

**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**

**Program of All-Inclusive Care
for the Elderly (PACE)**

**Data Book and Capitation Rates
Fiscal Year 2009**

Submitted by:

**PricewaterhouseCoopers LLP
Three Embarcadero Center
San Francisco, CA 94111**

**Contact Person:
Sandra S. Hunt
415/498-5365**

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PricewaterhouseCoopers LLP
3 Embarcadero Center
San Francisco CA 94111
Direct phone (415) 498-5365
Direct fax (813) 329-2666

October 22, 2008

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

Dear Bill:

Re: PACE Data Book and Capitation Rates - FY 2009

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for Fiscal Year 2009 for the Virginia Programs of All-Inclusive Care for the Elderly (PACE) that operates as a full PACE program and that anticipates approval to operate additional full PACE programs before the end of the fiscal year. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services requirements that the capitation rates be developed under guidelines that rates do not exceed the Fee-for-Service Upper Payment Limit, the amount that would be paid by the Medicaid program in the absence of a PACE program, and are appropriate for the population covered by the program.

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

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

Very Truly Yours,

A handwritten signature in cursive script that reads "Sandra S. Hunt".

Sandra S. Hunt, M.P.A.
Principal
PricewaterhouseCoopers LLP

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Virginia Medicaid
**Program of All-Inclusive Care
for the Elderly (PACE)**

**Data Book and Capitation Rates
Fiscal Year 2009**

Prepared by PricewaterhouseCoopers LLP

October 2008

PricewaterhouseCoopers LLP (PwC) has calculated capitation rates for the Virginia Medicaid Program of All-Inclusive Care for the Elderly (PACE). This includes PACE rates for programs already operational in the Tidewater and Rural regions and PACE rates for the other three geographic regions. There is one plan in the Tidewater region that operated as a Pre-PACE program and converted to a full PACE program in November 2007. Three other PACE programs became operational in FY 2008, a second in Tidewater and two in Rural. Another two PACE programs are expected to be operational before the end of FY 2009.

Rate setting for PACE programs is guided by regulations that limit payment to at or below the amount the Medicaid program would pay as a Fee-for-Service Equivalent (FFSE) cost in the absence of the PACE program; this is also referred to as the Upper Payment Limit (UPL).

The methodology presented in this report meets the UPL guidelines and conforms to appropriate standards of practice promulgated from time to time by the Actuarial Standards Board. Rates based on UPL guidelines do not require actuarial certification.

The final rates will be established through signed contracts with the health plans, which will ensure that the plans concur that the rates paid will allow for contracting with sufficient numbers of providers to ensure appropriate access to health care and that they expect to remain financially sound throughout the contract period.

Capitation rates are developed for a population aged 55 and over and vary by dual eligibility status (Medicaid/Medicare or Medicaid Only). The PACE rates for Tidewater and the other four regions in the state are developed for the four operating PACE programs and for the two new

PACE programs that are expected to become operational over the course of the fiscal year.¹ The rates would also apply to PACE programs under development if they become operational during the FY 2009 period.

Rates developed for FY 2009 take into consideration the implementation of the Medicare Part D prescription drug benefit effective January 1, 2006. As of that date, all dual eligibles were enrolled in the Part D benefit and obtained the majority of their prescription drugs under Medicare, rather than under the Medicaid program. The Virginia Medicaid program continues to cover the prescription drugs it currently covers under its formulary but which are specifically excluded by law from Medicare Part D and for which federal matching funds remain available. This includes benzodiazepines and barbiturates². DMAS continues to cover specific DMAS approved over the counter drugs, which are also excluded from Part D. For the Medicare Part B covered drugs, DMAS will continue to pay for coinsurance and deductibles. Because the Medicare Part D benefit is in effect through the entire State FY 2007, the dual rate development reports only the pharmacy claims for that year in the base data, beginning in Exhibit 1a.³ There was no such change for the non-dual, Medicaid only population.

Medicaid PACE rates include acute care, and long term care and personal care services under the Elderly or Disabled with Consumer Direction (EDCD) waiver. Total payments to PACE programs will also include payments from the Medicare program.

I. Background

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

Medicaid programs pay PACE sites a capitated fee designed to cover the full cost of all services required by PACE enrollees that would otherwise be paid through the Medicaid fee-for-service system. A PACE program is capitated for both Medicaid and Medicare covered services. Medicare's contribution to PACE costs is currently set based on the Average Adjusted Per Capita Cost (AAPCC) for the geographic area in which the PACE program operates and risk adjusted for a frailty factor. PACE centers typically enroll 100 to 200 individuals although there

¹ Scott County is moved from the Other MSA region to Rural for the purpose of PACE rate setting.

² In a provision of the Medicare Improvements for Patients and Providers Act (July 2008), Benzodiazepines and barbiturates, will be covered under Medicare Part D for beneficiaries with specific conditions, including cancer, epilepsy and chronic mental health conditions. This will apply to prescriptions dispensed on or after January 1, 2013.

³ Only the SFY07 pharmacy dollars are reported in Exhibit 1a and carried forward to Exhibit 4a. Other calculations, including PMPM and units per 1,000 are calculated using the SFY07 member months.

are multi-site programs with larger centers. Consequently, it is important that the capitation rates paid for the program provide an accurate estimate of costs for the specific population that enrolls in the program, as there is little ability for PACE programs to accommodate significant variations in the level of health care need of individual participants through high volume.

Our analysis includes all individuals eligible to participate in PACE. This includes the nursing home eligible population, both those who are residents of nursing homes, as well as those who are enrolled in Home and Community Based Services waiver programs. We have implicitly assumed that the distribution of enrollment in a PACE program will mirror the PACE-eligible population. In other words, if 70% of the PACE eligible population is currently residing in nursing homes, the rates reported here implicitly assume that 70% of the enrollees would otherwise have been nursing home residents for the base calculation. Virginia is currently contracting with four organizations to operate PACE programs. These and any new PACE programs are assumed to have the same proportion of residents of nursing homes, and Home and Community Based Service waiver programs as the eligible population in the Tidewater region. In this report we develop PACE rates for all regions of Virginia even though there are some regions that are not expected to have operational PACE programs in FY 2009.

PACE Capitation Rates

Payments to managed care plans for PACE are subject to federal rules. As a Medicaid program, the state must comply with federal regulations set by CMS regarding payment levels. Specifically, Pre-PACE program rates are subject to the Balanced Budget Act regulations and must meet the test of actuarial soundness. The one Pre-PACE program in Virginia converted to a full PACE program in the past year and the three new programs are all full PACE. Full PACE programs are subject to rate setting under UPL guidelines. In addition, CMS must approve the payment rates made to each plan.

The PACE capitation rates shown in this report are designed to comply with both the CMS definition of actuarial soundness and the UPL. In general, the methodological approach under either guideline can be similar.

Specifically, we have analyzed historical fee-for-service claims for the PACE-eligible population in each region. We then made adjustments to the historical data to reflect modifications of payment arrangements under the fee-for-service program, and updated the payment rates to reflect the contract period covered by these rates. We also reviewed 1) outpatient pharmacy pricing under pharmacy benefits management arrangements and 2) financial data provided by the contractor to assess comparability and the reasonableness of the distribution of medical and administrative costs. This financial review provided information used to adjust the fee-for-service results for expectations of managed care savings and an allowance for health plan administrative costs.

DMAS anticipates that two new PACE programs will become operational during FY 2009. These are expected to operate in the Richmond and Other MSA regions.

II. Data Sources

PwC obtained detailed historical fee-for-service claims and eligibility data from the Department of Medical Assistance Services (DMAS) for services incurred and months of enrollment during State Fiscal Years 2006 through 2007 with claims paid through August 2008. The claims included in the historical data base include Medicaid paid amounts, which are net of any third party insurance payments, Medicare payment amounts, and, for nursing facility and personal care services, include the amounts for which patients are responsible. Fee-for-service data are used to develop PACE rates because PACE rate setting guidelines do not permit direct use of encounter data from the contracting health plan.

The work in this report builds on analyses performed in developing capitation rates for the Medallion II program and rate development for a proposed Virginia Acute and Long Term Care (VALTC) program. In the Medallion II program, special adjustments were made to the historical data to reflect changes in payment arrangements due to other programmatic and legislative adjustments. Our Medallion II report, dated July 2008, provides a detailed description of the process used for developing those adjustments; where applicable, these same adjustment factors are used in the development of the PACE rates.

The claims and eligibility information used in this report includes data only for Medicaid recipients who are potentially eligible for the PACE program based on their age, eligibility category, and eligibility for nursing home services. All claims and eligibility data for members who are not eligible for the PACE program were excluded from the historical data used in these calculations. Members eligible for PACE were identified through an indicator on each eligibility record that signifies that the member is receiving nursing, personal care, adult day care or respite services.⁴ Members who would otherwise qualify through this indicator who incurred services indicated as “Nursing Facility/Mental Retardation” are not eligible to enroll in PACE. Another category of members who would otherwise qualify are those who receive a high level of special and complex services, such as ventilator assistance, but who are unlikely to enroll in PACE. All claims and eligibility for both of these groups were removed from the database prior to the calculations shown in this report.

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

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

⁴ This also includes those who may receive such services under the Virginia AIDS and the Elderly and Disabled with Consumer Direction waivers.

data and are the basis of all future calculations described here. These exhibits show, for informational purposes:

- member months for Fiscal Years 2006 and 2007,
- Medicaid payment amounts for the combined years,
- patient payment amounts for the combined years,⁵
- costs per member per month (PMPM) for the combined years (a combination of Medicaid and patient payment amounts),
- unadjusted units of service for Fiscal Years 2006 and 2007 (a definition of “units” for each category of service is provided in Exhibit 6),
- annual units/1,000 members for the combined years, calculated as the total units of service divided by the appropriate member months, multiplied by 1,000, multiplied by 12, and
- cost per unit of service.

III. Capitation Rate Calculations

The statewide capitation rates for Fiscal Year 2009 are calculated based on the historical data shown in Exhibits 1a – 1b adjusted to reflect changes in payment rates and covered services. Each of the adjustments to the historical data is described in the following section. The adjustments are applied to the historical data and the resulting capitation rates are calculated in Exhibits 4a – 4b.

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

1. The historical data for each Medicare eligibility status and the region are brought forward to Exhibits 4a and 4b from the corresponding cell in Exhibits 1a and 1b.⁶ This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Legislature or changes to the Medicaid State Plan. Several of these adjustments were developed in the Medallion II report and applied to these calculations; additional adjustments that apply to the PACE eligible group have been incorporated into these calculations. These adjustments are described in greater detail in Section IV.

⁵ Patient payment amounts are primarily for nursing home and personal care services.

⁶ Patient pay amounts for adult day care, consumer directed, nursing home and personal care services are carried forward to the capitation rate calculations in Exhibits 4a and 4b.

3. The claims data are adjusted to update to the FY 2009 contract period; these trend adjustments are described in Section VI.
4. These are further adjusted to reflect expected managed care savings. The resulting claims are shown in Exhibits 4a and 4b under the column “Completed, Adjusted and Trended Claims”.
5. The managed care adjusted claims from Step 4 are divided by the count of member months for each rate cell (from Exhibits 1a and 1b) to arrive at preliminary PMPM costs by service category. These PMPM costs are summarized for each dual eligibility status and region. Claims are summed to calculate health care cost components for PACE.
6. The final step is an allowance for health plan administrative costs. The rates shown in Exhibit 5a include only the Medicaid portion of the payment. The PACE program will also receive a capitation payment from the federal government for the Medicare component of services.

IV. Programmatic and Legislative Adjustments

Prescription Drug Adjustment

Under the guideline of actuarial soundness, States are no longer required to reduce the outpatient prescription drug payments by the amount of state drug rebates. However, the PACE rate-setting checklist requires that rates be developed based on the FFS equivalent cost.

The prescription drug adjustment was based upon a combination of analysis of the DMAS FFS pharmacy payments, including rebate amounts, unit cost, utilization rates, and application of co-payments.

DMAS Medicaid prescription co-payments on brand name drugs are set at \$3 and the co-payment for generic is \$1. As mandated by Federal law, co-payments are not imposed on recipients in nursing homes or in community based waivers, although a small amount of co-payment was reported in the FFS data. Because PACE members are certified as nursing home eligible, we have not calculated or applied any further co-payment adjustment.

Because Medicare Prescription Drug (Part D) coverage is mandatory for all Medicaid-Medicare dual eligibles, there are two pharmacy benefits management adjustments, one for the dual eligibles and one for the non-dual population. Part D was effective January 1, 2006, halfway through the first year of the historical data period. Review of the underlying data suggested that the change in coverage was not transitioned until at least the end of the first quarter of 2006 (March 31, 2006) and affected both the Dual and the Non Dual populations. Because of this, the historical data for pharmacy in Exhibit 1 for both the Dual and Non Dual population use 2007 claims and member months to calculate the unit cost, utilization rate and paid amount PMPM.

The DMAS discounts, rebates, and dispensing fees, are applied for the non-dual population, but different adjustments are applied for the dual eligible population. For the dual eligible population, the base reflects removal of outpatient drugs covered under the Medicare Part D benefit.

The Medicaid covered prescription drugs for the dual eligible population after Medicare Part D coverage is a different mix of drugs, including a higher proportion of over-the-counter (OTC) and some specialized drugs that do not receive the same discounts and rebates. For those drugs not covered by Medicare Part D, about 60% of the cost is for OTC drugs compared to less than 5% of the cost before Medicare Part D. The potential for rebate also changes based on shifts in the brand generic mix and single source or multi source options. The observed drug mix, based on units is 2% brand, 15% generic and 80% over the counter; the observed drug mix based on cost is 23% brand, 13% generic and 59% over the counter.⁷

Data provided by DMAS suggests the implementation of Medicare Part D reduced total FFS pharmacy spending by 55% to 60%; we estimate that the total FFS rebate amount of 32% in FY 2007 after the implementation of Medicare Part D reflects an increase of OTC to slightly more than 10% of the total pharmacy cost. We have re-weighted the total FFS rebate percentage for the higher percent of OTC drugs in the PACE dual eligible population post-Part D and the higher percentage of brand use drugs in the PACE non dual population.⁸ Based on analysis of the more recent non dual claims, we have kept the same level of assumed savings from future expected improvements in the Brand-Generic mix.

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

OB-GYN Professional Fee Increase Adjustment

The FY 2008 adjustment reflected a small component of the 34% increase in the professional fee schedule for Obstetrical and Gynecological services, effective September 1, 2004, and a 2.5% professional fee increase that was effective for FFS on May 1, 2006. The FY 2008 adjustment was 0.1% to 0.2%, reflecting limited utilization of OB-GYN CPT codes in this over 55 age population. Although the FY 2006 - FY 2007 historical base does not fully reflect the fee increase, the amount is considered insignificant and the adjustment is dropped for the FY 2009 PACE rate setting.

Emergency Department Professional Fee Increase Adjustment

The Legislature approved a 3% increase for physician payments in the emergency department effective May 1, 2006. The 3% adjustment is applied to 10 months of the historical data period. The adjustment factor is applied to the Physician - PCP service category.

⁷ In contrast, the drug mix for the non-Dual population based on cost, is 76% brand, 20% generic and 4% OTC.

⁸ OTC drugs require a prescription in Medicaid programs and are therefore included in the base for calculating the total FFS Pharmacy rebate percentage.

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

Evaluation and Management Fee Increase Adjustment

Professional fees for adult evaluation and management services were increased by 5% in the FFS program effective May 1, 2006. The adjustment is shown in Exhibit 2c and applied to 10 months of historical claims data in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Professional Fee Increase Adjustment (Excluding Pediatric and OB-GYN)

The adjustment passes through the FFS increase of 5% for all remaining professional services effective July 1, 2008. This increase excludes the OB-GYN services.

This adjustment is shown in Exhibit 2d and is applied to the 24-month historical period of Professional-E&M, Professional-Specialist and All Other Professional service lines in Exhibit 4a and 4b under the column labeled “Policy and Program Adjustments”.

Non-Emergency Transportation Adjustment

Non-emergency transportation (NET) services were contracted to a broker during the historical data period and services are not captured in the DMAS FFS claims. For FY 2006, DMAS issued a competitive bid RFP for these services, renewable through FY 2008. The non-emergency transportation adjustment is based on the service cost component (excluding the administrative cost) of the accepted bid for the ABAD nursing home population, as contractually adjusted for annual increases. The annual increase is based on the Bureau of Labor Statistics (BLS) transportation index for the Washington DC-Baltimore, MD - Virginia region. The increase for FY 2007 was 4.7% and the FY 2008 increase was 2.1% effective July 2007. A 5% increase was effective July 1, 2008. Because the NET regions differ from the PACE rate setting regions, each region adjustment is calculated as the weighted average of the NET rates for the appropriate county code weighted by the distribution of the eligibility during the historical base period. This is in addition to the value of claims for emergency transportation services that were extracted from the DMAS FFS data. The per member per month value is shown in Exhibit 2e and the adjustment is applied in Exhibits 4a and 4b.

