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

Program of All-Inclusive Care
for the Elderly (PACE)
Data Book and Capitation Rates
Fiscal Year 2012

June 2011

Submitted by:

PricewaterhouseCoopers LLP

Three Embarcadero Center

San Francisco, CA 94111

June 2011





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

June 24, 2011

Dear Bill:

Re: PACE Data Book and Capitation Rates – FY 2012

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for Fiscal Year 2012, effective July 1, 2011 to June 30, 2012, for the Virginia Programs of All-Inclusive Care for the Elderly (PACE) that operate as a full PACE program. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services requirements that the capitation rates be developed under guidelines that rates do not exceed the Fee-for-Service Upper Payment Limit, the amount that would be paid by the Medicaid program in the absence of a PACE program, and are appropriate for the population covered by the program.

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

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

Very Truly Yours,

A handwritten signature in cursive script that reads "PricewaterhouseCoopers".

PricewaterhouseCoopers LLP

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***Program of All-Inclusive Care for the Elderly
Data Book and Capitation Rates
Fiscal Year 2012
Prepared by PricewaterhouseCoopers LLP
June 2011***

PricewaterhouseCoopers LLP (PwC) has revised the calculation of the capitation rates for the Virginia Medicaid Program of All-Inclusive Care for the elderly (PACE) program for State Fiscal Year 2012 for rates effective July 1, 2011. This includes PACE rates for programs operational throughout the state.

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

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

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

Capitation rates are developed for a population aged 55 and over and vary by dual eligibility status (Medicaid/Medicare or Medicaid Only). The PACE rates for the five regions in the state are developed for the six operating PACE programs¹.

Rates developed for FY 2012 reflect implementation of the Medicare Part D prescription drug benefit effective January 1, 2006. As of that date, all dual eligibles were enrolled in the Part D benefit and obtained the majority of their prescription drugs under Medicare, rather than under the Medicaid program. FY 2012 is the second year where the entire two year historical base period reflects implementation of the Part D benefit for the Medicare - Medicaid dual eligibles; therefore the historical base experience is used without adjustment for changes in covered drugs. FY 2012 is the first year where the entire three-year historical period evaluated for contract period trend reflects the implementation of the Part D Drug benefit. The Virginia Medicaid program continues to cover the prescription drugs under its formulary for which federal matching funds remain available but which are specifically excluded by law from Medicare Part D. This includes benzodiazepines and barbiturates². DMAS continues to cover

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

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

specific DMAS approved over-the-counter drugs, which are also excluded from Part D. For the Medicare Part B covered drugs, DMAS will continue to pay for coinsurance and deductibles. There was no change for the non-dual, Medicaid only population.

Medicaid PACE rates include funding for acute care as well as the long term care and personal care services under the Elderly or Disabled with Consumer Direction (EDCD) waiver. Total payments to PACE programs include separate payments from the Medicare program for dual eligibles.

I. Background

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

Medicaid programs pay PACE sites a capitated fee designed to cover the full cost of all services required by PACE enrollees that would otherwise be paid through the Medicaid fee-for-service system. A PACE program is capitated for both Medicaid and Medicare covered services. Medicare's contribution to PACE costs is currently set based on the Average Adjusted Per Capita Cost (AAPCC) for the geographic area in which the PACE program operates and risk adjusted for a frailty factor. PACE centers typically enroll 100 to 200 individuals although there are multi-site programs with larger centers. Consequently, it is important that the capitation rates paid for the program provide an accurate estimate of costs for the specific population that enrolls in the program, as there is little ability for PACE programs to accommodate significant variations in the level of health care need of individual participants through high volume.

Our analysis includes data for all individuals eligible to participate in PACE. This includes the nursing home eligible population, both those who are residents of nursing homes, as well as those who are enrolled in Home and Community Based Services waiver programs. We have implicitly assumed that the distribution of enrollment in a PACE program will mirror the PACE-eligible population. In other words, if 70% of the PACE eligible population is currently residing in nursing homes, the UPLs reported here implicitly assume that 70% of the enrollees would otherwise have been nursing home residents for the base calculation. Virginia is currently contracting with five organizations to operate eight PACE programs. The rates for these and any new PACE programs are assumed to have the same proportion of residents of nursing homes, and Home and Community Based Service waiver programs as the eligible population statewide. .

PACE capitation rates

Payments to managed care plans for PACE enrollees are subject to federal rules. As a Medicaid program, the state must comply with federal regulations set by CMS regarding payment levels. Specifically, full PACE programs are subject to rate setting under UPL guidelines. In addition, CMS must approve the payment rates made to each plan.

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

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

II. Data sources

PwC obtained detailed historical fee-for-service claims and eligibility data from the Department of Medical Assistance Services (DMAS) for services incurred and months of enrollment during State Fiscal Years 2009 through 2010 with claims paid through December 2010. The claims in the historical data base include Medicaid paid amounts, which are net of any third party insurance payments, which are primarily Medicare payments, and for the nursing facility and personal care services, the amounts for which patients are responsible. Fee-for-service data are used to develop PACE rates because PACE rate setting guidelines do not permit direct use of encounter data from the contracting PACE plans.

We have incorporated changes to the service category definitions for PACE rate setting that were made in FY 2011. Service categories are primarily defined by bill type, CPT, and revenue code fields in the claims records. In FY 2011, we updated provider identification numbers with the National Provider Identifiers and modified CPT ranges to refine selected service categories. As a result, there were changes to the providers and codes that are included in a number of the service lines. These include:

1. Home health agency services reported on hospital outpatient department UB92 claims have been moved from outpatient hospital to the home health service line. Other home health agency services are identified by DMAS object code. Home health services continue to be included with Outpatient Hospital services for IBNR and trend calculations. Personal care services provided by home health agencies remain in the personal cares services line.
2. Durable medical equipment HCPCS codes reported on CMS 1500 professional claim detail lines have been moved to the DME service line. Other DME services are identified by DMAS object code.

The work in this report builds on analyses performed in developing FY 2012 capitation rates for the Medallion II program. In the Medallion II program, special adjustments were made to the historical data to reflect changes in payment arrangements due to other programmatic and legislative adjustments. The revised Medallion II report, dated May 31, 2011, provides a detailed description of the process used for developing the adjustment factors; where applicable, these same adjustment factors are used in the development of the PACE rates.

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

PACE eligibles identified in the DMAS eligibility files were also matched to two other data sets. These are 1) costs associated with personal care services received under the EDCD waiver and 2) acute care costs for the population enrolled in managed care organizations who continue to receive those services from their health plan and receive LTC services through Medicaid FFS. The costs for the Acute and Long Term Care (ALTC) population are added to the base for the non-dual PACE eligibles.

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

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

- Member months for Fiscal Years 2009 and 2010,
- Medicaid payment amounts for the combined years,
- Patient payment amounts for the combined years³,
- Costs per member per month (PMPM) for the combined years (a combination of Medicaid and patient payment amounts),
- Unadjusted units of service for Fiscal Years 2009 and 2010 (a definition of “units” for each category of service is provided in Exhibit 6),
- Annual units/1,000 members for the combined years, calculated as the total units of service divided by the appropriate member months, multiplied by 1,000, multiplied by 12, and
- Cost per unit of service.

III. Capitation rate calculations

The capitation rates for Fiscal Year 2012 are calculated based on the historical data shown in Exhibits 1a – 1b adjusted to reflect changes in payment rates and covered services. Each of the adjustments to the historical data is described in the following section. The adjustments are applied to the historical data and the resulting capitation rates are calculated in Exhibits 4a – 4b.

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

1. The historical data for each Medicare eligibility status and region are brought forward to Exhibits 4a and 4b from the corresponding cell in Exhibits 1a and 1b.⁴ This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Legislature or by changes to the Medicaid State Plan. Several of these adjustments were described in the Medallion II report

³ Patient payment amounts are primarily for nursing home and personal care services.

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

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- and applied to the PACE calculations; additional adjustments that apply to the PACE eligible group have been incorporated into these calculations. These adjustments are described in greater detail in Section IV.
3. The claims data are adjusted to update to the FY 2012 contract period; these trend adjustments are described in Section V. The resulting claims are shown in Exhibits 4a and 4b under the column “Completed & Trended Claims”.
 4. The data are further adjusted to reflect expected managed care savings, which is applied to the UPL PMPM and results in the PACE PMPM.
 5. The managed care adjusted claims from Step 4 are divided by the count of member months for each rate cell (from Exhibits 1a and 1b) to arrive at preliminary PMPM costs by service category. These PMPM costs are summarized for each dual eligibility status and region. Claims are summed to calculate health care cost components for PACE.
 6. The final step is adding an allowance for PACE plan administrative costs. The rates shown in Exhibit 5a and 5c include only the Medicaid portion of the payment. The PACE program will also receive a capitation payment from the federal government for the Medicare component of services.
 7. The PACE rates are compared to the estimated Upper Payment Limit cost to confirm that FY 2012 PACE rates meet federal rate setting guidelines.

IV. Programmatic and legislative adjustments

Prescription drug adjustment

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

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

The DMAS dispensing fee during FY 2009 was \$4.00 per script; this was reduced to \$3.75 in FY 2010. Dispensing fees during the base period were reported as \$4.00/\$3.75 or as \$0.00 because no dispensing fee is paid if the same prescription is filled more than one time in a month. Therefore the FY 2009 dispensing fee average is less than \$4.00 and the \$0.25 dispensing fee reduction is applied to the proportion of scripts that were paid at the full amount. The resulting FY 2012 average dispensing fees are \$2.69 for duals and \$2.97 for the non-dual population.

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

The DMAS discounts, rebates, and dispensing fees, are applied for the non-dual population, but different adjustments are applied for the dual eligible population.

The prescription drugs covered by Medicaid for the dual eligible population contains a different mix of drugs than that used by the non-dual population; it includes a higher proportion of over-the-counter (OTC) and specialized drugs that do not receive the same discounts and rebates as other Medicaid covered drugs. We re-weighted the total FFS rebate percentage for the higher percent of OTC drugs in the PACE-eligible dual population post-Part D implementation and the higher percentage of brand name drugs used by the PACE-eligible non-dual population. Based on analysis of the more recent non-dual claims, we kept the same level of assumed savings from future expected improvements in the Brand-Generic mix.

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

Non-emergency transportation adjustment

Non-emergency transportation (NET) services were contracted to a broker during the historical data period and services are not captured in the DMAS FFS claims. The non-emergency transportation adjustment is based on the service cost component (excluding the administrative cost) of the accepted bid for the ABAD nursing home population, as contractually adjusted for annual increases. The annual increase is based on the Bureau of Labor Statistics (BLS) transportation index for the Washington DC-Baltimore, MD - Virginia region. The most recent increase was 5% effective July 1, 2008. Since there have been no additional increases since then, rates are held flat. Because the NET regions differ from the PACE rate setting regions, each region adjustment is calculated as the weighted average of the NET rates for the appropriate county code weighted by the distribution of the member months during the historical base period. This is in addition to the value of claims for emergency transportation services that were extracted from the DMAS FFS data. The per member per month value is shown in Exhibit 2b and the adjustment is applied in Exhibits 4a and 4b.

Consumer directed long term care adjustment

Individuals in a home and community based waiver may receive personal care services. Traditionally this service has been provided by agencies. For several years, DMAS has given waiver recipients the option of consumer direction of personal care services for non-skilled respite care. Recipients increasingly are choosing this model. Payments are made directly to the caregivers, rather than to an agency, and are not captured through the current FFS claims system.

This adjustment factor calculates the sum of the personal care aide payroll plus the patient payment over FY 2009 and FY 2010 and includes the dollars in the base amounts on the Consumer Directed Service line in Exhibits 1a and 1b. A 3% fee increase, which took effect July 1, 2009, is applied to the first year of the base period for both the dual and non-dual population. The fee increase adjustment is shown in Exhibit 2c and applied to the Consumer Directed Service line in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Personal care services fee increase adjustment

Individuals who are in a home and community based waiver as an alternative to nursing facility placement may receive personal care services. A 3% fee increase, which took effect July 1, 2009, is applied to the first year of the base period. This is the same increase that is applied to consumer directed personal care services in Exhibit 2d. The fee increase adjustment is shown in Exhibit 2d and applied to the Personal Care Services line in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Durable medical equipment fee reduction 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 proportion of DME claims that are not affected by the reduction is the same as the proportion identified in the Medallion II ABAD rate development. The reduction reflects the weighted average impact based on this mix of DME codes.

The adjustment is shown in Exhibit 2e and is applied to the full base period to the DME service lines in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Clinical lab fee reduction adjustment

For FY 2011, DMAS will reduce clinical laboratory fees by an average of 5%. The affected clinical laboratory codes are similar to the Medicare clinical laboratory schedule. We compared current DMAS clinical laboratory payments rates to a value of 88% of Medicare payment, for the mix of clinical laboratory services used by the PACE eligibles. The average 5% reduction is applied to all clinical laboratory payments that are at or above 88% of the Medicare schedule. The proportion of lab claims that are not associated with the Medicare fee schedule is the same as the proportion identified in the Medallion II ABAD rate development. This adjustment is shown in Exhibit 2f and is applied to the full base period to the Lab service lines in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Hospital inpatient adjustments

The hospital inpatient adjustment factor reflects a FY 2010 reduction in capital reimbursement from 80% to 75% of cost for non-exempt hospitals (applied to the first year of the base data) and a FY 2012 capital reimbursement rate reduction from 75% to 71% of cost (applied to both years of the base data). These are applied to the capital component estimated at 10%. Unlike the FY 2010 capital reduction which exempted select hospitals, there are no FY 2012 exemptions and all hospitals are included. The result is that the FY 2010 exempt hospitals have a similar percentage reduction in FY 2012 taken from a different base. These changes apply to both inpatient medical/surgical and inpatient psychiatric hospitals.

For inpatient medical/surgical, the negative adjustment is 0.5%. For inpatient psychiatric in acute care hospitals, the negative adjustment is 0.6%.

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

In the FY 2010 and FY 2011 rate setting, there was a separate adjustment to reflect the no inflation policy for hospital rates since that was not reflected in the data used to develop trend. For the FY 2012 rate setting, the no inflation policy should be fully reflected in the trend and we have removed this operating component of the hospital inpatient adjustment and the freestanding inpatient psychiatric hospital adjustment described below.

Hospital outpatient adjustment

The Virginia General Assembly reduced the cost basis for reimbursement of outpatient hospital services from 80% to 77% for FY 2011 (eventually this was limited only to the period from July 1, 2010 through September 30, 2010) and then to 76% for FY 2012, a decrease of 5.0% from the original 80% base. This is applied to all outpatient services except for triage fees paid in an 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, which varies by aid category. The exemption produces a 4.7% reduction for Emergency Department, and the full 5.0% reduction is applied to the Outpatient-Other services line. There is no effect on outpatient psychological services.

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

Nursing facility adjustment

This is a two step adjustment. DMAS provided information on supplemental payments to nursing facilities that are based upon DMAS reconciliation to nursing home submitted cost reports and which are not included in the historical claims databases. An adjustment for the supplemental payments is calculated against the total remitted

claims. The 4.5% cost settlement percentage was provided by DMAS and is applied to the DMAS paid amount on the Nursing Facility service line. Nursing facility patient payments are not included.

The Virginia General Assembly reduced the nursing facility capital rental rate from 9% to 8%, a decrease of 11.1% effective FY2012. DMAS estimates that 10% of nursing facility payments are for the capital rent. Again, nursing facility patient payments are not included.

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

Home and community-based care fee reduction adjustment

The Virginia General Assembly reduced the home and community based care services fees by 1%, effective FY2012. This adjustment is applied to Adult Day Care, Consumer Directed Services, and Personal Care Services.

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

Other adjustments

Managed Care Utilization Adjustment

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

Because of the limited number of PACE programs, the voluntary nature of the programs and the small enrollment in each program, there are few estimates of managed care savings based upon actual utilization. Those that are available report net Medicaid savings on the order of 15 percent or more. We also reviewed administrative financial data provided by the contracting PACE plans and conducted discussions with DMAS staff.

The actual level of managed care savings that can be realized depends upon a number of factors. Consequently, there is a range of reasonable savings assumptions. We have assumed that PACE plan utilization management and cost controls will result in reductions in overall costs of 22%. Prescription drugs and non-emergency transportation are exempt from the adjustment⁵. A small brand-generic improvement factor for prescription drugs for the non-dual population is incorporated as a managed care savings in the Prescription Drug Adjustment described earlier. The managed care adjustment factor is shown in Exhibit 2k and is applied in Exhibits 4a and 4b under the column labeled “Managed Care Utilization Adjustment”. The managed care adjustment must be considered in conjunction with the administrative cost adjustment described below, to arrive at the expectation of net Medicaid savings.

