

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

FAMIS and FAMIS Moms
Data Book and Capitation Rates
Fiscal Year 2011

Submitted by:

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May 24, 2010

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

Dear Bill:

Re: FY 2011 FAMIS and FAMIS Moms Data Book and Capitation Rates

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for the Virginia Medicaid FAMIS and FAMIS Moms programs for FY 2011. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services and State Children's Health Insurance Program requirements.

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

Very Truly Yours,

PricewaterhouseCoopers LLP



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



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**Virginia Medicaid
FAMIS and FAMIS Moms**

Data Book and Capitation Rates

Fiscal Year 2011

Prepared by PricewaterhouseCoopers LLP

May 2010

PricewaterhouseCoopers LLP (PwC) has calculated capitation rates for the Virginia Family Access to Medical Insurance Security (FAMIS) program and for pregnant woman up to 200% FPL, FAMIS Moms program, for State Fiscal Year 2011. We use data submitted by the contracting health plans to estimate the cost of providing services. The development of these rates is discussed in this report and shown in the attached exhibits.

I. FAMIS Program Rate Development

I.A. FAMIS Program Description

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

Virginia began its program, called Children's Medical Security Insurance Plan (CMSIP), in October 1998 modeled on the Medicaid program. The program covered eligible children from birth through age 18 in families with income at or below 185% of the federal poverty level. State Legislation was passed in 2000 to change CMSIP to a more commercially-based model.

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

The FAMIS program covers eligible children from birth through age 18 in families with income at or below 200% of the Federal Poverty Level. Both a centralized eligibility

processing unit and Local Departments of Social Services work together to create a "no wrong door" process that simplifies eligibility determination, resulting in a streamlined and shorter application process. A 12-month waiting period for persons who voluntarily dropped health insurance was ultimately reduced to 4 months. Health care services are delivered through managed health care insurance and fee-for-service programs.

The FAMIS FFS benefit package is virtually the same as Medicaid with no copays. The FAMIS MCO benefit package is designed to be equivalent to the benefit package offered to Virginia State employees and therefore does not cover all of the services offered to children in the Medicaid program and includes copays.

The following services, which are covered under Medicaid, are not covered under the FAMIS MCO benefit package:

1. EPSDT services – Early and Period Screening Diagnosis and Treatment services, is not a covered service under FAMIS. However, many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS’ well child and immunization benefits.
2. Psychiatric Treatment in free standing facilities is not covered (but is covered when provided in a psychiatric unit of an acute hospital)
3. Routine transportation – to and from medical appointments is not covered. (Exception: Children living in non-managed care areas may receive non-emergency transportation services.) Emergency transportation is covered.

Enrollees share in the cost of certain services through limited co-payments similar to commercial health plan practices. The following table shows the schedule of co-payments for children in families above and below 150% federal poverty level.

FAMIS Cost Sharing Requirements By Service		
	Cost Sharing	
	>150% FPL	<=150% FPL
<u>Service</u>		
Office Visit Copay	\$5.00	\$2.00
Specialist Copay	\$5.00	\$2.00
IP Copay/Admit	\$25.00	\$15.00
Rx	\$5.00	\$2.00
Annual Co-payment Maximum	\$350	\$180

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

I.B. Federal Rate Setting Requirements

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

I.C. Data Book

In this section we describe the data available to PwC for developing the capitation rates, the process used for selecting the claims and the individuals that are ultimately included in the rate development process. In addition, adjustments that are made to the data in the early stages of the rate development process are described

The following sources were used for the FAMIS rate setting calculations:

- Department of Medical Assistance Services (DMAS) eligibility information based on capitation payments;
- Health plan claims/encounter data for their FAMIS population;
- Health plan financial data; and
- Other health plan administrative data.

The historical data period is FY 2008 and FY 2009 which covers services incurred during the period from July 1, 2007 to June 30, 2009. These data reported services paid during this two-year period with additional run out for the first four months of FY 2010, to the end of October 2009.

Supplemental health plan data are used for certain portions of the analysis. Specifically, the following health plan data were incorporated:

- Observed trends in utilization and cost per unit of service;

- Capitation arrangements with subcontractors;
- Supplemental payments, such as physician incentives and case management fees, not reflected in the encounter data;
- Prescription drug purchasing arrangements; and
- Health plan administrative costs.

The service categories are those that were developed for the FY 2005 rate setting and slightly modified for subsequent rate setting periods. These service categories are primarily defined by bill type, CPT code, and revenue code fields in the claims records.

For FY2011, we have updated provider identification numbers with the National Provider Identifiers and modified CPT ranges to refine selected service categories. As a result, there are changes to the providers and codes that are included in a number of the service lines. These include:

1. Added FQHC/RHC clinic codes,
2. Home health agency services reported on hospital outpatient department UB92 claims have been moved from outpatient hospital to the home health service line,
3. Outpatient hospital Emergency Department costs include the ED visit and the associated services reported on the UB92 claims detail, and
4. Durable medical equipment HCPCS codes reported on CMS 1500 professional claim detail lines have been move to the DME service line.

In this summarization process, unit counts were made for each service category. Table 1, Service Unit Definitions, describes the types of units that were counted for each detailed service category. In the table, “Units” indicates the actual unit counts that were recorded on each claim. “Claims” or “Prescriptions” or “Record Counts” refers to a count of “1” for each claim record in the historical database. This count is used for services in which recorded units are not meaningful, such as for pharmacy where the units recorded are often the number of pills dispensed. “Admits” are used for inpatient units, and represent the number of inpatient admits that were paid by the plans.

Service Unit Definitions		
Service Category	Unit Count	Multiple Units
DME/Supplies	Claims	
FQHC/RHC	Units	Yes
Home Health Services	Claims	
Inpatient – Maternity	Admits	
Inpatient – Newborn	Admits	
Inpatient – Other Med/Surg	Admits	
Inpatient – Psych	Days	
Lab	Record Count	
Outpatient – Emergency Room	Claims	
Outpatient – Other	Claims	
Pharmacy	Prescriptions	
Professional – Anesthesia	Units	Yes
Professional – Child EPSDT	Units	Yes
Professional – Evaluation & Management	Units	Yes
Professional – Maternity	Units	Yes
Professional – Other	Units	Yes
Professional – Psych	Units	Yes
Professional – Specialist	Units	Yes
Professional – Vision	Units	Yes
Radiology	Record Count	Yes
Transportation	Claims	

The claims and eligibility information used in this report includes data only for FAMIS members who are eligible for the program based on their eligibility category and service use during the data period.

FAMIS rates are developed as five rate cells with separate co-payment adjustments.

- **Age.** Capitation rates are paid separately for the following age groups: Under 1, 1-5, 6-14, 15-18 Female, and 15-18 Male.
- **Program.** FAMIS operates as a commercial program, is modeled on the Virginia State Employees health program benefit structure, and includes member co-payment requirements. There are separate rates for those under and over 150% of the Federal Poverty Level.

In the FAMIS rate setting process, historical claims data for the total population, both the $\leq 150\%$ FPL and the $> 150\%$ FPL, are combined, adjusted, and trended. The final adjustment reflects the difference in the co-payment schedules for the two income groups. Lastly, the administrative cost factor is applied.

Review of the Health Plan Claims/Encounter Data

The health plan encounter data review was conducted in six major steps.

1. Verification of health plan data submission
2. Edit of records for logical exclusions
3. Edit of records against DMAS capitation payment file
4. Summary of health plan fee-for-service paid claims
5. Addition of capitated and subcontractor services
6. Aggregation of data across all health plans

Review of the health plan data was performed separately for each plan. As a first step, the detailed claims data were converted to summary reports to provide comparison to the data request and confirmation that PwC received the expected data. Information was provided to the health plans regarding record and payment totals for each separate record type (e.g., UB92, CMS1500, pharmacy, subcontractors). The health plan reports also provided a general assessment of data quality, including beginning and end dates of service, the extent of missing variables and confirmation of the interpretation of plan-specific coding and variables in the data sets.

Two sets of edits were applied to each health plan's submitted data. The first edit tested for logical conditions for the historical data period. The logical condition tests and the processing decisions were:

1. Claims that were duplicates, pended or rejected during claims processing were removed.
2. Claims with dates of service outside the FY 2008 to FY 2009 period were removed.
3. Claims with paid amounts of \$0.00 were included if the service was provided under a health plan capitation contract. It was deleted if it was a service that was paid under fee-for-service payment arrangements, as they would contribute no value to the capitation rate development, but would have distorted unit counts.

The second level of edit compared the cleaned health plan claims/encounter records to the eligibility file provided by DMAS. As with the Medallion II rate setting, the DMAS capitation payment file¹, rather than the DMAS eligibility file or the demographic information coded on the claim record, determined whether the claim record was retained. The processing determinations were:

1. Claims matched to member eligibility with missing or invalid demographic or geographic information were removed.
2. Claims for members enrolled in the Medallion II program were removed.
3. Claims matched to FAMIS member eligibility periods outside the FY 2008 to FY 2009 period were removed.
4. Claims identified as paid to freestanding inpatient psychiatric hospitals were removed.
5. Newborns are identified through the standard claims edit process and by comparison to a newborn crosswalk provided by each health plan which permits identification of FAMIS claims incurred by newborns that were originally submitted under the mother's ID number or under a temporary ID.

Each health plan's data was then summarized by service type and the FAMIS rate cell categories by age and sex. This summarization was done only for those services that were paid by the health plans on a fee-for-service basis. The capitated and subcontractor service dollars and encounter information were added in a second step. Each plan's subcontractor services and payments were reviewed with health plan representatives and appropriate amounts were added to the base data.

Individual plan reports were sent to the health plans for review and approval. The reports provided the health plan claims/encounter data, with all adjustments by rate cell.

Inclusion of Health Plan Capitated and Subcontractor Services

The vast majority of the encounter records submitted by each of the health plans were paid under fee-for-service arrangements. The records included both charged and paid amounts and could be readily analyzed.

However, each health plan also had services that were paid, in part or in full, under capitation or subcontractor arrangements. For these services, health plans submitted data

¹ The FY 2010 and FY2011 member month count and claim matching process was revised to substitute the DMAS capitation payment file for the DMAS eligibility file as the record of health plan membership and the length of eligibility. Consistent with DMAS operations and the health plan contract terms, a person is assumed to be Medallion II or FAMIS eligible for the full month for which a capitation payment is made.

in a variety of forms. Each health plan provided a list of services that were provided under such arrangements and the pricing of the services on a PMPM basis. The PMPM amount represented either the actual contractual PMPM paid, or the contractual total dollar payments divided by the covered member months for the time period.

The financial information may or may not have been accompanied by encounter data for those services. All health plans submitted complete claims data for outpatient pharmacy services. They also provided encounter data for laboratory, vision, and mental health, the other service categories that were most often capitated. The dollars for the capitated and subcontractor services are incorporated into the historical data, but we cannot confirm that all encounters are reported and measures such as utilization rates and cost per unit for these services may not be accurate.

Behavioral and Mental Health Capitated Subcontractor Services

Capitation payments for behavioral and mental health services were distributed differently than other reported capitated services. Depending on the health plan, mental health services are reported as either FFS paid claims or as capitation amounts for contracted services. Prior to the FY08 rate setting, FFS claims were applied to the appropriate inpatient or professional psych service line, but all capitated dollars were included in the Professional-Psych service line with dollars allocated based on the member month distribution between rate cells.

For the health plans that capitate psychiatric services (CareNet and Optima), the capitated mental health data is provided as total dollars or an aggregate PMPM with limited detail by service type (inpatient vs. professional) or program (Medallion II vs. FAMIS). Approximately 45% of mental health dollars are represented by the plans that capitate these mental health services.

Beginning with FY08 rates, we analyzed mental health claims level detail provided by the three plans that do not capitate, Anthem, Virginia Premier, and AmeriGroup, by service type and aid category to determine a distribution of the capitated mental health service dollars.

Detailed analysis of the distribution of FAMIS mental health FFS encounter data showed differences in the total PMPM between FAMIS and LIFC and the distribution of inpatient and outpatient services. Overall, the FY 2008 - FY 2009 historical encounter FFS paid claims showed the FAMIS mental health PMPM was approximately two thirds the LIFC mental health PMPM, or \$2.73 PMPM compared to \$4.06 PMPM. For FAMIS, the distribution of dollars was 46.7% inpatient and 53.3% professional while the LIFC distribution was 52.4% inpatient and 47.6% professional.

The factors developed for the FAMIS population were applied to the CareNet and Optima reported mental health capitation payments to derive the FAMIS mental health PMPM and

to modify the individual historical data reports for the health plans that capitate mental health services. The modified reports were then aggregated for the historical data.

Historical Health Plan Encounter Data

The resulting historical claims and eligibility data were tabulated by service category and are shown in Exhibit I.1, generally referred to as the “Data Book”. These exhibits show unadjusted historical data, with the exception of the adjustments described above, and are the basis of all future calculations described here. These exhibits show, for informational purposes:

- Member months for fiscal years 2008 and 2009;
- Total dollar value of claims and capitated services for fiscal years 2008 and 2009; and
- Costs per member per month (PMPM) for fiscal years 2008 and 2009.

I.D. Capitation Rate Calculations

The capitation rates for FY 2011 are calculated based on the historical data shown in Exhibit I.1 adjusted to reflect changes in payment rates and covered services. Each adjustment to the historical data is described in the following section. The adjustments are applied to the historical data and resulting capitation rates are presented in Exhibits I.5a and I.5b.

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

1. The combined FY 2008 and FY 2009 historical data for each age-sex rate cell and service category are brought forward to Exhibit I.4 from the corresponding rate cell in Exhibit I.1. This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Virginia General Assembly. Each of these adjustments, as well as adjustments for other services not included in the source data, is described in detail below under Section I.E, and is shown in Exhibits I.2a – I.2i.
3. The claims data are adjusted to reflect the expected value of Incurred But Not Reported (IBNR) claims and to update the data to the FY 2011 contract period. These adjustments are described in Section I.F and are shown in Exhibit I.3. The resulting claims are shown in Exhibit I.4 under the column “Completed & Trended Claims”.