Consumer-Directed Long Term Care Adjustments

Those individuals who are in a home and community based waiver as an alternative to nursing facility placement may receive personal care services. Traditionally this service has been provided by agencies. For several years, DMAS has given waiver recipients the option of consumer direction of personal care services for non-skilled respite care. Recipients increasingly are choosing this model. Payments are made directly to the caregivers and are not captured through the current FFS claims system. This adjustment factor calculates the sum of the personal care aide payroll and the patient payment over FY 2006 and FY 2007. The dollars are added to the base amounts in Exhibits 1a and 1b. Summary analysis of FY 2008 payments on

behalf of those who participate in Consumer Directed care show continuing rapid increases in the program. We also include the 3% fee increase, the same increase applied to agency provided personal care services in adjustment 2g. The separate factors are applied for the dual and non-dual population by region. The calculations is shown in Exhibit 2f and applied to The Consumer Directed Service line in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Personal Care Services Fee Increase Adjustment

Those individuals who are in a home and community based waiver as an alternative to nursing facility placement may receive personal care services. There is a 2% fee increase effective May 1, 2006 and a second 3% fee increase effective July 1, 2007. This is applied to the proportion of historical claims preceding the fee increase. Calculations are shown in Exhibit 2g. and applied to the Personal Care Services line in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Adult Day Care Services Fee Increase Adjustment

There is a 2% fee increase effective May 1, 2006 and a second 5% fee increase for adult day care services effective January 1, 2007. The increases are applied to the relevant proportion of the historical data period. The adjustments are shown in Exhibit 2h and applied to Adult Day Care and Personal Care Services categories in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Hospital Inpatient Adjustments

The hospital inpatient adjustment factor reflects an increase in the percent of costs DMAS paid for hospital inpatient services in earlier years and a legislative reduction for FY 2009. The adjustment factor is calculated relative to the 76% operating cost base that was in place for FY 2006. In FY 2007 and FY 2008, for medical/surgical inpatient services, the Hospital Inpatient Adjustment was applied to 78% of the operating cost base. For FY 2009, the 78% operating cost base to which the Hospital Inpatient Adjustment applies will be reduced by 2.683%. The adjustment is developed using the increase from 76% to 78% of cost and is adjusted for a capital component estimated at 10.46%.

There is a separate adjustment for inpatient psychiatric services. The inpatient psychiatric adjustment factor is developed using the same increase; from 76% in FY 2006 and 78% in FY 2007 to an 84% operating cost base for FY 2008. For FY 2009, the 84% is also reduced by 2.683%. The inpatient psych adjustment also assumes a capital cost component of 10.46%. The inpatient psychiatric factor is applied to mental health claims that are submitted with encounter detail and the allocated mental health subcapitation payments.

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

Rural Wage Index Adjustment

This adjustment eliminates the rural wage index hospital factor for hospitals in the Rural and Other MSA regions. The estimated value of the increase was provided by DMAS.

This adjustment factor is shown in Exhibit 2j and applied to hospital inpatient service categories in Exhibits 4a and 4b under the column labeled “Other Adjustments”.

Nursing Facility Adjustment

DMAS provided information on supplemental payments to nursing facilities in FY 2006 and FY 2007 that are based upon DMAS reconciliation to nursing home submitted cost reports and which are not included in the historical claims databases. An adjustment for the supplemental payments is calculated against the total remitted claims. There are also two offsetting nursing home adjustments that are not shown in the calculations. The nursing home rebasing adjustment is a positive 1.2% on the operating rate and the nursing home operating rate decrease is a 1.329% reduction. The operating component is 91.25% of the total.

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

Other Adjustments

Managed Care Utilization Adjustment

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

Because of the limited number of PACE programs, the voluntary nature of the programs and the small enrollment in each program, there are few estimates of managed care savings based upon actual utilization. Those that are available report net Medicaid savings on the order of 15 percent or more. We also reviewed administrative financial data provided by one of the contracting health plans and conducted discussions with DMAS staff. The former Pre-PACE program is part of an integrated delivery system that has achieved economies of scale and reduced the cost of major categories of services used by this population.

The actual level of managed care savings that can be realized depends on a number of factors. Consequently, there is a range of reasonable savings assumptions. We have assumed that health plan utilization and cost controls will result in reductions in overall costs, excluding prescription drugs and non emergency transportation of 22%. This managed care adjustment must be considered in conjunction with the administrative cost adjustment, described below, to arrive at the expectation of net Medicaid savings.

A small brand-generic improvement factor for prescription drugs for the non-dual population is incorporated as a managed care savings in the Prescription Drug Adjustment described earlier.

The adjustment factor is shown in Exhibit 2l and is applied in Exhibits 4a and 4b under the column labeled “Managed Care Utilization Adjustment”. Their effect is shown in the column labeled “Completed, Adjusted and Trended Claims”.

Administrative Cost Adjustment

The CMS regulations require that administrative costs directly related to the provision of Medicaid State Plan approved services be incorporated into the rate-setting process. The health plan provided revenue and administrative cost data for CY 2007 as downloads from the financial reporting system. These were evaluated to determine an appropriate administrative factor. This adjustment is shown in Exhibit 2l.

The data submitted by the plan included overhead and allocation charges from the integrated delivery system operations that can be classified as medical costs. Using the same methodology applied in prior years, the administrative cost adjustment is 13.1% of capitation revenue. This is an increase of 0.7% compared to the 12.4% administrative factor applied for FY 2008. This 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 at the bottom of each rate cell worksheet in Exhibits 4a and 4b.

The net effect of the managed care adjustment and the administrative cost adjustment is that PACE rates are approximately 9% below the Upper Payment Limit and therefore meet CMS PACE rate setting checklist requirements.

V. Trend Adjustments

The data used for the calculations reflect experience for the period FY 2006 through FY 2008. The data must be adjusted to reflect the contract period of FY 2009 through the application of trend rates that reflect changes in payment levels and utilization rates between the data period and the contract period. In addition, the claims data are not 100% “complete” in that some cost information is not available in the claims databases provided. Incomplete data result from the time lag between when services are provided and claims are fully paid. The amount of incomplete claims is referred to as Incurred But Not Reported (IBNR) and can be measured through actuarial models.

Trend and IBNR adjustment factors were developed using historical Virginia Medicaid FFS expenditures for FY 2006 to FY 2007 and are calculated separately for the dual and the non-dual population. We also had paid claims information through August 2008 and took into consideration the actual experience and information from DMAS on projected utilization and fee increases in budget estimates.

The historical data were evaluated using a PricewaterhouseCoopers model that estimates IBNR amounts using a variety of actuarially accepted methods, and estimates trend using a least-squares regression methodology. Trend and IBNR factors were developed separately for the

following service categories: Inpatient, Outpatient, Practitioner, Prescription Drug, Prescription Drug with Medicare Part D in effect, and Other. The Other category includes Lab/X-Ray services. IBNR factors and trend rates for the Nursing Facility, Adult Day Care, Personal Care, including Consumer Directed personal care services, were developed from analysis of the historical data and budget figures provided by DMAS.

Annual trend rates must be applied to move the historical data from the midpoint of the data period (7/1/2006) to the midpoint of the contract period (1/1/2009), or two and a half years (30 months). Each category of service in Exhibits 3a and 3b shows a Data Period and a Contract Period trend. Data Period trends are applied from the midpoint of the data period to the end of the data period, and were developed from the historical regression analyses and budget work described above. The Contract Period trends are applied from the end of the data period to the midpoint of the contract period, and were developed from DMAS projections for long term care services and from analysis of the additional claims run out. For services with fee increases reflected in the adjustments in 2a through 2k, the contract period trend is in conjunction with the planned cost per unit increase.

Trend rates represent a combination of cost and utilization increases over time. The trend rates used reflect utilization and standard rate increases when additional legislative cost increases have been applied and represent PMPM increases otherwise. Specifically, the trend models are adjusted for the fee increases that occurred during the historical base period and that are presented as adjustments in Exhibits 2a to 2k. Adjustments to the historical data before the analysis of trend were applied to both the dual and the non-dual trend and are presented in the following table.

Table I		
Summary of Adjustments to Trend		
Service	Time Period	PACE
Adult Day Care	Jul 2005 - Apr 2006	1.070
	May 2006 - Dec 2006	1.050
	Jan 2007 - Aug 2008	1.000
Personal Care with Consumer Directed PC	Jul 2005 - Apr 2006	1.050
	May 2006 - Jun 2007	1.030
	Jul 2007 - Aug 2008	1.000
Inpatient - Med/Surg	Jul 2005 - Jun 2006	1.024
	Jul 2006 - Aug 2008	1.000
Professional	Jul 2005 - Apr 2006	1.053
	May 2006 - Jun 2007	1.050
	Jul 2007 - Aug 2008	1.000

IBNR adjustments are small given the additional year of claims run out.

Nursing facility trend shows consistent declines in underlying utilization, with greater declines observed in the dual population. This is consistent with a small but steady increase over the historical period in the proportion of eligibles in Home and Community Based Services waivers. The nursing home contract period trend incorporates the expectation that this will continue. Agency personal care services have had a modest growth rate while Consumer Directed personal care (CDPC) services payments have approximately doubled each year between 2005 to 2008, with some declines in the rate of growth between FY 2007 to the FY 2008 data that was available for review.⁹ Therefore, the CDPC component of personal care services is primarily responsible for the relatively high trend applied to the dual rate development.

The total trend rates shown in Exhibits 3a and 3b represent the combination of Data Period and Contract Period trends, and are calculated using compound interest calculations. These trend/IBNR factors are applied to the historical data in Exhibits 4a and 4b by applicable service category in Exhibits 4a and 4b. No trend is applied to the patient payment amounts.

VI. Summary Capitation Rates

The historical data presented in Exhibits 1a - 1b is adjusted by the factors shown in Exhibits 2a through 2l and the Trend and IBNR factors in Exhibits 3a and 3b. The resulting PACE rates are shown in Exhibit 5a. All averages are weighted by the distribution of member months for the historical FY 2006 - FY 2007 time period.

Analysis of the PACE eligible population by region indicates variation in the relative proportion of the eligible population that is in nursing homes and the proportion that is supported by home and community based services. These proportions, as reflected in member month counts for the historical data period, are shown in Table 2.

Table 2						
Nursing Home vs Non-Nursing Home Blending Factor						
Region	Dual Population			Non-Dual Population		
	Member Months			Member Months		
	NH	Non-NH	%NH	NH	Non-NH	%NH
Northern Virginia	54,815	16,540	76.8%	6,493	3,660	64.0%
Other MSA	95,072	22,684	80.7%	4,349	2,436	64.1%
Richmond / Charlottesville	76,581	37,797	67.0%	4,326	5,000	46.4%
Rural	122,570	53,648	69.6%	6,016	4,949	54.9%
Tidewater	84,592	34,635	71.0%	5,828	4,560	56.1%
Statewide-PACE	433,631	165,303	72.4%	27,010	20,604	56.7%

⁹ The CDPC increase is primarily a utilization trend, rather than a cost trend, effect. There has been an increase in both the proportion of eligibles that elect consumer direction and the approved CDPC level of care (hours per week).

DMAS adopted a policy that PACE rates for programs in other regions are to be benchmarked to the Tidewater program. Therefore, the rates in Exhibit 5a are re-weighted to reflect a dual population that is 71.0% in nursing homes and a non-dual population with 56.1% in nursing homes. The relative cost factors and the blending factors are presented in Exhibit 5b.

PACE capitation rates for FY 2009 after the re-weighting are presented in Exhibit 5c. A comparison of the rates before and after the blending is shown in Exhibit 5d. We present both the statewide change and the Rural and Tidewater average change, the regions with operating PACE programs. All averages are weighted by the distribution of member months for the historical FY 2006 - FY 2007 time period.

A comparison of FY 2009 PACE rates to FY 2008 rates in Exhibit 5d shows a 4.5% increase in the dual population rates, a 1.0% increase in the non-dual PACE rates, and an overall increase of 4.1%. The overall weighed increase ranges from 2.5% to 5.9% depending on the region. For information purposes, the year to year change for Rural and Tidewater are also presented. These are the two regions with existing operating plans. For those regions, there is a 4.4% increase in the dual population rates, a 0.8% increase in the non-dual PACE rates, and an overall increase of 4.1%.

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

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Northern Virginia	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	71,355						
Service Type							
Adult Day Care	\$569,289	\$11,511	\$580,801	\$8.14	12,387	2,083	\$46.89
Ambulatory Surgery Center	\$788	\$0	\$788	\$0.01	3	1	\$262.56
Case Management Services	\$15,819	\$0	\$15,819	\$0.22	4,832	813	\$3.27
Consumer Directed Services	\$4,523,684	\$92,170	\$4,615,854	\$64.69	4,903	825	\$941.40
DME/Supplies	\$1,040,915	\$492	\$1,041,407	\$14.59	15,063	2,533	\$69.14
Emergency	\$5,019	\$0	\$5,019	\$0.07	7	1	\$716.98
FQHC	\$753	\$0	\$753	\$0.01	8	1	\$94.07
Home Health Services	\$8,135	\$0	\$8,135	\$0.11	35	6	\$232.42
Inpatient - Medical/Surgical	\$4,349,388	\$78,427	\$4,427,815	\$62.05	828	139	\$5,347.60
Inpatient - Psych	\$312,762	\$1,863	\$314,625	\$4.41	740	124	\$425.17
Lab and X-ray Services	\$8,295	\$0	\$8,295	\$0.12	658	111	\$12.61
Medicare Xover - IP	\$1,236,936	\$0	\$1,236,936	\$17.33	1,310	220	\$944.23
Medicare Xover - Nursing Facility	\$834,924	\$30,487	\$865,412	\$12.13	73,616	12,380	\$11.76
Medicare Xover - OP	\$713,355	\$0	\$713,355	\$10.00	5,841	982	\$122.13
Medicare Xover - Other	\$834,025	\$0	\$834,025	\$11.69	34,519	5,805	\$24.16
Medicare Xover - Physician	\$1,467,096	\$12	\$1,467,108	\$20.56	30,239	5,085	\$48.52
Nursing Facility	\$173,775,702	\$40,360,420	\$214,136,122	\$3,000.99	1,376,682	231,520	\$155.55
Outpatient - Other	\$365,102	\$0	\$365,102	\$5.12	186	31	\$1,962.92
Outpatient - Psychological	\$15,802	\$0	\$15,802	\$0.22	5	1	\$3,160.37
Personal Care Services	\$24,237,740	\$406,963	\$24,644,702	\$345.38	322,383	54,216	\$76.45
Physician - Clinic	\$49,501	\$0	\$49,501	\$0.69	5,014	843	\$9.87
Physician - IP Mental Health	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Physician - OP Mental Health	\$4,694,213	\$3,337	\$4,697,549	\$65.83	317,211	53,346	\$14.81
Physician - Other Practitioner	\$284,854	\$25	\$284,878	\$3.99	21,211	3,567	\$13.43
Physician - PCP	\$87,410	\$683	\$88,093	\$1.23	1,524	256	\$57.80
Physician - Specialist	\$55,704	\$71	\$55,775	\$0.78	3,837	645	\$14.54
Pharmacy	\$882,359	\$2,068	\$884,427	\$24.23	89,274	29,347	\$9.91
Transportation - Emergency	\$24,359	\$0	\$24,359	\$0.34	223	38	\$109.23
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$220,393,928	\$40,988,528	\$261,382,456	\$3,674.95	2,322,539		

Note:

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

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Other MSA	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	117,756						
Service Type							
Adult Day Care	\$627,891	\$31,426	\$659,317	\$5.60	17,387	1,772	\$37.92
Ambulatory Surgery Center	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Case Management Services	\$4,585	\$0	\$4,585	\$0.04	1,377	140	\$3.33
Consumer Directed Services	\$3,375,251	\$89,214	\$3,464,465	\$29.42	5,671	578	\$610.94
DME/Supplies	\$1,256,546	\$1,362	\$1,257,908	\$10.68	22,060	2,248	\$57.02
Emergency	\$2,957	\$0	\$2,957	\$0.03	23	2	\$128.58
FQHC	\$194	\$0	\$194	\$0.00	3	0	\$64.64
Home Health Services	\$8,617	\$0	\$8,617	\$0.07	25	3	\$344.66
Inpatient - Medical/Surgical	\$1,645,457	\$62,060	\$1,707,516	\$14.50	501	51	\$3,408.22
Inpatient - Psych	\$2,676,419	\$136,972	\$2,813,391	\$23.89	6,468	659	\$434.97
Lab and X-ray Services	\$12,905	\$0	\$12,905	\$0.11	994	101	\$12.98
Medicare Xover - IP	\$1,938,038	\$0	\$1,938,038	\$16.46	3,007	306	\$644.51
Medicare Xover - Nursing Facility	\$1,819,809	\$80,444	\$1,900,253	\$16.14	192,033	19,569	\$9.90
Medicare Xover - OP	\$1,450,886	\$0	\$1,450,886	\$12.32	11,016	1,123	\$131.71
Medicare Xover - Other	\$1,633,981	\$22	\$1,634,003	\$13.88	66,926	6,820	\$24.42
Medicare Xover - Physician	\$1,911,175	\$110	\$1,911,285	\$16.23	66,107	6,737	\$28.91
Nursing Facility	\$243,088,047	\$57,649,165	\$300,737,212	\$2,553.91	2,360,017	240,499	\$127.43
Outpatient - Other	\$89,910	\$0	\$89,910	\$0.76	216	22	\$416.25
Outpatient - Psychological	\$13	\$0	\$13	\$0.00	1	0	\$12.83
Personal Care Services	\$18,331,201	\$533,470	\$18,864,671	\$160.20	442,931	45,137	\$42.59
Physician - Clinic	\$1,631	\$10	\$1,641	\$0.01	127	13	\$12.92
Physician - IP Mental Health	\$40	\$0	\$40	\$0.00	1	0	\$40.01
Physician - OP Mental Health	\$4,283,849	\$736	\$4,284,585	\$36.39	321,271	32,739	\$13.34
Physician - Other Practitioner	\$159,993	\$64	\$160,057	\$1.36	2,996	305	\$53.42
Physician - PCP	\$85,550	\$185	\$85,735	\$0.73	2,079	212	\$41.24
Physician - Specialist	\$35,990	\$386	\$36,377	\$0.31	933	95	\$38.99
Pharmacy	\$1,586,739	\$3,252	\$1,589,991	\$26.51	160,011	16,306	\$9.94
Transportation - Emergency	\$24,950	\$0	\$24,950	\$0.21	252	26	\$99.01
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$286,052,624	\$58,588,877	\$344,641,501	\$2,939.75	3,684,433		

Note:

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

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	114,378						
Service Type							
Adult Day Care	\$2,397,804	\$42,840	\$2,440,644	\$21.34	59,024	6,193	\$41.35
Ambulatory Surgery Center	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Case Management Services	\$1,908	\$0	\$1,908	\$0.02	573	60	\$3.33
Consumer Directed Services	\$4,977,508	\$141,874	\$5,119,382	\$44.76	8,138	854	\$629.04
DME/Supplies	\$2,649,629	\$238	\$2,649,867	\$23.17	41,435	4,347	\$63.95
Emergency	\$11,527	\$0	\$11,527	\$0.10	36	4	\$320.19
FQHC	\$3,318	\$0	\$3,318	\$0.03	58	6	\$57.21
Home Health Services	\$16,115	\$0	\$16,115	\$0.14	86	9	\$187.39
Inpatient - Medical/Surgical	\$2,433,033	\$121,775	\$2,554,808	\$22.34	657	69	\$3,888.60
Inpatient - Psych	\$2,275,762	\$97,595	\$2,373,357	\$20.75	5,598	587	\$423.97
Lab and X-ray Services	\$12,186	\$0	\$12,186	\$0.11	938	98	\$12.99
Medicare Xover - IP	\$2,642,837	\$0	\$2,642,837	\$23.11	2,847	299	\$928.29
Medicare Xover - Nursing Facility	\$1,688,811	\$172,498	\$1,861,309	\$16.27	166,335	17,451	\$11.19
Medicare Xover - OP	\$1,604,904	\$147	\$1,605,050	\$14.03	13,620	1,429	\$117.85
Medicare Xover - Other	\$2,092,395	\$31	\$2,092,426	\$18.29	80,584	8,455	\$25.97
Medicare Xover - Physician	\$2,419,553	\$49	\$2,419,602	\$21.15	61,786	6,482	\$39.16
Nursing Facility	\$199,498,468	\$50,239,753	\$249,738,221	\$2,183.45	1,906,035	199,973	\$131.02
Outpatient - Other	\$59,201	\$0	\$59,201	\$0.52	85	9	\$696.48
Outpatient - Psychological	\$3,121	\$0	\$3,121	\$0.03	3	0	\$1,040.43
Personal Care Services	\$42,240,649	\$1,273,302	\$43,513,950	\$380.44	797,927	83,715	\$54.53
Physician - Clinic	\$9,373	\$0	\$9,373	\$0.08	2,799	294	\$3.35
Physician - IP Mental Health	\$241	\$0	\$241	\$0.00	3	0	\$80.32
Physician - OP Mental Health	\$7,640,453	\$509	\$7,640,962	\$66.80	607,585	63,745	\$12.58
Physician - Other Practitioner	\$214,123	\$53	\$214,175	\$1.87	3,451	362	\$62.06
Physician - PCP	\$68,020	\$137	\$68,157	\$0.60	1,932	203	\$35.28
Physician - Specialist	\$50,106	\$487	\$50,593	\$0.44	1,651	173	\$30.64
Pharmacy	\$1,104,681	\$3,102	\$1,107,783	\$19.30	132,272	13,877	\$8.38
Transportation - Emergency	\$51,675	\$0	\$51,675	\$0.45	493	52	\$104.82
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$276,167,399	\$52,094,390	\$328,261,789	\$2,879.60	3,895,951		

Note:

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Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Rural	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	176,218						
Service Type							
Adult Day Care	\$578,049	\$17,190	\$595,239	\$3.38	13,762	937	\$43.25
Ambulatory Surgery Center	\$36	\$335	\$372	\$0.00	1	0	\$371.52
Case Management Services	\$109,327	\$0	\$109,327	\$0.62	32,831	2,236	\$3.33
Consumer Directed Services	\$4,425,554	\$94,954	\$4,520,507	\$25.65	7,489	510	\$603.66
DME/Supplies	\$3,102,907	\$6,163	\$3,109,071	\$17.64	53,078	3,614	\$58.58
Emergency	\$15,517	\$0	\$15,517	\$0.09	56	4	\$277.09
FQHC	\$11,621	\$0	\$11,621	\$0.07	184	13	\$63.16
Home Health Services	\$31,224	\$0	\$31,224	\$0.18	133	9	\$234.77
Inpatient - Medical/Surgical	\$2,842,153	\$87,994	\$2,930,148	\$16.63	749	51	\$3,912.08
Inpatient - Psych	\$1,308,175	\$34,323	\$1,342,497	\$7.62	3,082	210	\$435.59
Lab and X-ray Services	\$16,926	\$0	\$16,926	\$0.10	1,225	83	\$13.82
Medicare Xover - IP	\$3,272,593	\$35	\$3,272,628	\$18.57	4,483	305	\$730.01
Medicare Xover - Nursing Facility	\$2,943,440	\$124,938	\$3,068,378	\$17.41	310,347	21,134	\$9.89
Medicare Xover - OP	\$2,248,717	\$0	\$2,248,717	\$12.76	22,323	1,520	\$100.74
Medicare Xover - Other	\$4,168,433	\$2	\$4,168,434	\$23.66	154,291	10,507	\$27.02
Medicare Xover - Physician	\$3,823,410	\$210	\$3,823,620	\$21.70	116,609	7,941	\$32.79
Nursing Facility	\$295,214,936	\$61,759,037	\$356,973,973	\$2,025.75	3,007,001	204,769	\$118.71
Outpatient - Other	\$71,330	\$0	\$71,330	\$0.40	453	31	\$157.46
Outpatient - Psychological	\$3,620	\$0	\$3,620	\$0.02	3	0	\$1,206.52
Personal Care Services	\$53,361,763	\$1,658,423	\$55,020,186	\$312.23	1,232,483	83,929	\$44.64
Physician - Clinic	\$33,141	\$5	\$33,146	\$0.19	5,505	375	\$6.02
Physician - IP Mental Health	\$35	\$0	\$35	\$0.00	1	0	\$34.93
Physician - OP Mental Health	\$8,562,782	\$539	\$8,563,321	\$48.60	671,724	45,743	\$12.75
Physician - Other Practitioner	\$245,889	\$267	\$246,157	\$1.40	6,000	409	\$41.03
Physician - PCP	\$130,217	\$235	\$130,452	\$0.74	3,523	240	\$37.03
Physician - Specialist	\$65,319	\$1,403	\$66,721	\$0.38	2,227	152	\$29.96
Pharmacy	\$2,205,188	\$4,535	\$2,209,723	\$24.89	232,834	15,855	\$9.49
Transportation - Emergency	\$50,779	\$0	\$50,779	\$0.29	372	25	\$136.50
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$388,843,080	\$63,790,587	\$452,633,668	\$2,580.96	5,882,769		

Note:

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

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Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Tidewater	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	119,227						
Service Type							
Adult Day Care	\$539,881	\$43,201	\$583,082	\$4.89	13,427	1,351	\$43.43
Ambulatory Surgery Center	\$1,880	\$0	\$1,880	\$0.02	3	0	\$626.54
Case Management Services	\$3,533	\$0	\$3,533	\$0.03	1,061	107	\$3.33
Consumer Directed Services	\$1,374,171	\$55,626	\$1,429,797	\$11.99	2,215	223	\$645.46
DME/Supplies	\$2,631,568	\$4,697	\$2,636,265	\$22.11	37,741	3,799	\$69.85
Emergency	\$15,102	\$0	\$15,102	\$0.13	39	4	\$387.24
FQHC	\$91	\$0	\$91	\$0.00	1	0	\$90.50
Home Health Services	\$17,069	\$0	\$17,069	\$0.14	55	6	\$310.35
Inpatient - Medical/Surgical	\$2,164,383	\$102,423	\$2,266,806	\$19.01	474	48	\$4,782.29
Inpatient - Psych	\$2,523	\$0	\$2,523	\$0.02	4	0	\$630.85
Lab and X-ray Services	\$9,793	\$0	\$9,793	\$0.08	1,007	101	\$9.73
Medicare Xover - IP	\$2,165,839	\$0	\$2,165,839	\$18.17	2,231	225	\$970.79
Medicare Xover - Nursing Facility	\$1,895,895	\$112,303	\$2,008,198	\$16.84	282,924	28,476	\$7.10
Medicare Xover - OP	\$1,235,008	\$160	\$1,235,168	\$10.36	11,790	1,187	\$104.76
Medicare Xover - Other	\$2,657,127	\$15	\$2,657,142	\$22.29	107,136	10,783	\$24.80
Medicare Xover - Physician	\$2,960,518	\$341	\$2,960,860	\$24.83	76,150	7,664	\$38.88
Nursing Facility	\$208,673,491	\$61,301,249	\$269,974,740	\$2,264.37	2,157,960	217,194	\$125.11
Outpatient - Other	\$60,343	\$0	\$60,343	\$0.51	89	9	\$678.01
Outpatient - Psychological	\$16	\$0	\$16	\$0.00	2	0	\$7.95
Personal Care Services	\$42,113,919	\$1,152,592	\$43,266,511	\$362.89	830,231	83,561	\$52.11
Physician - Clinic	\$21,915	\$0	\$21,915	\$21.915	1,504	151	\$14.57
Physician - IP Mental Health	\$1,749	\$0	\$1,749	\$0.01	58	6	\$30.15
Physician - OP Mental Health	\$8,255,630	\$2,883	\$8,258,513	\$69.27	658,304	66,257	\$12.55
Physician - Other Practitioner	\$114,506	\$112	\$114,618	\$0.96	5,819	586	\$19.70
Physician - PCP	\$148,780	\$423	\$149,203	\$1.25	13,015	1,310	\$11.46
Physician - Specialist	\$93,824	\$317	\$94,141	\$0.79	4,287	431	\$21.96
Pharmacy	\$1,290,367	\$4,571	\$1,294,938	\$21.58	154,771	15,577	\$8.37
Transportation - Emergency	\$39,280	\$0	\$39,280	\$0.33	398	40	\$98.69
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$278,488,203	\$62,780,912	\$341,269,115	\$2,873.06	4,362,696		

Note:

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

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Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
All Regions	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	598,934						
Service Type							
Adult Day Care	\$4,712,915	\$146,168	\$4,859,083	\$8.11	115,987	2,324	\$41.89
Ambulatory Surgery Center	\$2,703	\$335	\$3,039	\$0.01	7	0	\$434.12
Case Management Services	\$135,172	\$0	\$135,172	\$0.23	40,674	815	\$3.32
Consumer Directed Services	\$18,676,168	\$473,838	\$19,150,005	\$31.97	28,416	569	\$673.92
DME/Supplies	\$10,681,565	\$12,953	\$10,694,518	\$17.86	169,377	3,394	\$63.14
Emergency	\$50,122	\$0	\$50,122	\$0.08	161	3	\$311.32
FQHC	\$15,976	\$0	\$15,976	\$0.03	254	5	\$62.90
Home Health Services	\$81,161	\$0	\$81,161	\$0.14	334	7	\$243.00
Inpatient - Medical/Surgical	\$13,434,414	\$452,679	\$13,887,093	\$23.19	3,209	64	\$4,327.55
Inpatient - Psych	\$6,575,640	\$270,753	\$6,846,393	\$11.43	15,892	318	\$430.81
Lab and X-ray Services	\$60,105	\$0	\$60,105	\$0.10	4,822	97	\$12.46
Medicare Xover - IP	\$11,256,242	\$35	\$11,256,277	\$18.79	13,878	278	\$811.09
Medicare Xover - Nursing Facility	\$9,182,880	\$520,669	\$9,703,550	\$16.20	1,025,255	20,542	\$9.46
Medicare Xover - OP	\$7,252,870	\$306	\$7,253,176	\$12.11	64,590	1,294	\$112.30
Medicare Xover - Other	\$11,385,960	\$70	\$11,386,030	\$19.01	443,456	8,885	\$25.68
Medicare Xover - Physician	\$12,581,752	\$722	\$12,582,474	\$21.01	350,891	7,030	\$35.86
Nursing Facility	\$1,120,250,645	\$271,309,623	\$1,391,560,268	\$2,323.40	10,807,695	216,539	\$128.76
Outpatient - Other	\$645,887	\$0	\$645,887	\$1.08	1,029	21	\$627.68
Outpatient - Psychological	\$22,571	\$0	\$22,571	\$0.04	14	0	\$1,612.24
Personal Care Services	\$180,285,272	\$5,024,750	\$185,310,021	\$309.40	3,625,955	72,648	\$51.11
Physician - Clinic	\$115,560	\$15	\$115,575	\$0.19	14,949	300	\$7.73
Physician - IP Mental Health	\$2,064	\$0	\$2,064	\$0.00	63	1	\$32.77
Physician - OP Mental Health	\$33,436,926	\$8,004	\$33,444,930	\$55.84	2,576,095	51,614	\$12.98
Physician - Other Practitioner	\$1,019,365	\$521	\$1,019,885	\$1.70	39,477	791	\$25.83
Physician - PCP	\$519,977	\$1,662	\$521,640	\$0.87	22,073	442	\$23.63
Physician - Specialist	\$300,943	\$2,664	\$303,607	\$0.51	12,935	259	\$23.47
Pharmacy	\$7,069,334	\$17,528	\$7,086,862	\$23.42	769,162	30,496	\$9.21
Transportation - Emergency	\$191,042	\$0	\$191,042	\$0.32	1,738	35	\$109.92
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$1,449,945,234	\$278,243,294	\$1,728,188,528	\$2,897.02	20,148,388		

Note:

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

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Northern Virginia	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	10,152						
Service Type							
Adult Day Care	\$104,578	\$0	\$104,578	\$10.30	2,414	2,853	\$43.32
Ambulatory Surgery Center	\$6,719	\$0	\$6,719	\$0.66	11	13	\$610.79
Case Management Services	\$3,072	\$0	\$3,072	\$0.30	936	1,106	\$3.28
Consumer Directed Services	\$1,042,733	\$105	\$1,042,838	\$102.72	1,098	1,297	\$950.03
DME/Supplies	\$929,282	\$0	\$929,282	\$91.53	5,293	6,256	\$175.57
Emergency	\$227,737	\$0	\$227,737	\$22.43	456	539	\$499.42
FQHC	\$3,752	\$0	\$3,752	\$0.37	51	60	\$73.56
Home Health Services	\$168,605	\$0	\$168,605	\$16.61	504	596	\$334.53
Inpatient - Medical/Surgical	\$5,899,555	\$3,878	\$5,903,433	\$581.49	548	648	\$10,772.69
Inpatient - Psych	\$30,448	\$0	\$30,448	\$3.00	44	52	\$692.00
Lab and X-ray Services	\$181,589	\$0	\$181,589	\$17.89	14,406	17,028	\$12.61
Medicare Xover - IP	\$34,380	\$0	\$34,380	\$3.39	48	57	\$716.25
Medicare Xover - Nursing Facility	\$4,969	\$0	\$4,969	\$0.49	1,210	1,430	\$4.11
Medicare Xover - OP	\$36,912	\$0	\$36,912	\$3.64	285	337	\$129.51
Medicare Xover - Other	\$20,432	\$0	\$20,432	\$2.01	832	983	\$24.56
Medicare Xover - Physician	\$68,758	\$0	\$68,758	\$6.77	1,106	1,307	\$62.17
Nursing Facility	\$22,186,073	\$1,866,315	\$24,052,388	\$2,369.18	152,506	180,263	\$157.71
Outpatient - Other	\$481,209	\$0	\$481,209	\$47.40	832	983	\$578.38
Outpatient - Psychological	\$13,024	\$0	\$13,024	\$1.28	5	6	\$2,604.81
Personal Care Services	\$5,313,242	\$28,270	\$5,341,512	\$526.14	67,552	79,847	\$79.07
Physician - Clinic	\$195,092	\$0	\$195,092	\$19.22	22,776	26,921	\$8.57
Physician - IP Mental Health	\$1,798	\$0	\$1,798	\$0.18	25	30	\$71.92
Physician - OP Mental Health	\$1,030,894	\$0	\$1,030,894	\$101.54	65,666	77,618	\$15.70
Physician - Other Practitioner	\$94,227	\$11	\$94,238	\$9.28	3,589	4,242	\$26.26
Physician - PCP	\$763,027	\$194	\$763,221	\$75.18	21,779	25,743	\$35.04
Physician - Specialist	\$427,237	\$417	\$427,655	\$42.12	11,972	14,151	\$35.72
Pharmacy	\$2,235,238	\$1,412	\$2,236,650	\$447.43	38,519	92,466	\$58.07
Transportation - Emergency	\$52,142	\$0	\$52,142	\$5.14	519	613	\$100.47
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$41,556,724	\$1,900,602	\$43,457,326	\$4,507.69	414,982		

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Other MSA	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	6,785						
Service Type							
Adult Day Care	\$49,246	\$5,721	\$54,967	\$8.10	1,409	2,492	\$39.01
Ambulatory Surgery Center	\$7,570	\$0	\$7,570	\$1.12	29	51	\$261.03
Case Management Services	\$393	\$0	\$393	\$0.06	118	209	\$3.33
Consumer Directed Services	\$610,636	\$5,752	\$616,388	\$90.85	810	1,433	\$760.78
DME/Supplies	\$545,404	\$13	\$545,417	\$80.39	5,395	9,542	\$101.10
Emergency	\$199,993	\$0	\$199,993	\$29.48	467	826	\$428.25
FQHC	\$18,833	\$0	\$18,833	\$2.78	240	424	\$78.47
Home Health Services	\$174,247	\$0	\$174,247	\$25.68	709	1,254	\$245.77
Inpatient - Medical/Surgical	\$4,536,945	\$67	\$4,537,012	\$668.70	474	838	\$9,571.76
Inpatient - Psych	\$73,779	\$250	\$74,029	\$10.91	144	255	\$514.09
Lab and X-ray Services	\$162,094	\$0	\$162,094	\$23.89	14,600	25,822	\$11.10
Medicare Xover - IP	\$14,846	\$0	\$14,846	\$2.19	21	37	\$706.95
Medicare Xover - Nursing Facility	\$8,416	\$0	\$8,416	\$1.24	1,104	1,953	\$7.62
Medicare Xover - OP	\$17,523	\$0	\$17,523	\$2.58	128	226	\$136.90
Medicare Xover - Other	\$19,615	\$0	\$19,615	\$2.89	675	1,194	\$29.06
Medicare Xover - Physician	\$30,709	\$0	\$30,709	\$4.53	747	1,321	\$41.11
Nursing Facility	\$12,527,676	\$785,017	\$13,312,693	\$1,962.13	104,924	185,574	\$126.88
Outpatient - Other	\$831,156	\$15	\$831,171	\$122.50	1,294	2,289	\$642.33
Outpatient - Psychological	\$409	\$0	\$409	\$0.06	7	12	\$58.43
Personal Care Services	\$1,746,238	\$10,342	\$1,756,579	\$258.90	40,812	72,182	\$43.04
Physician - Clinic	\$227,945	\$0	\$227,945	\$33.60	30,676	54,255	\$7.43
Physician - IP Mental Health	\$4,553	\$0	\$4,553	\$0.67	89	157	\$51.16
Physician - OP Mental Health	\$662,417	\$0	\$662,417	\$97.63	40,573	71,759	\$16.33
Physician - Other Practitioner	\$61,323	\$17	\$61,340	\$9.04	1,424	2,519	\$43.08
Physician - PCP	\$616,114	\$138	\$616,252	\$90.83	24,458	43,258	\$25.20
Physician - Specialist	\$364,823	\$35	\$364,858	\$53.78	9,382	16,593	\$38.89
Pharmacy	\$1,910,934	\$1,019	\$1,911,953	\$547.45	36,158	124,237	\$52.88
Transportation - Emergency	\$51,766	\$0	\$51,766	\$7.63	471	833	\$109.91
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$25,475,603	\$808,386	\$26,283,989	\$4,139.58	317,338		

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	9,326						
Service Type							
Adult Day Care	\$406,358	\$7,779	\$414,137	\$44.41	9,432	12,137	\$43.91
Ambulatory Surgery Center	\$9,606	\$0	\$9,606	\$1.03	14	18	\$686.15
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$436,990	\$10,279	\$447,269	\$47.96	618	795	\$723.49
DME/Supplies	\$821,205	\$10	\$821,215	\$88.06	8,082	10,400	\$101.61
Emergency	\$259,316	\$0	\$259,316	\$27.81	626	806	\$414.24
FQHC	\$23,613	\$0	\$23,613	\$2.53	309	398	\$76.42
Home Health Services	\$294,627	\$0	\$294,627	\$31.59	1,114	1,433	\$264.48
Inpatient - Medical/Surgical	\$7,161,948	\$7,714	\$7,169,662	\$768.81	615	791	\$11,657.99
Inpatient - Psych	\$209,590	\$0	\$209,590	\$22.47	300	386	\$698.63
Lab and X-ray Services	\$189,171	\$0	\$189,171	\$20.28	15,114	19,448	\$12.52
Medicare Xover - IP	\$29,179	\$0	\$29,179	\$3.13	42	54	\$694.74
Medicare Xover - Nursing Facility	\$18,916	\$0	\$18,916	\$2.03	2,121	2,729	\$8.92
Medicare Xover - OP	\$23,266	\$0	\$23,266	\$2.49	247	318	\$94.20
Medicare Xover - Other	\$31,886	\$0	\$31,886	\$3.42	1,041	1,340	\$30.63
Medicare Xover - Physician	\$73,003	\$1	\$73,004	\$7.83	1,300	1,673	\$56.16
Nursing Facility	\$13,632,138	\$906,003	\$14,538,140	\$1,558.93	111,534	143,518	\$130.35
Outpatient - Other	\$1,199,584	\$129	\$1,199,713	\$128.65	1,843	2,372	\$650.96
Outpatient - Psychological	\$2,238	\$0	\$2,238	\$0.24	30	39	\$74.58
Personal Care Services	\$5,183,852	\$52,784	\$5,236,636	\$561.53	102,930	132,447	\$50.88
Physician - Clinic	\$510,062	\$0	\$510,062	\$54.69	92,388	118,882	\$5.52
Physician - IP Mental Health	\$3,790	\$0	\$3,790	\$0.41	56	72	\$67.67
Physician - OP Mental Health	\$1,110,362	\$134	\$1,110,495	\$119.08	74,005	95,227	\$15.01
Physician - Other Practitioner	\$69,382	\$11	\$69,393	\$7.44	1,703	2,191	\$40.75
Physician - PCP	\$782,084	\$170	\$782,254	\$83.88	20,109	25,876	\$38.90
Physician - Specialist	\$470,284	\$155	\$470,439	\$50.45	10,910	14,039	\$43.12
Pharmacy	\$1,829,725	\$1,249	\$1,830,974	\$392.18	34,745	89,305	\$52.70
Transportation - Emergency	\$67,369	\$0	\$67,369	\$7.22	615	791	\$109.54
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$34,849,541	\$986,418	\$35,835,959	\$4,038.56	491,843		

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Rural	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	10,964						
Service Type							
Adult Day Care	\$45,579	\$1,452	\$47,031	\$4.29	1,064	1,165	\$44.20
Ambulatory Surgery Center	\$9,769	\$0	\$9,769	\$0.89	19	21	\$514.13
Case Management Services	\$8,695	\$0	\$8,695	\$0.79	2,634	2,883	\$3.30
Consumer Directed Services	\$510,759	\$2,448	\$513,207	\$46.81	804	880	\$638.18
DME/Supplies	\$1,056,610	\$531	\$1,057,141	\$96.42	10,393	11,375	\$101.72
Emergency	\$336,280	\$0	\$336,280	\$30.67	1,031	1,128	\$326.17
FQHC	\$151,786	\$17	\$151,803	\$13.85	2,111	2,310	\$71.91
Home Health Services	\$512,751	\$0	\$512,751	\$46.77	1,521	1,665	\$337.11
Inpatient - Medical/Surgical	\$7,430,856	\$0	\$7,430,856	\$677.74	883	966	\$8,415.47
Inpatient - Psych	\$67,369	\$0	\$67,369	\$6.14	104	114	\$647.78
Lab and X-ray Services	\$286,126	\$0	\$286,126	\$26.10	22,584	24,717	\$12.67
Medicare Xover - IP	\$61,779	\$0	\$61,779	\$5.63	42	46	\$1,470.93
Medicare Xover - Nursing Facility	\$18,591	\$0	\$18,591	\$1.70	2,183	2,389	\$8.52
Medicare Xover - OP	\$44,343	\$0	\$44,343	\$4.04	361	395	\$122.83
Medicare Xover - Other	\$50,861	\$0	\$50,861	\$4.64	1,366	1,495	\$37.23
Medicare Xover - Physician	\$52,945	\$20	\$52,965	\$4.83	1,610	1,762	\$32.90
Nursing Facility	\$15,543,973	\$628,028	\$16,172,001	\$1,474.98	135,891	148,729	\$119.01
Outpatient - Other	\$1,013,785	\$51	\$1,013,836	\$92.47	2,210	2,419	\$458.75
Outpatient - Psychological	\$3,075	\$0	\$3,075	\$0.28	13	14	\$236.50
Personal Care Services	\$3,903,727	\$54,771	\$3,958,498	\$361.04	97,681	106,909	\$40.52
Physician - Clinic	\$350,297	\$0	\$350,297	\$31.95	53,045	58,056	\$6.60
Physician - IP Mental Health	\$1,255	\$0	\$1,255	\$0.11	19	21	\$66.04
Physician - OP Mental Health	\$1,088,082	\$8	\$1,088,090	\$99.24	54,703	59,871	\$19.89
Physician - Other Practitioner	\$81,845	\$21	\$81,867	\$7.47	2,878	3,150	\$28.45
Physician - PCP	\$1,038,074	\$118	\$1,038,192	\$94.69	40,107	43,896	\$25.89
Physician - Specialist	\$537,078	\$139	\$537,217	\$49.00	14,643	16,026	\$36.69
Pharmacy	\$3,111,107	\$1,728	\$3,112,835	\$553.38	54,510	116,284	\$57.11
Transportation - Emergency	\$146,222	\$0	\$146,222	\$13.34	997	1,091	\$146.66
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$37,463,618	\$689,333	\$38,152,951	\$3,749.24	505,407		

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Consumer Directed Services payments are not reported as FFS claims but are obtained from supplemental payment files.
Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Tidewater	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	10,387						
Service Type							
Adult Day Care	\$57,081	\$0	\$57,081	\$5.50	1,303	1,505	\$43.81
Ambulatory Surgery Center	\$6,122	\$0	\$6,122	\$0.59	16	18	\$382.64
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$309,617	\$0	\$309,617	\$29.81	525	606	\$590.06
DME/Supplies	\$922,145	\$113	\$922,259	\$88.79	8,275	9,560	\$111.45
Emergency	\$277,679	\$134	\$277,813	\$26.75	642	742	\$432.73
FQHC	\$12,115	\$0	\$12,115	\$1.17	169	195	\$71.68
Home Health Services	\$350,751	\$63	\$350,814	\$33.77	1,102	1,273	\$318.34
Inpatient - Medical/Surgical	\$6,046,089	\$621	\$6,046,710	\$582.12	585	676	\$10,336.26
Inpatient - Psych	\$56,677	\$0	\$56,677	\$5.46	89	103	\$636.82
Lab and X-ray Services	\$221,826	\$0	\$221,826	\$21.36	23,128	26,719	\$9.59
Medicare Xover - IP	\$34,418	\$0	\$34,418	\$3.31	44	51	\$782.24
Medicare Xover - Nursing Facility	\$15,439	\$0	\$15,439	\$1.49	1,910	2,207	\$8.08
Medicare Xover - OP	\$24,952	\$0	\$24,952	\$2.40	222	256	\$112.40
Medicare Xover - Other	\$37,932	\$0	\$37,932	\$3.65	1,222	1,412	\$31.04
Medicare Xover - Physician	\$109,473	\$2	\$109,474	\$10.54	1,777	2,053	\$61.61
Nursing Facility	\$17,918,310	\$1,396,256	\$19,314,566	\$1,859.43	155,230	179,329	\$124.43
Outpatient - Other	\$708,986	\$0	\$708,986	\$68.25	1,032	1,192	\$687.00
Outpatient - Psychological	\$5,769	\$0	\$5,769	\$0.56	9	10	\$641.01
Personal Care Services	\$5,226,543	\$37,305	\$5,263,849	\$506.75	102,991	118,980	\$51.11
Physician - Clinic	\$739,664	\$0	\$739,664	\$71.21	100,001	115,526	\$7.40
Physician - IP Mental Health	\$1,581	\$0	\$1,581	\$0.15	18	21	\$87.83
Physician - OP Mental Health	\$1,155,420	\$0	\$1,155,420	\$111.23	83,683	96,675	\$13.81
Physician - Other Practitioner	\$135,303	\$1	\$135,304	\$13.03	3,467	4,005	\$39.03
Physician - PCP	\$998,530	\$192	\$998,722	\$96.15	29,244	33,784	\$34.15
Physician - Specialist	\$534,825	\$81	\$534,905	\$51.50	11,961	13,818	\$44.72
Pharmacy	\$2,239,816	\$1,242	\$2,241,058	\$432.71	43,906	101,730	\$51.04
Transportation - Emergency	\$64,653	\$0	\$64,653	\$6.22	668	772	\$96.79
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$38,211,716	\$1,436,010	\$39,647,725	\$4,033.88	573,219		

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

VIRGINIA MEDICAID
FY 2009 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
All Regions	Medicaid Payments FY06 - FY07	Patient Payments FY06 - FY07	Total Payments FY06 - FY07	Unadjusted PMPM	Units FY06 - FY07	Units/1000 FY06 - FY07	Cost/Unit FY06 - FY07
Member Months	47,614						
Service Type							
Adult Day Care	\$662,842	\$14,952	\$677,794	\$14.24	15,622	3,937	\$43.39
Ambulatory Surgery Center	\$39,786	\$0	\$39,786	\$0.84	89	22	\$447.03
Case Management Services	\$12,159	\$0	\$12,159	\$0.26	3,688	929	\$3.30
Consumer Directed Services	\$2,910,735	\$18,584	\$2,929,319	\$61.52	3,855	972	\$759.88
DME/Supplies	\$4,274,646	\$667	\$4,275,313	\$89.79	37,438	9,435	\$114.20
Emergency	\$1,301,006	\$134	\$1,301,139	\$27.33	3,222	812	\$403.83
FQHC	\$210,098	\$17	\$210,115	\$4.41	2,880	726	\$72.96
Home Health Services	\$1,500,981	\$63	\$1,501,044	\$31.53	4,950	1,248	\$303.24
Inpatient - Medical/Surgical	\$31,075,393	\$12,281	\$31,087,674	\$652.91	3,105	783	\$10,012.13
Inpatient - Psych	\$437,863	\$250	\$438,113	\$9.20	681	172	\$643.34
Lab and X-ray Services	\$1,040,806	\$0	\$1,040,806	\$21.86	89,832	22,640	\$11.59
Medicare Xover - IP	\$174,602	\$0	\$174,602	\$3.67	197	50	\$886.31
Medicare Xover - Nursing Facility	\$66,332	\$0	\$66,332	\$1.39	8,528	2,149	\$7.78
Medicare Xover - OP	\$146,996	\$0	\$146,996	\$3.09	1,243	313	\$118.26
Medicare Xover - Other	\$160,726	\$0	\$160,726	\$3.38	5,136	1,294	\$31.29
Medicare Xover - Physician	\$334,888	\$23	\$334,911	\$7.03	6,540	1,648	\$51.21
Nursing Facility	\$81,808,169	\$5,581,618	\$87,389,787	\$1,835.37	660,085	166,358	\$132.39
Outpatient - Other	\$4,234,720	\$195	\$4,234,915	\$88.94	7,211	1,817	\$587.29
Outpatient - Psychological	\$24,514	\$0	\$24,514	\$0.51	64	16	\$383.03
Personal Care Services	\$21,373,602	\$183,472	\$21,557,074	\$452.74	411,966	103,826	\$52.33
Physician - Clinic	\$2,023,060	\$0	\$2,023,060	\$42.49	298,886	75,327	\$6.77
Physician - IP Mental Health	\$12,977	\$0	\$12,977	\$0.27	207	52	\$62.69
Physician - OP Mental Health	\$5,047,176	\$142	\$5,047,318	\$106.00	318,630	80,303	\$15.84
Physician - Other Practitioner	\$442,080	\$62	\$442,142	\$9.29	13,061	3,292	\$33.85
Physician - PCP	\$4,197,828	\$812	\$4,198,640	\$88.18	135,697	34,199	\$30.94
Physician - Specialist	\$2,334,248	\$827	\$2,335,075	\$49.04	58,868	14,836	\$39.67
Pharmacy	\$11,326,819	\$6,650	\$11,333,469	\$472.93	207,838	104,073	\$54.53
Transportation - Emergency	\$382,151	\$0	\$382,151	\$8.03	3,270	824	\$116.87
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$177,557,203	\$5,820,748	\$183,377,951	\$4,086.22	2,302,789		

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.

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

Medicaid Payments for the Pharmacy service line contains historical FFS claims for FY07 only and copayments are presented in the Patient Payments column.

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Prescription Drug Adjustment**

Exhibit 2a

	Dual Eligibles	Non-Dual Eligibles	Source
1. Fee-for-Service Net Cost PMPM	\$23.36	\$472.65	DMAS FY07 FFS Invoices
2. Fee-for-Service Net Cost per Script	\$9.19	\$54.50	DMAS FY07 FFS Invoices
3. Average Fee-for-Service Copayment per Script	\$0.02	\$0.03	DMAS FY07 FFS Invoices
4. Fee-for-Service Gross Cost per Script	\$9.21	\$54.53	= (2.) + (3.)
5. Less Value of Average Fee-for-Service Dispensing Fees	\$2.99	\$3.16	DMAS FY07 FFS Invoices
6. Fee-for-Service Ingredient Cost per Script	\$6.22	\$51.38	= (4.) - (5.)
7. Average Fee-for-Service Rebate	11%	34%	Provided by DMAS
8. Fee-for-Service Cost per Script with Rebate	\$5.54	\$33.96	= (6.) * (1 - (7.))
9. Average Fee-for-Service Dispensing Fees	\$2.91	\$3.11	DMAS FY08 FFS Invoices
10. Adjusted Cost per Script	\$8.45	\$37.06	= (8.) + (9.)
11. Adjusted Cost PMPM	\$21.48	\$321.44	= (10.) * scripts / MM
12. Brand-Generic Improvement Adjustment	1.000	0.995	VA Claims Analysis
13. Adjusted Cost PMPM with Brand-Generic Improvement Adjustment	\$21.48	\$319.83	= (11.) * (12.)
14. Pharmacy Adjustment Factor	-8.1%	-32.3%	= (13.) / (1.) -1

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 ER Professional Fee Increase Adjustment**

Exhibit 2b

	Dual Eligibles	Non-Dual Eligibles	Source
1. Claims Associated with ER Procedure Codes	\$10,146	\$144,410	DMAS July 2005 - April 2006 FFS Invoices
2. % Fee Increase Effective May 2006	3.0%	3.0%	Provided by DMAS
3. Dollar Increase	\$304	\$4,332	= (1.) * (2.)
4. Total Claims in Physician - PCP Service Category	\$519,977	\$4,197,828	DMAS FY06 - FY07 FFS Invoices
5. ER Professional Fee Increase Adjustment	0.1%	0.1%	= (3.) / (4.)

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Evaluation and Management Fee Increase Adjustment**

Exhibit 2c

		Dual Eligibles	Non-Dual Eligibles	Source
1. Claims Associated with E&M Procedure Codes	a. FQHC	\$2,750	\$61,295	DMAS July 2005 - April 2006 FFS Invoices
	b. Physician - PCP	\$62,057	\$977,130	
	c. Physician - Specialist	\$21,079	\$216,680	
2. % Fee Increase Effective May 2006		5.0%	5.0%	Provided by DMAS
3. Dollar Increase	a. FQHC	\$137	\$3,065	= (1.) * (2.)
	b. Physician - PCP	\$3,103	\$48,856	
	c. Physician - Specialist	\$1,054	\$10,834	
4. Total Claims in Service Category	a. FQHC	\$15,976	\$210,098	DMAS FY06 - FY07 FFS Invoices
	b. Physician - PCP	\$519,977	\$4,197,828	
	c. Physician - Specialist	\$300,943	\$2,334,248	
5. E&M Fee Increase Adjustment	a. FQHC	0.9%	1.5%	= (3.) / (4.)
	b. Physician - PCP	0.6%	1.2%	
	c. Physician - Specialist	0.4%	0.5%	

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Professional Fee Increase Adjustment (Excluding OB-GYN Services)**

Exhibit 2d

		Dual Eligibles	Non-Dual Eligibles	Source
1. Claims Associated with Professional Services*	a. FQHC	\$15,976	\$210,098	DMAS FY06 - FY07 FFS Invoices
	b. Physician - PCP	\$519,977	\$4,196,552	
	c. Physician - Specialist	\$299,762	\$2,313,387	
	d. All Other Professional Categories	\$34,573,915	\$7,525,293	
2. % Fee Increase Effective FY08		5.0%	5.0%	Provided by DMAS
3. Dollar Increase	a. FQHC	\$799	\$10,505	= (1.) * (2.)
	b. Physician - PCP	\$25,999	\$209,828	
	c. Physician - Specialist	\$14,988	\$115,669	
	d. All Other Professional Categories	\$1,728,696	\$376,265	
4. Total claims in Service Category	a. FQHC	\$15,976	\$210,098	DMAS FY06 - FY07 FFS Invoices
	b. Physician - PCP	\$519,977	\$4,197,828	
	c. Physician - Specialist	\$300,943	\$2,334,248	
	d. All Other Professional Categories	\$34,573,915	\$7,525,293	
5. Professional Fee Increase Adjustment	a. FQHC	5.0%	5.0%	= (3.) / (4.)
	b. Physician - PCP	5.0%	5.0%	
	c. Physician - Specialist	5.0%	5.0%	
	d. All Other Professional Categories	5.0%	5.0%	

* Note:
 Claims associated with OB-GYN procedure codes have been excluded from this adjustment.

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Non-Emergency Transportation Adjustment**

Exhibit 2e

	Adjustment Values	Source
Non-ER Transportation Rate		
Northern Virginia	\$46.59	CPI Adjusted Non-Emergency Transportation Rate
Other MSA	\$18.62	- Service Cost Component Only
Richmond/Charlottesville	\$27.85	
Rural	\$23.00	
Tidewater	\$24.67	

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Consumer Directed Long Term Care Adjustment**

Exhibit 2f

		Dual Eligibles	Non-Dual Eligibles	Source
1. FY06 - FY07 Total CD Supplemental Fees (Included in the base on Exhibits 1a and 1b)	Statewide	\$19,150,341	\$2,929,339	Provided by DMAS
	Northern Virginia	\$4,615,935	\$1,042,845	
	Other MSA	\$3,464,525	\$616,392	
	Richmond/Charlottesville	\$5,119,472	\$447,272	
	Rural	\$4,520,587	\$513,211	
	Tidewater	\$1,429,822	\$309,619	
2. Fee Increase effective May 1, 2006		2.0%	2.0%	Provided by DMAS
3. Fee Increase effective July 1, 2007		3.0%	3.0%	Provided by DMAS
4. Proportion of claims, July 1, 2005 - April 30, 2006	Statewide	25%	31%	10 months
5. Proportion of claims, May 1, 2006 - June 30, 2006	Statewide	75%	69%	14 months
6. Dollar Increase	Statewide	\$674,295	\$139,102	= (1.) * (4.) * ((1 + (2.)) * (1 + (3.)) -1)
	Northern Virginia	\$161,111	\$71,025	+ (1.) * (7.) * (4.)
	Other MSA	\$120,877	\$22,367	
	Richmond/Charlottesville	\$181,861	\$15,882	
	Rural	\$159,932	\$18,255	
	Tidewater	\$50,514	\$11,573	
7. Consumer Directed Long Term Care Adjustment	Northern Virginia	3.5%	6.8%	= (6.) / (1.)
	Other MSA	3.5%	3.6%	
	Richmond/Charlottesville	3.6%	3.6%	
	Rural	3.5%	3.6%	
	Tidewater	3.5%	3.7%	

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Personal Care Services Fee Increase Adjustment**

Exhibit 2g

	Adjustment Values	Source
1. Total Claims in Personal Care Service Category	\$206,870,482	DMAS FY06 - FY07 FFS Invoices
2. Fee Increase effective May 1, 2006	2.0%	Provided by DMAS
3. Fee Increase effective July 1, 2007	3.0%	Provided by DMAS
4. Proportion of claims, July 1, 2005 - April 30, 2006	39%	10 months
5. Proportion of claims, May 1, 2006 - June 30, 2007	61%	14 months
6. Dollar increase for July 1, 2005 - April 30, 2006	\$4,107,759	= (1.) * (4.) * ((1 + (2.)) * (1 + (3.)) -1)
7. Dollar increase for May 1, 2006 - June 30, 2007	\$3,770,684	= (1.) * (5.) * (3.)
8. Total Dollar Increase	\$7,878,443	= (6.) + (7.)
9. Personal Care Services Fee Increase Adjustment	3.8%	= (8.) / (1.)

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Adult Day Care Services Fee Increase Adjustment**

Exhibit 2h

	Adjustment Values	Source
1. Total Claims in Adult Day Care Service Category	\$5,448,265	DMAS FY06 - FY07 FFS Invoices
2. Fee Increase effective May 1, 2006	2.0%	Provided by DMAS
3. Fee Increase effective January 1, 2007	5.0%	Provided by DMAS
4. Proportion of claims, July 1, 2005 - April 30, 2006	39%	10 months
5. Proportion of claims, May 1, 2006 - December 31, 2006	34%	8 months
6. Dollar increase for July 1, 2005 - April 30, 2006	\$149,487	= (1.) * (4.) * ((1 + (2.)) * (1 + (3.)) -1)
7. Dollar increase for May 1, 2006 - December 31, 2006	\$93,546	= (1.) * (5.) * (3.)
8. Total Dollar Increase	\$243,033	= (6.) + (7.)
9. Adult Day Care Services Fee Increase Adjustment	4.5%	= (8.) / (1.)

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Hospital Inpatient Adjustments**

Exhibit 2i

	Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1. FY06 Hospital Inpatient Operating Adjustment Factor	76.0%	76.0%	Provided by DMAS
FY07 Hospital Inpatient Operating Adjustment Factor	78.0%	78.0%	
2. FY06 Inpatient Claims	\$19,784,155	\$3,926,762	DMAS FY06 - FY07 FFS Invoices
FY07 Inpatient Claims	\$24,725,651	\$3,086,742	
3. FY06-07 Hospital Inpatient Operating Adjustment Factor	77.1%	76.9%	Weighted Average of FY06 - FY07
4. FY09 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	Provided by DMAS
5. FY09 Hospital Rate Reduction	2.7%	2.7%	Provided by DMAS
6. FY09 Hospital Capital Percentage	10.0%	10.0%	Provided by DMAS
7. Hospital Inpatient Adjustment	-1.4%	5.7%	= (((4.) * (1 - (5.)) / (3.)) * (1 - (6.)) + (6.)) - 1

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Health Plan Encounter Data
 Rural Wage Index Adjustment**

Exhibit 2j

	Rural	Other MSA	Source
1. Rural Wage Index Adjustment	1.1%	0.1%	As calculated and applied to FY09 Medallion II rate development

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Health Plan Encounter Data
Nursing Facility Cost Settlement Adjustment**

Exhibit 2k

	Adjustment Value	Source
1. Nursing Facility Cost Settlement Adjustmen	4.5%	Provided by DMAS

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Other Adjustments**

Exhibit 2I

	Adjustment Values	Source
1. Managed Care Utilization Savings	-22.0%	American Academy of Actuaries
2. Administrative Cost	13.1%	Review of Plan data

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Trend Adjustments for Dual Population**

Exhibit 3a

Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Nursing Facility	0.0%	4.5%	4.5%	6.3%	-4.2%	1.9%	0.0%	1.0192
Adult Day Care	0.0%	4.5%	4.5%	4.9%	0.4%	5.2%	10.0%	1.2134
Personal Care	0.0%	3.9%	3.9%	5.3%	7.7%	13.4%	15.0%	1.3987
IP Medical/Surgical - DRG Services	0.1%	-1.2%	-1.1%	10.4%	17.9%	30.2%	12.2%	1.5477
IP Psych - Per Diem Services	0.0%	5.7%	5.7%	0.0%	0.0%	0.0%	0.0%	1.0000
Outpatient Hospital	0.0%	0.0%	0.0%	75.9%	1.0%	77.6%	31.1%	2.6663
Practitioner	0.0%	3.8%	3.9%	25.4%	0.2%	25.7%	17.7%	1.6053
Prescription Drug	0.0%	-8.1%	-8.1%	-5.2%	-7.4%	-12.2%	-4.8%	0.8154
Other	0.1%	0.0%	0.1%	-2.8%	34.3%	30.6%	5.4%	1.4127
Weighted Average*	0.0%	4.2%	4.3%	6.7%	-2.4%	4.1%	2.4%	1.0787
Medicare Crossovers								
Nursing Facility	0.7%	0.0%	0.7%	23.9%	-4.9%	17.9%	10.9%	1.3768
Inpatient	0.0%	0.0%	0.0%	16.3%	-3.3%	12.6%	24.5%	1.5650
Outpatient	0.1%	0.0%	0.1%	-1.1%	3.0%	1.9%	0.0%	1.0190
Professional	0.1%	0.0%	0.1%	4.9%	4.4%	9.5%	9.1%	1.2473
Other	0.2%	0.0%	0.2%	5.9%	3.4%	9.5%	5.1%	1.1806
Weighted Average*	0.2%	0.0%	0.2%	10.5%	0.5%	10.8%	10.2%	1.2813
Months of Trend Applied:				12	12	12	18	

Notes:

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

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

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

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

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

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY06-07 Claims)

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Trend Adjustments for Non Dual Population**

Exhibit 3b

Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Nursing Facility	0.0%	4.5%	4.5%	6.3%	-5.5%	0.4%	0.0%	1.0040
Adult Day Care	0.0%	4.6%	4.6%	3.6%	-3.6%	-0.1%	-4.9%	0.9269
Personal Care	0.0%	4.0%	4.0%	2.0%	5.8%	8.0%	3.5%	1.1371
IP Medical/Surgical - DRG Services	0.0%	-1.1%	-1.1%	5.6%	12.5%	18.8%	14.9%	1.4633
IP Psych - Per Diem Services	0.0%	5.7%	5.7%	0.0%	0.0%	0.0%	0.0%	1.0000
Outpatient Hospital	0.0%	0.0%	0.0%	-3.5%	6.4%	2.8%	8.3%	1.1587
Practitioner	0.0%	4.2%	4.2%	17.1%	-0.2%	16.9%	12.6%	1.3966
Prescription Drug	0.0%	-32.3%	-32.3%	-2.3%	1.3%	-1.0%	0.1%	0.9914
Other	0.1%	0.0%	0.1%	23.8%	6.0%	31.2%	15.7%	1.6339
Weighted Average*	0.0%	-0.3%	-0.3%	5.6%	0.5%	6.1%	4.4%	1.1323
Months of Trend Applied:				12	12	12	18	

Notes:

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

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

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

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY06-07 Claims)

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over									
Northern Virginia	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$569,289	\$0	\$11,511	\$25,908	\$606,709	1.213	0.78	\$574,216	\$8.05
Ambulatory Surgery Center	\$788	\$0			\$788	1.605	0.78	\$987	\$0.01
Case Management Services	\$15,819	\$4			\$15,824	1.605	0.78	\$19,813	\$0.28
Consumer Directed Services	\$4,523,684	\$81	\$92,170	\$161,111	\$4,777,047	1.399	0.78	\$5,211,724	\$73.04
DME/Supplies	\$1,040,915	\$292			\$1,041,206	1.605	0.78	\$1,303,694	\$18.27
Emergency	\$5,019	\$0			\$5,019	2.666	0.78	\$10,438	\$0.15
FQHC	\$753	\$0		\$44	\$797	1.605	0.78	\$998	\$0.01
Home Health Services	\$8,135	\$0			\$8,135	2.666	0.78	\$16,918	\$0.24
Inpatient - Medical/Surgical	\$4,349,388	\$2,841		(\$61,167)	\$4,291,062	1.548	0.78	\$5,180,206	\$72.60
Inpatient - Psych	\$312,762	\$0		\$17,822	\$330,584	1.000	0.78	\$257,856	\$3.61
Lab and X-ray Services	\$8,295	\$9			\$8,304	1.413	0.78	\$9,150	\$0.13
Medicare Xover - IP	\$1,236,936	\$0			\$1,236,936	1.565	0.78	\$1,509,970	\$21.16
Medicare Xover - Nursing Facility	\$834,924	\$6,190	\$30,487		\$871,602	1.377	0.78	\$935,998	\$13.12
Medicare Xover - OP	\$713,355	\$595			\$713,950	1.019	0.78	\$567,461	\$7.95
Medicare Xover - Other	\$834,025	\$1,060			\$835,085	1.247	0.78	\$812,475	\$11.39
Medicare Xover - Physician	\$1,467,096	\$2,415			\$1,469,511	1.181	0.78	\$1,353,263	\$18.97
Nursing Facility	\$173,775,702	\$13,682	\$40,360,420	\$7,820,522	\$221,970,327	1.019	0.78	\$176,465,520	\$2,473.06
Outpatient - Other	\$365,102	\$0			\$365,102	2.666	0.78	\$759,317	\$10.64
Outpatient - Psychological	\$15,802	\$0			\$15,802	2.666	0.78	\$32,864	\$0.46
Personal Care Services	\$24,237,740	\$435	\$406,963	\$938,584	\$25,583,722	1.399	0.78	\$27,911,661	\$391.16
Physician - Clinic	\$49,501	\$14		\$2,476	\$51,990	1.605	0.78	\$65,097	\$0.91
Physician - IP Mental Health	\$0	\$0			\$0	1.605	0.78	\$0	\$0.00
Physician - OP Mental Health	\$4,694,213	\$1,316		\$234,776	\$4,930,305	1.605	0.78	\$6,173,231	\$86.51
Physician - Other Practitioner	\$284,854	\$80		\$14,247	\$299,180	1.605	0.78	\$374,603	\$5.25
Physician - PCP	\$87,410	\$25		\$4,945	\$92,379	1.605	0.78	\$115,668	\$1.62
Physician - Specialist	\$55,704	\$16		\$2,970	\$58,690	1.605	0.78	\$73,486	\$1.03
Pharmacy	\$882,359	\$0		(\$71,039)	\$811,321	0.815	1.00	\$661,569	\$18.12
Transportation - Emergency	\$24,359	\$26			\$24,385	1.413	0.78	\$26,871	\$0.38
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$46.59
Total	\$220,393,928	\$29,081	\$40,901,551	\$9,091,200	\$270,415,759			\$230,425,053	\$3,284.71
Admin Cost Adjustment									13.1%
Capitation Rate									\$3,781.14

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over									
Other MSA	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$627,891	\$0	\$11,511	\$28,522	\$667,924	1.213	0.78	\$632,153	\$5.37
Ambulatory Surgery Center	\$0	\$0			\$0	1.605	0.78	\$0	\$0.00
Case Management Services	\$4,585	\$1			\$4,586	1.605	0.78	\$5,742	\$0.05
Consumer Directed Services	\$3,375,251	\$61	\$89,214	\$120,877	\$3,585,402	1.399	0.78	\$3,911,648	\$33.22
DME/Supplies	\$1,256,546	\$352			\$1,256,898	1.605	0.78	\$1,573,761	\$13.36
Emergency	\$2,957	\$0			\$2,957	2.666	0.78	\$6,151	\$0.05
FQHC	\$194	\$0		\$11	\$205	1.605	0.78	\$257	\$0.00
Home Health Services	\$8,617	\$0			\$8,617	2.666	0.78	\$17,920	\$0.15
Inpatient - Medical/Surgical	\$1,645,457	\$1,075		(\$21,110)	\$1,625,421	1.548	0.78	\$1,962,222	\$16.66
Inpatient - Psych	\$2,676,419	\$0		\$152,511	\$2,828,929	1.000	0.78	\$2,206,565	\$18.74
Lab and X-ray Services	\$12,905	\$14			\$12,918	1.413	0.78	\$14,235	\$0.12
Medicare Xover - IP	\$1,938,038	\$0			\$1,938,038	1.565	0.78	\$2,365,828	\$20.09
Medicare Xover - Nursing Facility	\$1,819,809	\$13,491	\$80,444		\$1,913,744	1.377	0.78	\$2,055,137	\$17.45
Medicare Xover - OP	\$1,450,886	\$1,209			\$1,452,095	1.019	0.78	\$1,154,154	\$9.80
Medicare Xover - Other	\$1,633,981	\$2,077			\$1,636,058	1.247	0.78	\$1,591,763	\$13.52
Medicare Xover - Physician	\$1,911,175	\$3,147			\$1,914,322	1.181	0.78	\$1,762,886	\$14.97
Nursing Facility	\$243,088,047	\$19,140	\$57,649,165	\$10,939,823	\$311,696,175	1.019	0.78	\$247,797,211	\$2,104.33
Outpatient - Other	\$89,910	\$0			\$89,910	2.666	0.78	\$186,990	\$1.59
Outpatient - Psychological	\$13	\$0			\$13	2.666	0.78	\$27	\$0.00
Personal Care Services	\$18,331,201	\$329	\$533,470	\$718,454	\$19,583,454	1.399	0.78	\$21,365,411	\$181.44
Physician - Clinic	\$1,631	\$0		\$82	\$1,713	1.605	0.78	\$2,145	\$0.02
Physician - IP Mental Health	\$40	\$0		\$2	\$42	1.605	0.78	\$53	\$0.00
Physician - OP Mental Health	\$4,283,849	\$1,201		\$214,252	\$4,499,302	1.605	0.78	\$5,633,573	\$47.84
Physician - Other Practitioner	\$159,993	\$45		\$8,002	\$168,040	1.605	0.78	\$210,402	\$1.79
Physician - PCP	\$85,550	\$24		\$4,839	\$90,413	1.605	0.78	\$113,207	\$0.96
Physician - Specialist	\$35,990	\$10		\$1,919	\$37,920	1.605	0.78	\$47,479	\$0.40
Pharmacy	\$1,586,739	\$0		(\$127,748)	\$1,458,991	0.815	1.00	\$1,189,693	\$19.83
Transportation - Emergency	\$24,950	\$26			\$24,976	1.413	0.78	\$27,522	\$0.23
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$18.62
Total	\$286,052,624	\$42,202	\$58,363,803	\$12,040,436	\$356,499,065			\$295,834,136	\$2,540.62
Admin Cost Adjustment									13.1%
Capitation Rate									\$2,924.59

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over									
Richmond/Charlottesville	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$2,397,804	\$0	\$11,511	\$107,473	\$2,516,788	1.213	0.78	\$2,382,000	\$20.83
Ambulatory Surgery Center	\$0	\$0			\$0	1.605	0.78	\$0	\$0.00
Case Management Services	\$1,908	\$1			\$1,909	1.605	0.78	\$2,390	\$0.02
Consumer Directed Services	\$4,977,508	\$89	\$141,874	\$181,861	\$5,301,333	1.399	0.78	\$5,783,717	\$50.57
DME/Supplies	\$2,649,629	\$743			\$2,650,372	1.605	0.78	\$3,318,529	\$29.01
Emergency	\$11,527	\$0			\$11,527	2.666	0.78	\$23,973	\$0.21
FQHC	\$3,318	\$1		\$195	\$3,513	1.605	0.78	\$4,399	\$0.04
Home Health Services	\$16,115	\$0			\$16,115	2.666	0.78	\$33,516	\$0.29
Inpatient - Medical/Surgical	\$2,433,033	\$1,589		(\$34,217)	\$2,400,405	1.548	0.78	\$2,897,790	\$25.34
Inpatient - Psych	\$2,275,762	\$0		\$129,680	\$2,405,442	1.000	0.78	\$1,876,245	\$16.40
Lab and X-ray Services	\$12,186	\$13			\$12,199	1.413	0.78	\$13,442	\$0.12
Medicare Xover - IP	\$2,642,837	\$0			\$2,642,837	1.565	0.78	\$3,226,201	\$28.21
Medicare Xover - Nursing Facility	\$1,688,811	\$12,520	\$172,498		\$1,873,829	1.377	0.78	\$2,012,272	\$17.59
Medicare Xover - OP	\$1,604,904	\$1,338			\$1,606,241	1.019	0.78	\$1,276,673	\$11.16
Medicare Xover - Other	\$2,092,395	\$2,659			\$2,095,054	1.247	0.78	\$2,038,332	\$17.82
Medicare Xover - Physician	\$2,419,553	\$3,984			\$2,423,536	1.181	0.78	\$2,231,818	\$19.51
Nursing Facility	\$199,498,468	\$15,708	\$50,239,753	\$8,978,138	\$258,732,066	1.019	0.78	\$205,690,956	\$1,798.35
Outpatient - Other	\$59,201	\$0			\$59,201	2.666	0.78	\$123,122	\$1.08
Outpatient - Psychological	\$3,121	\$0			\$3,121	2.666	0.78	\$6,491	\$0.06
Personal Care Services	\$42,240,649	\$759	\$1,273,302	\$1,657,212	\$45,171,921	1.399	0.78	\$49,282,248	\$430.87
Physician - Clinic	\$9,373	\$3		\$469	\$9,844	1.605	0.78	\$12,326	\$0.11
Physician - IP Mental Health	\$241	\$0		\$12	\$253	1.605	0.78	\$317	\$0.00
Physician - OP Mental Health	\$7,640,453	\$2,142		\$382,130	\$8,024,725	1.605	0.78	\$10,047,752	\$87.85
Physician - Other Practitioner	\$214,123	\$60		\$10,709	\$224,892	1.605	0.78	\$281,587	\$2.46
Physician - PCP	\$68,020	\$19		\$3,848	\$71,887	1.605	0.78	\$90,010	\$0.79
Physician - Specialist	\$50,106	\$14		\$2,672	\$52,792	1.605	0.78	\$66,100	\$0.58
Pharmacy	\$1,104,681	\$0		(\$88,938)	\$1,015,744	0.815	1.00	\$828,260	\$14.43
Transportation - Emergency	\$51,675	\$54			\$51,729	1.413	0.78	\$57,002	\$0.50
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$27.85
Total	\$276,167,399	\$41,695	\$51,838,937	\$11,331,243	\$339,379,275			\$293,607,468	\$2,602.04
Admin Cost Adjustment									13.1%
Capitation Rate									\$2,995.29

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over									
Rural	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$578,049	\$0	\$11,511	\$26,299	\$615,859	1.213	0.78	\$582,877	\$3.31
Ambulatory Surgery Center	\$36	\$0			\$36	1.605	0.78	\$45	\$0.00
Case Management Services	\$109,327	\$31			\$109,358	1.605	0.78	\$136,927	\$0.78
Consumer Directed Services	\$4,425,554	\$79	\$94,954	\$159,932	\$4,680,519	1.399	0.78	\$5,106,413	\$28.98
DME/Supplies	\$3,102,907	\$870			\$3,103,777	1.605	0.78	\$3,886,237	\$22.05
Emergency	\$15,517	\$0			\$15,517	2.666	0.78	\$32,271	\$0.18
FQHC	\$11,621	\$3		\$681	\$12,306	1.605	0.78	\$15,408	\$0.09
Home Health Services	\$31,224	\$0			\$31,224	2.666	0.78	\$64,939	\$0.37
Inpatient - Medical/Surgical	\$2,842,153	\$1,857		(\$7,987)	\$2,836,023	1.548	0.78	\$3,423,671	\$19.43
Inpatient - Psych	\$1,308,175	\$0		\$74,544	\$1,382,718	1.000	0.78	\$1,078,520	\$6.12
Lab and X-ray Services	\$16,926	\$18			\$16,944	1.413	0.78	\$18,672	\$0.11
Medicare Xover - IP	\$3,272,593	\$0			\$3,272,593	1.565	0.78	\$3,994,965	\$22.67
Medicare Xover - Nursing Facility	\$2,943,440	\$21,821	\$124,938		\$3,090,200	1.377	0.78	\$3,318,512	\$18.83
Medicare Xover - OP	\$2,248,717	\$1,874			\$2,250,591	1.019	0.78	\$1,788,814	\$10.15
Medicare Xover - Other	\$4,168,433	\$5,298			\$4,173,731	1.247	0.78	\$4,060,730	\$23.04
Medicare Xover - Physician	\$3,823,410	\$6,295			\$3,829,704	1.181	0.78	\$3,526,748	\$20.01
Nursing Facility	\$295,214,936	\$23,244	\$61,759,037	\$13,285,718	\$370,282,935	1.019	0.78	\$294,373,450	\$1,670.51
Outpatient - Other	\$71,330	\$0			\$71,330	2.666	0.78	\$148,348	\$0.84
Outpatient - Psychological	\$3,620	\$0			\$3,620	2.666	0.78	\$7,528	\$0.04
Personal Care Services	\$53,361,763	\$959	\$1,658,423	\$2,095,422	\$57,116,567	1.399	0.78	\$62,313,774	\$353.62
Physician - Clinic	\$33,141	\$9		\$1,658	\$34,808	1.605	0.78	\$43,583	\$0.25
Physician - IP Mental Health	\$35	\$0		\$2	\$37	1.605	0.78	\$46	\$0.00
Physician - OP Mental Health	\$8,562,782	\$2,401		\$428,259	\$8,993,442	1.605	0.78	\$11,260,682	\$63.90
Physician - Other Practitioner	\$245,889	\$69		\$12,298	\$258,256	1.605	0.78	\$323,362	\$1.84
Physician - PCP	\$130,217	\$37		\$7,366	\$137,619	1.605	0.78	\$172,313	\$0.98
Physician - Specialist	\$65,319	\$18		\$3,483	\$68,820	1.605	0.78	\$86,169	\$0.49
Pharmacy	\$2,205,188	\$0		(\$177,539)	\$2,027,648	0.815	1.00	\$1,653,389	\$18.63
Transportation - Emergency	\$50,779	\$53			\$50,832	1.413	0.78	\$56,014	\$0.32
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$23.00
Total	\$388,843,080	\$64,936	\$63,648,863	\$15,910,134	\$468,467,014			\$401,474,407	\$2,310.53
Admin Cost Adjustment									13.1%
Capitation Rate									\$2,659.73

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over									
Tidewater	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$539,881	\$0	\$11,511	\$24,596	\$575,989	1.213	0.78	\$545,141	\$4.57
Ambulatory Surgery Center	\$1,880	\$1			\$1,880	1.605	0.78	\$2,354	\$0.02
Case Management Services	\$3,533	\$1			\$3,534	1.605	0.78	\$4,425	\$0.04
Consumer Directed Services	\$1,374,171	\$25	\$55,626	\$50,514	\$1,480,335	1.399	0.78	\$1,615,036	\$13.55
DME/Supplies	\$2,631,568	\$738			\$2,632,306	1.605	0.78	\$3,295,909	\$27.64
Emergency	\$15,102	\$0			\$15,102	2.666	0.78	\$31,409	\$0.26
FQHC	\$91	\$0		\$5	\$96	1.605	0.78	\$120	\$0.00
Home Health Services	\$17,069	\$0			\$17,069	2.666	0.78	\$35,500	\$0.30
Inpatient - Medical/Surgical	\$2,164,383	\$1,414		(\$30,439)	\$2,135,358	1.548	0.78	\$2,577,823	\$21.62
Inpatient - Psych	\$2,523	\$0		\$144	\$2,667	1.000	0.78	\$2,080	\$0.02
Lab and X-ray Services	\$9,793	\$10			\$9,804	1.413	0.78	\$10,803	\$0.09
Medicare Xover - IP	\$2,165,839	\$0			\$2,165,839	1.565	0.78	\$2,643,913	\$22.18
Medicare Xover - Nursing Facility	\$1,895,895	\$14,055	\$112,303		\$2,022,253	1.377	0.78	\$2,171,662	\$18.21
Medicare Xover - OP	\$1,235,008	\$1,029			\$1,236,038	1.019	0.78	\$982,428	\$8.24
Medicare Xover - Other	\$2,657,127	\$3,377			\$2,660,504	1.247	0.78	\$2,588,473	\$21.71
Medicare Xover - Physician	\$2,960,518	\$4,874			\$2,965,393	1.181	0.78	\$2,730,810	\$22.90
Nursing Facility	\$208,673,491	\$16,430	\$61,301,249	\$9,391,046	\$279,382,217	1.019	0.78	\$222,107,743	\$1,862.89
Outpatient - Other	\$60,343	\$0			\$60,343	2.666	0.78	\$125,498	\$1.05
Outpatient - Psychological	\$16	\$0			\$16	2.666	0.78	\$33	\$0.00
Personal Care Services	\$42,113,919	\$757	\$1,152,592	\$1,647,788	\$44,915,055	1.399	0.78	\$49,002,010	\$411.00
Physician - Clinic	\$21,915	\$6		\$1,096	\$23,017	1.605	0.78	\$28,819	\$0.24
Physician - IP Mental Health	\$1,749	\$0		\$87	\$1,837	1.605	0.78	\$2,299	\$0.02
Physician - OP Mental Health	\$8,255,630	\$2,315		\$412,897	\$8,670,842	1.605	0.78	\$10,856,755	\$91.06
Physician - Other Practitioner	\$114,506	\$32		\$5,727	\$120,265	1.605	0.78	\$150,583	\$1.26
Physician - PCP	\$148,780	\$42		\$8,416	\$157,238	1.605	0.78	\$196,878	\$1.65
Physician - Specialist	\$93,824	\$26		\$5,003	\$98,853	1.605	0.78	\$123,774	\$1.04
Pharmacy	\$1,290,367	\$0		(\$103,887)	\$1,186,480	0.815	1.00	\$967,482	\$16.12
Transportation - Emergency	\$39,280	\$41			\$39,321	1.413	0.78	\$43,330	\$0.36
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$24.67
Total	\$278,488,203	\$45,174	\$62,633,280	\$11,412,994	\$352,579,651			\$302,843,090	\$2,572.73
Admin Cost Adjustment									13.1%
Capitation Rate									\$2,961.55

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over									
Total	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$4,712,915	\$0	\$57,556	\$212,798	\$4,983,269	1.213	0.78	\$4,716,387	\$7.87
Ambulatory Surgery Center	\$2,703	\$1			\$2,704	1.605	0.78	\$3,386	\$0.01
Case Management Services	\$135,172	\$38			\$135,210	1.605	0.78	\$169,297	\$0.28
Consumer Directed Services	\$18,676,168	\$335	\$473,838	\$674,295	\$19,824,636	1.399	0.78	\$21,628,538	\$36.11
DME/Supplies	\$10,681,565	\$2,995			\$10,684,560	1.605	0.78	\$13,378,129	\$22.34
Emergency	\$50,122	\$0			\$50,122	2.666	0.78	\$104,241	\$0.17
FQHC	\$15,976	\$4		\$937	\$16,917	1.605	0.78	\$21,182	\$0.04
Home Health Services	\$81,161	\$0			\$81,161	2.666	0.78	\$168,793	\$0.28
Inpatient - Medical/Surgical	\$13,434,414	\$8,776		(\$154,920)	\$13,288,269	1.548	0.78	\$16,041,711	\$26.78
Inpatient - Psych	\$6,575,640	\$0		\$374,701	\$6,950,341	1.000	0.78	\$5,421,266	\$9.05
Lab and X-ray Services	\$60,105	\$63			\$60,168	1.413	0.78	\$66,302	\$0.11
Medicare Xover - IP	\$11,256,242	\$0			\$11,256,242	1.565	0.78	\$13,740,878	\$22.94
Medicare Xover - Nursing Facility	\$9,182,880	\$68,078	\$520,669		\$9,771,628	1.377	0.78	\$10,493,580	\$17.52
Medicare Xover - OP	\$7,252,870	\$6,045			\$7,258,914	1.019	0.78	\$5,769,530	\$9.63
Medicare Xover - Other	\$11,385,960	\$14,471			\$11,400,431	1.247	0.78	\$11,091,774	\$18.52
Medicare Xover - Physician	\$12,581,752	\$20,715			\$12,602,467	1.181	0.78	\$11,605,525	\$19.38
Nursing Facility	\$1,120,250,645	\$88,204	\$271,309,623	\$50,415,248	\$1,442,063,721	1.019	0.78	\$1,146,434,880	\$1,914.13
Outpatient - Other	\$645,887	\$0			\$645,887	2.666	0.78	\$1,343,274	\$2.24
Outpatient - Psychological	\$22,571	\$0			\$22,571	2.666	0.78	\$46,943	\$0.08
Personal Care Services	\$180,285,272	\$3,239	\$5,024,750	\$7,057,459	\$192,370,719	1.399	0.78	\$209,875,104	\$350.41
Physician - Clinic	\$115,560	\$32		\$5,780	\$121,372	1.605	0.78	\$151,970	\$0.25
Physician - IP Mental Health	\$2,064	\$1		\$103	\$2,168	1.605	0.78	\$2,715	\$0.00
Physician - OP Mental Health	\$33,436,926	\$9,375		\$1,672,315	\$35,118,616	1.605	0.78	\$43,971,993	\$73.42
Physician - Other Practitioner	\$1,019,365	\$286		\$50,983	\$1,070,633	1.605	0.78	\$1,340,539	\$2.24
Physician - PCP	\$519,977	\$146		\$29,414	\$549,538	1.605	0.78	\$688,076	\$1.15
Physician - Specialist	\$300,943	\$84		\$16,047	\$317,074	1.605	0.78	\$397,008	\$0.66
Pharmacy	\$7,069,334	\$0		(\$569,151)	\$6,500,183	0.815	1.00	\$5,300,392	\$17.51
Transportation - Emergency	\$191,042	\$201			\$191,243	1.413	0.78	\$210,739	\$0.35
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$26.21
Total	\$1,449,945,234	\$223,088	\$277,386,435	\$59,786,007	\$1,787,340,764			\$1,524,184,153	\$2,579.70
Admin Cost Adjustment									13.1%
Capitation Rate									\$2,969.58

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over									
Northern Virginia	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$104,578	\$0		\$4,665	\$109,243	0.927	0.78	\$78,981	\$7.78
Ambulatory Surgery Center	\$6,719	\$1			\$6,720	1.397	0.78	\$7,320	\$0.72
Case Management Services	\$3,072	\$1			\$3,072	1.397	0.78	\$3,347	\$0.33
Consumer Directed Services	\$1,042,733	\$7	\$105	\$71,025	\$1,113,871	1.137	0.78	\$987,940	\$97.31
DME/Supplies	\$929,282	\$157			\$929,439	1.397	0.78	\$1,012,504	\$99.73
Emergency	\$227,737	\$13			\$227,750	1.159	0.78	\$205,829	\$20.27
FQHC	\$3,752	\$1		\$242	\$3,995	1.397	0.78	\$4,352	\$0.43
Home Health Services	\$168,605	\$10			\$168,614	1.159	0.78	\$152,386	\$15.01
Inpatient - Medical/Surgical	\$5,899,555	\$969		(\$82,927)	\$5,817,597	1.463	0.78	\$6,639,953	\$654.04
Inpatient - Psych	\$30,448	\$0		\$1,735	\$32,183	1.000	0.78	\$25,103	\$2.47
Lab and X-ray Services	\$181,589	\$191			\$181,780	1.634	0.78	\$231,662	\$22.82
Medicare Xover - IP	\$34,380	\$0			\$34,380	1.000	1.00	\$34,380	\$3.39
Medicare Xover - Nursing Facility	\$4,969	\$0			\$4,969	1.000	1.00	\$4,969	\$0.49
Medicare Xover - OP	\$36,912	\$0			\$36,912	1.000	1.00	\$36,912	\$3.64
Medicare Xover - Other	\$20,432	\$0			\$20,432	1.000	1.00	\$20,432	\$2.01
Medicare Xover - Physician	\$68,758	\$0			\$68,758	1.000	1.00	\$68,758	\$6.77
Nursing Facility	\$22,186,073	\$912	\$1,866,315	\$998,414	\$25,051,715	1.004	0.78	\$19,618,499	\$1,932.44
Outpatient - Other	\$481,209	\$27			\$481,236	1.159	0.78	\$434,919	\$42.84
Outpatient - Psychological	\$13,024	\$1			\$13,025	1.159	0.78	\$11,771	\$1.16
Personal Care Services	\$5,313,242	\$37	\$28,270	\$203,427	\$5,544,976	1.137	0.78	\$4,918,080	\$484.43
Physician - Clinic	\$195,092	\$33		\$9,756	\$204,881	1.397	0.78	\$223,191	\$21.98
Physician - IP Mental Health	\$1,798	\$0		\$90	\$1,888	1.397	0.78	\$2,057	\$0.20
Physician - OP Mental Health	\$1,030,894	\$174		\$51,553	\$1,082,622	1.397	0.78	\$1,179,377	\$116.17
Physician - Other Practitioner	\$94,227	\$16		\$4,712	\$98,955	1.397	0.78	\$107,799	\$10.62
Physician - PCP	\$763,027	\$129		\$47,816	\$810,971	1.397	0.78	\$883,449	\$87.02
Physician - Specialist	\$427,237	\$72		\$23,158	\$450,467	1.397	0.78	\$490,726	\$48.34
Pharmacy	\$2,235,238	\$0		(\$722,701)	\$1,512,537	0.991	1.00	\$1,499,504	\$299.97
Transportation - Emergency	\$52,142	\$55			\$52,197	1.413	0.78	\$57,518	\$5.67
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$46.59
Total	\$41,556,724	\$2,805	\$1,894,690	\$610,966	\$44,065,185			\$38,941,717	\$4,034.64
Admin Cost Adjustment									13.1%
Capitation Rate									\$4,644.41

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over									
Other MSA	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$49,246	\$0	\$5,721	\$2,452	\$57,419	0.927	0.78	\$41,512	\$6.12
Ambulatory Surgery Center	\$7,570	\$1			\$7,571	1.397	0.78	\$8,248	\$1.22
Case Management Services	\$393	\$0			\$393	1.397	0.78	\$428	\$0.06
Consumer Directed Services	\$610,636	\$4	\$5,752	\$22,367	\$638,759	1.137	0.78	\$566,544	\$83.50
DME/Supplies	\$545,404	\$92			\$545,496	1.397	0.78	\$594,247	\$87.58
Emergency	\$199,993	\$11			\$200,005	1.159	0.78	\$180,755	\$26.64
FQHC	\$18,833	\$3		\$1,217	\$20,053	1.397	0.78	\$21,845	\$3.22
Home Health Services	\$174,247	\$10			\$174,257	1.159	0.78	\$157,486	\$23.21
Inpatient - Medical/Surgical	\$4,536,945	\$745		(\$58,178)	\$4,479,512	1.463	0.78	\$5,112,721	\$753.55
Inpatient - Psych	\$73,779	\$0		\$4,204	\$77,983	1.000	0.78	\$60,827	\$8.97
Lab and X-ray Services	\$162,094	\$171			\$162,265	1.634	0.78	\$206,791	\$30.48
Medicare Xover - IP	\$14,846	\$0			\$14,846	1.000	1.00	\$14,846	\$2.19
Medicare Xover - Nursing Facility	\$8,416	\$0			\$8,416	1.000	1.00	\$8,416	\$1.24
Medicare Xover - OP	\$17,523	\$0			\$17,523	1.000	1.00	\$17,523	\$2.58
Medicare Xover - Other	\$19,615	\$0			\$19,615	1.000	1.00	\$19,615	\$2.89
Medicare Xover - Physician	\$30,709	\$0			\$30,709	1.000	1.00	\$30,709	\$4.53
Nursing Facility	\$12,527,676	\$515	\$785,017	\$563,769	\$13,876,977	1.004	0.78	\$10,867,338	\$1,601.71
Outpatient - Other	\$831,156	\$47			\$831,203	1.159	0.78	\$751,202	\$110.72
Outpatient - Psychological	\$409	\$0			\$409	1.159	0.78	\$370	\$0.05
Personal Care Services	\$1,746,238	\$12	\$10,342	\$66,898	\$1,823,489	1.137	0.78	\$1,617,332	\$238.37
Physician - Clinic	\$227,945	\$38		\$11,399	\$239,383	1.397	0.78	\$260,777	\$38.44
Physician - IP Mental Health	\$4,553	\$1		\$228	\$4,782	1.397	0.78	\$5,209	\$0.77
Physician - OP Mental Health	\$662,417	\$112		\$33,126	\$695,656	1.397	0.78	\$757,827	\$111.69
Physician - Other Practitioner	\$61,323	\$10		\$3,067	\$64,400	1.397	0.78	\$70,156	\$10.34
Physician - PCP	\$616,114	\$104		\$38,609	\$654,827	1.397	0.78	\$713,349	\$105.14
Physician - Specialist	\$364,823	\$62		\$19,775	\$384,660	1.397	0.78	\$419,037	\$61.76
Pharmacy	\$1,910,934	\$0		(\$617,846)	\$1,293,088	0.991	1.00	\$1,281,945	\$367.06
Transportation - Emergency	\$51,766	\$54			\$51,820	1.413	0.78	\$57,103	\$8.42
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$18.62
Total	\$25,475,603	\$1,994	\$806,831	\$91,086	\$26,375,514			\$23,844,158	\$3,711.07
Admin Cost Adjustment									13.1%
Capitation Rate									\$4,271.94

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over									
Richmond/Charlottesville	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$406,358	\$0	\$7,779	\$18,474	\$432,611	0.927	0.78	\$312,769	\$33.54
Ambulatory Surgery Center	\$9,606	\$2			\$9,608	1.397	0.78	\$10,466	\$1.12
Case Management Services	\$0	\$0			\$0	1.397	0.78	\$0	\$0.00
Consumer Directed Services	\$436,990	\$3	\$10,279	\$15,882	\$463,153	1.137	0.78	\$410,791	\$44.05
DME/Supplies	\$821,205	\$139			\$821,344	1.397	0.78	\$894,748	\$95.94
Emergency	\$259,316	\$15			\$259,331	1.159	0.78	\$234,371	\$25.13
FQHC	\$23,613	\$4		\$1,525	\$25,142	1.397	0.78	\$27,389	\$2.94
Home Health Services	\$294,627	\$17			\$294,644	1.159	0.78	\$266,285	\$28.55
Inpatient - Medical/Surgical	\$7,161,948	\$1,177		(\$100,672)	\$7,062,452	1.463	0.78	\$8,060,776	\$864.36
Inpatient - Psych	\$209,590	\$0		\$11,943	\$221,533	1.000	0.78	\$172,796	\$18.53
Lab and X-ray Services	\$189,171	\$199			\$189,370	1.634	0.78	\$241,334	\$25.88
Medicare Xover - IP	\$29,179	\$0			\$29,179	1.000	1.00	\$29,179	\$3.13
Medicare Xover - Nursing Facility	\$18,916	\$0			\$18,916	1.000	1.00	\$18,916	\$2.03
Medicare Xover - OP	\$23,266	\$0			\$23,266	1.000	1.00	\$23,266	\$2.49
Medicare Xover - Other	\$31,886	\$0			\$31,886	1.000	1.00	\$31,886	\$3.42
Medicare Xover - Physician	\$73,003	\$0			\$73,003	1.000	1.00	\$73,003	\$7.83
Nursing Facility	\$13,632,138	\$561	\$906,003	\$613,471	\$15,152,172	1.004	0.78	\$11,865,969	\$1,272.40
Outpatient - Other	\$1,199,584	\$68			\$1,199,652	1.159	0.78	\$1,084,189	\$116.26
Outpatient - Psychological	\$2,238	\$0			\$2,238	1.159	0.78	\$2,022	\$0.22
Personal Care Services	\$5,183,852	\$36	\$52,784	\$199,433	\$5,436,105	1.137	0.78	\$4,821,517	\$517.01
Physician - Clinic	\$510,062	\$86		\$25,507	\$535,656	1.397	0.78	\$583,528	\$62.57
Physician - IP Mental Health	\$3,790	\$1		\$190	\$3,980	1.397	0.78	\$4,335	\$0.46
Physician - OP Mental Health	\$1,110,362	\$187		\$55,527	\$1,166,077	1.397	0.78	\$1,270,290	\$136.21
Physician - Other Practitioner	\$69,382	\$12		\$3,470	\$72,863	1.397	0.78	\$79,375	\$8.51
Physician - PCP	\$782,084	\$132		\$49,010	\$831,226	1.397	0.78	\$905,513	\$97.10
Physician - Specialist	\$470,284	\$79		\$25,491	\$495,854	1.397	0.78	\$540,169	\$57.92
Pharmacy	\$1,829,725	\$0		(\$591,590)	\$1,238,135	0.991	1.00	\$1,227,467	\$262.91
Transportation - Emergency	\$67,369	\$71			\$67,440	1.413	0.78	\$74,315	\$7.97
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$27.85
Total	\$34,849,541	\$2,787	\$976,845	\$327,661	\$36,156,835			\$33,266,667	\$3,726.34
Admin Cost Adjustment									13.1%
Capitation Rate									\$4,289.52

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over									
Rural	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$45,579	\$0	\$1,452	\$2,098	\$49,129	0.927	0.78	\$35,519	\$3.24
Ambulatory Surgery Center	\$9,769	\$2			\$9,770	1.397	0.78	\$10,643	\$0.97
Case Management Services	\$8,695	\$1			\$8,696	1.397	0.78	\$9,473	\$0.86
Consumer Directed Services	\$510,759	\$4	\$2,448	\$18,255	\$531,466	1.137	0.78	\$471,380	\$42.99
DME/Supplies	\$1,056,610	\$178			\$1,056,788	1.397	0.78	\$1,151,234	\$105.00
Emergency	\$336,280	\$19			\$336,299	1.159	0.78	\$303,932	\$27.72
FQHC	\$151,786	\$26		\$9,805	\$161,616	1.397	0.78	\$176,060	\$16.06
Home Health Services	\$512,751	\$29			\$512,780	1.159	0.78	\$463,427	\$42.27
Inpatient - Medical/Surgical	\$7,430,856	\$1,221		(\$20,873)	\$7,411,204	1.463	0.78	\$8,458,827	\$771.49
Inpatient - Psych	\$67,369	\$0		\$3,839	\$71,208	1.000	0.78	\$55,542	\$5.07
Lab and X-ray Services	\$286,126	\$301			\$286,427	1.634	0.78	\$365,025	\$33.29
Medicare Xover - IP	\$61,779	\$0			\$61,779	1.000	1.00	\$61,779	\$5.63
Medicare Xover - Nursing Facility	\$18,591	\$0			\$18,591	1.000	1.00	\$18,591	\$1.70
Medicare Xover - OP	\$44,343	\$0			\$44,343	1.000	1.00	\$44,343	\$4.04
Medicare Xover - Other	\$50,861	\$0			\$50,861	1.000	1.00	\$50,861	\$4.64
Medicare Xover - Physician	\$52,945	\$0			\$52,945	1.000	1.00	\$52,945	\$4.83
Nursing Facility	\$15,543,973	\$639	\$628,028	\$699,508	\$16,872,148	1.004	0.78	\$13,212,916	\$1,205.09
Outpatient - Other	\$1,013,785	\$58			\$1,013,843	1.159	0.78	\$916,264	\$83.57
Outpatient - Psychological	\$3,075	\$0			\$3,075	1.159	0.78	\$2,779	\$0.25
Personal Care Services	\$3,903,727	\$27	\$54,771	\$150,756	\$4,109,281	1.137	0.78	\$3,644,700	\$332.42
Physician - Clinic	\$350,297	\$59		\$17,518	\$367,874	1.397	0.78	\$400,751	\$36.55
Physician - IP Mental Health	\$1,255	\$0		\$63	\$1,318	1.397	0.78	\$1,435	\$0.13
Physician - OP Mental Health	\$1,088,082	\$184		\$54,413	\$1,142,679	1.397	0.78	\$1,244,801	\$113.53
Physician - Other Practitioner	\$81,845	\$14		\$4,093	\$85,952	1.397	0.78	\$93,634	\$8.54
Physician - PCP	\$1,038,074	\$175		\$65,052	\$1,103,301	1.397	0.78	\$1,201,904	\$109.62
Physician - Specialist	\$537,078	\$91		\$29,112	\$566,281	1.397	0.78	\$616,890	\$56.26
Pharmacy	\$3,111,107	\$0		(\$1,005,888)	\$2,105,219	0.991	1.00	\$2,087,079	\$371.03
Transportation - Emergency	\$146,222	\$154			\$146,376	1.413	0.78	\$161,298	\$14.71
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$23.00
Total	\$37,463,618	\$3,181	\$686,699	\$27,750	\$38,181,249			\$35,314,033	\$3,424.52
Admin Cost Adjustment									13.1%
Capitation Rate									\$3,942.08

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over									
Tidewater	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$57,081	\$0		\$2,546	\$59,627	0.927	0.78	\$43,109	\$4.15
Ambulatory Surgery Center	\$6,122	\$1			\$6,123	1.397	0.78	\$6,671	\$0.64
Case Management Services	\$0	\$0			\$0	1.397	0.78	\$0	\$0.00
Consumer Directed Services	\$309,617	\$2		\$11,573	\$321,192	1.137	0.78	\$284,879	\$27.43
DME/Supplies	\$922,145	\$156			\$922,301	1.397	0.78	\$1,004,728	\$96.73
Emergency	\$277,679	\$16			\$277,695	1.159	0.78	\$250,968	\$24.16
FQHC	\$12,115	\$2		\$783	\$12,899	1.397	0.78	\$14,052	\$1.35
Home Health Services	\$350,751	\$20			\$350,771	1.159	0.78	\$317,010	\$30.52
Inpatient - Medical/Surgical	\$6,046,089	\$993		(\$84,987)	\$5,962,095	1.463	0.78	\$6,804,876	\$655.11
Inpatient - Psych	\$56,677	\$0		\$3,230	\$59,907	1.000	0.78	\$46,727	\$4.50
Lab and X-ray Services	\$221,826	\$233			\$222,059	1.634	0.78	\$282,994	\$27.24
Medicare Xover - IP	\$34,418	\$0			\$34,418	1.000	1.00	\$34,418	\$3.31
Medicare Xover - Nursing Facility	\$15,439	\$0			\$15,439	1.000	1.00	\$15,439	\$1.49
Medicare Xover - OP	\$24,952	\$0			\$24,952	1.000	1.00	\$24,952	\$2.40
Medicare Xover - Other	\$37,932	\$0			\$37,932	1.000	1.00	\$37,932	\$3.65
Medicare Xover - Physician	\$109,473	\$0			\$109,473	1.000	1.00	\$109,473	\$10.54
Nursing Facility	\$17,918,310	\$737	\$1,396,256	\$806,357	\$20,121,660	1.004	0.78	\$15,757,674	\$1,517.00
Outpatient - Other	\$708,986	\$40			\$709,026	1.159	0.78	\$640,785	\$61.69
Outpatient - Psychological	\$5,769	\$0			\$5,769	1.159	0.78	\$5,214	\$0.50
Personal Care Services	\$5,226,543	\$36	\$37,305	\$200,469	\$5,464,354	1.137	0.78	\$4,846,573	\$466.58
Physician - Clinic	\$739,664	\$125		\$36,989	\$776,778	1.397	0.78	\$846,200	\$81.46
Physician - IP Mental Health	\$1,581	\$0		\$79	\$1,660	1.397	0.78	\$1,809	\$0.17
Physician - OP Mental Health	\$1,155,420	\$195		\$57,781	\$1,213,396	1.397	0.78	\$1,321,839	\$127.25
Physician - Other Practitioner	\$135,303	\$23		\$6,766	\$142,092	1.397	0.78	\$154,791	\$14.90
Physician - PCP	\$998,530	\$168		\$62,574	\$1,061,273	1.397	0.78	\$1,156,120	\$111.30
Physician - Specialist	\$534,825	\$90		\$28,989	\$563,905	1.397	0.78	\$614,301	\$59.14
Pharmacy	\$2,239,816	\$0		(\$724,181)	\$1,515,635	0.991	1.00	\$1,502,575	\$290.12
Transportation - Emergency	\$64,653	\$68			\$64,721	1.413	0.78	\$71,318	\$6.87
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$24.67
Total	\$38,211,716	\$2,907	\$1,433,561	\$408,969	\$40,057,152			\$36,197,427	\$3,654.89
Admin Cost Adjustment									13.1%
Capitation Rate									\$4,207.27

Note:

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

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over									
Total	Medicaid Payments FY06 - FY07	Completion Factor Adjustment	Patient Payments FY06 - FY07	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Managed Care Utilization Adjustment	Completed, Adjusted & Trended Claims	PACE PMPM FY09
Service Type									
Adult Day Care	\$662,842	\$0	\$14,952	\$30,235	\$708,029	0.927	0.78	\$511,890	\$10.75
Ambulatory Surgery Center	\$39,786	\$7			\$39,792	1.397	0.78	\$43,349	\$0.91
Case Management Services	\$12,159	\$2			\$12,161	1.397	0.78	\$13,248	\$0.28
Consumer Directed Services	\$2,910,735	\$20	\$18,584	\$139,102	\$3,068,441	1.137	0.78	\$2,721,534	\$57.16
DME/Supplies	\$4,274,646	\$721			\$4,275,368	1.397	0.78	\$4,657,461	\$97.82
Emergency	\$1,301,006	\$74			\$1,301,080	1.159	0.78	\$1,175,855	\$24.70
FQHC	\$210,098	\$35		\$13,572	\$223,705	1.397	0.78	\$243,698	\$5.12
Home Health Services	\$1,500,981	\$86			\$1,501,067	1.159	0.78	\$1,356,593	\$28.49
Inpatient - Medical/Surgical	\$31,075,393	\$5,105		(\$347,638)	\$30,732,860	1.463	0.78	\$35,077,154	\$736.69
Inpatient - Psych	\$437,863	\$0		\$24,951	\$462,814	1.000	0.78	\$360,995	\$7.58
Lab and X-ray Services	\$1,040,806	\$1,095			\$1,041,901	1.634	0.78	\$1,327,806	\$27.89
Medicare Xover - IP	\$174,602	\$0			\$174,602	1.000	1.00	\$174,602	\$3.67
Medicare Xover - Nursing Facility	\$66,332	\$0			\$66,332	1.000	1.00	\$66,332	\$1.39
Medicare Xover - OP	\$146,996	\$0			\$146,996	1.000	1.00	\$146,996	\$3.09
Medicare Xover - Other	\$160,726	\$0			\$160,726	1.000	1.00	\$160,726	\$3.38
Medicare Xover - Physician	\$334,888	\$0			\$334,888	1.000	1.00	\$334,888	\$7.03
Nursing Facility	\$81,808,169	\$3,364	\$5,581,618	\$3,681,519	\$91,074,671	1.004	0.78	\$71,322,396	\$1,497.92
Outpatient - Other	\$4,234,720	\$241			\$4,234,961	1.159	0.78	\$3,827,358	\$80.38
Outpatient - Psychological	\$24,514	\$1			\$24,516	1.159	0.78	\$22,156	\$0.47
Personal Care Services	\$21,373,602	\$148	\$183,472	\$820,984	\$22,378,206	1.137	0.78	\$19,848,203	\$416.85
Physician - Clinic	\$2,023,060	\$341		\$101,170	\$2,124,572	1.397	0.78	\$2,314,447	\$48.61
Physician - IP Mental Health	\$12,977	\$2		\$649	\$13,628	1.397	0.78	\$14,846	\$0.31
Physician - OP Mental Health	\$5,047,176	\$852		\$252,401	\$5,300,429	1.397	0.78	\$5,774,134	\$121.27
Physician - Other Practitioner	\$442,080	\$75		\$22,108	\$464,262	1.397	0.78	\$505,754	\$10.62
Physician - PCP	\$4,197,828	\$708		\$263,061	\$4,461,597	1.397	0.78	\$4,860,335	\$102.08
Physician - Specialist	\$2,334,248	\$394		\$126,525	\$2,461,166	1.397	0.78	\$2,681,123	\$56.31
Pharmacy	\$11,326,819	\$0		(\$3,662,206)	\$7,664,613	0.991	1.00	\$7,598,570	\$317.08
Transportation - Emergency	\$382,151	\$402			\$382,553	1.413	0.78	\$421,552	\$8.85
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	1.00	\$0	\$28.72
Total	\$177,557,203	\$13,675	\$5,798,626	\$1,466,432	\$184,835,936			\$167,564,001	\$3,705.40
Admin Cost Adjustment									13.1%
Capitation Rate									\$4,265.42

Note:

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

Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Summary of FY 2009 Capitation Rates
Before Nursing vs Non-Nursing Home Blending Factor Adjustment

Region	Dual Eligibles FY 2009	Non-Dual Eligibles FY 2009	Weighted Average FY 2009
PACE Rates			
Northern Virginia	\$3,781.14	\$4,644.41	\$3,888.66
Other MSA	\$2,924.59	\$4,271.94	\$2,997.99
Richmond / Charlottesville	\$2,995.29	\$4,289.52	\$3,092.86
Rural	\$2,659.73	\$3,942.08	\$2,734.84
Tidewater	\$2,961.55	\$4,207.27	\$3,061.38
Rural and Tidewater Average	\$2,781.53	\$4,071.09	\$2,868.45
Statewide Average	\$2,969.57	\$4,264.73	\$3,064.95

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-For-Service Claims
 Nursing Home vs Non-Nursing Home Blending Factor**

Exhibit 5b

Dual Population

Region	Cost		Tidewater NH Blending Weight	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.09	0.69	71.0%	0.9761
Other MSA	1.12	0.52	71.0%	0.9416
Richmond / Charlottesville	1.16	0.67	71.0%	1.0194
Rural	1.16	0.64	71.0%	1.0072
Tidewater	1.11	0.73	71.0%	1.0000

Non-Dual Population

Region	Cost		Tidewater NH Blending Weight	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.15	0.74	56.1%	0.9678
Other MSA	1.14	0.75	56.1%	0.9688
Richmond / Charlottesville	1.27	0.76	56.1%	1.0495
Rural	1.16	0.81	56.1%	1.0044
Tidewater	1.15	0.81	56.1%	1.0000

**Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Summary of FY 2009 Capitation Rates
After Nursing vs Non-Nursing Home Blending Factor Adjustment**

Region	Dual Eligibles FY 2009	Non-Dual Eligibles FY 2009	Weighted Average FY 2009
PACE Rates			
Northern Virginia	\$3,690.76	\$4,494.85	\$3,790.91
Other MSA	\$2,753.72	\$4,138.49	\$2,829.17
Richmond / Charlottesville	\$3,053.44	\$4,502.05	\$3,162.65
Rural	\$2,678.92	\$3,959.35	\$2,753.92
Tidewater	\$2,961.55	\$4,207.27	\$3,061.38
Rural and Tidewater Average	\$2,792.98	\$4,079.96	\$2,879.72
Statewide Average	\$2,941.96	\$4,259.43	\$3,038.98

**Virginia Medicaid
 FY 2009 Capitation Rate Development
 Comparison of Capitation Rates Before and After Blending Factor Adjustment**

Exhibit 5d

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change
PACE Rates									
Northern Virginia	\$3,781.14	\$3,690.76	-2.4%	\$4,644.41	\$4,494.85	-3.2%	\$3,888.66	\$3,790.91	-2.5%
Other MSA	\$2,924.59	\$2,753.72	-5.8%	\$4,271.94	\$4,138.49	-3.1%	\$2,997.99	\$2,829.17	-5.6%
Richmond / Charlottesville	\$2,995.29	\$3,053.44	1.9%	\$4,289.52	\$4,502.05	5.0%	\$3,092.86	\$3,162.65	2.3%
Rural	\$2,659.73	\$2,678.92	0.7%	\$3,942.08	\$3,959.35	0.4%	\$2,734.84	\$2,753.92	0.7%
Tidewater	\$2,961.55	\$2,961.55	0.0%	\$4,207.27	\$4,207.27	0.0%	\$3,061.38	\$3,061.38	0.0%
Rural and Tidewater Average	\$2,781.53	\$2,792.98	0.4%	\$4,071.09	\$4,079.96	0.2%	\$2,868.45	\$2,879.72	0.4%
Statewide Average	\$2,969.57	\$2,941.96	-0.9%	\$4,264.73	\$4,259.43	-0.1%	\$3,064.95	\$3,038.98	-0.8%

**Virginia Medicaid
FY 2009 Capitation Rate Development
Comparison of FY2008 and FY2009 Capitation Rates**

Exhibit 5e

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	FY2008	FY2009	% Change	FY2008	FY2009	% Change	FY2008	FY2009	% Change
PACE Rates									
Northern Virginia	\$3,533.48	\$3,690.76	4.5%	\$4,443.52	\$4,494.85	1.2%	\$3,646.83	\$3,790.91	4.0%
Other MSA	\$2,665.74	\$2,753.72	3.3%	\$4,380.13	\$4,138.49	-5.5%	\$2,759.14	\$2,829.17	2.5%
Richmond / Charlottesville	\$2,892.18	\$3,053.44	5.6%	\$4,247.49	\$4,502.05	6.0%	\$2,994.36	\$3,162.65	5.6%
Rural	\$2,591.57	\$2,678.92	3.4%	\$4,111.80	\$3,959.35	-3.7%	\$2,680.62	\$2,753.92	2.7%
Tidewater	\$2,795.86	\$2,961.55	5.9%	\$3,976.02	\$4,207.27	5.8%	\$2,890.44	\$3,061.38	5.9%
Rural and Tidewater Average	\$2,674.01	\$2,792.98	4.4%	\$4,045.75	\$4,079.96	0.8%	\$2,766.47	\$2,879.72	4.1%
Statewide Average	\$2,816.45	\$2,941.96	4.5%	\$4,217.72	\$4,259.43	1.0%	\$2,919.64	\$3,038.98	4.1%

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Member Months FY 2006 - FY 2007**

Exhibit 5f

Region	Dual Eligibles	Non-Dual Eligibles	Total
	Member Months		
Northern Virginia	71,355	10,152	81,507
Other MSA	117,756	6,785	124,541
Richmond / Charlottesville	114,378	9,326	123,703
Rural	176,218	10,964	187,182
Tidewater	119,227	10,387	129,615
Rural and Tidewater Average	295,445	21,352	316,797
Statewide Average	598,934	47,614	646,548

Virginia Medicaid
FY 2009 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Description of Unit Counts

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

**Virginia Medicaid
 FY 2009 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 County Listing by Region**

Exhibit 7

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

Scott County is in Other MSA for Medallion II rate setting, but is moved to Rural for PACE rate setting.