Administrative Cost Adjustment

The CMS regulations require that administrative costs directly related to the provision of Medicaid State Plan approved services be incorporated into the rate-setting process. The PACE plans provided revenue and administrative cost data for FY 2009 and/or FY 2010 as downloads from their financial reporting systems. These were evaluated to assist in determining an appropriate administrative factor.

The data submitted by the plans included overhead and allocation charges from the integrated delivery system operations that can be classified as medical costs. Because a number of the PACE programs are new and have small enrollment, there was wide variation in reported administrative cost. The administrative cost percentage is

⁵ The small amount of non-dual Medicare cross over services are also exempt from the managed care utilization adjustment

expected to decline as full operations are established and enrollment grows. A 15% administrative cost factor is applied to the total adjusted and trended claims amount for each rate payment category. This adjustment is shown in Exhibit 2k. This adjustment factor is applied in the final step of the per capita cost calculations at the bottom of each rate cell worksheet in Exhibits 4a and 4b.

V. Trend adjustments

The data used for the IBNR and trend calculations reflect experience for the period FY 2008 through FY 2010. Data for FY 2009 to FY 2010 is used to evaluate the base period trend and an additional year of data, FY 2008 through FY 2010, is used to develop contract period projected trend.

The data must be adjusted to reflect the contract period of FY 2012 through the application of trend rates that reflect changes in payment levels and utilization rates between the data period and the contract period. In addition, the claims data are not 100% “complete” in that some cost information is not available in the claims databases provided. Incomplete data result from the time lag between when services are provided and claims are fully paid. The amount of incomplete claims is referred to as Incurred but Not Reported (IBNR) and can be measured through actuarial models.

Trend and IBNR adjustment factors were developed using historical Virginia Medicaid FFS expenditures for FY 2009 to FY 2010 and are calculated separately for the dual and the non-dual populations. We also had paid claims information with run out through December 2010 and took into consideration the actual experience and information from DMAS on projected utilization and fee increases in budget estimates.

The historical data were evaluated using a PricewaterhouseCoopers model that estimates IBNR amounts using a variety of actuarially accepted methods, and trend using a least-squares regression methodology. Trend and IBNR factors were developed separately for the following service categories: Inpatient Medical/Surgical, Inpatient Psych, Outpatient Hospital, Practitioner, Prescription Drug, and Other. The Other category includes Lab/X-Ray services, DME and transportation. IBNR factors and trend rates for the Medicare cross-over, which are combined across all services, and long term care services, including Nursing Facility, Adult Day Care, and Personal Care, plus Consumer Directed personal care services, were developed from analysis of the historical data.

Annual trend rates must be applied to move the historical data from the midpoint of the data period (7/1/2009) to the midpoint of the contract period (1/1/2012), or two and a half years (30 months). Each category of service in Exhibits 3a and 3b shows a Data Period and a Contract Period trend. Data Period trends are applied from the midpoint of the data period to the end of the data period, and were developed from the historical regression analyses and budget work described above. The Contract Period trends are applied from the end of the data period to the midpoint of the contract period. For services with fee increases reflected in the adjustments in 2a through 2j, the contract period trend is in conjunction with the planned cost per unit increase.

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

Table I
Summary of Adjustments to Trend

Service	Time Period	PACE
Personal Care with Consumer Directed PC	Jul 2007 - Jun 2008	1.030
	Jul 2008 - Jun 2009	1.030
	Jul 2009 - Jun 2010	1.000
Inpatient - Med/Surg	Jul 2007 - Jun 2008	0.994
	Jul 2008 - Jun 2009	0.994
	Jul 2009 - Jun 2010	1.000
Inpatient - Psych	Jul 2007 - Jun 2008	0.994
	Jul 2008 - Jun 2009	0.994
	Jul 2009 - Jun 2010	1.000
Other	Jul 2007 - Jun 2008	0.932
	Jul 2008 - Jun 2009	0.932
	Jul 2009 - Jan 2010	0.932
	Feb 2010 - Jun 2010	0.937

Agency personal care services have had a modest growth rate while Consumer Directed Personal Care (CDPC) services payments have doubled each year from 2008 to 2010⁶. The evaluation of nursing home and personal care services trend included both DMAS and patient payment amounts. Trend evaluation for the Home and Community Based Care services includes both dual and non-dual experience. Adult Day Health was evaluated as an independent service and CDPC and personal care services were combined. Past home health services cost per unit fee reductions are reflected in the base data, so contract period trend is applied based on analysis of PMPM trend.

The total trend rates shown in Exhibits 3a and 3b represent the combination of Data Period and Contract Period trends, and are calculated using compound interest calculations. These trend/IBNR factors are applied to the historical data in Exhibits 4a and 4b by applicable service category in Exhibits 4a and 4b.

VI. Summary capitation rates

The historical data presented in Exhibits 1a and 1b is adjusted by the factors shown in Exhibits 2a through 2k and the Trend and IBNR factors in Exhibits 3a and 3b. These are applied in Exhibits 4a and 4b.

A column is added to Exhibits 4a and 4b to show the comparative Upper Payment Limit (UPL) calculation. For most of the service lines, the value of the UPL PMPM is equal to the base period Medicaid payment, the completion factor adjustment, applicable policy and program adjustments, and trend. UPL is before the application of the

⁶ The CDPC increase is primarily a utilization trend, rather than a cost trend, effect. There has been an increase in both the proportion of eligibles that elect consumer direction and the approved CDPC level of care (hours per week).

managed care adjustment. For prescription drug and non-emergency transportation, the projected PMPM value is the same in the UPL and the FY 2012 PACE rates. The 2% administrative factor is the estimated cost of DMAS staff and monitoring activities for the existing PACE programs.

The managed care adjustment and health plan administrative factor are applied to the UPL values to produce the PACE rates shown in Exhibit 5a. All averages are weighted by the distribution of member months for the historical FY 2009 to FY 2010 time period. This exhibit also presents the UPL rate summary for comparison. Overall, the PACE rates are approximately 9.6% below the Upper Payment Limit and therefore meet CMS PACE rate setting checklist requirements. A different weighting, using PACE enrollees as of December 2010, results in a slightly lower statewide total PMPM and PACE rates that are 9.7% below the Upper Payment Limit.

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

**Table 2
Nursing Home vs. Non-Nursing Home Blending Factor**

Region	Dual Population			Non-Dual Population		
	Member Months	Member Months	Member Months	Member Months	Member Months	Member Months
Region	NH	Non-NH	%NH	NH	Non-NH	%NH
Northern Virginia	53,605	31,704	62.8%	4,831	5,114	48.6%
Other MSA	91,025	32,179	73.9%	4,367	3,151	58.1%
Richmond/Charlottesville	73,606	46,778	61.1%	4,772	5,782	45.2%
Rural	115,348	69,014	62.6%	4,907	6,846	41.7%
Tidewater	77,834	41,777	65.1%	6,770	5,931	53.3%
Statewide-PACE	411,418	221,452	65.0%	25,647	26,823	48.9%

DMAS modified its policy and PACE rates are benchmarked to the statewide average proportion of the eligible population that is in nursing homes. Therefore, the rates in Exhibit 5a are re-weighted to reflect a dual population that is 65.0% in nursing homes and a non-dual population with 48.9% in nursing homes. This is used in conjunction with cost factors that are the ratio of the average PMPM for those in nursing homes and those in community based care relative to the regional average PMPM. The relative cost factors and the resulting blending factors are presented in Exhibit 5b.

PACE capitation rates for FY 2012 after the re-weighting are presented in Exhibit 5c. A comparison of the rates before and after the blending is shown in Exhibit 5d. All averages are weighted by the distribution of member months for the historical FY 2009 to FY 2010 time period.

A comparison of FY 2012 PACE rates to FY 2011 rates in Exhibit 5e shows a 4.9% increase in the dual population rates, a 4.2% increase in the non-dual PACE rates, and an overall increase of 4.8%. The composite year-to-year change by region ranges from a 3.7% to a 5.9% increase. If the regional rates are weighted by the PACE enrollee population as of December 2010, there is a 5.2% increase in the dual population rates, a 4.5% increase in the non-dual PACE rates, and an overall increase of 5.2%.

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Northern Virginia	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	85,309						
Service Type							
Adult Day Care	\$3,254,699	\$4,199	\$3,258,899	\$38.20	149,249	20,994	\$21.84
Ambulatory Surgery Center	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Case Management Services	\$8,745	\$0	\$8,745	\$0.10	2,662	374	\$3.29
Consumer Directed Services	\$18,738,174	\$134,827	\$18,873,001	\$221.23	1,499,457	210,920	\$12.59
DME/Supplies	\$1,899,036	\$4,060	\$1,903,097	\$22.31	17,446	2,454	\$109.08
Emergency	\$7,391	\$0	\$7,391	\$0.09	14	2	\$527.91
FQHC	\$499	\$0	\$499	\$0.01	7	1	\$71.29
Home Health Services	\$31,750	\$0	\$31,750	\$0.37	67	9	\$473.88
Inpatient - Medical/Surgical	\$6,234,070	\$93,943	\$6,328,013	\$74.18	959	135	\$6,598.55
Inpatient - Psych	\$719,060	\$14,360	\$733,420	\$8.60	1,477	208	\$496.56
Lab and X-ray Services	\$9,238	\$0	\$9,238	\$0.11	662	93	\$13.95
Medicare Xover - IP	\$2,070,281	\$0	\$2,070,281	\$24.27	1,926	271	\$1,074.91
Medicare Xover - Nursing Facility	\$1,339,812	\$34,893	\$1,374,705	\$16.11	88,832	12,496	\$15.48
Medicare Xover - OP	\$973,544	\$50	\$973,594	\$11.41	8,614	1,212	\$113.02
Medicare Xover - Other	\$708,402	\$428	\$708,830	\$8.31	27,867	3,920	\$25.44
Medicare Xover - Physician	\$2,104,364	\$43	\$2,104,407	\$24.67	60,635	8,529	\$34.71
Nursing Facility	\$202,933,077	\$44,393,106	\$247,326,183	\$2,899.17	1,398,975	196,786	\$176.79
Outpatient - Other	\$744,733	\$0	\$744,733	\$8.73	212	30	\$3,512.89
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$46,931,103	\$320,920	\$47,252,023	\$553.89	520,046	73,152	\$90.86
Physician - Clinic	\$51,025	\$0	\$51,025	\$0.60	16,443	2,313	\$3.10
Physician - IP Mental Health	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Physician - OP Mental Health	\$9,863,663	\$2,958	\$9,866,622	\$115.66	641,252	90,201	\$15.39
Physician - Other Practitioner	\$531,986	\$449	\$532,434	\$6.24	6,748	949	\$78.90
Physician - PCP	\$134,654	\$1,058	\$135,712	\$1.59	2,451	345	\$55.37
Physician - Specialist	\$68,884	\$1,483	\$70,368	\$0.82	2,241	315	\$31.40
Pharmacy	\$1,474,268	\$0	\$1,474,268	\$17.28	179,210	25,208	\$8.23
Transportation - Emergency	\$11,375	\$0	\$11,375	\$0.13	131	18	\$86.83
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$300,843,833	\$45,006,779	\$345,850,611	\$4,054.08	4,627,583		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Other MSA	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	123,203						
Service Type							
Adult Day Care	\$654,041	\$8,507	\$662,547	\$5.38	15,485	1,508	\$42.79
Ambulatory Surgery Center	\$921	\$0	\$921	\$0.01	2	0	\$460.33
Case Management Services	\$13,320	\$0	\$13,320	\$0.11	4,000	390	\$3.33
Consumer Directed Services	\$14,352,061	\$151,597	\$14,503,658	\$117.72	1,484,095	144,551	\$9.77
DME/Supplies	\$2,009,756	\$714	\$2,010,470	\$16.32	25,140	2,449	\$79.97
Emergency	\$851	\$0	\$851	\$0.01	7	1	\$121.57
FQHC	\$1,185	\$602	\$1,787	\$0.01	22	2	\$81.22
Home Health Services	\$12,662	\$0	\$12,662	\$0.10	51	5	\$248.28
Inpatient - Medical/Surgical	\$1,812,100	\$148,623	\$1,960,723	\$15.91	651	63	\$3,011.86
Inpatient - Psych	\$405,934	\$30,571	\$436,505	\$3.54	837	82	\$521.51
Lab and X-ray Services	\$17,377	\$0	\$17,377	\$0.14	1,024	100	\$16.97
Medicare Xover - IP	\$3,304,551	\$0	\$3,304,551	\$26.82	3,434	334	\$962.30
Medicare Xover - Nursing Facility	\$1,787,349	\$108,680	\$1,896,029	\$15.39	151,184	14,725	\$12.54
Medicare Xover - OP	\$1,134,957	\$0	\$1,134,957	\$9.21	10,577	1,030	\$107.30
Medicare Xover - Other	\$1,146,659	\$244	\$1,146,903	\$9.31	48,508	4,725	\$23.64
Medicare Xover - Physician	\$2,660,564	\$108	\$2,660,672	\$21.60	114,357	11,138	\$23.27
Nursing Facility	\$279,731,980	\$66,003,845	\$345,735,825	\$2,806.22	2,377,312	231,550	\$145.43
Outpatient - Other	\$72,677	\$0	\$72,677	\$0.59	468	46	\$155.29
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$26,812,400	\$214,263	\$27,026,663	\$219.37	490,941	47,818	\$55.05
Physician - Clinic	\$5,068	\$0	\$5,068	\$0.04	2,680	261	\$1.89
Physician - IP Mental Health	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Physician - OP Mental Health	\$7,764,457	\$376	\$7,764,833	\$63.02	528,956	51,520	\$14.68
Physician - Other Practitioner	\$507,058	\$270	\$507,329	\$4.12	9,722	947	\$52.18
Physician - PCP	\$70,398	\$1,710	\$72,107	\$0.59	2,258	220	\$31.93
Physician - Specialist	\$49,128	\$1,509	\$50,638	\$0.41	1,496	146	\$33.85
Pharmacy	\$2,692,399	\$0	\$2,692,399	\$21.85	330,673	32,207	\$8.14
Transportation - Emergency	\$26,564	\$0	\$26,564	\$0.22	360	35	\$73.79
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$347,046,416	\$66,671,618	\$413,718,034	\$3,358.01	5,604,240		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	120,384						
Service Type							
Adult Day Care	\$2,841,630	\$11,498	\$2,853,128	\$23.70	63,756	6,355	\$44.75
Ambulatory Surgery Center	\$2,237	\$0	\$2,237	\$0.02	5	0	\$447.46
Case Management Services	\$75	\$0	\$75	\$0.00	1	0	\$75.00
Consumer Directed Services	\$18,222,663	\$251,770	\$18,474,433	\$153.46	1,883,983	187,798	\$9.81
DME/Supplies	\$3,307,136	\$1,215	\$3,308,351	\$27.48	38,040	3,792	\$86.97
Emergency	\$3,133	\$0	\$3,133	\$0.03	17	2	\$184.29
FQHC	\$1,612	\$522	\$2,134	\$0.02	30	3	\$71.14
Home Health Services	\$13,807	\$0	\$13,807	\$0.11	94	9	\$146.88
Inpatient - Medical/Surgical	\$2,073,242	\$115,290	\$2,188,531	\$18.18	616	61	\$3,552.81
Inpatient - Psych	\$177,989	\$4,828	\$182,817	\$1.52	366	36	\$499.50
Lab and X-ray Services	\$8,937	\$0	\$8,937	\$0.07	616	61	\$14.51
Medicare Xover - IP	\$4,148,275	\$16	\$4,148,291	\$34.46	3,842	383	\$1,079.72
Medicare Xover - Nursing Facility	\$1,961,045	\$72,737	\$2,033,782	\$16.89	153,017	15,253	\$13.29
Medicare Xover - OP	\$1,224,154	\$0	\$1,224,154	\$10.17	13,527	1,348	\$90.50
Medicare Xover - Other	\$1,369,073	\$298	\$1,369,371	\$11.38	52,853	5,268	\$25.91
Medicare Xover - Physician	\$3,190,531	\$61	\$3,190,592	\$26.50	118,217	11,784	\$26.99
Nursing Facility	\$226,662,873	\$58,241,682	\$284,904,554	\$2,366.64	1,900,887	189,483	\$149.88
Outpatient - Other	\$276,691	\$525	\$277,216	\$2.30	128	13	\$2,165.75
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$52,355,156	\$553,853	\$52,909,010	\$439.50	840,895	83,821	\$62.92
Physician - Clinic	\$9,010	\$0	\$9,010	\$0.07	3,011	300	\$2.99
Physician - IP Mental Health	\$110	\$0	\$110	\$0.00	1	0	\$110.48
Physician - OP Mental Health	\$12,458,467	\$4,061	\$12,462,528	\$103.52	942,580	93,958	\$13.22
Physician - Other Practitioner	\$612,242	\$174	\$612,416	\$5.09	10,017	999	\$61.14
Physician - PCP	\$77,454	\$863	\$78,317	\$0.65	1,863	186	\$42.04
Physician - Specialist	\$63,381	\$776	\$64,158	\$0.53	1,522	152	\$42.15
Pharmacy	\$1,775,780	\$0	\$1,775,780	\$14.75	234,272	23,353	\$7.58
Transportation - Emergency	\$61,250	\$0	\$61,250	\$0.51	782	78	\$78.32
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$332,897,953	\$59,260,168	\$392,158,121	\$3,257.57	6,264,938		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Rural	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	184,362						
Service Type							
Adult Day Care	\$661,843	\$7,044	\$668,887	\$3.63	14,943	973	\$44.76
Ambulatory Surgery Center	\$558	\$0	\$558	\$0.00	1	0	\$557.82
Case Management Services	\$104,968	\$0	\$104,968	\$0.57	31,527	2,052	\$3.33
Consumer Directed Services	\$26,554,443	\$250,741	\$26,805,184	\$145.39	2,738,852	178,270	\$9.79
DME/Supplies	\$4,739,208	\$7,337	\$4,746,544	\$25.75	55,231	3,595	\$85.94
Emergency	\$7,939	\$0	\$7,939	\$0.04	27	2	\$294.05
FQHC	\$6,181	\$167	\$6,349	\$0.03	91	6	\$69.77
Home Health Services	\$53,234	\$0	\$53,234	\$0.29	107	7	\$497.52
Inpatient - Medical/Surgical	\$3,677,924	\$132,273	\$3,810,196	\$20.67	824	54	\$4,624.02
Inpatient - Psych	\$556,461	\$25,387	\$581,848	\$3.16	1,113	72	\$522.77
Lab and X-ray Services	\$15,015	\$0	\$15,015	\$0.08	1,119	73	\$13.42
Medicare Xover - IP	\$5,751,467	\$60	\$5,751,527	\$31.20	5,833	380	\$986.03
Medicare Xover - Nursing Facility	\$3,304,032	\$116,295	\$3,420,327	\$18.55	251,109	16,345	\$13.62
Medicare Xover - OP	\$2,348,714	\$148	\$2,348,862	\$12.74	25,799	1,679	\$91.04
Medicare Xover - Other	\$2,423,373	\$787	\$2,424,160	\$13.15	97,918	6,373	\$24.76
Medicare Xover - Physician	\$4,348,328	\$295	\$4,348,623	\$23.59	198,422	12,915	\$21.92
Nursing Facility	\$322,267,315	\$68,476,314	\$390,743,629	\$2,119.44	2,907,610	189,254	\$134.39
Outpatient - Other	\$63,446	\$17	\$63,463	\$0.34	505	33	\$125.67
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$65,954,160	\$597,138	\$66,551,298	\$360.98	1,252,871	81,549	\$53.12
Physician - Clinic	\$1,569	\$0	\$1,569	\$0.01	715	47	\$2.19
Physician - IP Mental Health	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Physician - OP Mental Health	\$15,307,947	\$4,674	\$15,312,621	\$83.06	1,149,464	74,818	\$13.32
Physician - Other Practitioner	\$974,609	\$1,486	\$976,096	\$5.29	16,583	1,079	\$58.86
Physician - PCP	\$132,970	\$3,247	\$136,217	\$0.74	8,718	567	\$15.62
Physician - Specialist	\$67,734	\$1,839	\$69,573	\$0.38	1,990	130	\$34.96
Pharmacy	\$3,660,915	\$0	\$3,660,915	\$19.86	437,585	28,482	\$8.37
Transportation - Emergency	\$50,538	\$0	\$50,538	\$0.27	427	28	\$118.36
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$463,034,891	\$69,625,249	\$532,660,140	\$2,889.21	9,199,384		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Tidewater	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	119,611						
Service Type							
Adult Day Care	\$386,514	\$2,103	\$388,617	\$3.25	8,448	848	\$46.00
Ambulatory Surgery Center	\$6,653	\$0	\$6,653	\$0.06	17	2	\$391.37
Case Management Services	\$5,277	\$0	\$5,277	\$0.04	1,586	159	\$3.33
Consumer Directed Services	\$7,728,205	\$66,895	\$7,795,100	\$65.17	799,037	80,163	\$9.76
DME/Supplies	\$3,678,193	\$1,835	\$3,680,028	\$30.77	34,820	3,493	\$105.69
Emergency	\$13,737	\$0	\$13,737	\$0.11	45	5	\$305.27
FQHC	\$206	\$0	\$206	\$0.00	5	1	\$41.25
Home Health Services	\$46,512	\$0	\$46,512	\$0.39	151	15	\$308.03
Inpatient - Medical/Surgical	\$2,480,014	\$76,563	\$2,556,577	\$21.37	518	52	\$4,935.48
Inpatient - Psych	\$188,280	\$13,674	\$201,954	\$1.69	377	38	\$535.69
Lab and X-ray Services	\$21,473	\$0	\$21,473	\$0.18	1,855	186	\$11.58
Medicare Xover - IP	\$3,342,529	\$1,719	\$3,344,248	\$27.96	3,178	319	\$1,052.31
Medicare Xover - Nursing Facility	\$1,763,210	\$172,867	\$1,936,077	\$16.19	187,076	18,768	\$10.35
Medicare Xover - OP	\$1,172,830	\$544	\$1,173,374	\$9.81	12,528	1,257	\$93.66
Medicare Xover - Other	\$1,485,698	(\$79)	\$1,485,620	\$12.42	53,968	5,414	\$27.53
Medicare Xover - Physician	\$3,388,108	\$77	\$3,388,185	\$28.33	128,793	12,921	\$26.31
Nursing Facility	\$224,320,851	\$65,791,687	\$290,112,538	\$2,425.46	2,032,466	203,907	\$142.74
Outpatient - Other	\$134,330	\$0	\$134,330	\$1.12	88	9	\$1,526.47
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$59,005,300	\$456,142	\$59,461,442	\$497.12	944,439	94,751	\$62.96
Physician - Clinic	\$42,648	\$0	\$42,648	\$0.36	12,084	1,212	\$3.53
Physician - IP Mental Health	\$856	\$0	\$856	\$0.01	16	2	\$53.48
Physician - OP Mental Health	\$15,207,123	\$2,461	\$15,209,584	\$127.16	1,167,409	117,120	\$13.03
Physician - Other Practitioner	\$356,058	\$207	\$356,265	\$2.98	7,254	728	\$49.11
Physician - PCP	\$135,168	\$1,603	\$136,771	\$1.14	3,970	398	\$34.45
Physician - Specialist	\$64,436	\$921	\$65,357	\$0.55	1,759	176	\$37.16
Pharmacy	\$2,336,409	\$0	\$2,336,409	\$19.53	267,789	26,866	\$8.72
Transportation - Emergency	\$28,675	\$0	\$28,675	\$0.24	335	34	\$85.60
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$327,339,293	\$66,589,218	\$393,928,512	\$3,293.41	5,670,011		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
All Regions	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	632,870						
Service Type							
Adult Day Care	\$7,798,727	\$33,351	\$7,832,078	\$12.38	251,881	4,776	\$31.09
Ambulatory Surgery Center	\$10,369	\$0	\$10,369	\$0.02	25	0	\$414.76
Case Management Services	\$132,385	\$0	\$132,385	\$0.21	39,776	754	\$3.33
Consumer Directed Services	\$85,595,545	\$855,830	\$86,451,376	\$136.60	8,405,424	159,377	\$10.29
DME/Supplies	\$15,633,330	\$15,161	\$15,648,491	\$24.73	170,677	3,236	\$91.68
Emergency	\$33,051	\$0	\$33,051	\$0.05	110	2	\$300.46
FQHC	\$9,684	\$1,291	\$10,975	\$0.02	155	3	\$70.81
Home Health Services	\$157,966	\$0	\$157,966	\$0.25	470	9	\$336.10
Inpatient - Medical/Surgical	\$16,277,348	\$566,692	\$16,844,040	\$26.62	3,568	68	\$4,720.86
Inpatient - Psych	\$2,047,724	\$88,820	\$2,136,544	\$3.38	4,170	79	\$512.36
Lab and X-ray Services	\$72,040	\$0	\$72,040	\$0.11	5,276	100	\$13.65
Medicare Xover - IP	\$18,617,104	\$1,794	\$18,618,899	\$29.42	18,213	345	\$1,022.29
Medicare Xover - Nursing Facility	\$10,155,449	\$505,472	\$10,660,921	\$16.85	831,218	15,761	\$12.83
Medicare Xover - OP	\$6,854,199	\$742	\$6,854,941	\$10.83	71,045	1,347	\$96.49
Medicare Xover - Other	\$7,133,206	\$1,678	\$7,134,884	\$11.27	281,114	5,330	\$25.38
Medicare Xover - Physician	\$15,691,895	\$584	\$15,692,479	\$24.80	620,424	11,764	\$25.29
Nursing Facility	\$1,255,916,095	\$302,906,634	\$1,558,822,728	\$2,463.10	10,617,250	201,316	\$146.82
Outpatient - Other	\$1,291,876	\$542	\$1,292,418	\$2.04	1,401	27	\$922.50
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$251,058,120	\$2,142,315	\$253,200,435	\$400.08	4,049,192	76,778	\$62.53
Physician - Clinic	\$109,319	\$0	\$109,319	\$0.17	34,933	662	\$3.13
Physician - IP Mental Health	\$966	\$0	\$966	\$0.00	17	0	\$56.83
Physician - OP Mental Health	\$60,601,657	\$14,530	\$60,616,187	\$95.78	4,429,661	83,992	\$13.68
Physician - Other Practitioner	\$2,981,953	\$2,587	\$2,984,540	\$4.72	50,324	954	\$59.31
Physician - PCP	\$550,644	\$8,481	\$559,125	\$0.88	19,260	365	\$29.03
Physician - Specialist	\$313,564	\$6,529	\$320,093	\$0.51	9,008	171	\$35.53
Pharmacy	\$11,939,770	\$0	\$11,939,770	\$18.87	1,449,529	27,485	\$8.24
Transportation - Emergency	\$178,401	\$0	\$178,401	\$0.28	2,035	39	\$87.67
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$1,771,162,386	\$307,153,032	\$2,078,315,418	\$3,283.95	31,366,156		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Northern Virginia	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	9,944						
Service Type							
Adult Day Care	\$158,385	\$0	\$158,385	\$15.93	5,913	7,136	\$26.79
Ambulatory Surgery Center	\$14,262	\$0	\$14,262	\$1.43	22	27	\$648.29
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$3,500,789	\$4,486	\$3,505,275	\$352.50	282,844	341,322	\$12.39
DME/Supplies	\$770,477	\$1	\$770,478	\$77.48	6,167	7,442	\$124.94
Emergency	\$398,444	\$0	\$398,444	\$40.07	609	735	\$654.26
FQHC	\$4,404	\$0	\$4,404	\$0.44	160	193	\$27.52
Home Health Services	\$322,862	\$0	\$322,862	\$32.47	758	915	\$425.94
Inpatient - Medical/Surgical	\$7,852,260	\$1,081	\$7,853,342	\$789.75	643	776	\$12,213.60
Inpatient - Psych	\$12,642	\$0	\$12,642	\$1.27	15	18	\$842.82
Lab and X-ray Services	\$244,187	\$0	\$244,187	\$24.56	17,848	21,538	\$13.68
Medicare Xover - IP	\$39,721	\$0	\$39,721	\$3.99	46	56	\$863.49
Medicare Xover - Nursing Facility	\$11,882	\$0	\$11,882	\$1.19	939	1,133	\$12.65
Medicare Xover - OP	\$23,343	\$0	\$23,343	\$2.35	231	279	\$101.05
Medicare Xover - Other	\$31,052	\$0	\$31,052	\$3.12	958	1,156	\$32.41
Medicare Xover - Physician	\$46,429	\$0	\$46,429	\$4.67	1,465	1,768	\$31.69
Nursing Facility	\$22,410,811	\$1,840,340	\$24,251,152	\$2,438.76	134,914	162,808	\$179.75
Outpatient - Other	\$1,042,594	\$0	\$1,042,594	\$104.85	1,113	1,343	\$936.74
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$7,585,456	\$15,696	\$7,601,152	\$764.39	84,771	102,298	\$89.67
Physician - Clinic	\$675,832	\$0	\$675,832	\$67.96	205,633	248,148	\$3.29
Physician - IP Mental Health	\$459	\$0	\$459	\$0.05	8	10	\$57.32
Physician - OP Mental Health	\$1,847,641	\$728	\$1,848,369	\$185.88	108,650	131,114	\$17.01
Physician - Other Practitioner	\$283,949	\$3	\$283,952	\$28.55	15,636	18,869	\$18.16
Physician - PCP	\$952,844	\$40	\$952,884	\$95.82	20,768	25,062	\$45.88
Physician - Specialist	\$633,166	\$304	\$633,470	\$63.70	21,899	26,427	\$28.93
Pharmacy	\$4,657,903	\$0	\$4,657,903	\$468.41	81,687	98,576	\$57.02
Transportation - Emergency	\$61,432	\$0	\$61,432	\$6.18	793	957	\$77.47
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$53,583,225	\$1,862,680	\$55,445,906	\$5,575.79	994,490		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Other MSA	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	7,518						
Service Type							
Adult Day Care	\$47,582	\$96	\$47,678	\$6.34	1,035	1,652	\$46.07
Ambulatory Surgery Center	\$15,030	\$0	\$15,030	\$2.00	26	41	\$578.06
Case Management Services	\$1,782	\$0	\$1,782	\$0.24	535	854	\$3.33
Consumer Directed Services	\$1,565,663	\$2,287	\$1,567,950	\$208.56	161,198	257,295	\$9.73
DME/Supplies	\$717,651	\$9	\$717,660	\$95.46	5,989	9,559	\$119.83
Emergency	\$220,152	\$0	\$220,152	\$29.28	494	788	\$445.65
FQHC	\$35,755	\$203	\$35,958	\$4.78	490	782	\$73.38
Home Health Services	\$259,621	\$0	\$259,621	\$34.53	876	1,398	\$296.37
Inpatient - Medical/Surgical	\$6,227,568	\$1,750	\$6,229,318	\$828.57	581	927	\$10,721.72
Inpatient - Psych	\$12,179	\$0	\$12,179	\$1.62	11	18	\$1,107.15
Lab and X-ray Services	\$242,658	\$0	\$242,658	\$32.28	16,942	27,042	\$14.32
Medicare Xover - IP	\$35,797	\$0	\$35,797	\$4.76	38	61	\$942.01
Medicare Xover - Nursing Facility	\$5,952	\$0	\$5,952	\$0.79	567	905	\$10.50
Medicare Xover - OP	\$20,080	\$0	\$20,080	\$2.67	149	238	\$134.77
Medicare Xover - Other	\$20,091	\$0	\$20,091	\$2.67	819	1,307	\$24.53
Medicare Xover - Physician	\$62,593	\$12	\$62,605	\$8.33	1,356	2,164	\$46.17
Nursing Facility	\$16,115,012	\$1,004,267	\$17,119,280	\$2,277.07	119,956	191,467	\$142.71
Outpatient - Other	\$986,957	\$0	\$986,957	\$131.28	1,466	2,340	\$673.23
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$2,218,262	\$19,035	\$2,237,297	\$297.59	41,479	66,206	\$53.94
Physician - Clinic	\$270,078	\$0	\$270,078	\$35.92	48,396	77,247	\$5.58
Physician - IP Mental Health	\$1,798	\$0	\$1,798	\$0.24	23	37	\$78.17
Physician - OP Mental Health	\$820,506	\$0	\$820,506	\$109.14	43,553	69,517	\$18.84
Physician - Other Practitioner	\$190,880	\$8	\$190,888	\$25.39	9,125	14,565	\$20.92
Physician - PCP	\$702,250	\$33	\$702,283	\$93.41	27,205	43,423	\$25.81
Physician - Specialist	\$481,964	\$25	\$481,989	\$64.11	11,300	18,036	\$42.65
Pharmacy	\$4,109,745	\$0	\$4,109,745	\$546.64	79,857	127,463	\$51.46
Transportation - Emergency	\$95,076	\$0	\$95,076	\$12.65	1,160	1,852	\$81.96
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$35,482,681	\$1,027,726	\$36,510,407	\$4,856.31	574,626		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Richmond/Charlottesville	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	10,554						
Service Type							
Adult Day Care	\$399,887	\$0	\$399,887	\$37.89	8,775	9,977	\$45.57
Ambulatory Surgery Center	\$13,105	\$0	\$13,105	\$1.24	24	27	\$546.04
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$2,579,596	\$1,443	\$2,581,039	\$244.55	266,930	303,496	\$9.67
DME/Supplies	\$1,169,942	\$0	\$1,169,942	\$110.85	9,662	10,986	\$121.09
Emergency	\$544,401	\$0	\$544,401	\$51.58	830	944	\$655.90
FQHC	\$36,019	\$0	\$36,019	\$3.41	455	517	\$79.16
Home Health Services	\$408,275	\$0	\$408,275	\$38.68	1,401	1,593	\$291.42
Inpatient - Medical/Surgical	\$10,461,915	\$543	\$10,462,458	\$991.31	824	937	\$12,697.16
Inpatient - Psych	\$23,723	\$0	\$23,723	\$2.25	32	36	\$741.35
Lab and X-ray Services	\$305,241	\$0	\$305,241	\$28.92	20,111	22,866	\$15.18
Medicare Xover - IP	\$37,744	\$0	\$37,744	\$3.58	51	58	\$740.09
Medicare Xover - Nursing Facility	\$8,616	\$910	\$9,526	\$0.90	808	919	\$11.79
Medicare Xover - OP	\$23,398	\$0	\$23,398	\$2.22	268	305	\$87.31
Medicare Xover - Other	\$40,842	\$0	\$40,842	\$3.87	1,233	1,402	\$33.12
Medicare Xover - Physician	\$83,933	\$0	\$83,933	\$7.95	1,756	1,997	\$47.80
Nursing Facility	\$19,387,824	\$1,226,819	\$20,614,644	\$1,953.22	134,860	153,334	\$152.86
Outpatient - Other	\$1,954,678	\$0	\$1,954,678	\$185.20	2,498	2,840	\$782.50
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$5,305,069	\$19,235	\$5,324,305	\$504.47	89,842	102,149	\$59.26
Physician - Clinic	\$784,986	\$4	\$784,990	\$74.38	185,541	210,958	\$4.23
Physician - IP Mental Health	\$2,775	\$0	\$2,775	\$0.26	42	48	\$66.07
Physician - OP Mental Health	\$1,561,672	\$0	\$1,561,672	\$147.97	99,208	112,798	\$15.74
Physician - Other Practitioner	\$360,210	\$86	\$360,296	\$34.14	27,440	31,199	\$13.13
Physician - PCP	\$920,765	\$176	\$920,940	\$87.26	20,202	22,969	\$45.59
Physician - Specialist	\$671,130	\$4	\$671,134	\$63.59	12,867	14,630	\$52.16
Pharmacy	\$4,633,195	\$0	\$4,633,195	\$438.99	92,279	104,920	\$50.21
Transportation - Emergency	\$136,077	\$0	\$136,077	\$12.89	1,852	2,106	\$73.48
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$51,855,018	\$1,249,221	\$53,104,239	\$5,031.58	979,791		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Rural	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	11,753						
Service Type							
Adult Day Care	\$6,363	\$0	\$6,363	\$0.54	138	141	\$46.11
Ambulatory Surgery Center	\$21,769	\$0	\$21,769	\$1.85	45	46	\$483.76
Case Management Services	\$7,093	\$0	\$7,093	\$0.60	2,130	2,175	\$3.33
Consumer Directed Services	\$2,518,297	\$3,677	\$2,521,975	\$214.58	258,995	264,431	\$9.74
DME/Supplies	\$1,530,342	\$643	\$1,530,984	\$130.26	13,311	13,590	\$115.02
Emergency	\$478,033	\$0	\$478,033	\$40.67	1,310	1,337	\$364.91
FQHC	\$219,623	\$20	\$219,643	\$18.69	3,366	3,437	\$65.25
Home Health Services	\$791,309	\$0	\$791,309	\$67.33	2,032	2,075	\$389.42
Inpatient - Medical/Surgical	\$8,561,966	\$3,929	\$8,565,896	\$728.81	900	919	\$9,517.66
Inpatient - Psych	\$2,600	\$0	\$2,600	\$0.22	3	3	\$866.73
Lab and X-ray Services	\$385,725	\$0	\$385,725	\$32.82	26,784	27,346	\$14.40
Medicare Xover - IP	\$61,700	\$0	\$61,700	\$5.25	69	70	\$894.21
Medicare Xover - Nursing Facility	\$8,780	\$0	\$8,780	\$0.75	1,394	1,423	\$6.30
Medicare Xover - OP	\$49,404	\$0	\$49,404	\$4.20	481	491	\$102.71
Medicare Xover - Other	\$66,067	\$9	\$66,076	\$5.62	2,160	2,205	\$30.59
Medicare Xover - Physician	\$94,163	\$6	\$94,169	\$8.01	3,071	3,135	\$30.66
Nursing Facility	\$17,420,247	\$594,341	\$18,014,588	\$1,532.73	133,830	136,639	\$134.61
Outpatient - Other	\$1,499,665	\$200	\$1,499,865	\$127.61	2,670	2,726	\$561.75
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$5,918,361	\$27,766	\$5,946,126	\$505.91	114,859	117,270	\$51.77
Physician - Clinic	\$754,083	\$17	\$754,100	\$64.16	209,942	214,349	\$3.59
Physician - IP Mental Health	\$1,574	\$0	\$1,574	\$0.13	26	27	\$60.53
Physician - OP Mental Health	\$1,799,243	\$26	\$1,799,269	\$153.09	97,033	99,070	\$18.54
Physician - Other Practitioner	\$247,191	\$11	\$247,202	\$21.03	20,338	20,765	\$12.15
Physician - PCP	\$1,221,529	\$341	\$1,221,871	\$103.96	38,956	39,774	\$31.37
Physician - Specialist	\$661,650	\$216	\$661,866	\$56.31	14,713	15,022	\$44.99
Pharmacy	\$6,578,932	\$0	\$6,578,932	\$559.75	123,797	126,395	\$53.14
Transportation - Emergency	\$204,507	\$0	\$204,507	\$17.40	1,913	1,953	\$106.90
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$51,110,216	\$631,203	\$51,741,419	\$4,402.29	1,074,266		

Note:

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

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

VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
Tidewater	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	12,701						
Service Type							
Adult Day Care	\$21,764	\$0	\$21,764	\$1.71	476	450	\$45.72
Ambulatory Surgery Center	\$13,845	\$0	\$13,845	\$1.09	20	19	\$692.26
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$1,057,082	\$0	\$1,057,082	\$83.23	109,432	103,395	\$9.66
DME/Supplies	\$1,425,323	\$1,493	\$1,426,816	\$112.34	10,065	9,510	\$141.76
Emergency	\$577,834	\$0	\$577,834	\$45.50	1,163	1,099	\$496.85
FQHC	\$10,036	\$0	\$10,036	\$0.79	152	144	\$66.03
Home Health Services	\$610,566	\$0	\$610,566	\$48.07	1,916	1,810	\$318.67
Inpatient - Medical/Surgical	\$10,257,041	\$5,659	\$10,262,700	\$808.05	828	782	\$12,394.57
Inpatient - Psych	\$7,597	\$0	\$7,597	\$0.60	5	5	\$1,519.43
Lab and X-ray Services	\$332,148	\$0	\$332,148	\$26.15	27,925	26,385	\$11.89
Medicare Xover - IP	\$41,594	\$0	\$41,594	\$3.27	42	40	\$990.34
Medicare Xover - Nursing Facility	\$3,217	\$0	\$3,217	\$0.25	332	314	\$9.69
Medicare Xover - OP	\$27,166	\$0	\$27,166	\$2.14	265	250	\$102.51
Medicare Xover - Other	\$37,618	\$0	\$37,618	\$2.96	1,125	1,063	\$33.44
Medicare Xover - Physician	\$101,196	\$18	\$101,214	\$7.97	1,951	1,843	\$51.88
Nursing Facility	\$25,175,188	\$1,944,647	\$27,119,835	\$2,135.32	188,848	178,431	\$143.61
Outpatient - Other	\$1,553,091	\$0	\$1,553,091	\$122.28	1,893	1,789	\$820.44
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$7,749,075	\$12,552	\$7,761,627	\$611.12	128,474	121,387	\$60.41
Physician - Clinic	\$1,094,853	\$0	\$1,094,853	\$86.20	325,228	307,287	\$3.37
Physician - IP Mental Health	\$1,685	\$0	\$1,685	\$0.13	28	26	\$60.17
Physician - OP Mental Health	\$2,166,381	\$292	\$2,166,672	\$170.60	152,084	143,695	\$14.25
Physician - Other Practitioner	\$402,381	\$55	\$402,436	\$31.69	66,785	63,101	\$6.03
Physician - PCP	\$1,152,967	\$101	\$1,153,068	\$90.79	26,175	24,731	\$44.05
Physician - Specialist	\$752,038	\$151	\$752,190	\$59.22	14,890	14,069	\$50.52
Pharmacy	\$6,111,227	\$0	\$6,111,227	\$481.18	114,507	108,190	\$53.37
Transportation - Emergency	\$183,382	\$0	\$183,382	\$14.44	2,337	2,208	\$78.47
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$60,866,295	\$1,964,967	\$62,831,262	\$4,947.11	1,176,946		

Note:

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

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VIRGINIA MEDICAID
FY 2012 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Non-Dual Population

Exhibit 1b

Age 55 and Over							
All Regions	Medicaid Payments FY09 - FY10	Patient Payments FY09 - FY10	Total Payments FY09 - FY10	Unadjusted PMPM	Units FY09 - FY10	Units/1000 FY09 - FY10	Cost/Unit FY09 - FY10
Member Months	52,470						
Service Type							
Adult Day Care	\$633,981	\$96	\$634,077	\$12.08	16,337	3,736	\$38.81
Ambulatory Surgery Center	\$78,012	\$0	\$78,012	\$1.49	137	31	\$569.43
Case Management Services	\$8,874	\$0	\$8,874	\$0.17	2,665	609	\$3.33
Consumer Directed Services	\$11,221,428	\$11,893	\$11,233,321	\$214.09	1,079,397	246,859	\$10.41
DME/Supplies	\$5,613,734	\$2,145	\$5,615,879	\$107.03	45,194	10,336	\$124.26
Emergency	\$2,218,864	\$0	\$2,218,864	\$42.29	4,406	1,008	\$503.60
FQHC	\$305,837	\$223	\$306,060	\$5.83	4,623	1,057	\$66.20
Home Health Services	\$2,392,633	\$0	\$2,392,633	\$45.60	6,983	1,597	\$342.64
Inpatient - Medical/Surgical	\$43,360,750	\$12,963	\$43,373,713	\$826.63	3,776	864	\$11,486.68
Inpatient - Psych	\$58,742	\$0	\$58,742	\$1.12	66	15	\$890.02
Lab and X-ray Services	\$1,509,959	\$0	\$1,509,959	\$28.78	109,610	25,068	\$13.78
Medicare Xover - IP	\$216,556	\$0	\$216,556	\$4.13	246	56	\$880.31
Medicare Xover - Nursing Facility	\$38,448	\$910	\$39,358	\$0.75	4,040	924	\$9.74
Medicare Xover - OP	\$143,390	\$0	\$143,390	\$2.73	1,394	319	\$102.86
Medicare Xover - Other	\$195,671	\$9	\$195,680	\$3.73	6,295	1,440	\$31.08
Medicare Xover - Physician	\$388,313	\$36	\$388,349	\$7.40	9,599	2,195	\$40.46
Nursing Facility	\$100,509,082	\$6,610,415	\$107,119,497	\$2,041.53	712,408	162,928	\$150.36
Outpatient - Other	\$7,036,985	\$200	\$7,037,186	\$134.12	9,640	2,205	\$730.00
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$28,776,222	\$94,285	\$28,870,507	\$550.23	459,425	105,071	\$62.84
Physician - Clinic	\$3,579,832	\$22	\$3,579,854	\$68.23	974,740	222,924	\$3.67
Physician - IP Mental Health	\$8,290	\$0	\$8,290	\$0.16	127	29	\$65.27
Physician - OP Mental Health	\$8,195,443	\$1,046	\$8,196,489	\$156.21	500,528	114,471	\$16.38
Physician - Other Practitioner	\$1,484,611	\$162	\$1,484,773	\$28.30	139,324	31,864	\$10.66
Physician - PCP	\$4,950,354	\$691	\$4,951,045	\$94.36	133,306	30,487	\$37.14
Physician - Specialist	\$3,199,949	\$700	\$3,200,649	\$61.00	75,669	17,306	\$42.30
Pharmacy	\$26,091,003	\$0	\$26,091,003	\$497.25	492,127	112,550	\$53.02
Transportation - Emergency	\$680,473	\$0	\$680,473	\$12.97	8,055	1,842	\$84.48
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$252,897,435	\$6,735,796	\$259,633,231	\$4,948.20	4,800,117		

Note:

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

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

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Prescription Drug Adjustment

Exhibit 2a

	Dual Eligibles	Non-Dual Eligibles	Source
1. Fee-for-Service Net Cost PMPM	\$18.87	\$497.37	DMAS FY09-FY10 FFS Invoices
2. Fee-for-Service Net Cost per Script	\$8.24	\$53.02	DMAS FY09-FY10 FFS Invoices
3. Average Fee-for-Service Copayment per Script	\$0.02	\$0.05	DMAS FY09-FY10 FFS Invoices
4. Fee-for-Service Gross Cost per Script	\$8.26	\$53.07	= (2.) + (3.)
5. Average Fee-for-Service Dispensing Fees	\$2.78	\$3.07	DMAS FY09-FY10 FFS Invoices
6. Fee-for-Service Ingredient Cost per Script	\$5.48	\$50.00	= (4.) - (5.)
7. Average Fee-for-Service Rebate	12%	36%	Provided by DMAS
8. Fee-for-Service Cost per Script with Rebate	\$4.80	\$32.11	= (6.) * (1 - (7.))
9. Brand-Generic Improvement Adjustment	1.000	0.995	VA Claims Analysis
10. Adjusted Cost PMPM with Brand-Generic Improvement Adjustment	\$4.80	\$31.94	= (8.) * (9.)
11. Average Adjusted Fee-for-Service Dispensing Fees	\$2.69	\$2.97	= (5.) with reduction in dispensing fee effective FY10
12. Adjusted Cost per Script	\$7.49	\$34.92	= (10.) + (11.)
13. Adjusted Cost PMPM	\$17.16	\$327.53	= (12.) * scripts / MM
14. Pharmacy Adjustment Factor	-9.1%	-34.1%	= (13.) / (1.) -1

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Non-Emergency Transportation Adjustment

Exhibit 2b

	Adjustment Values	Source
Non-ER Transportation Rate		
Northern Virginia	\$46.19	CPI Adjusted Non-Emergency Transportation Rate
Other MSA	\$18.62	- Service Cost Component Only
Richmond/Charlottesville	\$27.85	
Rural	\$23.07	
Tidewater	\$24.67	

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Consumer Directed Long Term Care Adjustment

Exhibit 2c

	Adjustment Value	Source
1. % Fee Increase Effective FY10	3.0%	Provided by DMAS
2. Percent of Dollars Affected by Change	43.4%	DMAS FY09 FFS Invoices
3. Consumer Directed Long Term Care Adjustment	1.3%	= (1.) * (2.)

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Personal Care Services Fee Increase Adjustment

Exhibit 2d

	Adjustment Value	Source
1. % Fee Increase Effective FY10	3.0%	Provided by DMAS
2. Percent of Dollars Affected by Change	46.4%	DMAS FY09 FFS Invoices
3. Personal Care Services Fee Increase Adjustment	1.4%	= (1.) * (2.)

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
DME/Supplies Fee Reduction Adjustment

Exhibit 2e

	Adjustment Value	Source
1. Total claims in DME/Supplies Service Category	\$21,312,080	DMAS FY09-FY10 FFS Invoices
2. % Fee Reduction Effective FY11	10.0%	Provided by DMAS
3. Percent of Dollars Affected by Change	70.0%	Estimate based on Medallion II ABAD population
4. DME/Supplies Fee Reduction Adjustment	-7.0%	= - (2.) * (3.)

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Clinical Lab Fee Reduction Adjustment

Exhibit 2f

	Adjustment Value	Source
1. Total claims in Lab Service Category	\$1,588,640	DMAS FY09-FY10 FFS Invoices
2. % Fee Reduction Effective February 1, 2010*	5.0%	Provided by DMAS
3. Claims Associated with Clinical Lab Procedure Codes	76.3%	Estimate based on Medallion II ABAD population
4. Clinical Lab Fee Reduction Adjustment	-3.0%	= - (19 / 24 months) * (2.) * (3.)

* Note:

Reduction of 5% is applied 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 2012 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Hospital Inpatient Adjustments**

Exhibit 2g

	Inpatient Medical/Surgical	Inpatient - Psych	Source
1a. Total Claims in IP Service Categories FY09	\$29,791,325	\$1,453,858	DMAS FY09 FFS Invoices
1b. Total Claims in IP Service Categories FY10	\$30,426,428	\$741,428	DMAS FY10 FFS Invoices
2a. FY9 Hospital Capital Percentage	10.0%	10.0%	Provided by DMAS
2b. FY10 Hospital Capital Percentage	9.4%	9.3%	Provided by DMAS
3a. FY10 Capital Reimbursement Reduction	6.3%	6.3%	Provided by DMAS
3b. FY12 Capital Reimbursement Reduction	5.3%	5.3%	Provided by DMAS
4a. FY09 Dollar Decrease	\$175,748	\$8,577	= (1a.) * (2a.) * (1 - (1 - (3a.)) * (1 - (3b.)))
4b. FY10 Dollar Decrease	\$152,199	\$3,696	= (1b.) * (2b.) * (1 - (1 - (3b.)))
5. Hospital Inpatient Adjustment	-0.5%	-0.6%	= - ((4a.) + (4b.)) / ((1a.) + (1b.))

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

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Hospital Outpatient Adjustment

Exhibit 2h

		Dual Eligibles	Non-Dual Eligibles	Source
1.	Claims Associated with Outpatient Services			
	a. Emergency	\$32,978	\$2,236,929	DMAS FY09-FY10 FFS Invoices
	b. Outpatient - Other	\$1,289,030	\$7,094,278	
	c. Outpatient - Psychological	\$0	\$0	
2.	% ER Triage of Total Outpatient	6.0%	6.0%	Provided by DMAS
3.	% Emergency and Outpatient - Other of Total Outpatient	100.0%	100.0%	= ((1a.) + (1b.)) / ((1a.) + (1b.) + (1c.))
4.	% of Claims Exempt from Fee Reduction	6.0%	6.0%	= (2.) / (3.)
5.	FY12 Hospital Rate Reduction	5.0%	5.0%	Provided by DMAS
6.	Dollar Decrease			
	a. Emergency	\$1,550	\$105,136	= (1a.) * (1 - (4.)) * (5.)
	b. Outpatient - Other	\$64,451	\$354,714	= (1b.) * (5.)
	c. Outpatient - Psychological	\$0	\$0	= (1c.) * (5.)
7.	Hospital Outpatient Adjustment			
	a. Emergency	-4.7%	-4.7%	= - (6a.) / (1a.)
	b. Outpatient - Other	-5.0%	-5.0%	= - (6b.) / (1b.)
	c. Outpatient - Psychological	0.0%	0.0%	= - (6c.) / (1c.)

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Nursing Facility Adjustments

Exhibit 2i

	Adjustment Value	Source
1. FY12 Nursing Facility Capital Rental Rate Reduction	11.1%	Provided by DMAS
2. FY12 Nursing Facility Capital Rental Rate Percentage	10.0%	Provided by DMAS
3. Nursing Facility Cost Settlement Adjustment	4.5%	Provided by DMAS
4. Nursing Facility Adjustment	3.3%	$= [1 + (-(1.) * (2.))] * [1 + (3.)] - 1$

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Home and Community-Based Care Fee Reduction Adjustment

Exhibit 2j

		Adjustment Value	Source
1.	Claims associated with Home and Community-Based Care (HCBC)		
	a. Adult Day Care	\$8,475,118	DMAS FY09-FY10 FFS Invoices
	b. Consumer Directed Services	\$97,699,821	
	c. Personal Care Services	\$282,260,657	
2.	FY12 HCBC Fee Reduction	1.0%	Provided by DMAS
3.	Dollar Decrease		= (1.) * (2.)
	a. Adult Day Care	\$84,751	
	b. Consumer Directed Services	\$976,998	
	c. Personal Care Services	\$2,822,607	
4.	Home and Community-Based Care Fee Reduction Adjustment	-1.0%	= - (4.) / (1.)

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Other Adjustments

Exhibit 2k

	Adjustment Values	Source
1. Managed Care Utilization Savings	-22.0%	American Academy of Actuaries
2. Administrative Cost	15.0%	Provided by DMAS

**Virginia Medicaid
 FY 2012 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Trend Adjustments for Dual Population**

Exhibit 3a

Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/Program	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Nursing Facility	0.1%	3.3%	3.4%	2.6%	-2.5%	0.0%	1.3%	1.0188
Adult Day Care	0.1%	-1.0%	-0.9%	-2.4%	9.5%	6.9%	12.2%	1.2704
Personal Care	0.1%	0.4%	0.4%	-6.9%	22.0%	13.6%	14.4%	1.3893
Consumer Directed Services	0.0%	0.3%	0.3%	-6.9%	22.0%	13.6%	14.4%	1.3893
IP Medical/Surgical - DRG Services	1.1%	-0.5%	0.6%	-9.4%	-1.3%	-10.6%	0.0%	0.8940
IP Psych - Per Diem Services	0.0%	-0.6%	-0.6%	-9.4%	-1.3%	-10.6%	0.0%	0.8940
Outpatient Hospital	-0.2%	-4.5%	-4.7%	-3.7%	17.6%	13.2%	27.1%	1.6228
Practitioner	0.0%	0.0%	0.0%	2.6%	13.5%	16.5%	17.3%	1.4802
Prescription Drug	0.0%	-9.1%	-9.0%	-2.0%	-12.6%	-14.4%	0.0%	0.8560
Other	0.3%	-6.9%	-6.7%	-9.8%	9.8%	-1.0%	11.2%	1.1616
Weighted Average*	0.1%	2.5%	2.6%	0.8%	2.2%	2.6%	4.0%	1.0887
Medicare Crossovers								
Inpatient	0.8%	0.0%	0.8%	7.0%	-3.6%	3.2%	0.0%	1.0320
Nursing Facility	0.8%	0.0%	0.8%	7.0%	-3.6%	3.2%	0.0%	1.0320
Outpatient	0.8%	0.0%	0.8%	7.0%	-3.6%	3.2%	0.0%	1.0320
Professional	0.8%	0.0%	0.8%	7.0%	-3.6%	3.2%	0.0%	1.0320
Other	0.8%	0.0%	0.8%	7.0%	-3.6%	3.2%	0.0%	1.0320
Weighted Average*	0.8%	0.0%	0.8%	7.0%	-3.6%	3.2%	0.0%	1.0320
Months of Trend Applied:				12	12	12	18	

Notes:

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

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

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

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

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2009-2010 Claims)

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Trend Adjustments for Non-Dual Population**

Exhibit 3b

Category of Service	Completion and Policy/Program Adjustments			Data Period Trend			Contract Period Cost and Utilization Trend	Total Trend Factor
	IBNR	Policy/ Program	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend		
Nursing Facility	0.1%	3.3%	3.4%	1.7%	-1.1%	0.5%	4.0%	1.0656
Adult Day Care	0.1%	-1.0%	-0.9%	-2.4%	9.5%	6.9%	12.2%	1.2704
Personal Care	0.1%	0.4%	0.4%	-6.9%	22.0%	13.6%	14.4%	1.3893
Consumer Directed Services	0.0%	0.3%	0.3%	-6.9%	22.0%	13.6%	14.4%	1.3893
IP Medical/Surgical - DRG Services	0.4%	-0.5%	-0.1%	2.3%	-6.5%	-4.3%	0.0%	0.9570
IP Psych - Per Diem Services	0.0%	-0.6%	-0.6%	2.3%	-6.5%	-4.3%	0.0%	0.9570
Outpatient Hospital	0.8%	-3.9%	-3.1%	5.9%	4.9%	11.1%	10.8%	1.2959
Practitioner	0.3%	0.0%	0.3%	-3.0%	11.0%	7.6%	4.1%	1.1425
Prescription Drug	0.0%	-34.1%	-34.1%	-0.3%	0.5%	0.2%	0.0%	1.0020
Other	0.4%	-5.6%	-5.2%	8.4%	-1.6%	6.6%	2.9%	1.1127
Weighted Average*	0.2%	-1.9%	-1.7%	0.2%	3.0%	3.0%	4.9%	1.1062
Months of Trend Applied:				12	12	12	18	

Notes:

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

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

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

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

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

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2009-2010 Claims)

*Weighted average is calculated using a distribution by Service Type, before Trend (Adjusted FY 2008-2009 Claims)

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Northern Virginia	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$3,254,699	\$3,460	\$4,199	(\$32,624)	\$3,229,735	1.270	\$4,103,139	\$48.10	0.78	\$37.52
Ambulatory Surgery Center	\$0	\$0			\$0	1.480	\$0	\$0.00	0.78	\$0.00
Case Management Services	\$8,745	\$0			\$8,745	1.480	\$12,945	\$0.15	0.78	\$0.12
Consumer Directed Services	\$18,738,174	\$2,927	\$134,827	\$54,447	\$18,930,375	1.389	\$26,300,765	\$308.30	0.78	\$240.47
DME/Supplies	\$1,899,036	\$4,984		(\$133,318)	\$1,770,702	1.162	\$2,056,917	\$24.11	0.78	\$18.81
Emergency	\$7,391	(\$16)		(\$347)	\$7,028	1.623	\$11,405	\$0.13	0.78	\$0.10
FQHC	\$499	\$0			\$499	1.480	\$739	\$0.01	0.78	\$0.01
Home Health Services	\$31,750	(\$70)			\$31,680	1.623	\$51,411	\$0.60	0.78	\$0.47
Inpatient - Medical/Surgical	\$6,234,070	\$68,886		(\$34,326)	\$6,268,630	0.894	\$5,604,155	\$65.69	0.78	\$51.24
Inpatient - Psych	\$719,060	\$0		(\$4,020)	\$715,040	0.894	\$639,246	\$7.49	0.78	\$5.84
Lab and X-ray Services	\$9,238	\$24		(\$280)	\$8,983	1.162	\$10,434	\$0.12	0.78	\$0.10
Medicare Xover - IP	\$2,070,281	\$16,192			\$2,086,473	1.032	\$2,153,240	\$25.24	0.78	\$19.69
Medicare Xover - Nursing Facility	\$1,339,812	\$10,479	\$34,893		\$1,385,184	1.032	\$1,429,510	\$16.76	0.78	\$13.07
Medicare Xover - OP	\$973,544	\$7,614			\$981,158	1.032	\$1,012,555	\$11.87	0.78	\$9.26
Medicare Xover - Other	\$708,402	\$5,540			\$713,942	1.032	\$736,789	\$8.64	0.78	\$6.74
Medicare Xover - Physician	\$2,104,364	\$16,458			\$2,120,823	1.032	\$2,188,689	\$25.66	0.78	\$20.01
Nursing Facility	\$202,933,077	\$107,060	\$44,393,106	\$6,779,285	\$254,212,527	1.019	\$259,003,791	\$3,036.05	0.78	\$2,368.12
Outpatient - Other	\$744,733	(\$1,641)		(\$37,155)	\$705,938	1.623	\$1,145,612	\$13.43	0.78	\$10.47
Outpatient - Psychological	\$0	\$0			\$0	1.623	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$46,931,103	\$31,817	\$320,920	\$178,571	\$47,462,411	1.389	\$65,941,519	\$772.97	0.78	\$602.92
Physician - Clinic	\$51,025	\$3			\$51,027	1.480	\$75,529	\$0.89	0.78	\$0.69
Physician - IP Mental Health	\$0	\$0			\$0	1.480	\$0	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$9,863,663	\$494			\$9,864,158	1.480	\$14,600,525	\$171.15	0.78	\$133.50
Physician - Other Practitioner	\$531,986	\$27			\$532,012	1.480	\$787,463	\$9.23	0.78	\$7.20
Physician - PCP	\$134,654	\$7			\$134,661	1.480	\$199,319	\$2.34	0.78	\$1.82
Physician - Specialist	\$68,884	\$3			\$68,888	1.480	\$101,965	\$1.20	0.78	\$0.93
Pharmacy	\$1,474,268	\$284		(\$133,632)	\$1,340,921	0.856	\$1,147,828	\$13.45	1.00	\$13.45
Transportation - Emergency	\$11,375	\$30			\$11,405	1.162	\$13,248	\$0.16	0.78	\$0.12
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$46.19	1.00	\$46.19
Total	\$300,843,833	\$274,564	\$44,887,946	\$6,636,603	\$352,642,945			\$4,609.92		\$3,608.86
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$4,704.00		\$4,245.72

Note:

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

Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Other MSA	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$654,041	\$695	\$8,507	(\$6,632)	\$656,610	1.270	\$834,175	\$6.77	0.78	\$5.28
Ambulatory Surgery Center	\$921	\$0			\$921	1.480	\$1,363	\$0.01	0.78	\$0.01
Case Management Services	\$13,320	\$1			\$13,321	1.480	\$19,717	\$0.16	0.78	\$0.12
Consumer Directed Services	\$14,352,061	\$2,242	\$151,597	\$41,842	\$14,547,742	1.389	\$20,211,788	\$164.05	0.78	\$127.96
DME/Supplies	\$2,009,756	\$5,274		(\$141,091)	\$1,873,939	1.162	\$2,176,841	\$17.67	0.78	\$13.78
Emergency	\$851	(\$2)		(\$40)	\$809	1.623	\$1,313	\$0.01	0.78	\$0.01
FQHC	\$1,185	\$0			\$1,185	1.480	\$1,754	\$0.01	0.78	\$0.01
Home Health Services	\$12,662	(\$28)			\$12,634	1.623	\$20,503	\$0.17	0.78	\$0.13
Inpatient - Medical/Surgical	\$1,812,100	\$20,024		(\$9,978)	\$1,822,146	0.894	\$1,628,998	\$13.22	0.78	\$10.31
Inpatient - Psych	\$405,934	\$0		(\$2,269)	\$403,664	0.894	\$360,876	\$2.93	0.78	\$2.28
Lab and X-ray Services	\$17,377	\$46		(\$526)	\$16,897	1.162	\$19,628	\$0.16	0.78	\$0.12
Medicare Xover - IP	\$3,304,551	\$25,845			\$3,330,396	1.032	\$3,436,969	\$27.90	0.78	\$21.76
Medicare Xover - Nursing Facility	\$1,787,349	\$13,979	\$108,680		\$1,910,008	1.032	\$1,971,128	\$16.00	0.78	\$12.48
Medicare Xover - OP	\$1,134,957	\$8,877			\$1,143,834	1.032	\$1,180,437	\$9.58	0.78	\$7.47
Medicare Xover - Other	\$1,146,659	\$8,968			\$1,155,627	1.032	\$1,192,607	\$9.68	0.78	\$7.55
Medicare Xover - Physician	\$2,660,564	\$20,809			\$2,681,373	1.032	\$2,767,177	\$22.46	0.78	\$17.52
Nursing Facility	\$279,731,980	\$147,576	\$66,003,845	\$9,344,867	\$355,228,268	1.019	\$361,923,423	\$2,937.61	0.78	\$2,291.33
Outpatient - Other	\$72,677	(\$160)		(\$3,626)	\$68,891	1.623	\$111,797	\$0.91	0.78	\$0.71
Outpatient - Psychological	\$0	\$0			\$0	1.623	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$26,812,400	\$18,178	\$214,263	\$102,137	\$27,146,977	1.389	\$37,716,435	\$306.13	0.78	\$238.78
Physician - Clinic	\$5,068	\$0			\$5,068	1.480	\$7,501	\$0.06	0.78	\$0.05
Physician - IP Mental Health	\$0	\$0			\$0	1.480	\$0	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$7,764,457	\$389			\$7,764,846	1.480	\$11,493,209	\$93.29	0.78	\$72.76
Physician - Other Practitioner	\$507,058	\$25			\$507,084	1.480	\$750,565	\$6.09	0.78	\$4.75
Physician - PCP	\$70,398	\$4			\$70,401	1.480	\$104,205	\$0.85	0.78	\$0.66
Physician - Specialist	\$49,128	\$2			\$49,131	1.480	\$72,722	\$0.59	0.78	\$0.46
Pharmacy	\$2,692,399	\$519		(\$244,046)	\$2,448,872	0.856	\$2,096,234	\$17.01	1.00	\$17.01
Transportation - Emergency	\$26,564	\$70			\$26,634	1.162	\$30,939	\$0.25	0.78	\$0.20
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$18.62	1.00	\$18.62
Total	\$347,046,416	\$273,333	\$66,486,891	\$9,080,638	\$422,887,278			\$3,672.19		\$2,872.15
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,747.13		\$3,379.00

Note:

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

Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.

No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$2,841,630	\$3,021	\$11,498	(\$28,561)	\$2,827,587	1.270	\$3,592,240	\$29.84	0.78	\$23.28
Ambulatory Surgery Center	\$2,237	\$0			\$2,237	1.480	\$3,312	\$0.03	0.78	\$0.02
Case Management Services	\$75	\$0			\$75	1.480	\$111	\$0.00	0.78	\$0.00
Consumer Directed Services	\$18,222,663	\$2,847	\$251,770	\$53,297	\$18,530,577	1.389	\$25,745,308	\$213.86	0.78	\$166.81
DME/Supplies	\$3,307,136	\$8,679		(\$232,172)	\$3,083,644	1.162	\$3,582,083	\$29.76	0.78	\$23.21
Emergency	\$3,133	(\$7)		(\$147)	\$2,979	1.623	\$4,834	\$0.04	0.78	\$0.03
FQHC	\$1,612	\$0			\$1,612	1.480	\$2,387	\$0.02	0.78	\$0.02
Home Health Services	\$13,807	(\$30)			\$13,776	1.623	\$22,356	\$0.19	0.78	\$0.14
Inpatient - Medical/Surgical	\$2,073,242	\$22,909		(\$11,416)	\$2,084,735	0.894	\$1,863,753	\$15.48	0.78	\$12.08
Inpatient - Psych	\$177,989	\$0		(\$995)	\$176,994	0.894	\$158,233	\$1.31	0.78	\$1.03
Lab and X-ray Services	\$8,937	\$23		(\$270)	\$8,690	1.162	\$10,095	\$0.08	0.78	\$0.07
Medicare Xover - IP	\$4,148,275	\$32,444			\$4,180,720	1.032	\$4,314,503	\$35.84	0.78	\$27.95
Medicare Xover - Nursing Facility	\$1,961,045	\$15,338	\$72,737		\$2,049,119	1.032	\$2,114,691	\$17.57	0.78	\$13.70
Medicare Xover - OP	\$1,224,154	\$9,574			\$1,233,728	1.032	\$1,273,208	\$10.58	0.78	\$8.25
Medicare Xover - Other	\$1,369,073	\$10,708			\$1,379,781	1.032	\$1,423,934	\$11.83	0.78	\$9.23
Medicare Xover - Physician	\$3,190,531	\$24,953			\$3,215,484	1.032	\$3,318,380	\$27.57	0.78	\$21.50
Nursing Facility	\$226,662,873	\$119,579	\$58,241,682	\$7,572,014	\$292,596,148	1.019	\$298,110,845	\$2,476.34	0.78	\$1,931.54
Outpatient - Other	\$276,691	(\$610)		(\$13,804)	\$262,277	1.623	\$425,629	\$3.54	0.78	\$2.76
Outpatient - Psychological	\$0	\$0			\$0	1.623	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$52,355,156	\$35,495	\$553,853	\$199,949	\$53,144,453	1.389	\$73,835,819	\$613.34	0.78	\$478.40
Physician - Clinic	\$9,010	\$0			\$9,010	1.480	\$13,337	\$0.11	0.78	\$0.09
Physician - IP Mental Health	\$110	\$0			\$110	1.480	\$164	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$12,458,467	\$625			\$12,459,091	1.480	\$18,441,440	\$153.19	0.78	\$119.49
Physician - Other Practitioner	\$612,242	\$31			\$612,272	1.480	\$906,261	\$7.53	0.78	\$5.87
Physician - PCP	\$77,454	\$4			\$77,458	1.480	\$114,650	\$0.95	0.78	\$0.74
Physician - Specialist	\$63,381	\$3			\$63,384	1.480	\$93,819	\$0.78	0.78	\$0.61
Pharmacy	\$1,775,780	\$343		(\$160,961)	\$1,615,161	0.856	\$1,382,578	\$11.48	1.00	\$11.48
Transportation - Emergency	\$61,250	\$161			\$61,410	1.162	\$71,337	\$0.59	0.78	\$0.46
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.85	1.00	\$27.85
Total	\$332,897,953	\$286,089	\$59,131,540	\$7,376,934	\$399,692,515			\$3,689.68		\$2,886.60
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,764.98		\$3,396.00

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Rural	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$661,843	\$704	\$7,044	(\$6,696)	\$662,894	1.270	\$842,158	\$4.57	0.78	\$3.56
Ambulatory Surgery Center	\$558	\$0			\$558	1.480	\$826	\$0.00	0.78	\$0.00
Case Management Services	\$104,968	\$5			\$104,973	1.480	\$155,377	\$0.84	0.78	\$0.66
Consumer Directed Services	\$26,554,443	\$4,148	\$250,741	\$77,331	\$26,886,663	1.389	\$37,354,769	\$202.62	0.78	\$158.04
DME/Supplies	\$4,739,208	\$12,437		(\$332,708)	\$4,418,937	1.162	\$5,133,213	\$27.84	0.78	\$21.72
Emergency	\$7,939	(\$17)		(\$372)	\$7,550	1.623	\$12,252	\$0.07	0.78	\$0.05
FQHC	\$6,181	\$0			\$6,182	1.480	\$9,150	\$0.05	0.78	\$0.04
Home Health Services	\$53,234	(\$117)			\$53,117	1.623	\$86,200	\$0.47	0.78	\$0.36
Inpatient - Medical/Surgical	\$3,677,924	\$40,641		(\$20,251)	\$3,698,313	0.894	\$3,306,292	\$17.93	0.78	\$13.99
Inpatient - Psych	\$556,461	\$0		(\$3,111)	\$553,350	0.894	\$494,695	\$2.68	0.78	\$2.09
Lab and X-ray Services	\$15,015	\$39		(\$454)	\$14,599	1.162	\$16,959	\$0.09	0.78	\$0.07
Medicare Xover - IP	\$5,751,467	\$44,983			\$5,796,450	1.032	\$5,981,936	\$32.45	0.78	\$25.31
Medicare Xover - Nursing Facility	\$3,304,032	\$25,841	\$116,295		\$3,446,169	1.032	\$3,556,446	\$19.29	0.78	\$15.05
Medicare Xover - OP	\$2,348,714	\$18,370			\$2,367,084	1.032	\$2,442,830	\$13.25	0.78	\$10.34
Medicare Xover - Other	\$2,423,373	\$18,953			\$2,442,327	1.032	\$2,520,481	\$13.67	0.78	\$10.66
Medicare Xover - Physician	\$4,348,328	\$34,009			\$4,382,337	1.032	\$4,522,572	\$24.53	0.78	\$19.13
Nursing Facility	\$322,267,315	\$170,016	\$68,476,314	\$10,765,824	\$401,679,470	1.019	\$409,250,112	\$2,219.82	0.78	\$1,731.46
Outpatient - Other	\$63,446	(\$140)		(\$3,165)	\$60,141	1.623	\$97,598	\$0.53	0.78	\$0.41
Outpatient - Psychological	\$0	\$0			\$0	1.623	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$65,954,160	\$44,714	\$597,138	\$251,505	\$66,847,517	1.389	\$92,874,060	\$503.76	0.78	\$392.93
Physician - Clinic	\$1,569	\$0			\$1,569	1.480	\$2,322	\$0.01	0.78	\$0.01
Physician - IP Mental Health	\$0	\$0			\$0	1.480	\$0	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$15,307,947	\$767			\$15,308,714	1.480	\$22,659,336	\$122.91	0.78	\$95.87
Physician - Other Practitioner	\$974,609	\$49			\$974,658	1.480	\$1,442,649	\$7.83	0.78	\$6.10
Physician - PCP	\$132,970	\$7			\$132,977	1.480	\$196,826	\$1.07	0.78	\$0.83
Physician - Specialist	\$67,734	\$3			\$67,737	1.480	\$100,262	\$0.54	0.78	\$0.42
Pharmacy	\$3,660,915	\$706		(\$331,835)	\$3,329,786	0.856	\$2,850,297	\$15.46	1.00	\$15.46
Transportation - Emergency	\$50,538	\$133			\$50,670	1.162	\$58,861	\$0.32	0.78	\$0.25
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$23.07	1.00	\$23.07
Total	\$463,034,891	\$416,252	\$69,447,532	\$10,396,067	\$543,294,742			\$3,255.66		\$2,547.89
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,322.11		\$2,997.52

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Tidewater	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$386,514	\$411	\$2,103	(\$3,890)	\$385,138	1.270	\$489,289	\$4.09	0.78	\$3.19
Ambulatory Surgery Center	\$6,653	\$0			\$6,654	1.480	\$9,848	\$0.08	0.78	\$0.06
Case Management Services	\$5,277	\$0			\$5,277	1.480	\$7,811	\$0.07	0.78	\$0.05
Consumer Directed Services	\$7,728,205	\$1,207	\$66,895	\$22,488	\$7,818,796	1.389	\$10,862,981	\$90.82	0.78	\$70.84
DME/Supplies	\$3,678,193	\$9,653		(\$258,221)	\$3,429,625	1.162	\$3,983,988	\$33.31	0.78	\$25.98
Emergency	\$13,737	(\$30)		(\$644)	\$13,063	1.623	\$21,199	\$0.18	0.78	\$0.14
FQHC	\$206	\$0			\$206	1.480	\$305	\$0.00	0.78	\$0.00
Home Health Services	\$46,512	(\$102)			\$46,410	1.623	\$75,315	\$0.63	0.78	\$0.49
Inpatient - Medical/Surgical	\$2,480,014	\$27,404		(\$13,655)	\$2,493,762	0.894	\$2,229,424	\$18.64	0.78	\$14.54
Inpatient - Psych	\$188,280	\$0		(\$1,053)	\$187,228	0.894	\$167,382	\$1.40	0.78	\$1.09
Lab and X-ray Services	\$21,473	\$56		(\$650)	\$20,880	1.162	\$24,255	\$0.20	0.78	\$0.16
Medicare Xover - IP	\$3,342,529	\$26,142			\$3,368,671	1.032	\$3,476,469	\$29.06	0.78	\$22.67
Medicare Xover - Nursing Facility	\$1,763,210	\$13,790	\$172,867		\$1,949,868	1.032	\$2,012,263	\$16.82	0.78	\$13.12
Medicare Xover - OP	\$1,172,830	\$9,173			\$1,182,003	1.032	\$1,219,827	\$10.20	0.78	\$7.95
Medicare Xover - Other	\$1,485,698	\$11,620			\$1,497,318	1.032	\$1,545,232	\$12.92	0.78	\$10.08
Medicare Xover - Physician	\$3,388,108	\$26,499			\$3,414,607	1.032	\$3,523,874	\$29.46	0.78	\$22.98
Nursing Facility	\$224,320,851	\$118,343	\$65,791,687	\$7,493,775	\$297,724,656	1.019	\$303,336,014	\$2,536.02	0.78	\$1,978.09
Outpatient - Other	\$134,330	(\$296)		(\$6,702)	\$127,332	1.623	\$206,637	\$1.73	0.78	\$1.35
Outpatient - Psychological	\$0	\$0			\$0	1.623	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$59,005,300	\$40,003	\$456,142	\$224,712	\$59,726,156	1.389	\$82,980,055	\$693.75	0.78	\$541.12
Physician - Clinic	\$42,648	\$2			\$42,650	1.480	\$63,128	\$0.53	0.78	\$0.41
Physician - IP Mental Health	\$856	\$0			\$856	1.480	\$1,267	\$0.01	0.78	\$0.01
Physician - OP Mental Health	\$15,207,123	\$762			\$15,207,886	1.480	\$22,510,093	\$188.19	0.78	\$146.79
Physician - Other Practitioner	\$356,058	\$18			\$356,076	1.480	\$527,049	\$4.41	0.78	\$3.44
Physician - PCP	\$135,168	\$7			\$135,175	1.480	\$200,081	\$1.67	0.78	\$1.30
Physician - Specialist	\$64,436	\$3			\$64,439	1.480	\$95,380	\$0.80	0.78	\$0.62
Pharmacy	\$2,336,409	\$451		(\$211,778)	\$2,125,081	0.856	\$1,819,069	\$15.21	1.00	\$15.21
Transportation - Emergency	\$28,675	\$75			\$28,750	1.162	\$33,397	\$0.28	0.78	\$0.22
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$24.67	1.00	\$24.67
Total	\$327,339,293	\$285,192	\$66,489,694	\$7,244,382	\$401,358,561			\$3,715.14		\$2,906.58
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,790.96		\$3,419.51

Note:

Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Total	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$7,798,727	\$8,290	\$33,351	(\$78,404)	\$7,761,964	1.270	\$9,861,000	\$15.58	0.78	\$12.15
Ambulatory Surgery Center	\$10,369	\$1			\$10,370	1.480	\$15,349	\$0.02	0.78	\$0.02
Case Management Services	\$132,385	\$7			\$132,392	1.480	\$195,961	\$0.31	0.78	\$0.24
Consumer Directed Services	\$85,595,545	\$13,371	\$855,830	\$249,406	\$86,714,153	1.389	\$120,475,611	\$190.36	0.78	\$148.48
DME/Supplies	\$15,633,330	\$41,027		(\$1,097,510)	\$14,576,847	1.162	\$16,933,042	\$26.76	0.78	\$20.87
Emergency	\$33,051	(\$73)		(\$1,550)	\$31,428	1.623	\$51,003	\$0.08	0.78	\$0.06
FQHC	\$9,684	\$0			\$9,684	1.480	\$14,335	\$0.02	0.78	\$0.02
Home Health Services	\$157,966	(\$348)			\$157,618	1.623	\$255,786	\$0.40	0.78	\$0.32
Inpatient - Medical/Surgical	\$16,277,348	\$179,864		(\$89,626)	\$16,367,587	0.894	\$14,632,622	\$23.12	0.78	\$18.03
Inpatient - Psych	\$2,047,724	\$0		(\$11,448)	\$2,036,276	0.894	\$1,820,430	\$2.88	0.78	\$2.24
Lab and X-ray Services	\$72,040	\$189		(\$2,180)	\$70,049	1.162	\$81,371	\$0.13	0.78	\$0.10
Medicare Xover - IP	\$18,617,104	\$145,606			\$18,762,711	1.032	\$19,363,117	\$30.60	0.78	\$23.86
Medicare Xover - Nursing Facility	\$10,155,449	\$79,427	\$505,472		\$10,740,348	1.032	\$11,084,039	\$17.51	0.78	\$13.66
Medicare Xover - OP	\$6,854,199	\$53,607			\$6,907,807	1.032	\$7,128,856	\$11.26	0.78	\$8.79
Medicare Xover - Other	\$7,133,206	\$55,790			\$7,188,995	1.032	\$7,419,043	\$11.72	0.78	\$9.14
Medicare Xover - Physician	\$15,691,895	\$122,728			\$15,814,623	1.032	\$16,320,691	\$25.79	0.78	\$20.11
Nursing Facility	\$1,255,916,095	\$662,575	\$302,906,634	\$41,955,766	\$1,601,441,069	1.019	\$1,631,624,185	\$2,578.13	0.78	\$2,010.95
Outpatient - Other	\$1,291,876	(\$2,847)		(\$64,451)	\$1,224,578	1.623	\$1,987,274	\$3.14	0.78	\$2.45
Outpatient - Psychological	\$0	\$0			\$0	1.623	\$0	\$0.00	1.00	\$0.00
Personal Care Services	\$251,058,120	\$170,206	\$2,142,315	\$956,874	\$254,327,515	1.389	\$353,347,888	\$558.33	0.78	\$435.49
Physician - Clinic	\$109,319	\$5			\$109,324	1.480	\$161,817	\$0.26	0.78	\$0.20
Physician - IP Mental Health	\$966	\$0			\$966	1.480	\$1,430	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$60,601,657	\$3,038			\$60,604,695	1.480	\$89,704,602	\$141.74	0.78	\$110.56
Physician - Other Practitioner	\$2,981,953	\$149			\$2,982,103	1.480	\$4,413,987	\$6.97	0.78	\$5.44
Physician - PCP	\$550,644	\$28			\$550,672	1.480	\$815,082	\$1.29	0.78	\$1.00
Physician - Specialist	\$313,564	\$16			\$313,579	1.480	\$464,147	\$0.73	0.78	\$0.57
Pharmacy	\$11,939,770	\$2,303		(\$1,082,252)	\$10,859,821	0.856	\$9,296,007	\$14.69	1.00	\$14.69
Transportation - Emergency	\$178,401	\$468			\$178,869	1.162	\$207,781	\$0.33	0.78	\$0.26
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$26.53	1.00	\$26.53
Total	\$1,771,162,386	\$1,535,429	\$306,443,602	\$40,734,624	\$2,119,876,041			\$3,688.70		\$2,886.25
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,763.98		\$3,395.59

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Medicare Xover - Nursing Facility, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Trend Adjustment application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Northern Virginia	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$158,385	\$168		(\$1,586)	\$156,968	1.270	\$199,416	\$20.05	0.78	\$15.64
Ambulatory Surgery Center	\$14,262	\$48			\$14,311	1.142	\$16,350	\$1.64	0.78	\$1.28
Case Management Services	\$0	\$0			\$0	1.142	\$0	\$0.00	0.78	\$0.00
Consumer Directed Services	\$3,500,789	\$547	\$4,486	\$10,112	\$3,515,934	1.389	\$4,884,835	\$491.23	0.78	\$383.16
DME/Supplies	\$770,477	\$3,292		(\$54,179)	\$719,591	1.113	\$800,668	\$80.52	0.78	\$62.80
Emergency	\$398,444	\$3,244		(\$18,879)	\$382,809	1.296	\$496,073	\$49.89	0.78	\$38.91
FQHC	\$4,404	\$15			\$4,419	1.142	\$5,048	\$0.51	0.78	\$0.40
Home Health Services	\$322,862	\$2,629			\$325,490	1.296	\$421,796	\$42.42	0.78	\$33.09
Inpatient - Medical/Surgical	\$7,852,260	\$31,638		(\$42,936)	\$7,840,963	0.957	\$7,503,801	\$754.60	0.78	\$588.59
Inpatient - Psych	\$12,642	\$0		(\$71)	\$12,572	0.957	\$12,031	\$1.21	0.78	\$0.94
Lab and X-ray Services	\$244,187	\$1,043		(\$7,402)	\$237,828	1.113	\$264,624	\$26.61	0.78	\$20.76
Medicare Xover - IP	\$39,721	\$0			\$39,721	1.000	\$39,721	\$3.99	1.00	\$3.99
Medicare Xover - Nursing Facility	\$11,882	\$0			\$11,882	1.000	\$11,882	\$1.19	1.00	\$1.19
Medicare Xover - OP	\$23,343	\$0			\$23,343	1.000	\$23,343	\$2.35	1.00	\$2.35
Medicare Xover - Other	\$31,052	\$0			\$31,052	1.000	\$31,052	\$3.12	1.00	\$3.12
Medicare Xover - Physician	\$46,429	\$0			\$46,429	1.000	\$46,429	\$4.67	1.00	\$4.67
Nursing Facility	\$22,410,811	\$12,512	\$1,840,340	\$748,690	\$25,012,353	1.066	\$26,654,165	\$2,680.42	0.78	\$2,090.72
Outpatient - Other	\$1,042,594	\$8,488		(\$52,554)	\$998,529	1.296	\$1,293,971	\$130.13	0.78	\$101.50
Outpatient - Psychological	\$0	\$0			\$0	1.296	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$7,585,456	\$5,143	\$15,696	\$28,726	\$7,635,020	1.389	\$10,607,654	\$1,066.73	0.78	\$832.05
Physician - Clinic	\$675,832	\$2,294			\$678,126	1.142	\$774,745	\$77.91	0.78	\$60.77
Physician - IP Mental Health	\$459	\$2			\$460	1.142	\$526	\$0.05	0.78	\$0.04
Physician - OP Mental Health	\$1,847,641	\$6,272			\$1,853,913	1.142	\$2,118,055	\$213.00	0.78	\$166.14
Physician - Other Practitioner	\$283,949	\$964			\$284,913	1.142	\$325,507	\$32.73	0.78	\$25.53
Physician - PCP	\$952,844	\$3,234			\$956,078	1.142	\$1,092,298	\$109.84	0.78	\$85.68
Physician - Specialist	\$633,166	\$2,149			\$635,316	1.142	\$725,834	\$72.99	0.78	\$56.93
Pharmacy	\$4,657,903	\$880		(\$1,590,867)	\$3,067,916	1.002	\$3,074,052	\$309.14	1.00	\$309.14
Transportation - Emergency	\$61,432	\$263			\$61,694	1.113	\$68,645	\$6.90	0.78	\$5.38
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$46.19	1.00	\$46.19
Total	\$53,583,225	\$84,825	\$1,860,523	(\$980,946)	\$54,547,628			\$6,230.05		\$4,940.99
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$6,357.20		\$5,812.92

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Other MSA	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$47,582	\$51	\$96	(\$477)	\$47,251	1.270	\$60,029	\$7.98	0.78	\$6.23
Ambulatory Surgery Center	\$15,030	\$51			\$15,081	1.142	\$17,229	\$2.29	0.78	\$1.79
Case Management Services	\$1,782	\$6			\$1,788	1.142	\$2,042	\$0.27	0.78	\$0.21
Consumer Directed Services	\$1,565,663	\$245	\$2,287	\$4,523	\$1,572,718	1.389	\$2,185,043	\$290.64	0.78	\$226.70
DME/Supplies	\$717,651	\$3,067		(\$50,464)	\$670,253	1.113	\$745,771	\$99.20	0.78	\$77.37
Emergency	\$220,152	\$1,792		(\$10,431)	\$211,513	1.296	\$274,095	\$36.46	0.78	\$28.44
FQHC	\$35,755	\$121			\$35,876	1.142	\$40,988	\$5.45	0.78	\$4.25
Home Health Services	\$259,621	\$2,114			\$261,735	1.296	\$339,177	\$45.11	0.78	\$35.19
Inpatient - Medical/Surgical	\$6,227,568	\$25,092		(\$34,052)	\$6,218,608	0.957	\$5,951,208	\$791.58	0.78	\$617.43
Inpatient - Psych	\$12,179	\$0		(\$68)	\$12,111	0.957	\$11,590	\$1.54	0.78	\$1.20
Lab and X-ray Services	\$242,658	\$1,037		(\$7,356)	\$236,339	1.113	\$262,967	\$34.98	0.78	\$27.28
Medicare Xover - IP	\$35,797	\$0			\$35,797	1.000	\$35,797	\$4.76	1.00	\$4.76
Medicare Xover - Nursing Facility	\$5,952	\$0			\$5,952	1.000	\$5,952	\$0.79	1.00	\$0.79
Medicare Xover - OP	\$20,080	\$0			\$20,080	1.000	\$20,080	\$2.67	1.00	\$2.67
Medicare Xover - Other	\$20,091	\$0			\$20,091	1.000	\$20,091	\$2.67	1.00	\$2.67
Medicare Xover - Physician	\$62,593	\$0			\$62,593	1.000	\$62,593	\$8.33	1.00	\$8.33
Nursing Facility	\$16,115,012	\$8,997	\$1,004,267	\$538,363	\$17,666,639	1.066	\$18,826,278	\$2,504.12	0.78	\$1,953.21
Outpatient - Other	\$986,957	\$8,036		(\$49,750)	\$945,243	1.296	\$1,224,919	\$162.93	0.78	\$127.08
Outpatient - Psychological	\$0	\$0			\$0	1.296	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$2,218,262	\$1,504	\$19,035	\$8,455	\$2,247,256	1.389	\$3,122,208	\$415.29	0.78	\$323.93
Physician - Clinic	\$270,078	\$917			\$270,995	1.142	\$309,606	\$41.18	0.78	\$32.12
Physician - IP Mental Health	\$1,798	\$6			\$1,804	1.142	\$2,061	\$0.27	0.78	\$0.21
Physician - OP Mental Health	\$820,506	\$2,785			\$823,292	1.142	\$940,593	\$125.11	0.78	\$97.59
Physician - Other Practitioner	\$190,880	\$648			\$191,528	1.142	\$218,816	\$29.11	0.78	\$22.70
Physician - PCP	\$702,250	\$2,384			\$704,634	1.142	\$805,029	\$107.08	0.78	\$83.52
Physician - Specialist	\$481,964	\$1,636			\$483,600	1.142	\$552,502	\$73.49	0.78	\$57.32
Pharmacy	\$4,109,745	\$776		(\$1,403,648)	\$2,706,873	1.002	\$2,712,286	\$360.77	1.00	\$360.77
Transportation - Emergency	\$95,076	\$406			\$95,482	1.113	\$106,240	\$14.13	0.78	\$11.02
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$18.62	1.00	\$18.62
Total	\$35,482,681	\$61,670	\$1,025,686	(\$1,004,906)	\$35,565,131			\$5,186.82		\$4,133.42
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,292.68		\$4,862.84

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$399,887	\$425		(\$4,003)	\$396,309	1.270	\$503,481	\$47.70	0.78	\$37.21
Ambulatory Surgery Center	\$13,105	\$44			\$13,150	1.142	\$15,023	\$1.42	0.78	\$1.11
Case Management Services	\$0	\$0			\$0	1.142	\$0	\$0.00	0.78	\$0.00
Consumer Directed Services	\$2,579,596	\$403	\$1,443	\$7,446	\$2,588,889	1.389	\$3,596,852	\$340.80	0.78	\$265.82
DME/Supplies	\$1,169,942	\$4,999		(\$82,269)	\$1,092,672	1.113	\$1,215,785	\$115.19	0.78	\$89.85
Emergency	\$544,401	\$4,432		(\$25,795)	\$523,038	1.296	\$677,794	\$64.22	0.78	\$50.09
FQHC	\$36,019	\$122			\$36,142	1.142	\$41,291	\$3.91	0.78	\$3.05
Home Health Services	\$408,275	\$3,324			\$411,599	1.296	\$533,383	\$50.54	0.78	\$39.42
Inpatient - Medical/Surgical	\$10,461,915	\$42,153		(\$57,205)	\$10,446,862	0.957	\$9,997,647	\$947.27	0.78	\$738.87
Inpatient - Psych	\$23,723	\$0		(\$133)	\$23,591	0.957	\$22,576	\$2.14	0.78	\$1.67
Lab and X-ray Services	\$305,241	\$1,304		(\$9,253)	\$297,292	1.113	\$330,788	\$31.34	0.78	\$24.45
Medicare Xover - IP	\$37,744	\$0			\$37,744	1.000	\$37,744	\$3.58	1.00	\$3.58
Medicare Xover - Nursing Facility	\$8,616	\$0	\$910		\$9,526	1.000	\$9,526	\$0.90	1.00	\$0.90
Medicare Xover - OP	\$23,398	\$0			\$23,398	1.000	\$23,398	\$2.22	1.00	\$2.22
Medicare Xover - Other	\$40,842	\$0			\$40,842	1.000	\$40,842	\$3.87	1.00	\$3.87
Medicare Xover - Physician	\$83,933	\$0			\$83,933	1.000	\$83,933	\$7.95	1.00	\$7.95
Nursing Facility	\$19,387,824	\$10,824	\$1,226,819	\$647,699	\$21,273,167	1.066	\$22,669,539	\$2,147.92	0.78	\$1,675.38
Outpatient - Other	\$1,954,678	\$15,914		(\$98,530)	\$1,872,063	1.296	\$2,425,965	\$229.86	0.78	\$179.29
Outpatient - Psychological	\$0	\$0			\$0	1.296	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$5,305,069	\$3,597	\$19,235	\$20,121	\$5,348,022	1.389	\$7,430,232	\$704.01	0.78	\$549.13
Physician - Clinic	\$784,986	\$2,665			\$787,651	1.142	\$899,874	\$85.26	0.78	\$66.50
Physician - IP Mental Health	\$2,775	\$9			\$2,784	1.142	\$3,181	\$0.30	0.78	\$0.24
Physician - OP Mental Health	\$1,561,672	\$5,301			\$1,566,973	1.142	\$1,790,232	\$169.62	0.78	\$132.31
Physician - Other Practitioner	\$360,210	\$1,223			\$361,433	1.142	\$412,930	\$39.12	0.78	\$30.52
Physician - PCP	\$920,765	\$3,126			\$923,890	1.142	\$1,055,524	\$100.01	0.78	\$78.01
Physician - Specialist	\$671,130	\$2,278			\$673,408	1.142	\$769,354	\$72.90	0.78	\$56.86
Pharmacy	\$4,633,195	\$875		(\$1,582,428)	\$3,051,642	1.002	\$3,057,745	\$289.72	1.00	\$289.72
Transportation - Emergency	\$136,077	\$581			\$136,658	1.113	\$152,056	\$14.41	0.78	\$11.24
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.85	1.00	\$27.85
Total	\$51,855,018	\$103,601	\$1,248,408	(\$1,184,349)	\$52,022,677			\$5,504.03		\$4,367.08
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,616.36		\$5,137.74

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Rural	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$6,363	\$7		(\$64)	\$6,306	1.270	\$8,012	\$0.68	0.78	\$0.53
Ambulatory Surgery Center	\$21,769	\$74			\$21,843	1.142	\$24,955	\$2.12	0.78	\$1.66
Case Management Services	\$7,093	\$24			\$7,117	1.142	\$8,131	\$0.69	0.78	\$0.54
Consumer Directed Services	\$2,518,297	\$393	\$3,677	\$7,276	\$2,529,644	1.389	\$3,514,540	\$299.03	0.78	\$233.24
DME/Supplies	\$1,530,342	\$6,540		(\$107,612)	\$1,429,270	1.113	\$1,590,307	\$135.31	0.78	\$105.54
Emergency	\$478,033	\$3,892		(\$22,650)	\$459,275	1.296	\$595,164	\$50.64	0.78	\$39.50
FQHC	\$219,623	\$746			\$220,368	1.142	\$251,766	\$21.42	0.78	\$16.71
Home Health Services	\$791,309	\$6,443			\$797,751	1.296	\$1,033,788	\$87.96	0.78	\$68.61
Inpatient - Medical/Surgical	\$8,561,966	\$34,497		(\$46,816)	\$8,549,647	0.957	\$8,182,012	\$696.15	0.78	\$542.99
Inpatient - Psych	\$2,600	\$0		(\$15)	\$2,586	0.957	\$2,474	\$0.21	0.78	\$0.16
Lab and X-ray Services	\$385,725	\$1,648		(\$11,693)	\$375,681	1.113	\$418,009	\$35.57	0.78	\$27.74
Medicare Xover - IP	\$61,700	\$0			\$61,700	1.000	\$61,700	\$5.25	1.00	\$5.25
Medicare Xover - Nursing Facility	\$8,780	\$0			\$8,780	1.000	\$8,780	\$0.75	1.00	\$0.75
Medicare Xover - OP	\$49,404	\$0			\$49,404	1.000	\$49,404	\$4.20	1.00	\$4.20
Medicare Xover - Other	\$66,067	\$0			\$66,067	1.000	\$66,067	\$5.62	1.00	\$5.62
Medicare Xover - Physician	\$94,163	\$0			\$94,163	1.000	\$94,163	\$8.01	1.00	\$8.01
Nursing Facility	\$17,420,247	\$9,726	\$594,341	\$581,967	\$18,606,281	1.066	\$19,827,598	\$1,686.98	0.78	\$1,315.85
Outpatient - Other	\$1,499,665	\$12,210		(\$75,594)	\$1,436,281	1.296	\$1,861,245	\$158.36	0.78	\$123.52
Outpatient - Psychological	\$0	\$0			\$0	1.296	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$5,918,361	\$4,012	\$27,766	\$22,471	\$5,972,610	1.389	\$8,297,998	\$706.01	0.78	\$550.69
Physician - Clinic	\$754,083	\$2,560			\$756,643	1.142	\$864,448	\$73.55	0.78	\$57.37
Physician - IP Mental Health	\$1,574	\$5			\$1,579	1.142	\$1,804	\$0.15	0.78	\$0.12
Physician - OP Mental Health	\$1,799,243	\$6,108			\$1,805,351	1.142	\$2,062,574	\$175.49	0.78	\$136.88
Physician - Other Practitioner	\$247,191	\$839			\$248,030	1.142	\$283,369	\$24.11	0.78	\$18.81
Physician - PCP	\$1,221,529	\$4,147			\$1,225,676	1.142	\$1,400,308	\$119.14	0.78	\$92.93
Physician - Specialist	\$661,650	\$2,246			\$663,896	1.142	\$758,487	\$64.53	0.78	\$50.34
Pharmacy	\$6,578,932	\$1,242		(\$2,246,978)	\$4,333,197	1.002	\$4,341,863	\$369.42	1.00	\$369.42
Transportation - Emergency	\$204,507	\$874			\$205,381	1.113	\$228,521	\$19.44	0.78	\$15.17
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$23.07	1.00	\$23.07
Total	\$51,110,216	\$98,232	\$625,784	(\$1,899,707)	\$49,934,525			\$4,773.86		\$3,815.20
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$4,871.28		\$4,488.47

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Tidewater	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$21,764	\$23		(\$218)	\$21,569	1.270	\$27,402	\$2.16	0.78	\$1.68
Ambulatory Surgery Center	\$13,845	\$47			\$13,892	1.142	\$15,872	\$1.25	0.78	\$0.97
Case Management Services	\$0	\$0			\$0	1.142	\$0	\$0.00	0.78	\$0.00
Consumer Directed Services	\$1,057,082	\$165		\$3,050	\$1,060,296	1.389	\$1,473,114	\$115.99	0.78	\$90.47
DME/Supplies	\$1,425,323	\$6,091		(\$100,227)	\$1,331,187	1.113	\$1,481,173	\$116.62	0.78	\$90.97
Emergency	\$577,834	\$4,705		(\$27,379)	\$555,159	1.296	\$719,418	\$56.64	0.78	\$44.18
FQHC	\$10,036	\$34			\$10,071	1.142	\$11,505	\$0.91	0.78	\$0.71
Home Health Services	\$610,566	\$4,971			\$615,537	1.296	\$797,661	\$62.80	0.78	\$48.99
Inpatient - Medical/Surgical	\$10,257,041	\$41,327		(\$56,085)	\$10,242,283	0.957	\$9,801,865	\$771.76	0.78	\$601.98
Inpatient - Psych	\$7,597	\$0		(\$42)	\$7,555	0.957	\$7,230	\$0.57	0.78	\$0.44
Lab and X-ray Services	\$332,148	\$1,419		(\$10,069)	\$323,499	1.113	\$359,948	\$28.34	0.78	\$22.11
Medicare Xover - IP	\$41,594	\$0			\$41,594	1.000	\$41,594	\$3.27	1.00	\$3.27
Medicare Xover - Nursing Facility	\$3,217	\$0			\$3,217	1.000	\$3,217	\$0.25	1.00	\$0.25
Medicare Xover - OP	\$27,166	\$0			\$27,166	1.000	\$27,166	\$2.14	1.00	\$2.14
Medicare Xover - Other	\$37,618	\$0			\$37,618	1.000	\$37,618	\$2.96	1.00	\$2.96
Medicare Xover - Physician	\$101,196	\$0			\$101,196	1.000	\$101,196	\$7.97	1.00	\$7.97
Nursing Facility	\$25,175,188	\$14,055	\$1,944,647	\$841,041	\$27,974,931	1.066	\$29,811,207	\$2,347.23	0.78	\$1,830.84
Outpatient - Other	\$1,553,091	\$12,645		(\$78,287)	\$1,487,449	1.296	\$1,927,553	\$151.77	0.78	\$118.38
Outpatient - Psychological	\$0	\$0			\$0	1.296	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$7,749,075	\$5,254	\$12,552	\$29,332	\$7,796,213	1.389	\$10,831,605	\$852.84	0.78	\$665.22
Physician - Clinic	\$1,094,853	\$3,717			\$1,098,569	1.142	\$1,255,091	\$98.82	0.78	\$77.08
Physician - IP Mental Health	\$1,685	\$6			\$1,690	1.142	\$1,931	\$0.15	0.78	\$0.12
Physician - OP Mental Health	\$2,166,381	\$7,354			\$2,173,734	1.142	\$2,483,444	\$195.54	0.78	\$152.52
Physician - Other Practitioner	\$402,381	\$1,366			\$403,747	1.142	\$461,272	\$36.32	0.78	\$28.33
Physician - PCP	\$1,152,967	\$3,914			\$1,156,880	1.142	\$1,321,710	\$104.07	0.78	\$81.17
Physician - Specialist	\$752,038	\$2,553			\$754,591	1.142	\$862,104	\$67.88	0.78	\$52.95
Pharmacy	\$6,111,227	\$1,154		(\$2,087,237)	\$4,025,144	1.002	\$4,033,194	\$317.56	1.00	\$317.56
Transportation - Emergency	\$183,382	\$784			\$184,166	1.113	\$204,916	\$16.13	0.78	\$12.58
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$24.67	1.00	\$24.67
Total	\$60,866,295	\$111,582	\$1,957,199	(\$1,486,122)	\$61,448,954			\$5,386.62		\$4,280.51
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,496.55		\$5,035.89

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Total	Medicaid Payments FY09 - FY10	Completion Factor Adjustment	Patient Payments FY09 - FY10	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY12	Managed Care Utilization Adjustment	PACE PMPM FY12
Service Type										
Adult Day Care	\$633,981	\$674	\$96	(\$6,348)	\$628,403	1.270	\$798,340	\$15.22	0.78	\$11.87
Ambulatory Surgery Center	\$78,012	\$265			\$78,276	1.142	\$89,429	\$1.70	0.78	\$1.33
Case Management Services	\$8,874	\$30			\$8,905	1.142	\$10,173	\$0.19	0.78	\$0.15
Consumer Directed Services	\$11,221,428	\$1,753	\$11,893	\$32,407	\$11,267,481	1.389	\$15,654,384	\$298.35	0.78	\$232.71
DME/Supplies	\$5,613,734	\$23,989		(\$394,750)	\$5,242,973	1.113	\$5,833,703	\$111.18	0.78	\$86.72
Emergency	\$2,218,864	\$18,065		(\$105,136)	\$2,131,793	1.296	\$2,762,544	\$52.65	0.78	\$41.07
FQHC	\$305,837	\$1,038			\$306,875	1.142	\$350,598	\$6.68	0.78	\$5.21
Home Health Services	\$2,392,633	\$19,480			\$2,412,113	1.296	\$3,125,804	\$59.57	0.78	\$46.47
Inpatient - Medical/Surgical	\$43,360,750	\$174,707		(\$237,094)	\$43,298,363	0.957	\$41,436,533	\$789.71	0.78	\$615.98
Inpatient - Psych	\$58,742	\$0		(\$328)	\$58,413	0.957	\$55,901	\$1.07	0.78	\$0.83
Lab and X-ray Services	\$1,509,959	\$6,452		(\$45,773)	\$1,470,638	1.113	\$1,636,336	\$31.19	0.78	\$24.33
Medicare Xover - IP	\$216,556	\$0			\$216,556	1.000	\$216,556	\$4.13	1.00	\$4.13
Medicare Xover - Nursing Facility	\$38,448	\$0	\$910		\$39,358	1.000	\$39,358	\$0.75	1.00	\$0.75
Medicare Xover - OP	\$143,390	\$0			\$143,390	1.000	\$143,390	\$2.73	1.00	\$2.73
Medicare Xover - Other	\$195,671	\$0			\$195,671	1.000	\$195,671	\$3.73	1.00	\$3.73
Medicare Xover - Physician	\$388,313	\$0			\$388,313	1.000	\$388,313	\$7.40	1.00	\$7.40
Nursing Facility	\$100,509,082	\$56,113	\$6,610,415	\$3,357,760	\$110,533,371	1.066	\$117,788,787	\$2,244.87	0.78	\$1,751.00
Outpatient - Other	\$7,036,985	\$57,293		(\$354,714)	\$6,739,565	1.296	\$8,733,653	\$166.45	0.78	\$129.83
Outpatient - Psychological	\$0	\$0			\$0	1.296	\$0	\$0.00	1.00	\$0.00
Personal Care Services	\$28,776,222	\$19,509	\$94,285	\$109,105	\$28,999,122	1.389	\$40,289,696	\$767.86	0.78	\$598.93
Physician - Clinic	\$3,579,832	\$12,152			\$3,591,984	1.142	\$4,103,763	\$78.21	0.78	\$61.00
Physician - IP Mental Health	\$8,290	\$28			\$8,318	1.142	\$9,503	\$0.18	0.78	\$0.14
Physician - OP Mental Health	\$8,195,443	\$27,820			\$8,223,263	1.142	\$9,394,897	\$179.05	0.78	\$139.66
Physician - Other Practitioner	\$1,484,611	\$5,040			\$1,489,651	1.142	\$1,701,893	\$32.44	0.78	\$25.30
Physician - PCP	\$4,950,354	\$16,804			\$4,967,158	1.142	\$5,674,869	\$108.15	0.78	\$84.36
Physician - Specialist	\$3,199,949	\$10,862			\$3,210,811	1.142	\$3,668,281	\$69.91	0.78	\$54.53
Pharmacy	\$26,091,003	\$4,927		(\$8,911,159)	\$17,184,771	1.002	\$17,219,141	\$328.17	1.00	\$328.17
Transportation - Emergency	\$680,473	\$2,908			\$683,381	1.113	\$760,378	\$14.49	0.78	\$11.30
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$28.16	1.00	\$28.16
Total	\$252,897,435	\$459,910	\$6,717,599	(\$6,556,030)	\$253,518,915			\$5,404.20		\$4,297.79
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,514.49		\$5,056.22

Note:
Patient Payments are carried forward for the following categories: Adult Day Care, Consumer Directed, Nursing Facility, and Personal Care Services.
Patient Payments for Nursing Facility are excluded from Policy and Program Adjustments application.
No Cost/Unit contract period trend applied to Home Health services.

**Virginia Medicaid
 FY 2012 PACE Capitation Rate Development
 Summary of FY 2012 Capitation Rates
 Before Nursing vs Non-Nursing Home Blending Factor Adjustment**

Region	Dual Eligibles FY 2012	Non-Dual Eligibles FY 2012	Weighted Average FY 2012	Difference from UPL Rates
PACE Rates				
Northern Virginia	\$4,245.72	\$5,812.92	\$4,409.33	-9.6%
Other MSA	\$3,379.00	\$4,862.84	\$3,464.34	-9.7%
Richmond/Charlottesville	\$3,396.00	\$5,137.74	\$3,536.39	-9.7%
Rural	\$2,997.52	\$4,488.47	\$3,086.88	-9.6%
Tidewater	\$3,419.51	\$5,035.89	\$3,574.67	-9.6%
Statewide Average weighted by PACE Eligibles	\$3,395.59	\$4,984.17	\$3,517.22	-9.6%

Region	Dual Eligibles FY 2012	Non-Dual Eligibles FY 2012	Weighted Average FY 2012
UPL			
Northern Virginia	\$4,704.00	\$6,357.20	\$4,876.59
Other MSA	\$3,747.13	\$5,292.68	\$3,836.02
Richmond/Charlottesville	\$3,764.98	\$5,616.36	\$3,914.21
Rural	\$3,322.11	\$4,871.28	\$3,414.95
Tidewater	\$3,790.96	\$5,496.55	\$3,954.68
Statewide Average weighted by PACE Eligibles	\$3,763.98	\$5,438.23	\$3,892.16

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

**Virginia Medicaid
 FY 2012 PACE Capitation Rate Development
 Historical Fee-For-Service Claims
 Nursing Home vs Non-Nursing Home Blending Factor**

Dual Population

Region	Cost		Statewide NH Blending	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.20	0.66	65.0%	1.0116
Other MSA	1.19	0.48	65.0%	0.9371
Richmond/Charlottesville	1.23	0.64	65.0%	1.0229
Rural	1.24	0.59	65.0%	1.0158
Tidewater	1.13	0.75	65.0%	0.9998

Non-Dual Population

Region	Cost		Statewide NH Blending	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.35	0.67	48.9%	1.0020
Other MSA	1.31	0.56	48.9%	0.9309
Richmond/Charlottesville	1.44	0.64	48.9%	1.0291
Rural	1.42	0.70	48.9%	1.0508
Tidewater	1.26	0.71	48.9%	0.9756

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Summary of FY 2012 Capitation Rates
After Nursing vs Non-Nursing Home Blending Factor Adjustment

Region	Dual Eligibles FY 2012	Non-Dual Eligibles FY 2012	Weighted Average FY 2012	Difference from UPL Rates
PACE Rates				
Northern Virginia	\$4,295.12	\$5,824.73	\$4,454.80	-9.6%
Other MSA	\$3,166.46	\$4,526.80	\$3,244.70	-9.7%
Richmond/Charlottesville	\$3,473.84	\$5,287.17	\$3,620.00	-9.7%
Rural	\$3,044.96	\$4,716.64	\$3,145.15	-9.6%
Tidewater	\$3,418.67	\$4,912.76	\$3,562.09	-9.6%
Statewide Average weighted by PACE Eligibles	\$3,389.34	\$5,061.67	\$3,517.38	-9.6%
Statewide Average weighted by PACE Enrollees*	\$3,333.23	\$4,987.34	\$3,450.00	-9.7%

Region	Dual Eligibles FY 2012	Non-Dual Eligibles FY 2012	Weighted Average FY 2012
UPL			
Northern Virginia	\$4,758.73	\$6,370.11	\$4,926.95
Other MSA	\$3,511.44	\$4,926.93	\$3,592.85
Richmond/Charlottesville	\$3,851.27	\$5,779.70	\$4,006.71
Rural	\$3,374.68	\$5,118.92	\$3,479.21
Tidewater	\$3,790.03	\$5,362.16	\$3,940.94
Statewide Average weighted by PACE Eligibles	\$3,757.03	\$5,520.32	\$3,892.03
Statewide Average weighted by PACE Enrollees*	\$3,695.24	\$5,441.66	\$3,818.53

Note:

Percent change and weighted average by region based on historical member months for PACE eligibles.

*Statewide weighted average based on December 2010 PACE Enrollees. No PACE plan in Northern Virginia until January 2012.

**Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Comparison of Capitation Rates
Before and After Blending Factor Adjustment**

Exhibit 5d

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change	Before Blending	After Blending	% Change
PACE Rates									
Northern Virginia	\$4,245.72	\$4,295.12	1.2%	\$5,812.92	\$5,824.73	0.2%	\$4,409.33	\$4,454.80	1.0%
Other MSA	\$3,379.00	\$3,166.46	-6.3%	\$4,862.84	\$4,526.80	-6.9%	\$3,464.34	\$3,244.70	-6.3%
Richmond/Charlottesville	\$3,396.00	\$3,473.84	2.3%	\$5,137.74	\$5,287.17	2.9%	\$3,536.39	\$3,620.00	2.4%
Rural	\$2,997.52	\$3,044.96	1.6%	\$4,488.47	\$4,716.64	5.1%	\$3,086.88	\$3,145.15	1.9%
Tidewater	\$3,419.51	\$3,418.67	0.0%	\$5,035.89	\$4,912.76	-2.4%	\$3,574.67	\$3,562.09	-0.4%
Statewide Average weighted by PACE Eligibles	\$3,395.59	\$3,389.34	-0.2%	\$4,984.17	\$5,061.67	1.6%	\$3,517.22	\$3,517.38	0.0%
Statewide Average weighted by PACE Enrollees*	\$3,331.85	\$3,333.23	0.0%	\$4,984.17	\$4,987.34	0.1%	\$3,448.49	\$3,450.00	0.0%

Note:

Percent change and weighted average by region based on historical member months for PACE eligibles.

*Statewide weighted average based on December 2010 PACE Enrollees. No PACE plan in Northern Virginia until January 2012.

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Comparison of FY 2011 and FY 2012 Capitation Rates

Exhibit 5e

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	FY 2011	FY 2012	% Change	FY 2011	FY 2012	% Change	FY 2011	FY 2012	% Change
PACE Rates									
Northern Virginia	\$4,074.09	\$4,295.12	5.4%	\$5,572.19	\$5,824.73	4.5%	\$4,230.48	\$4,454.80	5.3%
Other MSA	\$3,041.07	\$3,166.46	4.1%	\$4,553.86	\$4,526.80	-0.6%	\$3,128.08	\$3,244.70	3.7%
Richmond/Charlottesville	\$3,333.48	\$3,473.84	4.2%	\$5,045.07	\$5,287.17	4.8%	\$3,471.45	\$3,620.00	4.3%
Rural	\$2,906.90	\$3,044.96	4.7%	\$4,448.91	\$4,716.64	6.0%	\$2,999.32	\$3,145.15	4.9%
Tidewater	\$3,223.55	\$3,418.67	6.1%	\$4,695.54	\$4,912.76	4.6%	\$3,364.84	\$3,562.09	5.9%
Statewide Average weighted by PACE Eligibles	\$3,231.35	\$3,389.34	4.9%	\$4,856.44	\$5,061.67	4.2%	\$3,355.76	\$3,517.38	4.8%
Statewide Average weighted by PACE Enrollees*	\$3,167.26	\$3,333.23	5.2%	\$4,771.41	\$4,987.34	4.5%	\$3,280.50	\$3,450.00	5.2%

Note:

FY 2011 capitation rates were those effective October 1, 2010 with FMAP extension.

Percent change and weighted average by region based on historical member months for PACE eligibles.

*Statewide weighted average based on December 2010 PACE Enrollees. No PACE plan in Northern Virginia until January 2012.

**Virginia Medicaid
 FY 2012 PACE Capitation Rate Development
 Historical Eligibles and Enrollees**

Exhibit 5f

PACE Eligibles, Historical Member Months FY 2009 - FY 2010

Region	Dual Eligibles	Non-Dual Eligibles	Total
Member Months			
Northern Virginia	85,309	9,944	95,253
Other MSA	123,203	7,518	130,722
Richmond/Charlottesville	120,384	10,554	130,938
Rural	184,362	11,753	196,115
Tidewater	119,611	12,701	132,312
Statewide Total	632,870	52,470	685,340

PACE Enrollees, December 2010

Region	Dual Enrollees	Non-Dual Enrollees	Total
Member Months			
Northern Virginia	0	0	0
Other MSA	62	3	65
Richmond/Charlottesville	117	15	132
Rural	108	6	114
Tidewater	292	20	312
Statewide Total	579	44	623

Virginia Medicaid
FY 2012 PACE Capitation Rate Development
Historical Fee-For-Service Claims
Description of Unit Counts

Exhibit 6

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

**Virginia Medicaid
 FY 2012 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 County Listing by Region**

Exhibit 7

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

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