4. The adjusted claims costs from Step 3 are divided by the count of member months for each rate cell (from Exhibit I.1) to arrive at preliminary PMPM costs by service category.
5. The PMPM costs are summarized by rate cell across all service categories to arrive at the cost for each rate cell.
6. An adjustment is made to reflect the differences in the co-payment schedule applicable to FAMIS members below and above 150% of the Federal Poverty Level. Co-payment adjustments are made for major service categories; they are not added for all individual claims as health plans may require different collection of co-payments.
7. An adjustment is made to reflect average health plan administrative costs plus a 1.5% contribution to reserves. The derivation of this value is included in the Adjustments described in Section I.E.

I.E. FAMIS Legislative and Program Adjustments

Legislation and policy changes in the FAMIS program for FY 2008 and later must be reflected in the development of per capita rates, as the data used to develop rates do not fully include the effect of those changes.

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

Pharmacy Adjustment

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

The final pharmacy adjustment factors are shown in Exhibit I.2a. The PBM factor is a reduction of -3.8%.

Exempt Infant Formula Carveout Adjustment

DMAS altered its policy regarding reimbursement of selected formula for infants with diseases of inborn errors of metabolism and now requests direct billing for those services. Historically, the health plans referred members to the Woman, Infants, and Children (WIC) program for these services, but paid for services after the WIC benefit maximum is reached. This adjustment removes the amount that the health plans paid for selected formulas after children up to age 19 have met the WIC cap. For FY 2007, the exempt

formula adjustment was applied to children up to age 6; for FY 2008 and after, it is applied to all children up to age 19. DMAS provided a list of HCPCS codes to identify the exempt formula services.

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

Durable Medical Equipment Adjustment

This adjustment reflects a reduction in durable medical equipment payment rates. DMAS provided reductions by product category and modifiers for new or rented equipment. Adjustments ranged from no change to a 15% decrease. The reductions were applied as a weighted average based on the mix of affected DME codes reported in the health plan encounter data.

This adjustment is shown in Exhibit I.2c and is applied to the full base period to the DME service lines in Exhibit I.4 under the column labeled "Policy and Program Adjustments".

Clinical Laboratory Adjustment

For FY2011, DMAS will reduce clinical laboratory fees by an average of 5%. The clinical laboratory codes are similar to the Medicare clinical laboratory schedule. We compared health plan clinical laboratory payments rate to the DMAS payment rates, estimated at 88% of Medicare payment, for the mix of clinical laboratory services used by the Medallion II, FAMIS and FAMIS Moms population. Our analysis indicated that approximately one third of health plan clinical laboratory payments were already lower than 83% of the CMS Medicare fee schedule. The average 5% reduction is applied to the proportion of clinical laboratory payments that are at or above 88% of the Medicare schedule. Payments between 83% and 88% of the Medicare schedule were reduced proportionately to meet the 83% payment level.

This adjustment is shown in Exhibit 2d and is applied to the full base period to the Lab service lines in Exhibit I.4 under the column labeled "Policy and Program Adjustments".

Hospital Inpatient Adjustments

The hospital inpatient adjustment factor reflects no allowance for a cost per unit increase in FY2010 and FY 2011 mandated by the legislature. Based on projected inpatient cost trend for Virginia, this rate freeze reduces the operating cost component by 4.0% in FY 2010 and 2.7% in FY 2011.² An additional FY 2010 reduction is a capital reimbursement rate reduction from 80% to 75% of cost, which is applied to the capital component estimated at 10%. Three hospitals, University of Virginia Medical Center, Medical

² This is applied as a policy adjustment in Exhibit 2e rather than as a reduction to the cost per unit trend in Exhibits I.3a to 3c.

College of Virginia, and Children's Hospital of the Kings Daughters, are exempted from the capital payment reduction.

If stimulus funding is not extended, the budget passed by the Virginia General Assembly requires further reductions for inpatient hospital payment. There are two components to the further reductions:

1. Reduce the operating cost base for inpatient medical/surgical from 78% to 75%, a -3.85% reduction, and for inpatient psychiatric from 84% to 81%, a -3.57% reduction. This is applied to 90% of the hospital inpatient payment rate.
2. Reduce the cost basis for the capital component, from 75% to 72%, a -4.0% reduction. This is applied to 10% of the inpatient payment rate. This is in addition to the capital component reduction that was applied in the FY2010 rates. For FY2011, there are no hospital exemptions from the capital cost reduction.

The inpatient psychiatric factor is applied to mental health claims that are submitted with encounter detail and the allocated mental health subcapitation dollars.

For inpatient medical/surgical, the negative adjustment is -9.1%. For inpatient psychiatric, the negative adjustment is -8.9%. These adjustment factors are shown in Exhibit I.2e and applied to all hospital inpatient service categories in Exhibit I.4 under the column labeled "Policy and Program Adjustments".

Hospital Outpatient Reduction

If stimulus funding is not extended, the budget requires a new reduction for outpatient hospital services. The General Assembly reduced the cost basis from 80% to 77%, a decrease of -3.8%. This is applied to all outpatient services except for triage fees paid in the Emergency Department. DMAS estimates that 6% of outpatient hospital payments are for the triage fees. The impact of the triage exemption is calculated relative to the proportion of Emergency Room and Related outpatient payments.,

This produces a -3.2% reduction for FAMIS on the ER and Related service line. The full -3.8% reduction is applied to the Outpatient-Other services line for all programs and aid categories. These adjustment factors are shown in Exhibit I.2f and applied in Exhibit I.4 under the column labeled "Policy and Program Adjustments".

Professional Fee Reduction

If stimulus funding is not extended, the budget requires a new 3% reduction for professional services. The reduction is not applied to HCPCS codes billed as part of the professional claim submission.

The impact of the HCPCS code exemption varies by program and aid category. The HCPCS codes are approximately 3.8% of the dollars in the professional services for FAMIS. The 3% professional fee reduction is applied to the remainder of the dollars in all

professional services lines, (Prof-Anesthesia, Prof-Child EPSDT, Prof-Evaluation and Management, Prof-Maternity, Prof-Other, Prof-Psych and Prof-Vision) and to FQHC/RHC. The result is a professional fee reduction of -2.9% for FAMIS. These adjustment factors are shown in Exhibit I.2g and applied in Exhibit I.4 under the column labeled “Policy and Program Adjustments”.

Mental Health Parity

No adjustment is made for Mental Health Parity. Analysis of the health plan encounter data and additional information submitted by the plans indicates that mental health benefits appear to be administered similarly to EPSDT in the LIFC program. In the few cases where members approach benefit limits, the claims have been approved and paid.

Provider Incentive Adjustment

The Provider Incentive Payment Adjustment takes into consideration the various ways that health plans provide incentive payments to providers for coordinating care and ensuring access. Depending on the plan, this can be done through an increase in provider fee schedules, payment of case management fees, and/or provider incentive programs. To the extent that it has been used to increase professional fee schedules, the amount is already included in the claims and encounter data. Some plans reported the case management and incentive amounts as capitation payments. To avoid double counting, we did not include the value of the capitation amounts that plans reported as representing those payments in the base data. Their value has been incorporated into the Provider Incentive Payment Adjustment.

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS incentive is \$3.24 PMPM. Because of the small FAMIS base, this translates to 3.1% of the weighted average PMPM medical cost. This percentage is shown in Exhibit I.2h and is presented as the dollar value applicable to the rate cell in the service line labeled Provider Incentive Payment Adjustment in Exhibit I.4

Plan Administration 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. Each health plan provided revenue and administrative cost data for calendar year 2008, consistent with the information provided to the Virginia Bureau of Insurance on the required form entitled *Analysis of Operations by Lines of Business*, and as necessary, notes to interpret the financial figures. We also received the *Underwriting and Investment Exhibit, Part 3, Analysis of Expenses*. Separately, plans provided third and fourth quarter results for their Medicaid and FAMIS lines of business in order to evaluate the impact of the FY 2010 rates that went into effect in July 2009.

In FY 2010, there was a change in how the administrative allowance was trended and applied. In past rate setting, the administrative component was calculated as a percentage of the adjusted and trended medical cost data in Exhibit I.2g. This method trends the administrative adjustment factor with the weighted average medical trend and results in an administrative dollar PMPM that varies for each rate cell.

The revised methodology develops an administrative dollar PMPM and trends it to the contract period by national rates of change reported by the Bureau of Labor Statistics. We use the same source of data to develop the historical administrative PMPM and subtract the self-reported disallowed costs that were valued at 0.08% of the administrative expense. The administrative dollar PMPM is apportioned across the four eligibility groups enrolled in the Virginia Medicaid managed care programs - ABAD, LIFC, FAMIS and FAMIS MOMS using the ratio of the adjusted and trended base PMPM for each aid group. The CY 2009 FAMIS administrative PMPM is \$7.17.

Using the breakdown of administrative expenses from the BOI reports, the salary and all other general administrative components of the historical PMPM are separately trended to the FY 2011 contract period. The salary component is trended using the Bureau of Labor Statistics 2008 calendar year employment cost trend for total compensation, private industry, management, business and financial services. The non-salary administrative component and the Claims Adjustment expense components are trended using the 2009 calendar year Consumer Price Index for All Urban Consumers (CPI-U).

The trended value is then increased by a 1.5% contribution to reserves. The allowance for a contribution to reserve has been increased from 0.75% in last year's rate setting. Last year, the contribution to reserve was increased from 0.50% to 0.75% to offset a reduction in health plan invested assets due to the change in the capitation payment date from the beginning of the month to the end of the month.

The trended value of the administrative factor is \$7.41. This value is converted to an administrative allowance percentage of the base capitation rate, a value of 6.40%. The contribution to reserves is added to determine the final administrative factor of 7.90%.

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

I.F. FAMIS Trend and IBNR Adjustments

The data used for the PMPM calculations reflects experience in the Virginia FAMIS program from FY 2008 through FY 2009. These data must be adjusted to reflect the contract period of FY 2011 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 results 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 monthly historical health plan expenditures for FY 2007 to FY 2009; two years of data are used to develop the historical data period trend and a longer period, three years of data, are used to develop the projection contract period trend. Additional data submission by the health plans allowed for analysis of contract period trend with run out of paid claims through February 2010.

The historical data were evaluated using a PricewaterhouseCoopers model that calculates IBNR amounts using a variety of actuarially accepted methods, and calculates trend using a least-squares regression methodology. FAMIS trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug, and Other (Transportation, DME, Lab/X-Ray). The underlying data were adjusted to incorporate the impact due to the DMAS increase in the hospital inpatient psychiatric operating adjustment factor that occurred during the historical period.

Trend rates must be applied to move the historical data from the midpoint of the data period (July 1, 2008) to the midpoint of the contract period (January 1, 2011), or two and half years (30 months). Data period trend rates for these groups are developed from a regression analysis on the 24 months of historical Virginia health plan data used for these capitation rates. Contract period trend rates are adjusted to reflect our best estimate of trend in the future and are based on the three year historical trends where appropriate. Where we considered the historical trend experience to be an unreliable indicator of future trend, we examined the additional data provided by the plans, estimates of cost increase provided by DMAS, and other sources, as well as the overall rate of change to derive the recommended trend assumptions.

Evaluation and presentation of FAMIS trend factors match changes made in FY 2009 for the Medallion II report. Data period trend was evaluated using the base year FY 2008 and FY 2009 data. Total data period PMPM trend is derived from separate consideration of utilization and cost per unit trend. Contract period trend was developed by reviewing the past three years (FY 2007 - FY 2009) of paid claims data and include analysis of additional health plan paid claims paid through February 2010. Both were evaluated with adjustments for increases in the Medicaid FFS fee schedule during the base years to the extent they were significant.

Table 1 provides a summary of the adjustments applied to the data used for contract period trend before the regression analysis. The professional adjustment reflects the impact of four fee increases, ER Professional, Pediatric E&M, and Adult E&M. The Psych Hospital

Inpatient factors reflect changes in the DMAS operating cost base during the historical period. There are no underlying adjustments made before evaluation of Acute Hospital Inpatient, Hospital Outpatient or Pharmacy trend.

ADJUSTMENTS PRIOR TO TREND ANALYSIS		
Service	FY	ALL FAMIS
Professional	FY07	1.0525
	FY08	1.0000
	FY09	1.0000
Psych Inpt	FY07	1.0432
	FY08	1.0432
	FY09	1.0000

Incurred But Not Reported (IBNR) completion factors in the first column of Exhibit I.3 are applied to the total claims in the first column of Exhibit I.4, and the dollar value of the IBNR completion factors are shown in the second column of that exhibit. The data used in this analysis has run out through October 2009, or four months past the end of the data reporting period, and the resulting IBNR factors are generally small. IBNR factors for Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug and Other services are all calculated to be 1.0% or less.

The second column of Exhibit I.3 provides information on the cumulative impact of the policy and program adjustments in Exhibits I.2a - I.2g. This is for information purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. Overall, the data period trend is flat while there is an aggregate 5% increase for the contract period trend.

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

I.G. Capitation Rates for FAMIS

Adjustment for FAMIS Co-payment Schedule

The FAMIS benefit package includes member co-payments for inpatient admissions, physician office visits, and outpatient pharmacy services. Each plan was surveyed for the FY 2008 rate setting to determine how these co-payments were administered in their program, and FAMIS copayments have not changed since that time. Using this information, the historical data for each plan was increased separately for the under and over 150% FPL populations by the value of the co-payments. The total value of the co-payments was added to the historical claims base to arrive at a total cost of services. The

co-payment adjustment was applied for major service categories. There are some differences in plan co-payment schedules, such as variation between medical supplies and DME co-payments, which are not applied because of insufficient information or lack of claims detail.

