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

Program of All-Inclusive Care
for the Elderly (PACE)
Data Book and Capitation Rates
Fiscal Year 2013

June 2012

Submitted by:

PricewaterhouseCoopers LLP

Three Embarcadero Center

San Francisco, CA 94111

June 2012



pwc



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

June 27, 2012

Dear Bill:

Re: PACE Data Book and Capitation Rates – FY 2013

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for Fiscal Year 2013, effective July 1, 2012 to June 30, 2013, 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 2013
Prepared by PricewaterhouseCoopers LLP
June 2012***

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 2013 for rates effective July 1, 2012. 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 are developed for five regions in the state and nine operating PACE sites¹.

Rates developed for FY 2013 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. Therefore both the two year historical base period and the 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 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.

¹ Scott County is moved from the Other MSA region to Rural for the purpose of PACE rate setting; similarly, Bedford County is moved from Roanoke/Alleghany region as defined in the Medallion II program to Other MSA.

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, 2014.

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. Those in the Home and Community Based Services waiver programs may either be in Medicaid Fee for Service or in the Medallion II managed care program. We have implicitly assumed that the distribution of enrollment in a PACE program will mirror the PACE-eligible population. In other words, if 60% of the PACE eligible population is currently residing in nursing homes, the UPLs reported here implicitly assume that 60% of the enrollees would otherwise have been nursing home residents for the base calculation. Virginia is currently contracting with six organizations to operate nine 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 2010 through 2011 with claims paid through December 2011. 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 care 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 2013 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, 2012, 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, and 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 2010 and 2011,
- 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 2010 and 2011 (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 2013 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 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 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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3. The claims data are adjusted to update to the FY 2013 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 2013 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 the data period of FY 2010 and FY 2011 was \$3.75 per script. Dispensing fees during the base period were reported as \$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 data period dispensing fee average is less than \$3.75. The resulting FY 2013 average dispensing fees are \$2.73 for duals and \$2.98 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, a statewide rate at \$27.38 PMPM for FY 2013. 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 the total UPL column in Exhibits 4a and 4b.

Emergency transportation adjustment

The Virginia General Assembly increased Medicaid emergency transportation rates for FY 2013 to 40% of the applicable Virginia Medicare Ambulance Fee Schedule. Using payments reported for FY 2011, DMAS estimated current emergency transportation fee schedule at approximately 29% of the Medicare rates. Based on a comparison of historical payments and the estimated dollars to move to 40% of the CY 2012 Medicare ambulance fee schedule, DMAS calculated a 38.4% increase over current DMAS rates. The full value is applied to the dual eligible population. For the non-dual population, the proportion of claims for the ALTC population currently covered by Medallion II MCOs receives the 0.5% increase based on the Medallion II ABAD estimate, resulting in an weighted adjustment of 25.3%. These values are shown in Exhibit 2c and are applied in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

DME/supplies fee reduction adjustment

This adjustment reflects a reduction in durable medical equipment payment rates effective FY 2011. 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 2d and is applied to the DME service line in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Clinical lab fee reduction adjustment

Effective February 1, 2010, DMAS reduced 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 2e and is applied to the full base period to the Lab service line in Exhibits 4a and 4b under the column labeled "Policy and Program Adjustments".

Home and community-based care fee adjustment

This adjustment incorporates and replaces the Consumer Directed and the Personal Care Services adjustments from the FY 2012 PACE rate setting. The Virginia General Assembly reduced the home and community based care (HCBC) waiver services fees and mental health therapeutic day treatment rates by 1% effective FY 2012. This reduction also applied to personal care provided by agencies and under consumer direction, and nursing services under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Effective FY 2013, personal care service rates under the HCBC waivers and EPSDT program will increase by 1%. These personal care services include personal care, respite care, companion care and service facilitation provided through the waivers, as well as

personal care services provided under the EPSDT program. Specific procedure codes were provided by DMAS and a comparison showed that there is significant overlap between the procedures that are affected by the two rate changes. The result is no net change for Consumer Directed Services and Personal Care Services categories and a slight decrease for Adult Day Care. The calculation is shown in Exhibit 2f, and the adjustment is applied in Exhibits 4a and 4b under the column labeled “Policy and Program Adjustments”.

Hospital inpatient adjustment

The hospital inpatient adjustment includes a 2.6% allowance for a cost per unit increase authorized by the Virginia General Assembly effective July 1, 2012. It is applied to the operating cost component. There were no unit cost increases in the FY 2010 and FY 2011 period used in the base data.

The hospital inpatient base period incorporates a FY 2010 reduction in capital reimbursement from 80% to 75% of cost for non-exempt hospitals. We apply 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 2013 exemptions and all hospitals are included. 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, the negative adjustment is also 0.5%. In the

FY 2010 and FY 2011 base period, historical costs reflect the no inflation of unit cost policy for hospital rates.

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”.

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 for the non-dual population and, because Medicare is the primary payer, the estimate is 0.0% for the dual population. The impact of the triage exemption is calculated relative to the proportion of Emergency Room and Related outpatient payments, which varies by dual eligibility. The exemption produces a 5.0% reduction for the dual eligible population and a 3.5% reduction for the non-dual population. The full 5.0% reduction is applied to the Outpatient - Other services line both populations. 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 authorized a 2.2% increase in operating rates and a 1% increase in the operating base, for a net increase of 2.8%. It reduced the nursing facility capital rental rate from 9% in FY 2010 and FY 2011 (except for three months in FY 2011 from July to September where it was 8.75%) to 8.5% for FY 2013, a net decrease of 5.6% from the base period. DMAS estimates that 10% of the nursing facility payment is 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”.

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 and the non emergency adjustment is added as the contracted FY 2013 value. The managed care adjustment factor is shown in Exhibit 2j 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 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 2j. 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 2009 through FY 2011. Data for FY 2010 to FY 2011 is used to evaluate the base period trend and an additional year of data, FY 2009 through FY 2011, is used to develop contract period projected trend.

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

The data must be adjusted to reflect the contract period of FY 2013 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 2010 to FY 2011 and are calculated separately for the dual and the non-dual populations. We also had paid claims information with run out through December 2011 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 service categories, 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 (7/1/2010) to the midpoint of the contract period (1/1/2013), 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 2i, 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 or decreases have been applied and represent PMPM increases otherwise. Specifically, the trend models are adjusted for the fee increases or decreases that occurred during the historical base period that are presented as adjustments in Exhibits 2a to 2i. A positive number reflects an increase to the underlying data to meet most recent periods while a number less than one represents a decrease. 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
Nursing Facility	Jul 2010 - Sep 2010	1.030
Personal Care with Consumer Directed PC	Jul 2008 - Jun 2009	1.030
	Jul 2010 - Sep 2010	1.050
Inpatient - Med/Surg	Jul 2008 - Jun 2009	0.994
	Jul 2010 - Sep 2010	1.031
Inpatient - Psych	Jul 2008 - Jun 2009	0.994
	Jul 2010 - Sep 2010	1.029
Outpatient Hospital	Jul 2010 - Sep 2010	1.037
Practitioner	Jul 2010 - Sep 2010	1.024
Pharmacy (Dual)	Jul 2010 - Sep 2010	1.021
Pharmacy (Non-Dual)	Jul 2010 - Sep 2010	1.004
Other	Jul 2008 - Jan 2010	0.965
	Feb 2010 - Jun 2010	0.969

Agency personal care services have had a modest growth rate while Consumer Directed Personal Care (CDPC) services payments have doubled each year from 2009 to 2011⁶. 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 2i 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 2013 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. Averages are weighted by the distribution of member months for the historical FY 2010 to FY 2011 time period. This exhibit also presents the UPL rate summary. Overall, the PACE rates are approximately 9.6% below the Upper Payment Limit and therefore meet CMS PACE rate setting checklist requirements. Weighting by PACE enrollees as of December 2011 results in a slightly lower statewide total PMPM but PACE rates that are 9.6% 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. The statewide proportion of the PACE eligible population in nursing homes has been decreasing over time. In the FY 2008-2009 base period used for the FY 2011 PACE rate setting, 68.2% of the dual eligible population and 51.1% of the non-dual population was in nursing homes. For the FY 2010-2011 base period used in this year's PACE rate setting, 62.1% of the dual eligible population and 46.7% of the non-dual population was in nursing homes. These proportions, as reflected in member month counts for the historical data period, are shown in Table 2.

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

Region	Dual Population			Non-Dual Population		
	Member Months			Member Months		
	NH	Non-NH	%NH	NH	Non-NH	%NH
Northern Virginia	53,063	37,344	58.7%	4,946	5,748	46.2%
Other MSA	90,033	35,351	71.8%	4,346	3,635	54.5%
Richmond/Charlottesville	74,338	51,009	59.3%	4,878	6,546	42.7%
Rural	111,938	76,061	59.5%	5,259	7,698	40.6%
Tidewater	76,893	47,982	61.6%	7,235	6,802	51.5%
Statewide-PACE	406,264	247,748	62.1%	26,665	30,430	46.7%

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 62.1% in nursing homes and a non-dual population with 46.7% 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 2013 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 2010 to FY 2011 time period.

A comparison of FY 2013 PACE rates to FY 2012 rates in Exhibit 5e shows a 1.5% increase in the dual PACE rates and a 4.8% increase in the non-dual PACE rates, resulting in an overall increase of 1.9%. The composite year-to-year change by region ranges from a 0.9% to a 3.6% increase. If the regional rates are weighted by the PACE enrollee population as of December 2011, there is a 2.1% increase in the dual population rates, a 6.5% increase in the non-dual PACE rates, and an overall increase of 2.5%.

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 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	90,407						
Service Type							
Adult Day Care	\$3,807,958	\$22,954	\$3,830,911	\$42.37	177,343	23,539	\$21.60
Ambulatory Surgery Center	\$2,019	\$0	\$2,019	\$0.02	78	10	\$25.89
Case Management Services	\$12,506	\$0	\$12,506	\$0.14	3,809	506	\$3.28
Consumer Directed Services	\$23,410,553	\$215,932	\$23,626,485	\$261.33	1,870,563	248,284	\$12.63
DME/Supplies	\$1,902,442	\$3,917	\$1,906,359	\$21.09	20,904	2,775	\$91.20
Emergency	\$6,176	\$0	\$6,176	\$0.07	10	1	\$617.56
FQHC	\$287	\$0	\$287	\$0.00	4	1	\$71.74
Home Health Services	\$41,174	\$0	\$41,174	\$0.46	71	9	\$579.91
Inpatient - Medical/Surgical	\$5,846,008	\$125,262	\$5,971,270	\$66.05	988	131	\$6,043.80
Inpatient - Psych	\$778,895	\$33,227	\$812,122	\$8.98	1,626	216	\$499.46
Lab and X-ray Services	\$9,010	\$0	\$9,010	\$0.10	656	87	\$13.74
Medicare Xover - IP	\$2,098,270	\$0	\$2,098,270	\$23.21	1,955	259	\$1,073.28
Medicare Xover - Nursing Facility	\$1,369,201	\$19,621	\$1,388,822	\$15.36	87,098	11,561	\$15.95
Medicare Xover - OP	\$984,514	\$116	\$984,629	\$10.89	9,377	1,245	\$105.00
Medicare Xover - Other	\$720,811	\$614	\$721,425	\$7.98	30,483	4,046	\$23.67
Medicare Xover - Physician	\$2,303,088	\$53	\$2,303,141	\$25.48	68,093	9,038	\$33.82
Nursing Facility	\$208,997,740	\$45,170,423	\$254,168,163	\$2,811.36	1,399,412	185,747	\$181.62
Outpatient - Other	\$709,953	\$0	\$709,953	\$7.85	214	28	\$3,317.54
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$58,004,981	\$367,017	\$58,371,999	\$645.65	614,300	81,537	\$95.02
Physician - Clinic	\$21,625	\$0	\$21,625	\$0.24	7,106	943	\$3.04
Physician - IP Mental Health	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Physician - OP Mental Health	\$13,517,122	\$4,896	\$13,522,019	\$149.57	885,006	117,469	\$15.28
Physician - Other Practitioner	\$644,660	\$258	\$644,918	\$7.13	8,816	1,170	\$73.15
Physician - PCP	\$137,645	\$717	\$138,362	\$1.53	2,552	339	\$54.22
Physician - Specialist	\$80,866	\$531	\$81,397	\$0.90	2,167	288	\$37.56
Pharmacy	\$1,276,939	\$0	\$1,276,939	\$14.12	169,856	22,545	\$7.52
Transportation - Emergency	\$11,015	\$0	\$11,015	\$0.12	186	25	\$59.22
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$326,695,459	\$45,965,537	\$372,660,996	\$4,122.01	5,362,673		

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 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	125,384						
Service Type							
Adult Day Care	\$590,813	\$6,355	\$597,168	\$4.76	13,118	1,255	\$45.52
Ambulatory Surgery Center	\$921	\$0	\$921	\$0.01	2	0	\$460.33
Case Management Services	\$8,968	\$0	\$8,968	\$0.07	2,693	258	\$3.33
Consumer Directed Services	\$19,024,305	\$215,372	\$19,239,676	\$153.45	1,961,557	187,733	\$9.81
DME/Supplies	\$1,921,610	\$1,289	\$1,922,899	\$15.34	28,291	2,708	\$67.97
Emergency	\$747	\$0	\$747	\$0.01	6	1	\$124.55
FQHC	\$722	\$902	\$1,624	\$0.01	19	2	\$85.48
Home Health Services	\$10,006	\$0	\$10,006	\$0.08	47	4	\$212.89
Inpatient - Medical/Surgical	\$1,922,753	\$152,731	\$2,075,484	\$16.55	623	60	\$3,331.44
Inpatient - