	31,347	11,212	11,437	\$54.95	\$57.84
Prof - Psych	\$135	\$0	\$16,000	\$15,538	\$0.47	\$0.47	4	0	1	-	\$4,033.73	-
Prof - Specialist	\$283,772	\$220,799	\$0	\$0	\$8.27	\$6.71	1,883	1,730	659	631	\$150.70	\$127.63
Prof - Vision	\$14,974	\$14,732	\$35,854	\$36,946	\$1.48	\$1.57	272	238	95	87	\$186.87	\$217.13
Radiology	\$48,779	\$42,978	\$0	\$0	\$1.42	\$1.31	3,338	2,889	1,168	1,054	\$14.61	\$14.88
Transportation/Ambulance	\$39,245	\$26,086	\$2,107	\$1,952	\$1.21	\$0.85	187	197	65	72	\$221.14	\$142.33
<b>Total</b>	<b>\$15,355,224</b>	<b>\$14,403,242</b>	<b>\$115,488</b>	<b>\$112,628</b>	<b>\$451.05</b>	<b>\$441.35</b>	<b>120,871</b>	<b>114,085</b>				

Note:  
\*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development for the FAMIS Program**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Historical Eligibility, Claims, and Utilization Data**

**Section I**  
**Exhibit 1**

Age 1-5												
<b>MCO Statewide</b>	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	219,321	214,758										
<b>Service Type</b>												
DME/Supplies	\$316,294	\$310,574	\$0	\$0	\$1.44	\$1.45	4,399	3,981	241	222	\$71.90	\$78.01
FQHC / RHC	\$152,104	\$134,692	\$0	\$0	\$0.69	\$0.63	4,050	3,056	222	171	\$37.56	\$44.07
Home Health	\$5,646	\$21,102	\$0	\$0	\$0.03	\$0.10	29	99	2	6	\$194.67	\$213.15
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$1,646,242	\$1,831,053	\$0	\$0	\$7.51	\$8.53	473	313	26	17	\$3,480.43	\$5,850.01
IP - Psych	\$11,586	\$0	\$86,527	\$86,281	\$0.45	\$0.40	16	0	1	-	\$6,132.08	-
Lab	\$408,586	\$339,418	\$200,407	\$199,870	\$2.78	\$2.51	45,258	32,476	2,476	1,815	\$13.46	\$16.61
OP - Emergency Room & Related	\$2,027,318	\$1,645,162	\$0	\$0	\$9.24	\$7.66	11,613	9,962	635	557	\$174.57	\$165.14
OP - Other	\$3,295,285	\$3,360,008	\$0	\$0	\$15.02	\$15.65	8,314	8,191	455	458	\$396.35	\$410.21
Pharmacy	\$3,107,973	\$3,174,503	\$0	\$0	\$14.17	\$14.78	72,107	61,969	3,945	3,463	\$43.10	\$51.23
Prof - Anesthesia	\$199,434	\$178,679	\$0	\$0	\$0.91	\$0.83	1,383	1,364	76	76	\$144.20	\$131.00
Prof - Child EPSDT	\$880,515	\$735,163	\$0	\$0	\$4.01	\$3.42	27,302	23,243	1,494	1,299	\$32.25	\$31.63
Prof - Evaluation & Management	\$6,343,575	\$5,753,274	\$71,887	\$60,669	\$29.25	\$27.07	96,927	87,672	5,303	4,899	\$66.19	\$66.31
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$1,694,866	\$1,973,369	\$21,970	\$19,393	\$7.83	\$9.28	53,575	56,067	2,931	3,133	\$32.05	\$35.54
Prof - Psych	\$52,569	\$43,523	\$100,556	\$100,270	\$0.70	\$0.67	1,298	994	71	56	\$117.97	\$144.66
Prof - Specialist	\$591,332	\$518,691	\$0	\$0	\$2.70	\$2.42	5,632	5,740	308	321	\$104.99	\$90.36
Prof - Vision	\$109,466	\$119,244	\$231,661	\$245,932	\$1.56	\$1.70	2,146	2,077	117	116	\$158.96	\$175.82
Radiology	\$117,700	\$104,428	\$0	\$0	\$0.54	\$0.49	7,034	6,121	385	342	\$16.73	\$17.06
Transportation/Ambulance	\$89,700	\$62,369	\$9,963	\$8,583	\$0.45	\$0.33	632	528	35	30	\$157.69	\$134.38
<b>Total</b>	<b>\$21,050,190</b>	<b>\$20,305,250</b>	<b>\$722,970</b>	<b>\$720,998</b>	<b>\$99.28</b>	<b>\$97.91</b>	<b>342,188</b>	<b>303,853</b>				

Note:  
\*Plans may not provide complete unit counts for subcapitated encounters, thus Cost/Unit may not be accurate.

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development for the FAMIS Program**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Historical Eligibility, Claims, and Utilization Data**

**Section I**  
**Exhibit 1**

Age 6-14												
MCO Statewide	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	345,791	352,264										
<b>Service Type</b>												
DME/Supplies	\$447,772	\$459,414	\$0	\$0	\$1.29	\$1.30	4,321	4,167	150	142	\$103.63	\$110.25
FQHC / RHC	\$169,527	\$116,712	\$0	\$0	\$0.49	\$0.33	4,094	2,714	142	92	\$41.41	\$43.00
Home Health	\$7,182	\$20,147	\$0	\$0	\$0.02	\$0.06	59	88	2	3	\$121.73	\$228.94
IP - Maternity	\$4,037	\$3,859	\$0	\$0	\$0.01	\$0.01	2	1	0	0	\$2,018.56	\$3,859.49
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$1,709,398	\$2,431,509	\$0	\$0	\$4.94	\$6.90	302	469	10	16	\$5,660.26	\$5,184.45
IP - Psych	\$274,140	\$331,431	\$136,915	\$140,372	\$1.19	\$1.34	637	710	22	24	\$645.30	\$664.51
Lab	\$478,984	\$406,533	\$145,125	\$325,730	\$1.80	\$2.08	56,584	40,392	1,964	1,376	\$11.03	\$18.13
OP - Emergency Room & Related	\$2,357,263	\$2,169,616	\$0	\$0	\$6.82	\$6.16	10,484	9,364	364	319	\$224.84	\$231.70
OP - Other	\$3,375,946	\$3,767,053	\$0	\$0	\$9.76	\$10.69	10,194	11,022	354	375	\$331.17	\$341.78
Pharmacy	\$8,908,894	\$9,547,037	\$0	\$0	\$25.76	\$27.10	118,521	112,079	4,113	3,818	\$75.17	\$85.18
Prof - Anesthesia	\$149,252	\$146,938	\$0	\$0	\$0.43	\$0.42	975	1,097	34	37	\$153.08	\$133.95
Prof - Child EPSDT	\$215,784	\$158,175	\$0	\$0	\$0.62	\$0.45	8,836	6,541	307	223	\$24.42	\$24.18
Prof - Evaluation & Management	\$6,596,788	\$6,410,681	\$93,415	\$80,885	\$19.35	\$18.43	99,020	96,297	3,436	3,280	\$67.56	\$67.41
Prof - Maternity	\$2,224	\$872	\$0	\$0	\$0.01	\$0.00	5	1	0	0	\$444.79	\$872.08
Prof - Other	\$4,766,750	\$3,159,322	\$35,751	\$32,540	\$13.89	\$9.06	64,569	68,661	2,241	2,339	\$74.38	\$46.49
Prof - Psych	\$472,552	\$477,372	\$170,411	\$174,880	\$1.86	\$1.85	12,082	10,738	419	366	\$53.22	\$60.74
Prof - Specialist	\$798,060	\$860,861	\$0	\$0	\$2.31	\$2.44	7,521	7,774	261	265	\$106.11	\$110.74
Prof - Vision	\$254,393	\$290,010	\$368,478	\$407,809	\$1.80	\$1.98	9,363	6,451	325	220	\$66.52	\$108.17
Radiology	\$275,855	\$282,639	\$0	\$0	\$0.80	\$0.80	12,716	12,696	441	432	\$21.69	\$22.26
Transportation/Ambulance	\$100,224	\$94,013	\$10,570	\$11,257	\$0.32	\$0.30	959	883	33	30	\$115.53	\$119.22
<b>Total</b>	<b>\$31,365,026</b>	<b>\$31,134,195</b>	<b>\$960,665</b>	<b>\$1,173,472</b>	<b>\$93.48</b>	<b>\$91.71</b>	<b>421,244</b>	<b>392,145</b>				

Note:  
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**Virginia Medicaid**  
**FY 2016 Capitation Rate Development for the FAMIS Program**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Historical Eligibility, Claims, and Utilization Data**

**Section I**  
**Exhibit 1**

Age 15-18 Female												
MCO Statewide	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	60,196	61,213										
<b>Service Type</b>												
DME/Supplies	\$115,647	\$96,182	\$0	\$0	\$1.92	\$1.57	746	755	149	148	\$155.02	\$127.39
FQHC / RHC	\$52,914	\$37,842	\$0	\$0	\$0.88	\$0.62	1,301	953	259	187	\$40.67	\$39.71
Home Health	\$1,194	\$1,866	\$0	\$0	\$0.02	\$0.03	8	17	2	3	\$149.28	\$109.75
IP - Maternity	\$235,571	\$233,105	\$0	\$0	\$3.91	\$3.81	133	95	27	19	\$1,771.21	\$2,453.73
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$517,199	\$707,253	\$0	\$0	\$8.59	\$11.55	94	90	19	18	\$5,502.11	\$7,858.37
IP - Psych	\$158,313	\$182,493	\$21,120	\$23,884	\$2.98	\$3.37	423	398	84	78	\$424.19	\$518.53
Lab	\$193,055	\$183,070	\$56,362	\$57,938	\$4.14	\$3.94	21,575	15,349	4,301	3,009	\$11.56	\$15.70
OP - Emergency Room & Related	\$890,282	\$854,492	\$0	\$0	\$14.79	\$13.96	3,101	3,013	618	591	\$287.10	\$283.60
OP - Other	\$1,144,010	\$1,161,209	\$0	\$0	\$19.00	\$18.97	2,898	3,244	578	636	\$394.76	\$357.96
Pharmacy	\$1,570,871	\$1,673,120	\$0	\$0	\$26.10	\$27.33	31,300	31,238	6,240	6,124	\$50.19	\$53.56
Prof - Anesthesia	\$54,147	\$41,518	\$0	\$0	\$0.90	\$0.68	300	302	60	59	\$180.49	\$137.48
Prof - Child EPSDT	\$52,892	\$39,833	\$0	\$0	\$0.88	\$0.65	1,789	1,550	357	304	\$29.56	\$25.70
Prof - Evaluation & Management	\$1,400,978	\$1,461,468	\$14,025	\$11,438	\$23.51	\$24.06	20,726	21,308	4,132	4,177	\$68.27	\$69.12
Prof - Maternity	\$159,289	\$136,881	\$0	\$0	\$2.65	\$2.24	273	262	54	51	\$583.48	\$522.44
Prof - Other	\$522,865	\$635,002	\$6,275	\$5,812	\$8.79	\$10.47	10,242	11,708	2,042	2,295	\$51.66	\$54.73
Prof - Psych	\$136,781	\$161,537	\$33,044	\$32,887	\$2.82	\$3.18	3,122	3,482	622	683	\$54.40	\$55.84
Prof - Specialist	\$226,086	\$205,204	\$0	\$0	\$3.76	\$3.35	2,372	2,374	473	465	\$95.31	\$86.44
Prof - Vision	\$37,697	\$42,620	\$64,531	\$71,690	\$1.70	\$1.87	1,793	1,063	357	208	\$57.02	\$107.53
Radiology	\$170,828	\$171,803	\$0	\$0	\$2.84	\$2.81	4,143	4,448	826	872	\$41.23	\$38.62
Transportation/Ambulance	\$37,748	\$46,610	\$2,419	\$2,266	\$0.67	\$0.80	377	416	75	82	\$106.55	\$117.49
<b>Total</b>	<b>\$7,678,365</b>	<b>\$8,073,106</b>	<b>\$197,777</b>	<b>\$205,915</b>	<b>\$130.84</b>	<b>\$135.25</b>	<b>106,716</b>	<b>102,065</b>				

Note:  
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**Virginia Medicaid**  
**FY 2016 Capitation Rate Development for the FAMIS Program**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Historical Eligibility, Claims, and Utilization Data**

**Section I**  
**Exhibit 1**

Age 15-18 Male												
MCO Statewide	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	60,551	60,405										
<b>Service Type</b>												
DME/Supplies	\$144,861	\$123,848	\$0	\$0	\$2.39	\$2.05	961	933	190	185	\$150.74	\$132.74
FQHC / RHC	\$30,739	\$22,603	\$0	\$0	\$0.51	\$0.37	749	500	148	99	\$41.04	\$45.21
Home Health	\$5,310	\$1,325	\$0	\$0	\$0.09	\$0.02	21	11	4	2	\$252.87	\$120.44
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$611,296	\$549,034	\$0	\$0	\$10.10	\$9.09	90	66	18	13	\$6,792.18	\$8,318.69
IP - Psych	\$175,998	\$60,500	\$25,614	\$24,446	\$3.33	\$1.41	333	240	66	48	\$605.44	\$353.94
Lab	\$70,878	\$64,048	\$55,877	\$54,860	\$2.09	\$1.97	8,507	6,037	1,686	1,199	\$14.90	\$19.70
OP - Emergency Room & Related	\$615,757	\$558,827	\$0	\$0	\$10.17	\$9.25	2,223	1,990	441	395	\$276.99	\$280.82
OP - Other	\$956,822	\$1,031,926	\$0	\$0	\$15.80	\$17.08	2,218	2,394	440	476	\$431.39	\$431.05
Pharmacy	\$1,965,780	\$2,036,682	\$0	\$0	\$32.46	\$33.72	20,090	19,580	3,981	3,890	\$97.85	\$104.02
Prof - Anesthesia	\$40,121	\$31,765	\$0	\$0	\$0.66	\$0.53	235	233	47	46	\$170.73	\$136.33
Prof - Child EPSDT	\$29,398	\$27,529	\$0	\$0	\$0.49	\$0.46	1,129	1,026	224	204	\$26.04	\$26.83
Prof - Evaluation & Management	\$1,003,760	\$985,769	\$14,743	\$12,825	\$16.82	\$16.53	14,715	14,461	2,916	2,873	\$69.22	\$69.05
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$975,957	\$711,273	\$6,336	\$5,653	\$16.22	\$11.87	9,788	10,245	1,940	2,035	\$100.36	\$69.98
Prof - Psych	\$115,467	\$111,132	\$33,060	\$32,149	\$2.45	\$2.37	2,628	2,437	521	484	\$56.52	\$58.79
Prof - Specialist	\$246,023	\$223,803	\$0	\$0	\$4.06	\$3.71	1,906	1,851	378	368	\$129.08	\$120.91
Prof - Vision	\$30,642	\$39,605	\$64,861	\$70,453	\$1.58	\$1.82	1,359	909	269	181	\$70.27	\$121.08
Radiology	\$99,033	\$92,354	\$0	\$0	\$1.64	\$1.53	3,546	3,448	703	685	\$27.93	\$26.78
Transportation/Ambulance	\$38,620	\$32,476	\$2,426	\$2,096	\$0.68	\$0.57	352	324	70	64	\$116.61	\$106.70
<b>Total</b>	<b>\$7,156,461</b>	<b>\$6,704,499</b>	<b>\$202,918</b>	<b>\$202,481</b>	<b>\$121.54</b>	<b>\$114.34</b>	<b>70,850</b>	<b>66,685</b>				

Note:  
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**Virginia Medicaid**  
**FY 2016 Capitation Rate Development for the FAMIS Program**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Historical Eligibility, Claims, and Utilization Data**

**Section I**  
**Exhibit 1**

All Age Categories												
MCO Statewide	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	720,158	721,530										
<b>Service Type</b>												
DME/Supplies	\$1,124,593	\$1,088,744	\$0	\$0	\$1.56	\$1.51	12,135	11,372	202	189	\$92.67	\$95.74
FQHC / RHC	\$466,988	\$356,323	\$0	\$0	\$0.65	\$0.49	11,460	8,113	191	135	\$40.75	\$43.92
Home Health	\$46,990	\$49,888	\$0	\$0	\$0.07	\$0.07	172	242	3	4	\$273.20	\$206.15
IP - Maternity	\$239,608	\$236,964	\$0	\$0	\$0.33	\$0.33	135	96	2	2	\$1,774.87	\$2,468.38
IP - Newborn	\$6,739,511	\$5,789,983	\$0	\$0	\$9.36	\$8.02	2,093	1,621	35	27	\$3,220.02	\$3,571.86
IP - Other	\$5,163,348	\$6,576,255	\$0	\$0	\$7.17	\$9.11	1,307	1,058	22	18	\$3,950.53	\$6,215.74
IP - Psych	\$620,038	\$574,423	\$283,944	\$288,352	\$1.26	\$1.20	1,409	1,348	23	22	\$641.58	\$640.04
Lab	\$1,199,642	\$1,039,583	\$489,966	\$670,605	\$2.35	\$2.37	137,429	98,844	2,290	1,644	\$12.29	\$17.30
OP - Emergency Room & Related	\$6,315,936	\$5,546,693	\$0	\$0	\$8.77	\$7.69	29,802	26,445	497	440	\$211.93	\$209.74
OP - Other	\$9,313,540	\$9,803,580	\$0	\$0	\$12.93	\$13.59	25,572	26,933	426	448	\$364.21	\$364.00
Pharmacy	\$16,138,664	\$17,063,794	\$0	\$0	\$22.41	\$23.65	252,189	233,835	4,202	3,889	\$63.99	\$72.97
Prof - Anesthesia	\$487,933	\$432,657	\$0	\$0	\$0.68	\$0.60	3,115	3,185	52	53	\$156.64	\$135.84
Prof - Child EPSDT	\$1,928,067	\$1,683,746	\$0	\$0	\$2.68	\$2.33	57,044	50,199	951	835	\$33.80	\$33.54
Prof - Evaluation & Management	\$18,552,966	\$17,665,831	\$206,386	\$175,604	\$26.05	\$24.73	270,843	257,443	4,513	4,282	\$69.26	\$69.30
Prof - Maternity	\$161,513	\$137,753	\$0	\$0	\$0.22	\$0.19	278	263	5	4	\$580.98	\$523.77
Prof - Other	\$9,718,248	\$8,289,187	\$73,580	\$66,226	\$13.60	\$11.58	170,221	178,028	2,836	2,961	\$57.52	\$46.93
Prof - Psych	\$777,504	\$793,563	\$353,072	\$355,724	\$1.57	\$1.59	19,134	17,651	319	294	\$59.09	\$65.11
Prof - Specialist	\$2,145,273	\$2,029,357	\$0	\$0	\$2.98	\$2.81	19,314	19,469	322	324	\$111.07	\$104.24
Prof - Vision	\$447,171	\$506,210	\$765,385	\$832,829	\$1.68	\$1.86	14,933	10,738	249	179	\$81.20	\$124.70
Radiology	\$712,196	\$694,202	\$0	\$0	\$0.99	\$0.96	30,777	29,602	513	492	\$23.14	\$23.45
Transportation/Ambulance	\$305,537	\$261,555	\$27,485	\$26,153	\$0.46	\$0.40	2,507	2,348	42	39	\$132.84	\$122.53
<b>Total</b>	<b>\$82,605,266</b>	<b>\$80,620,291</b>	<b>\$2,199,818</b>	<b>\$2,415,493</b>	<b>\$117.76</b>	<b>\$115.08</b>	<b>1,061,869</b>	<b>978,833</b>				

Note:  
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**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Pharmacy Adjustment**

**Section I**  
**Exhibit 2a**

	FAMIS	Source
1. Health Plan Total Drug Cost PMPM	\$23.03	FY13-14 Health Plan Encounter Data
2. Health Plan Drug Ingredient Cost PMPM	\$22.57	Health Plan Encounter Analysis
3. Change in Average Managed Care Discount	0.4%	From Plan Data
4. Current Average Managed Care Rebate	1.7%	From Plan Data
5. FY16 Managed Care Dispensing Fee PMPM	\$0.46	From Plan Data
6. Average PBM Admin Cost PMPM	\$0.18	From Plan Data
7. Adjusted PMPM with FY16 Pharmacy Pricing Arrangemen	\$22.74	= (2.) * (1 - (3.)) * (1 - (4.)) + (5.) + (6.)
<b>8. Pharmacy Adjustment</b>	<b>-1.2%</b>	= (7.) / (1.) - 1

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Exempt Infant Formula Carveout Adjustment**

**Section I**  
**Exhibit 2b**

	FAMIS Age 0-5	FAMIS Age 6-18	Source
1. Claims Associated with Exempt Infant Formula	\$11,875	\$4,515	FY13-14 Health Plan Encounter Data
2. Total Claims in DME/Supplies Service Category	\$825,613	\$1,387,724	FY13-14 Health Plan Encounter Data
<b>3. Exempt Infant Formula Carveout Adjustment</b>	<b>-1.4%</b>	<b>-0.3%</b>	<b>= - (1.) / (2.)</b>

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Hospital Inpatient Adjustments**

**Section I**  
**Exhibit 2c**

	<b>Inpatient Medical/Surgical</b>	<b>Inpatient Psychiatric</b>	<b>Source</b>
1a. FY13 Total Claims in IP Service Categories	\$12,142,467	\$620,038	FY13 Health Plan Encounter Data
1b. FY14 Total Claims in IP Service Categories	\$12,603,202	\$574,423	FY14 Health Plan Encounter Data
2. FY13-14 Hospital Capital Percentage Adjusted	10.2%	10.2%	Provided by DMAS
3a. FY14 Hospital Rate Change	4.7%	-7.4%	Provided by DMAS
3b. Dollar Change	\$508,990	(\$41,013)	= (1a.) * (1 - (2.)) * (3a.)
<b>4. Hospital Inpatient Adjustment</b>	<b>2.1%</b>	<b>-3.4%</b>	= ((3b.)) / ((1a.) + (1b.))

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**DME Fee Adjustment**

**Section I**  
**Exhibit 2d**

	FAMIS	Source
1. Claims Associated with DME/Supplies Service Category	\$2,213,337	FY13-14 Health Plan Encounter Data
2. Proportion of Claims subject to change	\$110,380	Provided by DMAS
3a. FY15 DME Fee Change	-27.3%	Provided by DMAS
3b. Dollar Change	(\$30,094)	= (2.) * (3a.)
<b>4. DME Fee Adjustment</b>	<b>-1.4%</b>	= (3b.) / (1.)

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Provider Incentive Payment Adjustment**

**Section I**  
**Exhibit 2e**

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	<b>Adjustment Value</b>	<b>Source</b>
<b>Provider Incentive Payment Adjustment</b>	<b>0.7%</b>	<b>From Plan Data</b>

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**Virginia Medicaid  
 FY 2016 Capitation Rate Development  
 Health Plan Encounter Data  
 Hepatitis C Treatment Adjustment**

**Section I  
 Exhibit 2f**

	FAMIS	Source
1. Total Claims in Pharmacy Service Categories	\$33,202,457	FY13-14 Health Plan Encounter Data
2. Unique Individuals in Base Period	127,353	FY13-14 Health Plan Encounter Data
3a. Proportion of Population Being Tested for Hepatitis C	0.3%	FY13-14 Health Plan Encounter Data
3b. Number of Individuals Being Tested	399	FY13-14 Health Plan Encounter Data
3c. Projected Testing Change in FY16	15%	Estimate
3d. Additional Number of People Being Tested	60	= (3b.) * (3c.)
3e. Average Cost Per Test Per Person	\$61.70	FY13-14 Health Plan Encounter Data
4a. Proportion of Population Diagnosed With Hepatitis C	0.02%	FY13-14 Health Plan Encounter Data
4b. Number of Individuals Diagnosed With Hepatitis C	20	FY13-14 Health Plan Encounter Data
4c. Projected Increase in People Diagnosed With Hepatitis C	5%	Estimate
4d. Projected Number of People With Hepatitis C	21	= (4b.) * (1 + (4c.))
5a. Proportion of People With Hepatitis C With Drug Therapy	5.0%	FY13-14 Health Plan Encounter Data
5b. Number of Individuals With Hepatitis C With Drug Therapy in Base Period	1	FY13-14 Health Plan Encounter Data
5c. Increase in Proportion of Hepatitis C Receiving Drug Therapy	30%	Estimate
5d. Projected Number of Additional People Going Through Drug Therapy	1	= (4d.) * (5a.) * (1 + (5c.)) - (5b.)
5e. Average Cost of Current Drug Therapy	\$60,000	FY13-14 Health Plan Encounter Data
5f. Average Cost of New Drug Therapy	\$90,000	Estimate
6. Additional Cost of Hepatitis C Treatment	\$156,543	= ((3d.) * (3e.)) + ((5f.) - (5e.)) * (5b.) + (5d.) * (5f.)
<b>7. Hepatitis C Treatment Adjustment</b>	<b>0.5%</b>	= (6.) / (1.)

Note: Based on analysis of FY13 - FY14 base data experience

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Emergency Room Triage Adjustment**

**Section I**  
**Exhibit 2g**

	FAMIS	Source
1. Total Claims in Prof - Evaluation & Management	\$36,218,797	FY13-14 Health Plan Encounter Data
2. FY13-14 Number of Claims in ER Triage Level 3	7,339	FY13-14 Health Plan Encounter Data
3. ER Cost No Triage Level 3	\$44.67	FY13-14 Health Plan Encounter Data
4. ER Triage Cost	\$22.06	Provided by DMAS
5. FY16 ER Triage Financial Impact (2 year)	\$165,920	= (2.) * ((3.) - (4.))
<b>6. FY16 ER Triage Adjustment</b>	<b>0.5%</b>	= (5.) / (1.)

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Resource Based Relative Value Scale Adjustment**

**Section I**  
**Exhibit 2h**

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**FAMIS**

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1. Professional Fee Adjustment - Effective FY16	-0.2%	Provided by DMAS
2. Proportion of claims subject to fee adjustment	93%	FY13-14 Health Plan Encounter Data
3. <b>Final Professional Fee Adjustment</b>	<b>-0.2%</b>	<b>= (1.) * (2.)</b>

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**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Administrative Cost Adjustment**

**Section I**  
**Exhibit 2i**

	FAMIS	Source
1. Claims Adjustment Expense PMPM	\$2.96	Expense from CY2014 BOI Reports; CY2014 Member months from capitation payment files
2. General Admin Expense PMPM	\$5.21	Expense from CY2014 BOI Reports; CY2014 Member months from capitation payment files
3. Claims Adjustment Expense Increase %	0.8%	BLS CPI-U
4. General Admin Expense Increase %	2.6%	Weighted average of BLS Compensation Trend and CPI
5a. Administrative PMPM*	\$8.41	= (1.) * (1+ (3.)) ^ (18 months/12) + (2.) * (1+ (4.)) ^ (18 months/12)
5b. Administrative PMPM Weighted by Claims	\$11.20	Reallocation of administrative costs weighted by claims
6. Adjusted and Trended Base PMPM	\$121.61	Weighted average of medical component of FY2016 FAMIS Base Rates
7. Administrative allowance as % of Base Capitation Rate	8.3%	= (5b.) / (((5b.) + (6.)) / (1 - (8.)))
8. Contribution to Reserves as % of Base Capitation Rate	1.5%	Provided by DMAS
<b>9. Administrative Factor as % of Base Capitation Rate</b>	<b>9.8%</b>	<b>= (7.) + (8.)</b>

\*Note:

Administrative increases are applied from midpoint of CY2014 to the midpoint of the contract period (18 months) using compound interest calculations

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**Incurred But Not Reported (IBNR), Policy/Program, and Trend Adjustments**

**Section I**  
**Exhibit 3**

FAMIS								
Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program <sup>1</sup>	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Inpatient Medical/Surgical	0.6%	2.1%	2.6%	2.1%	-0.7%	1.5%	5.0%	1.0914
Inpatient Psychiatric	0.3%	-3.4%	-3.1%	1.9%	-16.1%	-14.5%	0.0%	0.8550
Outpatient Hospital	0.6%	0.0%	0.6%	1.1%	-3.5%	-2.4%	0.1%	0.9778
Practitioner	0.8%	0.0%	0.8%	-5.8%	-5.3%	-10.8%	0.4%	0.8973
Prescription Drug	0.0%	-0.8%	-0.8%	13.9%	-9.6%	2.9%	5.2%	1.1112
Other	0.9%	-0.6%	0.3%	3.0%	0.5%	3.5%	0.9%	1.0487
<b>Weighted Average<sup>2</sup></b>	<b>0.6%</b>	<b>0.1%</b>	<b>0.7%</b>	<b>1.0%</b>	<b>-5.0%</b>	<b>-4.1%</b>	<b>2.0%</b>	<b>0.9893</b>
<b>Months of Trend Applied</b>				12	12	12	18	

<sup>1</sup> The Policy and Program Adjustments are summarized in this table as weighted averages and are applied at the rate cell level in Exhibit 4.

<sup>2</sup> Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY13-14), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY13-14 Claims)

Trend rates for managed care plans are calculated based on regression studies of historical health plan data.

Trend rates have been calculated separately for the broad service categories shown above. Utilization trend is based on service units per thousand.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations; includes FY13-14 incurred claims paid through Oct 2014

Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations; includes FY12-14 incurred claims paid through Feb 2015.

**Total Trend = [(1 + data period trend) ^ (months/12) \* (1 + contract period trend) ^ (months/12)]**

Virginia Medicaid

FY 2016 Capitation Rate Development

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

Capitation Rate Calculations

Section I  
Exhibit 4

Age Under 1										
Statewide	Total Base Claims FY13-14	Base Claims Redistribution FY13-14	Total Redistributed Base Claims FY13-14	Completion Factor Adjustments <sup>1</sup>	Policy and Program Adjustments <sup>2</sup>	Patient Copay	Completed and Adjusted Claims FY13-14	Trend Adjustment	Completed & Trended Claims FY16	PMPM FY16
<b>Service Type</b>										
DME/Supplies	\$198,745		\$198,745	\$1,850	(\$5,613)	\$380	\$195,362	1.049	\$204,884	\$3.05
FQHC / RHC	\$106,176		\$106,176	\$857		\$3,344	\$110,377	0.897	\$99,040	\$1.47
Home Health	\$33,106		\$33,106	\$209		\$364	\$33,680	0.978	\$32,933	\$0.49
IP - Maternity	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Newborn	\$12,529,494	(\$126,349)	\$12,403,145	\$69,267	\$256,543	\$80,527	\$12,809,482	1.091	\$13,979,885	\$208.07
IP - Other	\$1,736,619	(\$17,512)	\$1,719,107	\$9,601	\$35,558	\$11,246	\$1,775,511	1.091	\$1,937,740	\$28.84
IP - Psych	\$27,138		\$27,138		(\$932)	\$0	\$26,206	0.855	\$22,406	\$0.33
Lab	\$159,054		\$159,054	\$881		\$9,490	\$169,425	1.049	\$177,682	\$2.64
OP - Emergency Room	\$743,914		\$743,914	\$4,701		\$61,954	\$810,568	0.978	\$792,590	\$11.80
OP - Other	\$1,024,862		\$1,024,862	\$6,476		\$16,770	\$1,048,109	0.978	\$1,024,861	\$15.25
Pharmacy	\$1,217,597		\$1,217,597	\$3	(\$9,446)	\$80,098	\$1,288,252	1.111	\$1,431,532	\$21.31
Prof - Anesthesia	\$78,738		\$78,738	\$636		\$22	\$79,395	0.897	\$71,241	\$1.06
Prof - Child EPSDT	\$1,472,525		\$1,472,525	\$11,887	(\$3,315)	\$0	\$1,481,096	0.897	\$1,328,975	\$19.78
Prof - Evaluation & Management	\$6,284,607		\$6,284,607	\$50,554	\$14,872	\$308,867	\$6,658,900	0.897	\$5,974,974	\$88.93
Prof - Maternity	\$0		\$0			\$0	\$0	0.897	\$0	\$0.00
Prof - Other	\$3,574,107		\$3,574,107	\$28,803	(\$8,047)	\$120,735	\$3,715,598	0.897	\$3,333,974	\$49.62
Prof - Psych	\$31,673		\$31,673	\$1	(\$71)	\$10	\$31,614	0.897	\$28,367	\$0.42
Prof - Specialist	\$504,571		\$504,571	\$4,073	(\$1,136)	\$15,170	\$522,678	0.897	\$468,995	\$6.98
Prof - Vision	\$102,506		\$102,506	\$240	(\$229)	\$1,596	\$104,112	0.897	\$93,418	\$1.39
Radiology	\$91,757		\$91,757	\$854		\$23,620	\$116,231	1.049	\$121,896	\$1.81
Transportation/Ambulance	\$69,391		\$69,391	\$608		\$265	\$70,264	1.049	\$73,688	\$1.10
Provider Incentive Payment Adjustment										\$3.08
<b>Total</b>	<b>\$29,986,581</b>	<b>(\$143,862)</b>	<b>\$29,842,720</b>	<b>\$191,498</b>	<b>\$278,184</b>	<b>\$734,458</b>	<b>\$31,046,859</b>		<b>\$31,199,080</b>	<b>\$467.43</b>

<sup>1</sup> Completion Factor Adjustment is applied to non-capitated claims only

<sup>2</sup> Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

# Virginia Medicaid

## FY 2016 Capitation Rate Development

### Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

#### Capitation Rate Calculations

# Section I

## Exhibit 4

Age 1-5										
Statewide	Total Base Claims FY13-14	Base Claims Redistribution FY13-14	Total Redistributed Base Claims FY13-14	Completion Factor Adjustments <sup>1</sup>	Policy and Program Adjustments <sup>2</sup>	Patient Copay	Completed and Adjusted Claims FY13-14	Trend Adjustment	Completed & Trended Claims FY16	PMPM FY16
<b>Service Type</b>										
DME/Supplies	\$626,868		\$626,868	\$5,835	(\$17,703)	\$971	\$615,970	1.049	\$645,992	\$1.49
FQHC / RHC	\$286,796		\$286,796	\$2,315		\$13,074	\$302,185	0.897	\$271,148	\$0.62
Home Health	\$26,747		\$26,747	\$169		\$615	\$27,531	0.978	\$26,921	\$0.06
IP - Maternity	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Newborn	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Other	\$3,477,294	\$33,673	\$3,510,967	\$19,223	\$72,612	\$18,130	\$3,620,932	1.091	\$3,951,777	\$9.10
IP - Psych	\$184,394		\$184,394	\$39	(\$6,333)	\$70	\$178,170	0.855	\$152,330	\$0.35
Lab	\$1,148,281		\$1,148,281	\$6,962		\$69,921	\$1,225,164	1.049	\$1,284,877	\$2.96
OP - Emergency Room	\$3,672,479		\$3,672,479	\$23,206		\$300,667	\$3,996,352	0.978	\$3,907,712	\$9.00
OP - Other	\$6,655,292		\$6,655,292	\$42,054		\$66,596	\$6,763,942	0.978	\$6,613,916	\$15.24
Pharmacy	\$6,282,476		\$6,282,476	\$14	(\$48,737)	\$568,351	\$6,802,103	1.111	\$7,558,636	\$17.41
Prof - Anesthesia	\$378,113		\$378,113	\$3,052		\$186	\$381,351	0.897	\$342,183	\$0.79
Prof - Child EPSDT	\$1,615,678		\$1,615,678	\$13,042	(\$3,638)	\$0	\$1,625,083	0.897	\$1,458,173	\$3.36
Prof - Evaluation & Management	\$12,229,405		\$12,229,405	\$97,651	\$28,938	\$809,117	\$13,165,112	0.897	\$11,812,942	\$27.21
Prof - Maternity	\$0		\$0			\$0	\$0	0.897	\$0	\$0.00
Prof - Other	\$3,709,598		\$3,709,598	\$29,612	(\$8,352)	\$272,082	\$4,002,940	0.897	\$3,591,803	\$8.27
Prof - Psych	\$296,918		\$296,918	\$776	(\$665)	\$5,901	\$302,930	0.897	\$271,816	\$0.63
Prof - Specialist	\$1,110,022		\$1,110,022	\$8,961	(\$2,499)	\$49,791	\$1,166,275	0.897	\$1,046,488	\$2.41
Prof - Vision	\$706,302		\$706,302	\$1,846	(\$1,582)	\$9,390	\$715,956	0.897	\$642,421	\$1.48
Radiology	\$222,128		\$222,128	\$2,067		\$51,640	\$275,835	1.049	\$289,279	\$0.67
Transportation/Ambulance	\$170,615		\$170,615	\$1,415		\$797	\$172,827	1.049	\$181,250	\$0.42
Provider Incentive Payment Adjustment										\$0.67
<b>Total</b>	<b>\$42,799,408</b>	<b>\$33,673</b>	<b>\$42,833,080</b>	<b>\$258,239</b>	<b>\$12,042</b>	<b>\$2,237,298</b>	<b>\$45,340,659</b>		<b>\$44,049,665</b>	<b>\$102.15</b>

<sup>1</sup> Completion Factor Adjustment is applied to non-capitated claims only

<sup>2</sup> Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Virginia Medicaid

FY 2016 Capitation Rate Development

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

Capitation Rate Calculations

Section I  
Exhibit 4

Age 6-14										
Statewide	Total Base Claims FY13-14	Base Claims Redistribution FY13-14	Total Redistributed Base Claims FY13-14	Completion Factor Adjustments <sup>1</sup>	Policy and Program Adjustments <sup>2</sup>	Patient Copay	Completed and Adjusted Claims FY13-14	Trend Adjustment	Completed & Trended Claims FY16	PMPM FY16
<b>Service Type</b>										
DME/Supplies	\$907,186		\$907,186	\$8,444	(\$15,428)	\$1,098	\$901,299	1.049	\$945,227	\$1.35
FQHC / RHC	\$286,240		\$286,240	\$2,311		\$14,577	\$303,127	0.897	\$271,994	\$0.39
Home Health	\$27,329		\$27,329	\$173		\$543	\$28,045	0.978	\$27,422	\$0.04
IP - Maternity	\$7,897	\$48	\$7,944	\$44	\$164	\$63	\$8,215	1.091	\$8,966	\$0.01
IP - Newborn	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Other	\$4,140,908	\$25,103	\$4,166,010	\$22,892	\$86,161	\$18,215	\$4,293,278	1.091	\$4,685,556	\$6.71
IP - Psych	\$882,857		\$882,857	\$2,022	(\$30,383)	\$3,035	\$857,532	0.855	\$733,165	\$1.05
Lab	\$1,356,372		\$1,356,372	\$8,242		\$76,664	\$1,441,278	1.049	\$1,511,524	\$2.17
OP - Emergency Room	\$4,526,878		\$4,526,878	\$28,605		\$279,125	\$4,834,608	0.978	\$4,727,375	\$6.77
OP - Other	\$7,142,999		\$7,142,999	\$45,135		\$89,140	\$7,277,274	0.978	\$7,115,863	\$10.19
Pharmacy	\$18,455,931		\$18,455,931	\$40	(\$143,175)	\$969,018	\$19,281,814	1.111	\$21,426,345	\$30.69
Prof - Anesthesia	\$296,190		\$296,190	\$2,391		\$146	\$298,726	0.897	\$268,045	\$0.38
Prof - Child EPSDT	\$373,959		\$373,959	\$3,019	(\$842)	\$0	\$376,136	0.897	\$337,503	\$0.48
Prof - Evaluation & Management	\$13,181,769		\$13,181,769	\$105,002	\$31,191	\$851,126	\$14,169,088	0.897	\$12,713,801	\$18.21
Prof - Maternity	\$3,096		\$3,096	\$25	(\$7)	\$6	\$3,120	0.897	\$2,800	\$0.00
Prof - Other	\$7,994,364		\$7,994,364	\$63,983	(\$17,998)	\$353,829	\$8,394,177	0.897	\$7,532,023	\$10.79
Prof - Psych	\$1,295,215		\$1,295,215	\$7,668	(\$2,910)	\$60,962	\$1,360,935	0.897	\$1,221,155	\$1.75
Prof - Specialist	\$1,658,921		\$1,658,921	\$13,392	(\$3,735)	\$66,176	\$1,734,754	0.897	\$1,556,580	\$2.23
Prof - Vision	\$1,320,690		\$1,320,690	\$4,395	(\$2,960)	\$20,801	\$1,342,926	0.897	\$1,204,996	\$1.73
Radiology	\$558,495		\$558,495	\$5,198		\$99,038	\$662,731	1.049	\$695,031	\$1.00
Transportation/Ambulance	\$216,064		\$216,064	\$1,808		\$1,211	\$219,083	1.049	\$229,761	\$0.33
Provider Incentive Payment Adjustment										\$0.64
<b>Total</b>	<b>\$64,633,358</b>	<b>\$25,150</b>	<b>\$64,658,508</b>	<b>\$324,787</b>	<b>(\$99,921)</b>	<b>\$2,904,774</b>	<b>\$67,788,147</b>		<b>\$67,215,131</b>	<b>\$96.93</b>

<sup>1</sup> Completion Factor Adjustment is applied to non-capitated claims only

<sup>2</sup> Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Virginia Medicaid

FY 2016 Capitation Rate Development

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

Capitation Rate Calculations

Section I  
Exhibit 4

Age 15-18 Female										
Statewide	Total Base Claims FY13-14	Base Claims Redistribution FY13-14	Total Redistributed Base Claims FY13-14	Completion Factor Adjustments <sup>1</sup>	Policy and Program Adjustments <sup>2</sup>	Patient Copay	Completed and Adjusted Claims FY13-14	Trend Adjustment	Completed & Trended Claims FY16	PMPM FY16
<b>Service Type</b>										
DME/Supplies	\$211,829		\$211,829	\$1,972	(\$3,603)	\$177	\$210,375	1.049	\$220,629	\$1.82
FQHC / RHC	\$90,757		\$90,757	\$733		\$4,687	\$96,177	0.897	\$86,299	\$0.71
Home Health	\$3,060		\$3,060	\$19		\$112	\$3,191	0.978	\$3,121	\$0.03
IP - Maternity	\$468,675	\$13,967	\$482,643	\$2,591	\$9,981	\$5,078	\$500,292	1.091	\$546,004	\$4.50
IP - Newborn	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Other	\$1,224,452	\$36,491	\$1,260,943	\$6,769	\$26,075	\$4,100	\$1,297,887	1.091	\$1,416,475	\$11.67
IP - Psych	\$385,810		\$385,810	\$1,138	(\$13,286)	\$3,420	\$377,082	0.855	\$322,394	\$2.66
Lab	\$490,425		\$490,425	\$3,501		\$22,199	\$516,125	1.049	\$541,280	\$4.46
OP - Emergency Room	\$1,744,774		\$1,744,774	\$11,025		\$85,830	\$1,841,629	0.978	\$1,800,781	\$14.83
OP - Other	\$2,305,219		\$2,305,219	\$14,566		\$25,776	\$2,345,561	0.978	\$2,293,536	\$18.89
Pharmacy	\$3,243,991		\$3,243,991	\$7	(\$25,166)	\$262,170	\$3,481,002	1.111	\$3,868,160	\$31.86
Prof - Anesthesia	\$95,664		\$95,664	\$772		\$34	\$96,470	0.897	\$86,562	\$0.71
Prof - Child EPSDT	\$92,725		\$92,725	\$749	(\$209)	\$0	\$93,265	0.897	\$83,685	\$0.69
Prof - Evaluation & Management	\$2,887,909		\$2,887,909	\$23,107	\$6,834	\$185,307	\$3,103,156	0.897	\$2,784,435	\$22.93
Prof - Maternity	\$296,170		\$296,170	\$2,391	(\$667)	\$529	\$298,422	0.897	\$267,772	\$2.21
Prof - Other	\$1,169,954		\$1,169,954	\$9,347	(\$2,634)	\$64,703	\$1,241,369	0.897	\$1,113,870	\$9.17
Prof - Psych	\$364,249		\$364,249	\$2,408	(\$819)	\$19,595	\$385,433	0.897	\$345,846	\$2.85
Prof - Specialist	\$431,290		\$431,290	\$3,482	(\$971)	\$21,070	\$454,870	0.897	\$408,151	\$3.36
Prof - Vision	\$216,537		\$216,537	\$648	(\$485)	\$3,038	\$219,738	0.897	\$197,169	\$1.62
Radiology	\$342,631		\$342,631	\$3,189		\$32,192	\$378,012	1.049	\$396,436	\$3.27
Transportation/Ambulance	\$89,044		\$89,044	\$785		\$524	\$90,353	1.049	\$94,757	\$0.78
Provider Incentive Payment Adjustment										\$0.92
<b>Total</b>	<b>\$16,155,163</b>	<b>\$50,458</b>	<b>\$16,205,621</b>	<b>\$89,198</b>	<b>(\$4,949)</b>	<b>\$740,540</b>	<b>\$17,030,410</b>		<b>\$16,877,362</b>	<b>\$139.93</b>

<sup>1</sup> Completion Factor Adjustment is applied to non-capitated claims only

<sup>2</sup> Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Virginia Medicaid

FY 2016 Capitation Rate Development

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

Capitation Rate Calculations

Section I  
Exhibit 4

Age 15-18 Male										
Statewide	Total Base Claims FY13-14	Base Claims Redistribution FY13-14	Total Redistributed Base Claims FY13-14	Completion Factor Adjustments <sup>1</sup>	Policy and Program Adjustments <sup>2</sup>	Patient Copay	Completed and Adjusted Claims FY13-14	Trend Adjustment	Completed & Trended Claims FY16	PMPM FY16
<b>Service Type</b>										
DME/Supplies	\$268,709		\$268,709	\$2,501	(\$4,570)	\$228	\$266,868	1.049	\$279,875	\$2.31
FQHC / RHC	\$53,342		\$53,342	\$431		\$2,866	\$56,638	0.897	\$50,821	\$0.42
Home Health	\$6,635		\$6,635	\$42		\$133	\$6,810	0.978	\$6,659	\$0.06
IP - Maternity	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Newborn	\$0	\$0	\$0			\$0	\$0	1.091	\$0	\$0.00
IP - Other	\$1,160,330	\$34,580	\$1,194,910	\$6,415	\$24,710	\$3,420	\$1,229,455	1.091	\$1,341,790	\$11.09
IP - Psych	\$286,558		\$286,558	\$790	(\$9,866)	\$1,560	\$279,041	0.855	\$238,572	\$1.97
Lab	\$245,663		\$245,663	\$1,256		\$9,316	\$256,235	1.049	\$268,724	\$2.22
OP - Emergency Room	\$1,174,584		\$1,174,584	\$7,422		\$59,051	\$1,241,057	0.978	\$1,213,530	\$10.03
OP - Other	\$1,988,748		\$1,988,748	\$12,567		\$19,651	\$2,020,966	0.978	\$1,976,140	\$16.34
Pharmacy	\$4,002,462		\$4,002,462	\$9	(\$31,050)	\$163,895	\$4,135,316	1.111	\$4,595,248	\$37.99
Prof - Anesthesia	\$71,886		\$71,886	\$580		\$31	\$72,497	0.897	\$65,051	\$0.54
Prof - Child EPSDT	\$56,927		\$56,927	\$460	(\$128)	\$0	\$57,258	0.897	\$51,377	\$0.42
Prof - Evaluation & Management	\$2,017,097		\$2,017,097	\$16,060	\$4,773	\$128,001	\$2,165,931	0.897	\$1,943,472	\$16.07
Prof - Maternity	\$0		\$0			\$0	\$0	0.897	\$0	\$0.00
Prof - Other	\$1,699,219		\$1,699,219	\$13,620	(\$3,826)	\$52,762	\$1,761,775	0.897	\$1,580,826	\$13.07
Prof - Psych	\$291,808		\$291,808	\$1,829	(\$656)	\$13,793	\$306,774	0.897	\$275,266	\$2.28
Prof - Specialist	\$469,826		\$469,826	\$3,793	(\$1,058)	\$15,861	\$488,422	0.897	\$438,257	\$3.62
Prof - Vision	\$205,560		\$205,560	\$567	(\$460)	\$2,722	\$208,389	0.897	\$186,986	\$1.55
Radiology	\$191,387		\$191,387	\$1,781		\$26,695	\$219,864	1.049	\$230,580	\$1.91
Transportation/Ambulance	\$75,618		\$75,618	\$662		\$447	\$76,727	1.049	\$80,466	\$0.67
Provider Incentive Payment Adjustment										\$0.81
<b>Total</b>	<b>\$14,266,359</b>	<b>\$34,580</b>	<b>\$14,300,939</b>	<b>\$70,783</b>	<b>(\$22,131)</b>	<b>\$500,433</b>	<b>\$14,850,024</b>		<b>\$14,823,638</b>	<b>\$123.37</b>

<sup>1</sup> Completion Factor Adjustment is applied to non-capitated claims only

<sup>2</sup> Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

# Virginia Medicaid

## FY 2016 Capitation Rate Development

### Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

#### Summary of FY 2016 Base Capitation Rates Below & Above 150% Federal Poverty Level

# Section I Exhibit 5a

Age Group	Combined Base Rates	Copay Value PMPM		Admin Cost Adjustment	Statewide		
		FAMIS <=150%	FAMIS >150%		FAMIS <=150% Total with Admin	FAMIS >150% Total with Admin	
Under 1	\$467.43	\$2.10	\$5.00	9.80%	\$515.91	\$512.69	
1-5	\$102.15	\$2.03	\$4.88	9.80%	\$111.01	\$107.85	
6-14	\$96.93	\$2.04	\$4.97	9.80%	\$105.20	\$101.95	
Female 15-18	\$139.93	\$2.10	\$5.06	9.80%	\$152.81	\$149.53	
Male 15-18	\$123.37	\$2.12	\$5.13	9.80%	\$134.42	\$131.09	
<b>Overall FAMIS</b>							
<b>Average</b>					\$116.05	\$119.48	\$119.10

Note:

Average is weighted by health plan enrollment distribution as of March 2015

# Virginia Medicaid

## FY 2016 Capitation Rate Development

### Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)

#### Comparison of FY 2015 and FY 2016 Capitation Rates

# Section I Exhibit 5b

		Statewide					
Aid Category		FAMIS <=150%			FAMIS >150%		
Age Group		FY 2015	FY 2016	% Change	FY 2015	FY 2016	% Change
FAMIS	Under 1	\$556.14	\$515.91	-7.23%	\$552.99	\$512.69	-7.29%
	1-5	\$130.91	\$111.01	-15.20%	\$127.78	\$107.85	-15.60%
	6-14	\$120.89	\$105.20	-12.98%	\$117.68	\$101.95	-13.36%
	Female 15-18	\$175.97	\$152.81	-13.16%	\$172.73	\$149.53	-13.43%
	Male 15-18	\$149.66	\$134.42	-10.18%	\$146.36	\$131.09	-10.43%
<b>Average</b>		\$133.70	\$116.05	-13.20%	\$137.57	\$119.48	-13.15%

Overall FAMIS Average		
FY 2015	FY 2016	% Difference
\$137.14	\$119.10	-13.15%

Note:

Average is weighted by health plan enrollment distribution as of March 2015

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)**  
**March 2015 Member Month Distribution**

**Section I**  
**Exhibit 5c**

<b>Aid Category</b>	<b>Age Group</b>	<b>Statewide</b>
<b>FAMIS &lt;= 150%</b>	Under 1	33
	1-5	1,847
	6-14	3,397
	Female 15-18	591
	Male 15-18	612
<b>Aid Category Total</b>		<b>6,480</b>
<b>FAMIS &gt;150%</b>	Under 1	1,142
	1-5	14,667
	6-14	26,788
	Female 15-18	4,620
	Male 15-18	4,514
<b>Aid Category Total</b>		<b>51,731</b>
<b>Total</b>		<b>58,211</b>

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Drug Reinsurance Adjustment**

**Section I**  
**Exhibit 6**

	FAMIS	Source
1a. FY13 Number of Individuals Exceeding the Threshold	7	FY13 Health Plan Encounter Data
1b. FY13 Total Dollars For Individuals Exceeding the Discounted Threshold	\$3,011,467	FY13 Health Plan Encounter Data
1c. FY13 Trended to FY16 Total Dollars For Individuals Exceeding the Threshold	\$4,230,894	FY13 Health Plan Encounter Data
1d. FY13 Amount of Reinsurance	\$2,862,805	= ((1c.) - ((1a.) * \$150,000)) * 90%
2a. FY14 Number of Individuals Exceeding the Threshold	7	FY14 Health Plan Encounter Data
2b. FY14 Total Dollars For Individuals Exceeding the Discounted Threshold	\$1,196,014	FY14 Health Plan Encounter Data
2c. FY14 Trended to FY16 Total Dollars For Individuals Exceeding the Threshold	\$1,500,279	FY14 Health Plan Encounter Data
2d. FY14 Amount of Reinsurance	\$405,251	= ((2c.) - ((2a.) * \$150,000)) * 90%
3. Average Reinsurance Amount	\$1,634,028	= ((1d.) + (2d.)) / 2
4. Annualized Historical Member Months	720,844	Health Plan Encounter Data
<b>5. Estimated PMPM</b>	<b>\$2.27</b>	<b>= (3.) / (4.)</b>

Note:  
Discounted threshold is based upon FY16 reinsurance threshold of \$150,000 per person per year discounted by 12% unit cost trend per year

# Virginia Medicaid

## FY 2016 Capitation Rate Development

### FAMIS Capitation Rates Net of Drug Reinsurance Adjustment

#### Summary of FY 2016 Base Capitation Rates Below & Above 150% Federal Poverty Level

# Section I Exhibit 7

Age Group	Statewide		
	FAMIS <=150% Total with Admin	FAMIS >150% Total with Admin	
Under 1	\$513.64	\$510.42	
1-5	\$108.74	\$105.58	
6-14	\$102.93	\$99.69	
Female 15-18	\$150.54	\$147.26	
Male 15-18	\$132.15	\$128.82	
<b>Overall FAMIS</b>			
<b>Average</b>	\$113.78	\$117.22	\$116.83

Note:

Average is weighted by health plan enrollment distribution as of March 2015

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Historical Eligibility, Claims, and Utilization Data**

**Section II**  
**Exhibit 1**

Age 10 and Over Female												
Statewide	Raw Claims FY13	Raw Claims FY14	Capitation FY13	Capitation FY14	Unadjusted PMPM 13	Unadjusted PMPM 14	Units FY13	Units FY14	Units/1000 FY13	Units/1000 FY14	Cost/Unit FY13	Cost/Unit FY14
Member Months	16,417	13,529										
<b>Service Type</b>												
DME/Supplies	\$41,214	\$56,101	\$0	\$0	\$2.51	\$4.15	261	364	191	323	\$157.91	\$154.12
FQHC / RHC	\$61,433	\$41,858	\$0	\$0	\$3.74	\$3.09	579	373	423	331	\$106.10	\$112.22
Home Health	\$11,110	\$8,690	\$0	\$0	\$0.68	\$0.64	45	42	33	37	\$246.88	\$206.91
IP - Maternity	\$5,882,167	\$5,606,790	\$0	\$0	\$358.30	\$414.43	2,753	2,324	2,012	2,061	\$2,136.64	\$2,412.56
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	0	0	-	-
IP - Other	\$197,401	\$166,621	\$0	\$0	\$12.02	\$12.32	59	88	43	78	\$3,345.77	\$1,893.42
IP - Psych	\$17,308	\$3,420	\$0	\$0	\$1.05	\$0.25	23	7	17	6	\$752.51	\$488.60
Lab	\$243,714	\$172,006	\$8,330	\$7,222	\$15.35	\$13.25	25,570	12,778	18,690	11,334	\$9.86	\$14.03
OP - Emergency Room & Related	\$532,089	\$379,440	\$0	\$0	\$32.41	\$28.05	1,609	1,355	1,176	1,202	\$330.70	\$280.03
OP - Other	\$1,040,818	\$902,097	\$0	\$0	\$63.40	\$66.68	4,802	4,396	3,510	3,899	\$216.75	\$205.21
Pharmacy	\$504,485	\$420,013	\$0	\$0	\$30.73	\$31.05	14,258	12,068	10,422	10,704	\$35.38	\$34.80
Prof - Anesthesia	\$341,680	\$281,267	\$0	\$0	\$20.81	\$20.79	2,065	1,769	1,509	1,569	\$165.46	\$159.00
Prof - Child EPSDT	\$17,103	\$14,604	\$0	\$0	\$1.04	\$1.08	440	406	322	360	\$38.87	\$35.97
Prof - Evaluation & Management	\$745,680	\$610,905	\$7,017	\$4,499	\$45.85	\$45.49	10,828	9,040	7,915	8,018	\$69.51	\$68.08
Prof - Maternity	\$3,418,987	\$2,986,315	\$0	\$0	\$208.26	\$220.73	5,769	4,944	4,217	4,385	\$592.65	\$604.03
Prof - Other	\$331,773	\$289,967	\$930	\$606	\$20.27	\$21.48	3,159	2,975	2,309	2,639	\$105.32	\$97.67
Prof - Psych	\$12,629	\$8,652	\$0	\$0	\$0.77	\$0.64	198	155	145	137	\$63.78	\$55.82
Prof - Specialist	\$181,113	\$121,153	\$0	\$0	\$11.03	\$8.96	2,410	1,945	1,762	1,725	\$75.15	\$62.29
Prof - Vision	\$4,289	\$4,634	\$18,015	\$16,029	\$1.36	\$1.53	146	107	107	95	\$152.77	\$193.12
Radiology	\$777,741	\$613,059	\$0	\$0	\$47.37	\$45.31	9,303	7,730	6,800	6,856	\$83.60	\$79.31
Transportation/Ambulance	\$33,305	\$25,673	\$43,903	\$37,405	\$4.70	\$4.66	761	430	556	381	\$101.45	\$146.69
<b>Total</b>	<b>\$14,396,038</b>	<b>\$12,713,264</b>	<b>\$78,196</b>	<b>\$65,761</b>	<b>\$881.66</b>	<b>\$944.57</b>	<b>85,038</b>	<b>63,296</b>				

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Pharmacy Adjustment**

**Section II**  
**Exhibit 2a**

	FAMIS MOMS	Source
1. Health Plan Total Drug Cost PMPM	\$30.87	FY13-14 Health Plan Encounter Data
2. Health Plan Drug Ingredient Cost PMPM	\$29.70	Health Plan Encounter Analysis
3. Change in Average Managed Care Discount	0.4%	From Plan Data
4. Current Average Managed Care Rebate	1.7%	From Plan Data
5. FY16 Managed Care Dispensing Fee PMPM	\$1.18	From Plan Data
6. Average PBM Admin Cost PMPM	\$0.44	From Plan Data
7. Adjusted PMPM with FY16 Pharmacy Pricing Arrangements	\$30.69	= (2.) * (1 - (3.)) * (1 - (4.)) + (5.) + (6.)
<b>8. Pharmacy Adjustment</b>	<b>-0.6%</b>	= (7.) / (1.) - 1

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Hospital Inpatient Adjustments**

**Section II**  
**Exhibit 2b**

	<b>Inpatient Medical/Surgical</b>	<b>Inpatient Psychiatric</b>	<b>Source</b>
1a. FY13 Total Claims in IP Service Categories	\$6,079,568	\$17,308	FY13 Health Plan Encounter Data
1b. FY14 Total Claims in IP Service Categories	\$5,773,411	\$3,420	FY14 Health Plan Encounter Data
2. FY13-14 Hospital Capital Percentage	10.2%	10.2%	Provided by DMAS
3a. FY14 Hospital Rate Change	4.7%	-7.4%	Provided by DMAS
3b. Dollar Change	\$254,844	(\$1,145)	= (1a.) * (1 - (2.)) * (3a.)
<b>4. Hospital Inpatient Adjustment</b>	<b>2.2%</b>	<b>-5.5%</b>	= ((3b.)) / ((1a.) + (1b.))

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**DME Fee Adjustment**

**Section II**  
**Exhibit 2c**

	<b>FAMIS MOMS</b>	<b>Source</b>
1. Claims Associated with DME/Supplies Service Category	\$97,315	FY13-14 Health Plan Encounter Data
2. Proportion of Claims subject to change	\$4,405	Provided by DMAS
3a. FY15 DME Fee Change	-22.0%	Provided by DMAS
3b. Dollar Change	(\$970)	= (2.) * (3a.)
<b>4. DME Fee Adjustment</b>	<b>-1.0%</b>	= (3b.) / (1.)

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Provider Incentive Payment Adjustment**

**Section II**  
**Exhibit 2d**

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	<b>Adjustment Value</b>	<b>Source</b>
<b>Provider Incentive Payment Adjustment</b>	<b>0.1%</b>	<b>From Plan Data</b>

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**Virginia Medicaid  
FY 2016 Capitation Rate Development  
Health Plan Encounter Data  
Hepatitis C Treatment Adjustment**

**Section II  
Exhibit 2e**

	FAMIS MOMS	Source
1. Total Claims in Pharmacy Service Categories	\$924,498	FY13-14 Health Plan Encounter Data
2. Unique Individuals in Base Period	5,246	FY13-14 Health Plan Encounter Data
3a. Proportion of Population Being Tested for Hepatitis C	2.0%	FY13-14 Health Plan Encounter Data
3b. Number of Individuals Being Tested	107	FY13-14 Health Plan Encounter Data
3c. Projected Testing Change in FY16	15%	Estimate
3d. Additional Number of People Being Tested	16	= (3b.) * (3c.)
3e. Average Cost Per Test Per Person	\$61.70	FY13-14 Health Plan Encounter Data
4a. Proportion of Population Diagnosed With Hepatitis C	0.25%	FY13-14 Health Plan Encounter Data
4b. Number of Individuals Diagnosed With Hepatitis C	13	FY13-14 Health Plan Encounter Data
4c. Projected Increase in People Diagnosed With Hepatitis C	5%	Estimate
4d. Projected Number of People With Hepatitis C	14	= (4b.) * (1 + (4c.))
5a. Proportion of People With Hepatitis C With Drug Therapy	0.0%	FY13-14 Health Plan Encounter Data
5b. Number of Individuals With Hepatitis C With Drug Therapy in Base Period	0	FY13-14 Health Plan Encounter Data
5c. Increase in Proportion of Hepatitis C Receiving Drug Therapy	30%	Estimate
5d. Projected Number of Additional People Going Through Drug Therapy	0	= (4d.) * (5a.) * (1 + (5c.)) - (5b.)
5e. Average Cost of Current Drug Therapy	\$60,000	FY13-14 Health Plan Encounter Data
5f. Average Cost of New Drug Therapy	\$90,000	Estimate
6. Additional Cost of Hepatitis C Treatment	\$990.24	= ((3d.) * (3e.)) + ((5f.) - (5e.)) * (5b.) + (5d.) * (5f.)
<b>7. Hepatitis C Treatment Adjustment</b>	<b>0.1%</b>	= (6.) / (1.)

Note: Based on analysis of FY13 - FY14 base data experience

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Emergency Room Triage Adjustment**

**Section II**  
**Exhibit 2f**

	FAMIS MOMS	Source
1. Total Claims in Prof - Evaluation & Management	\$1,356,585	FY13-14 Health Plan Encounter Data
2. FY13-14 Number of Claims in ER Triage Level 3	205	FY13-14 Health Plan Encounter Data
3. ER Cost No Triage Level 3	\$44.67	FY13-14 Health Plan Encounter Data
4. ER Triage Cost	\$22.06	Provided by DMAS
5. FY16 ER Triage Financial Impact (2 year)	\$4,635	= (2.) * ((3.) - (4.))
<b>6. FY16 ER Triage Adjustment</b>	<b>0.3%</b>	= (5.) / (1.)

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Resource Based Relative Value Scale Adjustment**

**Section II**  
**Exhibit 2g**

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**FAMIS**

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1. Professional Fee Adjustment - Effective FY16	-0.2%	Provided by DMAS
2. Proportion of claims subject to fee adjustment	89%	FY13-14 Health Plan Encounter Data
3. <b>Final Professional Fee Adjustment</b>	<b>-0.2%</b>	<b>= (1.) * (2.)</b>

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**Virginia Medicaid  
 FY 2016 Capitation Rate Development  
 Health Plan Encounter Data - FAMIS MOMS  
 Administrative Cost Adjustment**

**Section II  
 Exhibit 2h**

	FAMIS MOMS	Source
1. Claims Adjustment Expense PMPM	\$25.57	Expense from CY2014 BOI Reports; CY2014 Member months from capitation payment files
2. General Admin Expense PMPM	\$44.96	Expense from CY2014 BOI Reports; CY2014 Member months from capitation payment files
3. Claims Adjustment Expense Increase %	0.8%	BLS CPI-U
4. General Admin Expense Increase %	2.6%	Weighted average of BLS Compensation Trend and CPI
5a. Administrative PMPM*	\$72.61	$= (1.) * (1 + (3.)) ^ (18 \text{ months}/12) + (2.) * (1 + (4.)) ^ (18 \text{ months}/12)$
5b. Administrative PMPM Weighted by Claims	\$36.25	Reallocation of administrative costs weighted by claims
6. Adjusted and Trended Base PMPM	\$1,050.00	Weighted average of med component of FY2016 FAMIS Moms Base Rates
7. Administrative allowance as % of Base Capitation Rate	3.3%	$= (5b.) / (((5b.) + (6.)) / (1 - (8.)))$
8. Contribution to Reserves as % of Base Capitation Rate	1.5%	Provided by DMAS
<b>9. Administrative Factor as % of Base Capitation Rate</b>	<b>4.8%</b>	$= (7.) + (8.)$

\*Note:

Administrative increases are applied from midpoint of CY2014 to the midpoint of the contract period (18 months) using compound interest calculations

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Incurred But Not Reported (IBNR), Policy/Program, and Trend Adjustments**

**Section II**  
**Exhibit 3**

Category of Service	FAMIS MOMS							
	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program <sup>1</sup>	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Inpatient Medical/Surgical	0.2%	2.2%	2.3%	7.7%	4.0%	11.9%	4.4%	1.1945
Inpatient Psychiatric <sup>2</sup>	0.9%	-5.5%	-4.7%	6.4%	1.0%	7.6%	5.1%	1.1584
Outpatient Hospital	0.4%	0.0%	0.4%	-11.9%	12.8%	-0.6%	0.0%	0.9933
Practitioner	0.4%	-0.1%	0.2%	3.2%	5.3%	8.7%	4.2%	1.1562
Prescription Drug	0.0%	-0.5%	-0.5%	-1.7%	2.6%	0.9%	0.0%	1.0090
Other	0.3%	0.0%	0.2%	1.4%	-4.7%	-3.4%	2.9%	1.0087
<b>Weighted Average<sup>3</sup></b>	<b>0.3%</b>	<b>0.9%</b>	<b>1.1%</b>	<b>3.3%</b>	<b>4.7%</b>	<b>8.0%</b>	<b>3.6%</b>	<b>1.1400</b>

<b>Months of Trend Applied</b>	12	12	12	18
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<sup>1</sup> The Policy and Program Adjustments are summarized in this table as weighted averages and are applied at the rate cell level in Exhibit 4.

<sup>2</sup> Inpatient Psych trend rates have been defaulted to LIFC Adult values.

<sup>3</sup> Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY13-14), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY13-14 Claims)

Trend rates for managed care plans are calculated based on regression studies of historical health plan data.

Trend rates have been calculated separately for the broad service categories shown above. Utilization trend is based on service units per thousand.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations; includes FY13-14 incurred claims paid through Oct 2014

Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations; includes FY12-14 incurred claims paid through Feb 2015.

**Total Trend = [(1 + data period trend) ^ (months/12) \* (1 + contract period trend) ^ (months/12)]**

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Capitation Rate Calculations**

**Section II**  
**Exhibit 4**

<b>Age 10 and Over Female</b>							
<b>Statewide</b>	Total Base Claims FY13-14	Completion Factor Adjustments <sup>1</sup>	Policy and Program Adjustments <sup>2</sup>	Completed and Adjusted Claims FY13-14	Trend Adjustment	Completed & Trended Claims FY16	PMPM FY16
<b>Service Type</b>							
DME/Supplies	\$97,315	\$260	(\$972)	\$96,602	1.009	\$97,441	\$3.25
FQHC / RHC	\$103,291	\$394		\$103,685	1.156	\$119,886	\$4.00
Home Health	\$19,800	\$88		\$19,888	0.993	\$19,754	\$0.66
IP - Maternity	\$11,488,957	\$18,178	\$247,409	\$11,754,544	1.195	\$14,040,920	\$468.87
IP - Newborn	\$0	\$0		\$0	1.195	\$0	\$0.00
IP - Other	\$364,021	\$576	\$7,839	\$372,436	1.195	\$444,879	\$14.86
IP - Psych	\$20,728	\$185	(\$1,155)	\$19,758	1.158	\$22,887	\$0.76
Lab	\$431,272	\$1,111		\$432,383	1.009	\$436,137	\$14.56
OP - Emergency Room	\$911,529	\$4,064		\$915,592	0.993	\$909,441	\$30.37
OP - Other	\$1,942,915	\$8,662		\$1,951,577	0.993	\$1,938,466	\$64.73
Pharmacy	\$924,498	\$0	(\$4,332)	\$920,166	1.009	\$928,482	\$31.01
Prof - Anesthesia	\$622,947	\$2,378		\$625,325	1.156	\$723,028	\$24.14
Prof - Child EPSDT	\$31,706	\$121	(\$68)	\$31,759	1.156	\$36,721	\$1.23
Prof - Evaluation & Management	\$1,368,101	\$5,179	\$1,751	\$1,375,031	1.156	\$1,589,870	\$53.09
Prof - Maternity	\$6,405,302	\$24,454	(\$13,769)	\$6,415,986	1.156	\$7,418,438	\$247.73
Prof - Other	\$623,277	\$2,374	(\$1,340)	\$624,311	1.156	\$721,855	\$24.11
Prof - Psych	\$21,281	\$81	(\$46)	\$21,316	1.156	\$24,647	\$0.82
Prof - Specialist	\$302,266	\$1,154	(\$650)	\$302,771	1.156	\$350,076	\$11.69
Prof - Vision	\$42,968	\$34	(\$92)	\$42,909	1.156	\$49,614	\$1.66
Radiology	\$1,390,800	\$3,717		\$1,394,517	1.009	\$1,406,624	\$46.97
Transportation/Ambulance	\$140,286	\$158		\$140,443	1.009	\$141,663	\$4.73
Provider Incentive Payment Adjustment							\$0.75
<b>Total</b>	<b>\$27,253,259</b>	<b>\$73,168</b>	<b>\$234,574</b>	<b>\$27,561,001</b>		<b>\$31,420,830</b>	<b>\$1,050.00</b>
Admin Cost Adjustment							\$52.79
<b>FAMIS MOMS Capitation Rate</b>							<b>\$1,102.79</b>

<sup>1</sup> Completion Factor Adjustment is applied to non-capitated claims only

<sup>2</sup> Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

**Virginia Medicaid**  
**FY 2016 Capitation Rate Development**  
**Health Plan Encounter Data - FAMIS MOMS**  
**Comparison of FY 2015 and FY 2016 Capitation Rates and Member Months**

**Section II**  
**Exhibit 5**

FAMIS MOMS - Age 10 and Over Female	Statewide		
	FY 2015	FY 2016	% Change
Capitation Rate	\$987.03	\$1,102.79	11.73%
Capitation Rate (6 Month Base)	\$1,319.06		-16.40%
March 2015 Member Months		368	