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

The co-payment adjustments for FY 2011 are slightly higher than those that were applied to the FY 2010 FAMIS rate setting. The Copay Value PMPM is subtracted from the combined base rate in Exhibit I.5a.

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

Exhibit I.5b is the summary comparison of FY 2010 and FY 2011 FAMIS rates. Although there was a state budget cap of 7% established for FY 2010, the cap was applied to the combined FAMIS and FAMIS MOMS program. As a result the final FY 2010 FAMIS rates represented an increase of more than 9%. Compared to those rates, average statewide FAMIS \leq 150% FPL rates decrease -2.40% and average statewide FAMIS $>$ 150% FPL rates decrease -2.86%, with a weighted average decrease of -2.75%. This comparison uses the FAMIS member months as of May 2010 and reflects the withdrawal of VA Premier and Optima from selected counties in FY 2010.

II. FAMIS MOMS Program Rate Development

II.A. FAMIS MOMS Program Description

Authorization and Program Description

The 2004-2005 Virginia General Assembly budgeted funding for a program “to expand prenatal care, pregnancy-related services, and 60 days of post-partum care under FAMIS to an annual estimated 380 pregnant women who are over the age of 19 with annual family income less than or equal to 150 percent of the federal poverty level”. It is also expected that a small number of women, aged 10 to 19, who are not eligible and enrolled in FAMIS, may qualify for the program once they become pregnant.

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

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

FAMIS MOMS Income Eligibility	
Federal Poverty Level	Effective Date
133-150% FPL	August 1, 2005
133-166% FPL	September 1, 2007
133-185% FPL	July 1, 2008
133-200% FPL	July 1, 2009

Eligibility begins with a determination of pregnancy and income verification and continues through the month of delivery, plus an additional two months. One important difference between Medicaid for pregnant women (under either fee-for-service (FFS) or Medallion II) and FAMIS MOMS is that Medicaid offers up to three months of retro active coverage while the FAMIS MOMS' effective date of coverage is the first of the month that the signed application was received. There is no retroactive coverage for FAMIS MOMS enrollees. Babies born to FAMIS Moms are not automatically covered beyond the first three months; the parent or guardian must submit an application to Medicaid or FAMIS on behalf of the newborn.

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

II.B. Data Book

Approach to Rate Setting for FAMIS MOMS

The FY 2011 FAMIS MOMS rate setting uses MCO data for the period FY 2008 and FY 2009, the period from July 1, 2007 to June 30, 2009.

In past rate setting, PwC has used the available health plan encounter and claims data for a similar LIFC population, program category PD-91, in conjunction with the available FAMIS MOMS data, to develop rates for FAMIS MOMS. All data used in the prior rate setting is from the MCO encounter data submission.

In developing proposed capitation rates, a key consideration is the method by which women will be enrolled in the health plan and the potential variation in the length of plan enrollment. A very small difference in the average length of plan enrollment can have a material difference in the capitation rate, since most of the cost is incurred at the time of delivery and is not evenly spread over the entire pregnancy and eligibility period.

Because of these operational changes, we assessed whether the data for the FAMIS Moms population was sufficient on its own to establish a capitation rate. That analysis showed that while there are some unexpected anomalies in the data, the results are sufficiently stable to allow development of the capitation rate directly from the population that is covered by the program. Therefore, the FY 2011 rate setting uses FAMIS MOMS encounter information for the base data.

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

II.C. FAMIS MOMS Legislative and Program Adjustments

Changes in the FAMIS program due to legislation and policy changes for FY 2008 and later must be reflected in the development of per capita rates, as the data used to develop rates does not fully include the effect of those changes. These are described in the following section. Program adjustments use values derived from the FAMIS MOMS encounter data.

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

Pharmacy Adjustment

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

The final pharmacy adjustment factors are shown in Exhibit II.2a. The PBM factor is a reduction of -3.6%.

Exempt Infant Formula Carveout Adjustment

DMAS altered its policy regarding reimbursement of selected formula for infants with diseases of inborn errors of metabolism and now requests direct billing for those services. The health plans have referred members to the Woman, Infants, and Children (WIC) program for these services, but have paid for members after the WIC benefit maximum is reached. This adjustment removes the amount that the health plans pay for selected formulas after children up to age 19 have met the WIC cap. DMAS provided a list of HCPCS codes to identify these services.

We did not identify any dollars associated with exempt formula claims for FAMIS MOMS newborns and therefore the adjustment value is 0.0%. This is shown in Exhibit II.2b. It is applied to the DME/Supplies service line in Exhibit II.4 under the column labeled "Policy and Program Adjustments".

Durable Medical Equipment Adjustment

This adjustment reflects a reduction in durable medical equipment payment rates. DMAS provided reductions by product category and modifiers for new or rented equipment. Adjustments ranged from no decrease to a 15% decrease. The reductions were applied as a weighted average based on the mix of affected DME codes reported in the health plan encounter data.

This adjustment is shown in Exhibit II.2c and is applied to the full base period to the DME service lines in Exhibit II.4 under the column labeled "Policy and Program Adjustments".

Clinical Laboratory Adjustment

For FY2011, DMAS will reduce clinical laboratory fees by an average of 5%. The clinical laboratory codes are similar to the Medicare clinical laboratory schedule. We compared health plan clinical laboratory payments rates to the DMAS payment rates, estimated at 88% of Medicare payment, for the mix of clinical laboratory services used by the Medallion II, FAMIS and FAMIS Moms population. Our analysis indicated that

approximately one third of health plan clinical laboratory payments were already lower than 83% of the CMS Medicare fee schedule. The average 5% reduction is applied to the proportion of clinical laboratory payments that are at or above 88% of the Medicare schedule.

This adjustment is shown in Exhibit II.2d and is applied to the full base period to the Lab service lines in Exhibit II.4 under the column labeled “Policy and Program Adjustments”.

Hospital Inpatient Adjustments

The hospital inpatient adjustment factor reflects no allowance for a cost per unit increase in FY2010 and FY 2011 mandated by the General Assembly. Based on projected inpatient cost trend for Virginia, this rate freeze reduces the operating cost component by 4.0% in FY 2010 and 2.7% in FY 2011.³ An additional FY 2010 reduction is a capital reimbursement rate reduction from 80% to 75% of cost, which is applied to the capital component estimated at 10%. Three hospitals, University of Virginia Medical Center, Medical College of Virginia, and Children's Hospital of the Kings Daughters, are exempted from the capital payment reduction.

If stimulus funding is not extended, the budget passed by the Virginia General Assembly requires further reductions for inpatient hospital payment. There are two components to the further reductions:

1. Reduce the operating cost base for inpatient medical/surgical from 78% to 75%, a -3.85% reduction and for inpatient psychiatric from 84% to 81%, a -3.57% reduction. This is applied to 90% of the hospital inpatient payment rate.
2. Reduce the cost basis for the capital component, from 75% to 72%, a -4.0% reduction. This is applied to 10% of the inpatient payment rate. This is in addition to the capital component reduction that was applied in the FY2010 rates. For FY2011, there are no hospital exemptions from the capital cost reduction.

The inpatient psychiatric factor is applied to mental health claims that are submitted with encounter detail and the allocated mental health subcapitation dollars.

For inpatient medical/surgical, the negative adjustment is -9.1%. For inpatient psychiatric in acute care hospitals, the negative adjustment is -8.9%. These adjustment factors are shown in Exhibit II.2e and applied to all hospital inpatient service categories in Exhibit II.4 under the column labeled “Policy and Program Adjustments”.

Hospital Outpatient Reduction

If stimulus funding is not extended, the final budget requires a new reduction for outpatient hospital services. The General Assembly reduced the cost basis from 80% to

³ This is applied as a policy adjustment in Exhibit 2e rather than as a reduction to the cost per unit trend in Exhibits I.3a to 3c.

77%, a decrease of -3.8%. This is applied to all outpatient services except for triage fees paid in the Emergency Department. DMAS estimates that 6% of outpatient hospital payments are for the triage fees. The impact of the triage exemption is calculated relative to the proportion of Emergency Room and Related outpatient payments.,

This produces a -2.9% reduction for FAMIS MOMs on the ER and Related service line. The full -3.8% reduction is applied to the Outpatient-Other services line for all programs and aid categories. These adjustment factors are shown in Exhibit II.2f and applied in Exhibit I.4 under the column labeled “Policy and Program Adjustments”.

Professional Fee Reduction

If stimulus funding is not extended, the budget requires a new 3% reduction for professional services. The reduction is not applied to HCPCS codes billed as part of the professional claim submission.

The impact of the HCPCS code exemption varies by program and aid category. The HCPCS codes are approximately 3.5% of the dollars in the professional services for FAMIS MOMS. The 3% professional fee reduction is applied to the remainder of the dollars in all professional services lines, (Prof-Anesthesia, Prof-Child EPSDT, Prof-Evaluation and Management, Prof-Maternity, Prof-Other, Prof-Psych and Prof-Vision) and to FQHC/RHC. The result is a professional fee reduction of -2.9% for FAMIS MOMS. These adjustment factors are shown in Exhibit II.2g and applied in Exhibit II.4 under the column labeled “Policy and Program Adjustments”.

Mental Health Parity

No adjustment is made for Mental Health Parity. Analysis of the health plan encounter data and additional information submitted by the plans indicates that in the three year base period 6 members used mental health inpatient services and no one exceeded the mental health benefit day limit. A small number of users and visits were also reported for the professional psych services.

Provider Incentive Adjustment

The Provider Incentive Payment Adjustment takes into consideration the various ways that health plans provide incentive payments to providers for coordinating care and ensuring access. Depending on the plan, this can be done through an increase in provider fee schedules, payment of case management fees, and/or provider incentive programs. To the extent that it has been used to increase professional fee schedules, the amount is already included in the claims and encounter data. Some plans reported the case management and incentive amounts as capitation payments. To avoid double counting, we did not include the value of the capitation amounts that plans reported as representing those payments in the base data. Their value has been incorporated into the Provider Incentive Payment Adjustment.

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS MOMS incentive is \$3.64 PMPM. Because of the relatively high FAMIS base, this translates to 0.4% of the weighted average PMPM medical cost. The amount is similar in dollar value and as a percent compared to the provider incentive factor in the FY 2010 FAMIS MOMS health plan rates. This percentage is shown in Exhibit II.2h and is presented as the dollar value applicable to rate cell in the line labeled Provider Incentive Payment Adjustment in Exhibit II.4.

Plan Administration Adjustment

The administrative allowance for FAMIS MOMS is calculated using the same revised approach that was used to develop the administrative allowance for the FAMIS program. The CY 2009 FAMIS MOMS administrative PMPM is \$58.09. The salary and all other general administrative components of this historical PMPM are separately trended to the FY 2011 contract period value of \$60.00 PMPM.

This value is converted to an administrative allowance percentage of the base capitation rate, a value of 6.40%. The 1.5% contribution to reserves is added to determine the final administrative factor of 7.90%.

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

II.D. FAMIS MOMS Trend and IBNR Adjustments

The data used for the PMPM calculations reflects experience in the Virginia FAMIS MOMS program and the health plan LIFC PD91 population from FY 2008 through FY 2009. These data must be adjusted to reflect the contract period of FY 2011 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 results 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 monthly historical health plan expenditures for FY 2007 to FY 2009. Additional data submission by the health plans allowed for analysis of contract period trend with run out of paid claims through February 2010. Because of the small number of members in FAMIS MOMS, trend estimates include PD91 experience, but exclude the data points after April 2009, the date when DMAS made changes to the disenrollment process. Contract period trend includes the additional run out through February 2010.

The historical data were evaluated using a PricewaterhouseCoopers model that calculates IBNR amounts using a variety of actuarially accepted methods, and calculates trend using a least-squares regression methodology. FAMIS MOMS trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug, and Other (Transportation, DME, Lab/X-Ray). We have adjusted the underlying data for calculation of the inpatient hospital psychiatric trend factors to incorporate the impact due to the DMAS increase in the hospital inpatient psychiatric operating adjustment factor that occurred during the historical period.

Trend rates must be applied to move the historical data from the midpoint of the data period (July 1, 2008) to the midpoint of the contract period (January 1, 2011), or two and half years (30 months). Data period trend rates for these groups are developed from a regression analysis on the 24 months of historical Virginia health plan data used for these capitation rates. Contract period trend rates are adjusted to reflect our best estimate of trend in the future and are based on the three year historical trends where appropriate. Where we considered the historical trend experience to be an unreliable indicator of future trend, we examined the additional data provided by the plans, estimates of cost increase provided by DMAS, and other sources, as well as the overall rate of change to derive recommended trend assumptions. We have revised the evaluation and presentation of trend factors to match the presentation in the Medallion II report. Data period trend was evaluated using FY2008 and FY2009, the base year data. Total data period PMPM trend is derived from separate consideration of utilization and cost per unit trend. Contract period trend was developed by reviewing the past three years (FY 2007 - FY 2009) of paid claims data with additional health plan paid claims data through February 2010. . Both were evaluated with adjustments for increases in the Medicaid FFS fee schedule during the base years to the extent they were significant.

Table 1 provides a summary of the adjustments applied to the data used for contract period trend before the regression analysis. The professional adjustment reflects the impact of four fee increases, ER Professional, Pediatric E&M, and Adult E&M. The Psych Hospital Inpatient factors reflect changes in the DMAS operating cost base during the historical period. There are no underlying adjustments made before evaluation of Acute Hospital Inpatient, Hospital Outpatient or for Pharmacy trend,

ADJUSTMENTS PRIOR TO TREND ANALYSIS		
Service	FY	ALL FAMIS
Professional	FY07	1.0669
	FY08	1.0000
	FY09	1.0000
Psych Inpt	FY07	1.0432
	FY08	1.0432
	FY09	1.0000

Incurred But Not Reported (IBNR) completion factors in the first column of Exhibit II.3 are applied to the total claims in the first column of Exhibit II.4 and the dollar value of the IBNR completion factors are shown in the second column of that exhibit. Since the data used in this analysis has run out through October 2009, or four months past the end of the data reporting period, the resulting IBNR factors are generally small. IBNR factors for Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient Hospital, Practitioner, Prescription Drug and Other services are all set to 0.8% or less.

The second column of Exhibit II.3 is information on the cumulative impact of the policy and program adjustments in Exhibits II.2a - II.2g. This is for information purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. Overall, the data period trend assigned is nearly two times the contract period trend. The Total Trend rates are calculated using compound interest calculations as a combination of the data period and contract period trends.

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

II.E. Capitation Rates for FAMIS MOMS

The historical data presented in Exhibit II.1 is adjusted by the factors shown in Exhibits II.2a through II.2i and the Trend and IBNR factors in Exhibit II.3. The result of these calculations is shown in Exhibit II.4.

FY 2011 FAMIS MOMS base rate is presented in Exhibit II.5a. Unlike the FAMIS program, there is no adjustment for co-payments. The comparison of FAMIS MOMS rates from FY 2010 and FY 2011 is shown in Exhibit II.5b and is an increase of 14.24%.

**Virginia Medicaid
FY 2011 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age Under 1												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	16,197	16,742										
Service Type												
DME/Supplies	\$45,272	\$53,448	\$0	\$0	\$2.80	\$3.19	566	735	419	527	\$79.99	\$72.72
FQHC / RHC	\$22,709	\$21,832	\$0	\$0	\$1.40	\$1.30	668	728	495	522	\$34.00	\$29.99
Home Health	\$3,055	\$5,599	\$0	\$0	\$0.19	\$0.33	19	34	14	24	\$160.77	\$164.66
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$305,985	\$715,723	\$0	\$0	\$18.89	\$42.75	55	68	41	49	\$5,563.37	\$10,525.34
IP - Other	\$395,299	\$518,286	\$0	\$0	\$24.41	\$30.96	95	101	70	72	\$4,161.04	\$5,131.54
IP - Psych	\$0	\$0	\$4,786	\$5,761	\$0.30	\$0.34	0	0	-	-	-	-
Lab	\$18,154	\$22,692	\$9,828	\$9,786	\$1.73	\$1.94	2,362	2,977	1,750	2,134	\$11.85	\$10.91
OP - Emergency Room	\$177,876	\$194,075	\$0	\$0	\$10.98	\$11.59	1,022	1,160	757	831	\$174.05	\$167.31
OP - Other	\$196,235	\$176,247	\$0	\$0	\$12.12	\$10.53	661	634	490	454	\$296.88	\$277.99
Pharmacy	\$301,085	\$281,570	\$0	\$0	\$18.59	\$16.82	5,698	5,669	4,222	4,063	\$52.84	\$49.67
Prof - Anesthesia	\$14,721	\$17,547	\$0	\$0	\$0.91	\$1.05	90	93	67	67	\$163.57	\$188.68
Prof - Child EPSDT	\$526,096	\$567,583	\$0	\$0	\$32.48	\$33.90	13,729	12,585	10,172	9,020	\$38.32	\$45.10
Prof - Evaluation & Management	\$917,291	\$1,068,415	\$22,695	\$19,066	\$58.03	\$64.96	14,524	15,808	10,761	11,331	\$64.72	\$68.79
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$215,311	\$315,478	\$2,017	\$2,095	\$13.42	\$18.97	12,558	14,990	9,304	10,744	\$17.31	\$21.19
Prof - Psych	\$28	\$215	\$5,455	\$6,567	\$0.34	\$0.41	3	2	2	1	\$1,827.69	\$3,391.10
Prof - Specialist	\$55,409	\$64,893	\$0	\$0	\$3.42	\$3.88	580	626	430	449	\$95.53	\$103.66
Prof - Vision	\$4,580	\$5,808	\$15,352	\$16,588	\$1.23	\$1.34	108	120	80	86	\$184.56	\$186.63
Radiology	\$13,925	\$15,870	\$0	\$0	\$0.86	\$0.95	828	1,072	613	768	\$16.82	\$14.80
Transportation/Ambulance	\$12,141	\$14,635	\$0	\$0	\$0.75	\$0.87	30	50	22	36	\$404.70	\$292.71
Total	\$3,225,173	\$4,059,917	\$60,132	\$59,863	\$202.83	\$246.07	53,596	57,452				

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

**Virginia Medicaid
FY 2011 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 1-5												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	172,941	196,642										
Service Type												
DME/Supplies	\$253,253	\$292,569	\$0	\$0	\$1.46	\$1.49	2,404	3,003	167	183	\$105.35	\$97.43
FQHC / RHC	\$121,447	\$131,972	\$0	\$0	\$0.70	\$0.67	4,170	4,395	289	268	\$29.12	\$30.03
Home Health	\$4,673	\$8,802	\$0	\$0	\$0.03	\$0.04	31	36	2	2	\$150.73	\$244.51
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$1,959,260	\$2,066,271	\$0	\$0	\$11.33	\$10.51	366	369	25	23	\$5,353.17	\$5,599.65
IP - Psych	\$16,351	\$0	\$56,605	\$67,842	\$0.42	\$0.35	26	0	2	-	\$2,806.02	-
Lab	\$213,391	\$249,896	\$111,582	\$118,639	\$1.88	\$1.87	24,274	31,523	1,684	1,924	\$13.39	\$11.69
OP - Emergency Room	\$1,352,508	\$1,636,423	\$0	\$0	\$7.82	\$8.32	7,598	9,078	527	554	\$178.01	\$180.26
OP - Other	\$2,210,656	\$2,692,662	\$0	\$0	\$12.78	\$13.69	5,346	5,709	371	348	\$413.52	\$471.65
Pharmacy	\$2,478,195	\$2,480,211	\$0	\$0	\$14.33	\$12.61	55,451	59,991	3,848	3,661	\$44.69	\$41.34
Prof - Anesthesia	\$217,426	\$169,435	\$0	\$0	\$1.26	\$0.86	1,067	1,105	74	67	\$203.77	\$153.33
Prof - Child EPSDT	\$818,666	\$962,025	\$0	\$0	\$4.73	\$4.89	27,572	32,592	1,913	1,989	\$29.69	\$29.52
Prof - Evaluation & Management	\$4,363,748	\$5,026,186	\$237,185	\$220,447	\$26.60	\$26.68	74,820	85,052	5,192	5,190	\$61.49	\$61.69
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$902,389	\$1,048,927	\$24,748	\$27,991	\$5.36	\$5.48	63,019	83,233	4,373	5,079	\$14.71	\$12.94
Prof - Psych	\$41,406	\$43,318	\$64,519	\$77,327	\$0.61	\$0.61	1,108	1,076	77	66	\$95.60	\$112.12
Prof - Specialist	\$505,187	\$486,801	\$0	\$0	\$2.92	\$2.48	4,654	5,131	323	313	\$108.55	\$94.87
Prof - Vision	\$44,281	\$56,652	\$170,325	\$200,301	\$1.24	\$1.31	1,260	1,480	87	90	\$170.32	\$173.62
Radiology	\$186,807	\$102,492	\$0	\$0	\$1.08	\$0.52	5,466	5,973	379	364	\$34.18	\$17.16
Transportation/Ambulance	\$49,438	\$41,206	\$0	\$0	\$0.29	\$0.21	296	266	21	16	\$167.02	\$154.91
Total	\$15,739,081	\$17,495,848	\$664,965	\$712,546	\$94.85	\$92.60	278,928	330,012				

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

**Virginia Medicaid
FY 2011 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 6-14												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	236,735	276,723										
Service Type												
DME/Supplies	\$264,974	\$309,162	\$0	\$0	\$1.12	\$1.12	2,058	2,439	104	106	\$128.75	\$126.76
FQHC / RHC	\$115,777	\$129,036	\$0	\$0	\$0.49	\$0.47	3,522	4,153	179	180	\$32.87	\$31.07
Home Health	\$9,908	\$8,667	\$0	\$0	\$0.04	\$0.03	61	47	3	2	\$162.43	\$184.40
IP - Maternity	\$8,105	\$6,328	\$0	\$0	\$0.03	\$0.02	3	3	0	0	\$2,701.69	\$2,109.17
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$2,311,114	\$1,986,238	\$0	\$0	\$9.76	\$7.18	282	267	14	12	\$8,195.44	\$7,439.09
IP - Psych	\$103,166	\$231,679	\$72,470	\$86,819	\$0.74	\$1.15	337	588	17	25	\$521.17	\$541.66
Lab	\$238,238	\$307,385	\$158,256	\$173,936	\$1.67	\$1.74	24,676	34,084	1,251	1,478	\$16.07	\$14.12
OP - Emergency Room	\$1,342,553	\$1,815,567	\$0	\$0	\$5.67	\$6.56	5,989	7,626	304	331	\$224.17	\$238.08
OP - Other	\$2,151,764	\$2,703,575	\$0	\$0	\$9.09	\$9.77	5,729	6,786	290	294	\$375.59	\$398.40
Pharmacy	\$5,420,892	\$6,069,486	\$0	\$0	\$22.90	\$21.93	75,387	85,904	3,821	3,725	\$71.91	\$70.65
Prof - Anesthesia	\$116,279	\$141,950	\$0	\$0	\$0.49	\$0.51	705	889	36	39	\$164.93	\$159.67
Prof - Child EPSDT	\$276,852	\$344,656	\$0	\$0	\$1.17	\$1.25	18,064	11,050	916	479	\$15.33	\$31.19
Prof - Evaluation & Management	\$3,524,888	\$4,327,373	\$310,359	\$303,571	\$16.20	\$16.73	59,023	71,119	2,992	3,084	\$64.98	\$65.12
Prof - Maternity	\$4,125	\$4,535	\$0	\$0	\$0.02	\$0.02	3	4	0	0	\$1,375.01	\$1,133.77
Prof - Other	\$1,434,003	\$1,350,984	\$34,734	\$40,337	\$6.20	\$5.03	92,777	93,588	4,703	4,058	\$15.83	\$14.87
Prof - Psych	\$350,294	\$381,453	\$105,900	\$128,282	\$1.93	\$1.84	9,399	10,273	476	445	\$48.54	\$49.62
Prof - Specialist	\$513,887	\$611,018	\$0	\$0	\$2.17	\$2.21	4,596	5,643	233	245	\$111.81	\$108.28
Prof - Vision	\$76,217	\$112,299	\$237,323	\$287,856	\$1.32	\$1.45	5,857	6,858	297	297	\$53.53	\$58.35
Radiology	\$168,471	\$214,209	\$0	\$0	\$0.71	\$0.77	7,777	9,726	394	422	\$21.66	\$22.02
Transportation/Ambulance	\$54,490	\$67,117	\$0	\$0	\$0.23	\$0.24	256	361	13	16	\$212.85	\$185.92
Total	\$18,485,998	\$21,122,716	\$919,041	\$1,020,800	\$81.97	\$80.02	316,501	351,408				

Note:
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**Virginia Medicaid
FY 2011 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 15-18 Female												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	42,318	49,741										
Service Type												
DME/Supplies	\$42,210	\$41,053	\$0	\$0	\$1.00	\$0.83	260	306	74	74	\$162.35	\$134.16
FQHC / RHC	\$38,534	\$61,065	\$0	\$0	\$0.91	\$1.23	1,256	1,616	356	390	\$30.68	\$37.79
Home Health	\$7,911	\$10,592	\$0	\$0	\$0.19	\$0.21	20	31	6	7	\$395.54	\$341.68
IP - Maternity	\$380,884	\$408,145	\$0	\$0	\$9.00	\$8.21	141	146	40	35	\$2,701.30	\$2,795.51
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$464,397	\$470,367	\$0	\$0	\$10.97	\$9.46	67	82	19	20	\$6,931.30	\$5,736.19
IP - Psych	\$236,064	\$121,965	\$15,801	\$17,840	\$5.95	\$2.81	345	268	98	65	\$730.04	\$521.66
Lab	\$112,422	\$159,334	\$28,613	\$31,257	\$3.33	\$3.83	11,296	15,218	3,203	3,671	\$12.49	\$12.52
OP - Emergency Room	\$617,109	\$827,807	\$0	\$0	\$14.58	\$16.64	2,021	2,481	573	599	\$305.35	\$333.66
OP - Other	\$660,876	\$720,989	\$0	\$0	\$15.62	\$14.49	1,661	1,968	471	475	\$397.88	\$366.36
Pharmacy	\$1,557,857	\$1,415,153	\$0	\$0	\$36.81	\$28.45	18,641	22,324	5,286	5,386	\$83.57	\$63.39
Prof - Anesthesia	\$64,912	\$59,694	\$0	\$0	\$1.53	\$1.20	318	289	90	70	\$204.13	\$206.55
Prof - Child EPSDT	\$34,385	\$39,841	\$0	\$0	\$0.81	\$0.80	2,437	1,789	691	432	\$14.11	\$22.27
Prof - Evaluation & Management	\$785,990	\$978,752	\$52,114	\$50,531	\$19.80	\$20.69	13,046	15,779	3,699	3,807	\$64.24	\$65.23
Prof - Maternity	\$222,851	\$214,864	\$0	\$0	\$5.27	\$4.32	459	493	130	119	\$485.52	\$435.83
Prof - Other	\$319,735	\$337,389	\$6,357	\$7,268	\$7.71	\$6.93	11,980	14,561	3,397	3,513	\$27.22	\$23.67
Prof - Psych	\$91,478	\$111,370	\$20,695	\$26,166	\$2.65	\$2.77	2,106	2,691	597	649	\$53.26	\$51.11
Prof - Specialist	\$153,037	\$151,165	\$0	\$0	\$3.62	\$3.04	1,842	1,836	522	443	\$83.08	\$82.33
Prof - Vision	\$11,614	\$18,049	\$42,762	\$51,750	\$1.28	\$1.40	1,415	1,623	401	392	\$38.43	\$43.01
Radiology	\$118,967	\$158,336	\$0	\$0	\$2.81	\$3.18	2,877	3,619	816	873	\$41.35	\$43.75
Transportation/Ambulance	\$18,429	\$26,506	\$0	\$0	\$0.44	\$0.53	127	177	36	43	\$145.11	\$149.75
Total	\$5,939,662	\$6,332,437	\$166,342	\$184,812	\$144.29	\$131.02	72,315	87,297				

Note:
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**Virginia Medicaid
FY 2011 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

Age 15-18 Male												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	40,640	47,500										
Service Type												
DME/Supplies	\$66,907	\$57,617	\$0	\$0	\$1.65	\$1.21	331	380	98	96	\$202.14	\$151.62
FQHC / RHC	\$16,998	\$16,149	\$0	\$0	\$0.42	\$0.34	510	526	151	133	\$33.33	\$30.70
Home Health	\$7,280	\$2,560	\$0	\$0	\$0.18	\$0.05	26	12	8	3	\$280.01	\$213.36
IP - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
IP - Other	\$742,169	\$596,154	\$0	\$0	\$18.26	\$12.55	63	76	19	19	\$11,780.46	\$7,844.14
IP - Psych	\$78,037	\$63,599	\$14,402	\$18,867	\$2.27	\$1.74	147	121	43	31	\$628.84	\$681.54
Lab	\$35,561	\$45,317	\$27,320	\$29,802	\$1.55	\$1.58	3,478	4,898	1,027	1,237	\$18.08	\$15.34
OP - Emergency Room	\$378,358	\$489,050	\$0	\$0	\$9.31	\$10.30	1,233	1,469	364	371	\$306.86	\$332.91
OP - Other	\$765,604	\$694,379	\$0	\$0	\$18.84	\$14.62	1,101	1,222	325	309	\$695.37	\$568.23
Pharmacy	\$937,339	\$1,145,715	\$0	\$0	\$23.06	\$24.12	11,318	13,476	3,342	3,404	\$82.82	\$85.02
Prof - Anesthesia	\$23,420	\$26,307	\$0	\$0	\$0.58	\$0.55	138	152	41	38	\$169.71	\$173.07
Prof - Child EPSDT	\$19,236	\$24,524	\$0	\$0	\$0.47	\$0.52	1,021	1,018	301	257	\$18.84	\$24.09
Prof - Evaluation & Management	\$489,476	\$617,381	\$51,332	\$48,967	\$13.31	\$14.03	7,864	9,712	2,322	2,454	\$68.77	\$68.61
Prof - Maternity	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	-	-	-	-
Prof - Other	\$145,373	\$448,096	\$6,108	\$7,074	\$3.73	\$9.58	8,255	14,402	2,438	3,638	\$18.35	\$31.60
Prof - Psych	\$75,597	\$89,741	\$19,378	\$24,692	\$2.34	\$2.41	1,897	2,409	560	609	\$50.07	\$47.50
Prof - Specialist	\$143,222	\$161,580	\$0	\$0	\$3.52	\$3.40	1,082	1,194	319	302	\$132.37	\$135.33
Prof - Vision	\$10,010	\$12,850	\$40,859	\$49,403	\$1.25	\$1.31	924	1,117	273	282	\$55.05	\$55.73
Radiology	\$53,841	\$70,436	\$0	\$0	\$1.32	\$1.48	2,158	2,577	637	651	\$24.95	\$27.33
Transportation/Ambulance	\$28,808	\$21,569	\$0	\$0	\$0.71	\$0.45	202	123	60	31	\$142.62	\$175.36
Total	\$4,017,237	\$4,583,023	\$159,399	\$178,805	\$102.77	\$100.25	41,748	54,884				

Note:
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**Virginia Medicaid
FY 2011 Capitation Rate Development
Health Plan Encounter Data**

**Section I
Exhibit 1**

Historical Eligibility, Claims, and Utilization Data - Family Access to Medical Insurance Security (FAMIS)

All Age Categories												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	508,831	587,348										
Service Type												
DME/Supplies	\$672,617	\$753,849	\$0	\$0	\$1.32	\$1.28	5,619	6,863	133	140	\$119.70	\$109.84
FQHC / RHC	\$315,465	\$360,055	\$0	\$0	\$0.62	\$0.61	10,126	11,418	239	233	\$31.15	\$31.53
Home Health	\$32,826	\$36,220	\$0	\$0	\$0.06	\$0.06	157	160	4	3	\$209.08	\$226.37
IP - Maternity	\$388,989	\$414,472	\$0	\$0	\$0.76	\$0.71	144	149	3	3	\$2,701.31	\$2,781.69
IP - Newborn	\$305,985	\$715,723	\$0	\$0	\$0.60	\$1.22	55	68	1	1	\$5,563.37	\$10,525.34
IP - Other	\$5,872,238	\$5,637,316	\$0	\$0	\$11.54	\$9.60	873	895	21	18	\$6,726.50	\$6,298.68
IP - Psych	\$433,618	\$417,243	\$164,064	\$197,129	\$1.17	\$1.05	855	977	20	20	\$699.04	\$628.84
Lab	\$617,767	\$784,623	\$335,599	\$363,420	\$1.87	\$1.95	66,086	88,700	1,559	1,812	\$14.43	\$12.94
OP - Emergency Room	\$3,868,405	\$4,962,924	\$0	\$0	\$7.60	\$8.45	17,863	21,814	421	446	\$216.56	\$227.51
OP - Other	\$5,985,135	\$6,987,851	\$0	\$0	\$11.76	\$11.90	14,498	16,319	342	333	\$412.82	\$428.20
Pharmacy	\$10,695,368	\$11,392,133	\$0	\$0	\$21.02	\$19.40	166,495	187,364	3,927	3,828	\$64.24	\$60.80
Prof - Anesthesia	\$436,759	\$414,933	\$0	\$0	\$0.86	\$0.71	2,318	2,528	55	52	\$188.42	\$164.13
Prof - Child EPSDT	\$1,675,235	\$1,938,629	\$0	\$0	\$3.29	\$3.30	62,823	59,034	1,482	1,206	\$26.67	\$32.84
Prof - Evaluation & Management	\$10,081,392	\$12,018,107	\$673,684	\$642,582	\$21.14	\$21.56	169,277	197,470	3,992	4,034	\$63.54	\$64.11
Prof - Maternity	\$226,976	\$219,399	\$0	\$0	\$0.45	\$0.37	462	497	11	10	\$491.29	\$441.45
Prof - Other	\$3,016,811	\$3,500,874	\$73,964	\$84,765	\$6.07	\$6.10	188,589	220,774	4,448	4,511	\$16.39	\$16.24
Prof - Psych	\$558,802	\$626,097	\$215,947	\$263,033	\$1.52	\$1.51	14,513	16,451	342	336	\$53.38	\$54.05
Prof - Specialist	\$1,370,742	\$1,475,456	\$0	\$0	\$2.69	\$2.51	12,754	14,430	301	295	\$107.48	\$102.25
Prof - Vision	\$146,703	\$205,658	\$506,621	\$605,897	\$1.28	\$1.38	9,564	11,198	226	229	\$68.31	\$72.47
Radiology	\$542,012	\$561,343	\$0	\$0	\$1.07	\$0.96	19,106	22,967	451	469	\$28.37	\$24.44
Transportation/Ambulance	\$163,307	\$171,034	\$0	\$0	\$0.32	\$0.29	911	977	21	20	\$179.26	\$175.06
Total	\$47,407,150	\$53,593,940	\$1,969,879	\$2,156,826	\$97.04	\$94.92	763,088	881,053				

Note:
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Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Pharmacy Adjustment

Section I
Exhibit 2a

	FAMIS All Ages	Source
1. Health Plan Total Drug Cost PMPM	\$20.15	FY08-FY09 Health Plan Encounter Data
2. Average Managed Care Rebate	4.0%	From Plan Data
3. Adjusted PMPM with Managed Care Rebate	\$19.34	= (1.) * (1 - (2.))
4. Average PBM Admin Cost PMPM	\$0.03	From Plan Data
5. Adjusted PMPM with Pharmacy Pricing Arrangements	\$19.38	= (3.) + (4.)
6. Pharmacy Adjustment	-3.8%	= (5.) / (1.) - 1

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Exempt Infant Formula Carveout Adjustment

Section I
Exhibit 2b

	FAMIS Age 0-5	FAMIS Age 6-18	Source
1. Claims Associated with Exempt Infant Formula	\$13,378	\$10,157	FY08-FY09 Health Plan Encounter Data
2. Total Claims in DME/Supplies Service Category	\$644,542	\$781,925	FY08-FY09 Health Plan Encounter Data
3. Exempt Infant Formula Carveout Adjustment	-2.1%	-1.3%	= -(1.) / (2.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
DME/Supplies Fee Reduction Adjustment

Section I
Exhibit 2c

	FAMIS	Source
1. FY08-09 Claims Associated with DME HCPCs	\$1,071,966	FY08-09 Health Plan Encounter Data
2. % Fee Reduction Effective FY11	10.0%	Provided by DMAS
3. Dollar Decrease	\$107,197	= (1.) * (2.)
4. Total claims in DME/Supplies Service Category	\$1,426,466	FY08-09 Health Plan Encounter Data
5. DME/Supplies Fee Reduction Adjustment	-7.5%	= (3.) / (4.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Clinical Lab Fee Reduction Adjustment

Section I
Exhibit 2d

	FAMIS	Source
1. % Fee Reduction Effective FY11*	3.7%	Provided by DMAS
2. Claims Associated with Clinical Lab Procedure Codes	\$743,380	FY09 Health Plan Encounter Data
3. Dollar Decrease	\$27,304	= (1.) * (2.)
4. Total claims in Lab Service Category	\$784,623	FY09 Health Plan Encounter Data
5. Clinical Lab Fee Reduction Adjustment	-3.5%	= (3.) / (4.)

* Note:

Reduction of 5% is applied to to claims paid at 88% of CMS Fee Schedule

Fee reduction % calculated as a weighted average based on claims paid above and below 88% of FY09 CMS Fee Schedule

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Hospital Inpatient Adjustments
With No Additional Stimulus Funding

Section I
Exhibit 2e

	Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1. % Excluded Claims from Exempt Hospitals for FY10*	23.4%	13.2%	FY08-FY09 Health Plan Encounter Data
2. FY10 Hospital Rate Reduction	4.0%	4.0%	Provided by DMAS
3. FY11 Hospital Rate Reduction	2.7%	2.7%	Provided by DMAS
4. FY10 Hospital Capital Percentage for Exempt Hospitals	10.0%	10.0%	Provided by DMAS
5. FY10 Hospital Capital Percentage for Non-Exempt Hospitals	9.3%	9.3%	Provided by DMAS
6. FY10 Weighted Average Capital Percentage	9.5%	9.4%	= ((1.) * (4.) + (1 - (1.)) * (5.))
7. FY11 Hospital Capital Percentage	9.3%	9.3%	Provided by DMAS
8. FY11 Hospital Inpatient Adjustment with Additional Stimulus Funding	-6.0%	-6.0%	= ((1 - (2.)) * (1 - (6.)) + (6.)) * ((1 - (3.)) * (1 - (7.)) + (7.)) - 1
9. FY08-11 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	Provided by DMAS
10. FY11 Hospital Inpatient Operating Adjustment Factor	75.0%	81.0%	Provided by DMAS
11. FY08-11 Weighted Hospital Average Capital Percentage	9.3%	9.3%	Provided by DMAS
12. FY11 Hospital Capital Percentage	9.0%	9.0%	Provided by DMAS
13. FY11 Hospital Inpatient Adjustment with No Additional Stimulus Funding	-9.1%	-8.9%	= ((10.) * (1 + (8.)) / (9.)) * (1 - (11.)) + (12.) - 1

*Exempt hospitals are CHKD, UVA, and MCV for FY10.

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Hospital Outpatient Adjustment
With No Additional Stimulus Funding

Section I
Exhibit 2f

		Outpatient	Source
1. Claims Associated with Outpatient Services	a. OP - Emergency Room & Related	\$8,831,328	FY08-09 Health Plan Encounter Data
	b. OP - Other	\$12,972,986	FY08-09 Health Plan Encounter Data
2. % ER Triage of Total Outpatient		6.0%	Provided by DMAS
3. % OP - Emergency Room & Related of Total Outpatient		40.5%	= (1a.) / ((1a.) + (1b.))
4. % of Claims Exempt from Fee Reduction		14.8%	= (2.) / (3.)
5. FY11 Hospital Rate Reduction		3.8%	Provided by DMAS
6. Dollar Decrease	a. OP - Emergency Room & Related	\$282,115	= (1a.) * (1 - (4.)) * (5.)
	b. OP - Other	\$486,487	= (1b.) * (5.)
7. Hospital Outpatient Adjustment	a. OP - Emergency Room & Related	-3.2%	= (6.) / (1.)
	b. OP - Other	-3.8%	= (6.) / (1.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Physician Fee Reduction Adjustment
With No Additional Stimulus Funding

Section I
Exhibit 2g

	Professional Service Categories	Source
1. Total Claims in Professional Service Categories	\$38,588,092	FY08-09 Health Plan Encounter Data
2. % of Claims Exempt - HCPCs	3.8%	FY08-09 Health Plan Encounter Data
3. FY11 Physician Fee Reduction	3.0%	Provided by DMAS
4. Dollar Decrease	\$1,113,285	= (1.) * (1 - (2.)) * (3.)
5. Physician Fee Reduction Adjustment	-2.9%	= (4.) / (1.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Provider Incentive Payment Adjustment
With No Additional Stimulus Funding

Section I
Exhibit 2h

	Adjustment Value	Source
Provider Incentive Payment Adjustment	3.1%	From Plan Data

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FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Administrative Cost Adjustment
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Exhibit 2i

	FAMIS	Source
1. Claims Adjustment Expense PMPM	\$1.44	Expense from CY2009 BOI Reports; Member months from capitation payment files
2. General Admin Expense PMPM	\$5.73	Expense from CY2009 BOI Reports; Member months from capitation payment files
3. Claims Adjustment Expense Increase %	2.7%	BLS CPI-U
4. General Admin Expense Increase %	2.0%	Weighted average of BLS Compensation Trend and CPI
5. Administrative PMPM*	\$7.41	$= (1.) * (1 + (3.)) ^ (18 \text{ months}/12) + (2.) * (1 + (4.)) ^ (18 \text{ months}/12)$
6. Adjusted and Trended Base PMPM	\$106.51	Weighted average of medical component of FY2011 MedII Base Rates
7. Administrative allowance as % of Base Capitation Rate	6.40%	$= (5.) / (((5.) + (6.)) / (1 - 1.5\%))$
8. Contribution to Reserves as % of Base Capitation Rate	1.50%	Provided by DMAS
9. Administrative Factor as % of Base Capitation Rate	7.90%	$= (7.) + (8.)$

*Note:

Administrative increases are applied from midpoint of CY2009 to the midpoint of the contract period (18 months) using compound interest calculations.

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FY 2011 Capitation Rate Development for FAMIS Program
Health Plan Encounter Data
Trend and Incurred But Not Reported (IBNR) Adjustments - FAMIS
With No Additional Stimulus Funding

Section I
Exhibit 3

Category of Service	FAMIS							
	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program ¹	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Inpatient Medical/Surgical	0.8%	-9.1%	-8.4%	6.4%	-9.5%	-3.7%	3.1%	1.0086
Inpatient Psychiatric	0.1%	-8.9%	-8.7%	-5.2%	-11.0%	-15.6%	12.2%	1.0031
Outpatient Hospital	0.7%	-3.5%	-2.8%	4.2%	3.4%	7.7%	6.9%	1.1912
Practitioner	0.6%	-2.9%	-2.3%	-1.0%	4.3%	3.3%	6.2%	1.1303
Prescription Drug	0.0%	-3.8%	-3.8%	-5.1%	-3.1%	-8.0%	0.3%	0.9248
Other	1.0%	-4.1%	-3.2%	-6.3%	8.7%	1.8%	3.1%	1.0654
Weighted Average*	0.5%	-4.1%	-3.6%	-0.2%	1.0%	0.7%	4.6%	1.0799

Months of Trend Applied	12	12	12	18

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

² Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY08-FY09), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY08-FY09 Claims)

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

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

Inpatient contract period trend included consideration of cost per unit projections provided by DMAS.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations; includes FY08-09 incurred claims paid through October 2009.

Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations; includes July 2006 - October 2009 incurred claims paid through February 2010 for Inpatient Medical/Surgical and incurred through December 2009 for all other service categories.

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

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Family Access to Medical Insurance Security (FAMIS)
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Section I
Exhibit 4

Age Under 1								
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type								
DME/Supplies	\$98,720	\$969	(\$9,561)	\$0	\$90,128	1.065	\$96,021	\$2.92
FQHC / RHC	\$44,541	\$264	(\$1,293)	\$2,104	\$45,617	1.130	\$51,560	\$1.57
Home Health	\$8,653	\$62		\$240	\$8,955	1.179	\$10,562	\$0.32
IP - Maternity	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Newborn	\$1,021,708	\$8,214	(\$93,707)	\$4,418	\$940,635	1.009	\$948,763	\$28.80
IP - Other	\$913,584	\$7,345	(\$83,790)	\$6,885	\$844,025	1.009	\$851,318	\$25.85
IP - Psych	\$10,547		(\$935)	\$0	\$9,612	1.003	\$9,609	\$0.29
Lab	\$60,459	\$401	(\$2,118)	\$5,480	\$64,223	1.065	\$67,140	\$2.04
OP - Emergency Room	\$371,952	\$2,656	(\$11,967)	\$20,314	\$382,955	1.191	\$456,167	\$13.85
OP - Other	\$372,483	\$2,660	(\$14,068)	\$5,491	\$366,565	1.191	\$436,644	\$13.26
Pharmacy	\$582,655		(\$22,355)	\$45,744	\$606,044	0.925	\$560,451	\$17.01
Prof - Anesthesia	\$32,268	\$192	(\$936)	\$0	\$31,523	1.130	\$35,630	\$1.08
Prof - Child EPSDT	\$1,093,680	\$6,493	(\$31,740)	\$0	\$1,068,432	1.130	\$1,207,631	\$36.66
Prof - Evaluation & Management	\$2,027,467	\$11,788	(\$58,833)	\$89,193	\$2,069,614	1.130	\$2,333,810	\$70.85
Prof - Maternity	\$0			\$0	\$0	1.130	\$0	\$0.00
Prof - Other	\$534,900	\$3,151	(\$15,523)	\$21,172	\$543,700	1.130	\$614,000	\$18.64
Prof - Psych	\$12,265	\$1	(\$354)	\$4	\$11,917	1.130	\$11,903	\$0.36
Prof - Specialist	\$120,302	\$714	(\$3,491)	\$2,040	\$119,565	1.130	\$135,142	\$4.10
Prof - Vision	\$42,328	\$62	(\$1,223)	\$481	\$41,648	1.130	\$42,913	\$1.30
Radiology	\$29,795	\$292		\$6,638	\$36,726	1.065	\$39,127	\$1.19
Transportation/Ambulance	\$26,776	\$263		\$139	\$27,178	1.065	\$28,955	\$0.88
Provider Incentive Payment Adjustment								\$7.55
Total	\$7,405,085	\$45,527	(\$351,894)	\$210,344	\$7,309,061		\$7,937,346	\$248.53

Virginia Medicaid
FY 2011 Capitation Rate Development
Capitation Rate Calculations - Health Plan Encounter Data
Family Access to Medical Insurance Security (FAMIS)
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Section I
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Age 1-5								
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type								
DME/Supplies	\$545,822	\$5,356	(\$52,860)	\$0	\$498,318	1.065	\$530,899	\$1.44
FQHC / RHC	\$253,420	\$1,504	(\$7,355)	\$15,819	\$263,389	1.130	\$297,704	\$0.81
Home Health	\$13,475	\$96		\$290	\$13,861	1.179	\$16,348	\$0.04
IP - Maternity	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Newborn	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Other	\$4,025,531	\$32,365	(\$369,204)	\$25,810	\$3,714,502	1.009	\$3,746,599	\$10.14
IP - Psych	\$140,799	\$23	(\$12,486)	\$75	\$128,411	1.003	\$128,423	\$0.35
Lab	\$693,507	\$4,546	(\$24,291)	\$57,895	\$731,658	1.065	\$764,444	\$2.07
OP - Emergency Room	\$2,988,931	\$21,343	(\$96,163)	\$155,529	\$3,069,640	1.191	\$3,656,482	\$9.89
OP - Other	\$4,903,317	\$35,013	(\$185,187)	\$47,523	\$4,800,666	1.191	\$5,718,439	\$15.47
Pharmacy	\$4,958,405		(\$190,245)	\$469,326	\$5,237,486	0.925	\$4,843,473	\$13.11
Prof - Anesthesia	\$386,861	\$2,297	(\$11,227)	\$0	\$377,930	1.130	\$427,168	\$1.16
Prof - Child EPSDT	\$1,780,691	\$10,571	(\$51,679)	\$0	\$1,739,583	1.130	\$1,966,222	\$5.32
Prof - Evaluation & Management	\$9,847,565	\$55,742	(\$285,715)	\$524,999	\$10,142,591	1.130	\$11,404,383	\$30.86
Prof - Maternity	\$0			\$0	\$0	1.130	\$0	\$0.00
Prof - Other	\$2,004,056	\$11,584	(\$58,152)	\$101,400	\$2,058,887	1.130	\$2,320,256	\$6.28
Prof - Psych	\$226,570	\$503	(\$6,551)	\$5,034	\$225,556	1.130	\$236,462	\$0.64
Prof - Specialist	\$991,987	\$5,889	(\$28,789)	\$18,577	\$987,664	1.130	\$1,116,341	\$3.02
Prof - Vision	\$471,559	\$599	(\$13,622)	\$4,539	\$463,075	1.130	\$475,120	\$1.29
Radiology	\$289,299	\$2,839		\$40,846	\$332,984	1.065	\$354,756	\$0.96
Transportation/Ambulance	\$90,644	\$890		\$1,035	\$92,569	1.065	\$98,622	\$0.27
Provider Incentive Payment Adjustment								\$3.23
Total	\$34,612,440	\$191,160	(\$1,393,527)	\$1,468,697	\$34,878,770		\$38,102,141	\$106.33

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Age 6-14								
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type								
DME/Supplies	\$574,137	\$5,634	(\$51,100)	\$0	\$528,671	1.065	\$563,238	\$1.10
FQHC / RHC	\$244,814	\$1,453	(\$7,105)	\$15,903	\$255,065	1.130	\$288,296	\$0.56
Home Health	\$18,575	\$133		\$425	\$19,133	1.179	\$22,565	\$0.04
IP - Maternity	\$14,433	\$116	(\$1,324)	\$185	\$13,410	1.009	\$13,526	\$0.03
IP - Newborn	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Other	\$4,297,352	\$34,550	(\$394,134)	\$19,580	\$3,957,349	1.009	\$3,991,544	\$7.77
IP - Psych	\$494,133	\$472	(\$43,854)	\$4,890	\$455,641	1.003	\$456,574	\$0.89
Lab	\$877,815	\$5,354	(\$30,733)	\$59,374	\$911,811	1.065	\$949,708	\$1.85
OP - Emergency Room	\$3,158,120	\$22,551	(\$101,606)	\$126,133	\$3,205,199	1.191	\$3,817,957	\$7.44
OP - Other	\$4,855,338	\$34,671	(\$183,375)	\$54,137	\$4,760,770	1.191	\$5,670,916	\$11.04
Pharmacy	\$11,490,378		(\$440,865)	\$641,307	\$11,690,819	0.925	\$10,811,325	\$21.06
Prof - Anesthesia	\$258,228	\$1,533	(\$7,494)	\$0	\$252,267	1.130	\$285,133	\$0.56
Prof - Child EPSDT	\$621,508	\$3,690	(\$18,037)	\$0	\$607,160	1.130	\$686,263	\$1.34
Prof - Evaluation & Management	\$8,466,191	\$46,614	(\$245,599)	\$421,074	\$8,688,281	1.130	\$9,740,237	\$18.97
Prof - Maternity	\$8,660	\$51	(\$251)	\$10	\$8,470	1.130	\$9,573	\$0.02
Prof - Other	\$2,860,058	\$16,533	(\$82,991)	\$112,233	\$2,905,833	1.130	\$3,274,635	\$6.38
Prof - Psych	\$965,928	\$4,344	(\$27,993)	\$48,606	\$990,885	1.130	\$1,089,471	\$2.12
Prof - Specialist	\$1,124,905	\$6,678	(\$32,647)	\$19,978	\$1,118,914	1.130	\$1,264,690	\$2.46
Prof - Vision	\$713,695	\$1,119	(\$20,623)	\$8,072	\$702,263	1.130	\$725,334	\$1.41
Radiology	\$382,680	\$3,755		\$57,752	\$444,188	1.065	\$473,230	\$0.92
Transportation/Ambulance	\$121,608	\$1,193		\$983	\$123,784	1.065	\$131,877	\$0.26
Provider Incentive Payment Adjustment								\$2.70
Total	\$41,548,555	\$190,445	(\$1,689,731)	\$1,590,642	\$41,639,911		\$44,266,094	\$88.91

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Age 15-18 Female								
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type								
DME/Supplies	\$83,264	\$817	(\$7,411)	\$0	\$76,670	1.065	\$81,683	\$0.89
FQHC / RHC	\$99,598	\$591	(\$2,891)	\$5,641	\$102,940	1.130	\$116,351	\$1.26
Home Health	\$18,503	\$132		\$200	\$18,835	1.179	\$22,214	\$0.24
IP - Maternity	\$789,029	\$6,344	(\$72,366)	\$10,700	\$733,706	1.009	\$740,046	\$8.04
IP - Newborn	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Other	\$934,764	\$7,515	(\$85,732)	\$5,385	\$861,932	1.009	\$869,380	\$9.44
IP - Psych	\$391,671	\$505	(\$34,772)	\$3,420	\$360,823	1.003	\$361,853	\$3.93
Lab	\$331,627	\$2,667	(\$11,633)	\$24,291	\$346,951	1.065	\$365,722	\$3.97
OP - Emergency Room	\$1,444,916	\$10,318	(\$46,487)	\$40,915	\$1,449,662	1.191	\$1,726,803	\$18.76
OP - Other	\$1,381,865	\$9,867	(\$52,190)	\$15,301	\$1,354,844	1.191	\$1,613,858	\$17.53
Pharmacy	\$2,973,009		(\$114,069)	\$158,142	\$3,017,082	0.925	\$2,790,109	\$30.31
Prof - Anesthesia	\$124,607	\$740	(\$3,616)	\$0	\$121,730	1.130	\$137,590	\$1.49
Prof - Child EPSDT	\$74,225	\$441	(\$2,154)	\$0	\$72,512	1.130	\$81,959	\$0.89
Prof - Evaluation & Management	\$1,867,387	\$10,476	(\$54,177)	\$92,366	\$1,916,052	1.130	\$2,152,309	\$23.38
Prof - Maternity	\$437,715	\$2,598	(\$12,703)	\$1,073	\$428,683	1.130	\$484,534	\$5.26
Prof - Other	\$670,749	\$3,901	(\$19,464)	\$26,930	\$682,116	1.130	\$769,210	\$8.36
Prof - Psych	\$249,708	\$1,204	(\$7,239)	\$12,653	\$256,326	1.130	\$283,616	\$3.08
Prof - Specialist	\$304,202	\$1,806	(\$8,828)	\$6,134	\$303,313	1.130	\$342,830	\$3.72
Prof - Vision	\$124,175	\$176	(\$3,588)	\$1,232	\$121,996	1.130	\$125,576	\$1.36
Radiology	\$277,303	\$2,721		\$19,651	\$299,675	1.065	\$319,269	\$3.47
Transportation/Ambulance	\$44,935	\$441		\$522	\$45,898	1.065	\$48,899	\$0.53
Provider Incentive Payment Adjustment								\$4.58
Total	\$12,623,253	\$63,260	(\$539,321)	\$424,556	\$12,571,748		\$13,433,812	\$150.50

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Section I
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Age 15-18 Male								
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type								
DME/Supplies	\$124,524	\$1,222	(\$11,083)	\$0	\$114,663	1.065	\$122,160	\$1.39
FQHC / RHC	\$33,147	\$197	(\$962)	\$2,127	\$34,509	1.130	\$39,005	\$0.44
Home Health	\$9,841	\$70		\$135	\$10,046	1.179	\$11,848	\$0.13
IP - Maternity	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Newborn	\$0			\$0	\$0	1.009	\$0	\$0.00
IP - Other	\$1,338,323	\$10,760	(\$122,745)	\$5,150	\$1,231,488	1.009	\$1,242,129	\$14.09
IP - Psych	\$174,905	\$200	(\$15,526)	\$1,475	\$161,054	1.003	\$161,456	\$1.83
Lab	\$138,000	\$794	(\$4,830)	\$7,298	\$141,262	1.065	\$146,763	\$1.67
OP - Emergency Room	\$867,409	\$6,194	(\$27,907)	\$24,774	\$870,470	1.191	\$1,036,883	\$11.76
OP - Other	\$1,459,983	\$10,425	(\$55,140)	\$9,871	\$1,425,139	1.191	\$1,697,591	\$19.26
Pharmacy	\$2,083,054		(\$79,923)	\$95,686	\$2,098,817	0.925	\$1,940,924	\$22.02
Prof - Anesthesia	\$49,727	\$295	(\$1,443)	\$0	\$48,579	1.130	\$54,908	\$0.62
Prof - Child EPSDT	\$43,760	\$260	(\$1,270)	\$0	\$42,750	1.130	\$48,320	\$0.55
Prof - Evaluation & Management	\$1,207,155	\$6,571	(\$35,017)	\$58,740	\$1,237,449	1.130	\$1,385,602	\$15.72
Prof - Maternity	\$0			\$0	\$0	1.130	\$0	\$0.00
Prof - Other	\$606,651	\$3,523	(\$17,604)	\$14,299	\$606,869	1.130	\$684,217	\$7.76
Prof - Psych	\$209,408	\$982	(\$6,070)	\$10,413	\$214,732	1.130	\$236,967	\$2.69
Prof - Specialist	\$304,801	\$1,809	(\$8,846)	\$4,333	\$302,098	1.130	\$341,456	\$3.87
Prof - Vision	\$113,122	\$136	(\$3,268)	\$979	\$110,969	1.130	\$113,667	\$1.29
Radiology	\$124,277	\$1,220		\$14,939	\$140,436	1.065	\$149,618	\$1.70
Transportation/Ambulance	\$50,377	\$494		\$423	\$51,294	1.065	\$54,648	\$0.62
Provider Incentive Payment Adjustment								\$3.37
Total	\$8,938,464	\$45,151	(\$391,633)	\$250,642	\$8,842,623		\$9,468,162	\$110.79

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All Age Categories								
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments	Patient Copay	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type								
DME/Supplies	\$1,426,466	\$13,998	(\$132,014)	\$0	\$1,308,450	1.065	\$1,394,001	\$1.27
FQHC / RHC	\$675,520	\$4,010	(\$19,605)	\$41,594	\$701,519	1.130	\$792,916	\$0.72
Home Health	\$69,046	\$493	\$0	\$1,290	\$70,829	1.179	\$83,538	\$0.08
IP - Maternity	\$803,461	\$6,460	(\$73,690)	\$10,885	\$747,116	1.009	\$753,572	\$0.69
IP - Newborn	\$1,021,708	\$8,214	(\$93,707)	\$4,418	\$940,635	1.009	\$948,763	\$0.87
IP - Other	\$11,509,555	\$92,536	(\$1,055,605)	\$62,810	\$10,609,295	1.009	\$10,700,970	\$9.76
IP - Psych	\$1,212,054	\$1,199	(\$107,573)	\$9,860	\$1,115,540	1.002	\$1,117,916	\$1.02
Lab	\$2,101,410	\$13,762	(\$73,605)	\$154,338	\$2,195,905	1.045	\$2,293,776	\$2.09
OP - Emergency Room	\$8,831,328	\$63,062	(\$284,130)	\$367,666	\$8,977,927	1.191	\$10,694,293	\$9.76
OP - Other	\$12,972,986	\$92,636	(\$489,961)	\$132,323	\$12,707,984	1.191	\$15,137,449	\$13.81
Pharmacy	\$22,087,501	\$0	(\$847,458)	\$1,410,205	\$22,650,248	0.925	\$20,946,282	\$19.11
Prof - Anesthesia	\$851,691	\$5,056	(\$24,718)	\$0	\$832,030	1.130	\$940,429	\$0.86
Prof - Child EPSDT	\$3,613,864	\$21,453	(\$104,881)	\$0	\$3,530,436	1.130	\$3,990,395	\$3.64
Prof - Evaluation & Management	\$23,415,765	\$131,191	(\$679,341)	\$1,186,372	\$24,053,987	1.123	\$27,016,341	\$24.65
Prof - Maternity	\$446,376	\$2,650	(\$12,955)	\$1,082	\$437,153	1.130	\$494,107	\$0.45
Prof - Other	\$6,676,414	\$38,692	(\$193,734)	\$276,034	\$6,797,406	1.127	\$7,662,317	\$6.99
Prof - Psych	\$1,663,879	\$7,034	(\$48,207)	\$76,710	\$1,699,417	1.094	\$1,858,420	\$1.70
Prof - Specialist	\$2,846,198	\$16,896	(\$82,602)	\$51,062	\$2,831,554	1.130	\$3,200,459	\$2.92
Prof - Vision	\$1,464,879	\$2,092	(\$42,323)	\$15,303	\$1,439,951	1.030	\$1,482,610	\$1.35
Radiology	\$1,103,355	\$10,827	\$0	\$139,826	\$1,254,008	1.065	\$1,336,000	\$1.22
Transportation/Ambulance	\$334,341	\$3,281	\$0	\$3,101	\$340,723	1.065	\$363,001	\$0.33
Provider Incentive Payment Adjustment								\$3.24
Total	\$105,127,796	\$535,543	(\$4,366,107)	\$3,944,881	\$105,242,113		\$113,207,554	\$106.51

Virginia Medicaid

FY 2011 Capitation Rate Development

Summary of FY 2011 Base Capitation Rates Below & Above 150% Federal Poverty Level

Family Access to Medical Insurance Security (FAMIS)

With No Additional Stimulus Funding

Section I Exhibit 5a

Age Group	Combined Base Rates	Copay Value PMPM FAMIS <=150%	Copay Value PMPM FAMIS >150%	Admin Cost Adjustment	Statewide		
					FAMIS <=150% Total with Admin	FAMIS >150% Total with Admin	
Under 1	\$248.53	\$1.98	\$4.71	7.90%	\$267.71	\$264.74	
1-5	\$106.33	\$2.04	\$4.93	7.90%	\$113.23	\$110.10	
6-14	\$88.91	\$2.06	\$5.02	7.90%	\$94.30	\$91.10	
Female 15-18	\$150.50	\$2.16	\$5.15	7.90%	\$161.07	\$157.82	
Male 15-18	\$110.79	\$2.13	\$5.13	7.90%	\$117.98	\$114.72	
					Overall FAMIS		
Average					\$113.50	\$109.82	\$110.67

Note: Average is based on health plan enrollment distribution as of May 2010.

Virginia Medicaid
FY 2011 Capitation Rate Development
Comparison of FAMIS Capitation Rates FY 2010 v. FY 2011
With No Additional Stimulus Funding

Section I
Exhibit 5b

		Statewide					
Aid Category		FAMIS <=150%			FAMIS >150%		
	Age Group	FY 2010	FY 2011	% Difference	FY 2010	FY 2011	% Difference
FAMIS	Under 1	\$265.76	\$267.71	0.73%	\$263.24	\$264.74	0.57%
	1-5	\$113.52	\$113.23	-0.25%	\$110.85	\$110.10	-0.68%
	6-14	\$95.71	\$94.30	-1.47%	\$92.97	\$91.10	-2.01%
	Female 15-18	\$177.29	\$161.07	-9.15%	\$174.56	\$157.82	-9.59%
	Male 15-18	\$125.08	\$117.98	-5.67%	\$122.32	\$114.72	-6.21%
Average		\$116.29	\$113.50	-2.40%	\$113.05	\$109.82	-2.86%

Overall FAMIS Average		
FY 2010	FY 2011	% Difference
\$113.80	\$110.67	-2.75%

Note: Average is based on health plan enrollment distribution as of May 2010.
FY2010 FAMIS Rates based on blending with FAMIS Moms for Budget Cap

**Virginia Medicaid
 FY 2011 Capitation Rate Development
 May 2010 FAMIS Member Month Distribution**

**Section I
 Exhibit 5c**

Aid Category	Age Group	Statewide
FAMIS <= 150%	Under 1	312
	1-5	3,392
	6-14	5,055
	Female 15-18	958
	Male 15-18	956
Aid Category Total		10,673
FAMIS >150%	Under 1	967
	1-5	11,113
	6-14	16,988
	Female 15-18	3,133
	Male 15-18	2,984
Aid Category Total		35,186
Total		45,859

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data
Historical Eligibility, Claims and Utilization - FAMIS MOMS

Section II
Exhibit 1

All Ages												
Statewide	Raw Claims FY08	Raw Claims FY09	Capitation FY08	Capitation FY09	Unadjusted PMPM 08	Unadjusted PMPM 09	Units FY08	Units FY09	Units/1000 FY08	Units/1000 FY09	Cost/Unit FY08	Cost/Unit FY09
Member Months	9,627	11,446										
Service Type												
DME/Supplies	\$18,793	\$14,029	\$0	\$0	\$1.95	\$1.23	97	123	121	129	\$193.74	\$114.06
FQHC / RHC	\$69,325	\$77,095	\$0	\$0	\$7.20	\$6.74	1,124	1,294	1,401	1,357	\$61.68	\$59.58
Home Health	\$12,548	\$23,140	\$0	\$0	\$1.30	\$2.02	46	63	57	66	\$272.78	\$367.30
IP - Maternity	\$3,134,833	\$4,269,966	\$0	\$0	\$325.63	\$373.05	1,211	1,501	1,510	1,574	\$2,588.63	\$2,844.75
IP - Newborn	\$0	\$0	\$0	\$0	\$0.00	\$0.00	0	0	0	0	-	-
IP - Other	\$55,160	\$65,187	\$0	\$0	\$5.73	\$5.70	18	13	22	14	\$3,064.43	\$5,014.38
IP - Psych	\$0	\$20,631	\$0	\$0	\$0.00	\$1.80	0	29	0	30	-	\$711.40
Lab	\$94,540	\$127,968	\$6,296	\$6,754	\$10.47	\$11.77	7,188	9,522	8,960	9,983	\$14.03	\$14.15
OP - Emergency Room & Related	\$231,522	\$252,853	\$0	\$0	\$24.05	\$22.09	647	705	806	739	\$357.84	\$358.66
OP - Other	\$630,427	\$804,803	\$0	\$0	\$65.49	\$70.31	2,389	3,036	2,978	3,183	\$263.89	\$265.09
Pharmacy	\$236,987	\$365,099	\$0	\$0	\$24.62	\$31.90	8,024	10,619	10,002	11,133	\$29.53	\$34.38
Prof - Anesthesia	\$273,256	\$357,679	\$0	\$0	\$28.38	\$31.25	1,155	1,492	1,440	1,564	\$236.59	\$239.73
Prof - Child EPSDT	\$8,794	\$13,094	\$0	\$0	\$0.91	\$1.14	210	956	262	1,002	\$41.88	\$13.70
Prof - Evaluation & Management	\$344,318	\$438,663	\$15,404	\$16,316	\$37.37	\$39.75	5,327	6,751	6,640	7,078	\$67.53	\$67.39
Prof - Maternity	\$1,814,166	\$2,261,240	\$0	\$0	\$188.45	\$197.56	3,563	4,434	4,441	4,649	\$509.17	\$509.98
Prof - Other	\$113,792	\$157,237	\$1,319	\$1,275	\$11.96	\$13.85	6,426	7,846	8,010	8,226	\$17.91	\$20.20
Prof - Psych	\$4,299	\$3,273	\$0	\$0	\$0.45	\$0.29	68	58	85	61	\$63.21	\$56.43
Prof - Specialist	\$107,582	\$137,863	\$0	\$0	\$11.18	\$12.04	1,313	1,587	1,637	1,664	\$81.94	\$86.87
Prof - Vision	\$2,019	\$2,345	\$8,942	\$10,487	\$1.14	\$1.12	37	39	46	41	\$296.25	\$329.03
Radiology	\$304,859	\$445,014	\$0	\$0	\$31.67	\$38.88	3,487	4,949	4,347	5,189	\$87.43	\$89.92
Transportation/Ambulance	\$16,210	\$23,400	\$21,930	\$27,320	\$3.96	\$4.43	120	191	150	200	\$317.83	\$265.55
Total	\$7,473,427	\$9,860,580	\$53,892	\$62,153	\$781.90	\$866.92	42,450	55,208				

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Pharmacy Adjustment

Section II
Exhibit 2a

	FAMIS MOMS	Source
1. Health Plan Total Drug Cost PMPM	\$28.57	FY08-FY09 Health Plan Encounter Data
2. Average Managed Care Rebate	4.0%	From Plan Data
3. Adjusted PMPM with Managed Care Rebate	\$27.43	= (3.) * (1 - (2.))
4. Average PBM Admin Cost PMPM	\$0.10	From Plan Data
5. Adjusted PMPM with Pharmacy Pricing Arrangements	\$27.53	= (3.) + (4.)
6. Pharmacy Adjustment	-3.6%	= (5.) / (1.) - 1

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Exempt Infant Formula Carveout Adjustment

Section II
Exhibit 2b

	FAMIS MOMS	Source
1. Claims Associated with Exempt Infant Formula for Children	\$0	FY08-FY09 Health Plan Encounter Data
2. Total Claims in DME/Supplies Service Category	\$32,822	FY08-FY09 Health Plan Encounter Data
3. Exempt Infant Formula Carveout Adjustment	0.0%	= (1.) / (2.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
DME/Supplies Fee Reduction Adjustment

Section II
Exhibit 2c

	FAMIS MOMS		Source
1. FY08-09 Claims Associated with DME HCPCs	\$23,777		FY08-09 Health Plan Encounter Data
2. % Fee Reduction Effective FY11	10.0%		Provided by DMAS
3. Dollar Decrease	\$2,378	= (1.) * (2.)	
4. Total claims in DME/Supplies Service Category	\$32,822		FY08-09 Health Plan Encounter Data
5. DME/Supplies Fee Reduction Adjustment	-7.2%	= (3.) / (4.)	

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Clinical Lab Fee Reduction Adjustment

Section II
Exhibit 2d

	FAMIS MOMS	Source
1. % Fee Reduction Effective FY11*	2.3%	Provided by DMAS
2. Claims Associated with Clinical Lab Procedure Codes	\$118,491	FY09 Health Plan Encounter Data
3. Dollar Decrease	\$2,728	= (1.) * (2.)
4. Total claims in Lab Service Category	\$127,968	FY09 Health Plan Encounter Data
5. Clinical Lab Fee Reduction Adjustment	-2.1%	= (3.) / (4.)

* Note:

Reduction of 5% is applied to to claims paid at 88% of CMS Fee Schedule

Fee reduction % calculated as a weighted average based on claims paid above and below 88% of FY09 CMS Fee Schedule

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Hospital Inpatient Adjustments
With No Additional Stimulus Funding

Section II
Exhibit 2e

	Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1. % Excluded Claims from Exempt Hospitals for FY10*	3.4%	0.0%	FY08-FY09 Health Plan Encounter Data
2. % Excluded Claims from Freestanding Psych Hospitals	0.0%	69.2%	FY08-FY09 Health Plan Encounter Data
3. FY10 Hospital Rate Reduction	4.0%	4.0%	Provided by DMAS
4. FY11 Hospital Rate Reduction	2.7%	2.7%	Provided by DMAS
5. FY10 Hospital Capital Percentage for Exempt Hospitals	10.0%	10.0%	Provided by DMAS
6. FY10 Hospital Capital Percentage for Non-Exempt Hospitals	9.3%	9.3%	Provided by DMAS
7. FY10 Weighted Average Capital Percentage	9.4%	9.8%	= ((1.) + (2.)) * (5.) + (1 - (1.) - (2.)) * (6.)
8. FY11 Hospital Capital Percentage	9.3%	9.3%	Provided by DMAS
9. FY11 Hospital Inpatient Adjustment with Additional Stimulus Funding	-6.0%	-6.0%	= ((1 - (3.)) * (1 - (7.)) + (7.)) * ((1 - (4.)) * (1 - (8.)) + (8.)) - 1
10. FY08-11 Hospital Inpatient Operating Adjustment Factor	78.0%	84.0%	Provided by DMAS
11. FY11 Hospital Inpatient Operating Adjustment Factor	75.0%	81.0%	Provided by DMAS
12. FY08-11 Weighted Hospital Average Capital Percentage	9.3%	9.3%	Provided by DMAS
13. FY11 Hospital Capital Percentage	9.0%	9.0%	Provided by DMAS
14. FY11 Hospital Inpatient Adjustment with No Additional Stimulus Funding	-9.1%	-8.9%	= ((11.) * (1 + (9.)) / (10.)) * (1 - (12.)) + (13.) - 1

*Exempt hospitals are CHKD, UVA, and MCV for FY10.

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Hospital Outpatient Adjustment
With No Additional Stimulus Funding

Section II
Exhibit 2f

		Outpatient	Source
1. Claims Associated with Outpatient Services	a. OP - Emergency Room & Related	\$484,376	FY08-09 Health Plan Encounter Data
	b. OP - Other	\$1,435,230	FY08-09 Health Plan Encounter Data
2. % ER Triage of Total Outpatient		6.0%	Provided by DMAS
3. % OP - Emergency Room & Related of Total Outpatient		25.2%	= (1a.) / ((1a.) + (1b.))
4. % of Claims Exempt from Fee Reduction		23.8%	= (2.) / (3.)
5. FY11 Hospital Rate Reduction		3.8%	Provided by DMAS
6. Dollar Decrease	a. OP - Emergency Room & Related	\$13,845	= (1a.) * (1 - (4.)) * (5.)
	b. OP - Other	\$53,821	= (1b.) * (5.)
7. Hospital Outpatient Adjustment	a. OP - Emergency Room & Related	-2.9%	= (6.) / (1.)
	b. OP - Other	-3.8%	= (6.) / (1.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Physician Fee Reduction Adjustment
With No Additional Stimulus Funding

Section II
Exhibit 2g

	Professional Service Categories	Source
1. Total Claims in Professional Service Categories	\$6,186,040	FY08-09 Health Plan Encounter Data
2. % of Claims Exempt - HCPCs	3.5%	FY08-09 Health Plan Encounter Data
3. FY11 Physician Fee Reduction	3.0%	Provided by DMAS
4. Dollar Decrease	\$179,020	= (1.) * (1 - (2.)) * (3.)
5. Physician Fee Reduction Adjustment	-2.9%	= (4.) / (1.)

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Provider Incentive Payment Adjustment
With No Additional Stimulus Funding

Section II
Exhibit 2h

	Adjustment Value	Source
Provider Incentive Payment Adjustment	0.4%	From Plan Data

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Administrative Cost Adjustment
With No Additional Stimulus Funding

Section II
Exhibit 2i

	FAMIS MOMS	Source
1. Claims Adjustment Expense PMPM	\$11.67	Expense from CY2009 BOI Reports; Member months from capitation payment files
2. General Admin Expense PMPM	\$46.42	Expense from CY2009 BOI Reports; Member months from capitation payment files
3. Claims Adjustment Expense Increase %	2.7%	BLS CPI-U
4. General Admin Expense Increase %	2.0%	Weighted average of BLS Compensation Trend and CPI
5. Administrative PMPM*	\$60.00	= (1.) * (1+ (3.))^(18 months/12) + (2.) * (1+ (4.))^(18 months/12)
6. Adjusted and Trended Base PMPM	\$862.87	Weighted average of medical component of FY2011 MedII Base Rates
7. Administrative allowance as % of Base Capitation Rate	6.40%	= (5.) / (((5.) + (6.)) / (1 - 1.5%))
8. Contribution to Reserves as % of Base Capitation Rate	1.50%	Provided by DMAS
9. Administrative Factor as % of Base Capitation Rate	7.90%	= (7.) + (8.)

*Note:

Administrative increases are applied from midpoint of CY2009 to the midpoint of the contract period (18 months) using compound interest calculations.

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Trend and Incurred But Not Reported (IBNR) Adjustments
With No Additional Stimulus Funding

Section II
Exhibit 3

Category of Service	Age 10 and Over Female							
	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program ¹	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Inpatient Medical/Surgical	0.4%	-9.1%	-8.8%	3.8%	-1.3%	2.4%	-0.1%	1.0227
Inpatient Psychiatric	0.4%	-8.9%	-8.5%	-0.5%	-3.7%	-4.3%	12.0%	1.1348
Outpatient Hospital	0.8%	-3.5%	-2.7%	4.2%	0.9%	5.1%	7.9%	1.1781
Practitioner	0.6%	-2.9%	-2.3%	-1.8%	5.8%	3.9%	0.8%	1.0508
Prescription Drug	0.0%	-3.6%	-3.6%	12.7%	4.7%	18.0%	9.3%	1.3487
Other	0.8%	-0.7%	0.1%	2.2%	16.8%	19.4%	16.7%	1.5047
Weighted Average*	0.5%	-5.5%	-5.0%	2.0%	3.0%	4.9%	2.6%	1.0947

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

² Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY08-FY09), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY08-FY09 Claims)

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

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

Inpatient contract period trend included consideration of cost per unit projections provided by DMAS.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations; includes July 2007 - April 2009 incurred claims paid through October 2009 for FAMIS Moms and Program Designation 91.

Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations; includes includes July 2007 - April 2009 incurred claims paid through February 2010 for FAMIS Moms and Program Designation 91.

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

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Capitation Rate Calculations - Health Plan Encounter Data
FAMIS MOMS
With No Additional Stimulus Funding

Section II
Exhibit 4

Age 10 and Over Female							
Statewide	Total Claims FY08 - FY09	Completion Factor Adjustment	Policy and Program Adjustments ¹	Completed and Adjusted Claims FY08 - FY09	Trend Adjustment	Completed & Trended Claims FY11	PMPM FY11
Service Type							
DME/Supplies	\$32,822	\$275	(\$2,398)	\$30,700	1.505	\$46,194	\$2.19
FQHC / RHC	\$146,420	\$912	(\$4,264)	\$143,068	1.051	\$150,330	\$7.13
Home Health	\$35,688	\$276		\$35,963	1.159	\$41,690	\$1.98
IP - Maternity	\$7,404,798	\$28,441	(\$676,623)	\$6,756,616	1.023	\$6,910,312	\$327.92
IP - Newborn	\$0	\$0		\$0	1.023	\$0	\$0.00
IP - Other	\$120,347	\$462	(\$10,997)	\$109,812	1.023	\$112,310	\$5.33
IP - Psych	\$20,631	\$85	(\$1,834)	\$18,881	1.135	\$21,426	\$1.02
Lab	\$235,558	\$1,866	(\$5,062)	\$232,363	1.505	\$343,048	\$16.28
OP - Emergency Room	\$484,376	\$3,742	(\$13,952)	\$474,166	1.178	\$558,629	\$26.51
OP - Other	\$1,435,230	\$11,087	(\$54,237)	\$1,392,080	1.178	\$1,640,052	\$77.83
Pharmacy	\$602,086	\$3	(\$21,945)	\$580,144	1.349	\$782,449	\$37.13
Prof - Anesthesia	\$630,935	\$3,930	(\$18,373)	\$616,493	1.051	\$647,782	\$30.74
Prof - Child EPSDT	\$21,889	\$136	(\$637)	\$21,388	1.051	\$22,473	\$1.07
Prof - Evaluation & Management	\$814,701	\$4,877	(\$23,718)	\$795,860	1.051	\$834,643	\$39.61
Prof - Maternity	\$4,075,406	\$25,387	(\$118,675)	\$3,982,118	1.051	\$4,184,224	\$198.56
Prof - Other	\$273,622	\$1,688	(\$7,967)	\$267,343	1.051	\$280,780	\$13.32
Prof - Psych	\$7,571	\$47	(\$220)	\$7,398	1.051	\$7,774	\$0.37
Prof - Specialist	\$245,445	\$1,529	(\$7,147)	\$239,827	1.051	\$251,999	\$11.96
Prof - Vision	\$23,793	\$27	(\$689)	\$23,131	1.051	\$23,319	\$1.11
Radiology	\$749,873	\$6,289		\$756,162	1.505	\$1,137,793	\$53.99
Transportation/Ambulance	\$88,860	\$332		\$89,192	1.505	\$109,351	\$5.19
Provider Incentive Payment Adjustment							\$3.64
Total	\$17,450,052	\$91,391	(\$968,739)	\$16,572,705		\$18,106,576	\$862.87
Admin Cost Adjustment							\$74.05
FAMIS MOMS Capitation Rate							\$936.92

¹ Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.
 No Cost/Unit contract period trend applied to Home Health services.

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Summary of FY 2011 Capitation Rate
With No Additional Stimulus Funding

Section II
Exhibit 5a

Aid Category	Age Group	Statewide
FAMIS MOMS	Age 10 and Over Female	\$936.92

Virginia Medicaid
FY 2011 Capitation Rate Development for FAMIS Moms Program
Health Plan Encounter Data - FAMIS MOMS
Comparison of FY 2010 and FY 2011 Capitation Rates
With No Additional Stimulus Funding

Section II
Exhibit 5b

Aid Category	Age Group	Statewide		
		FY 2010 ¹	FY 2011	% Change 2010-2011
FAMIS MOMS	Age 10 and Over Female	\$820.14	\$936.92	14.24%

¹ FY 2010 Rates are based on Program Designation 91 as well as FAMIS MOMS

Virginia Medicaid
FY 2011 Capitation Rate Development
May 2010 FAMIS Moms Member Month Distribution

Section II
Exhibit 5c

Aid Category	Age Group	Statewide
FAMIS MOMS	Age 10 and Over Female	964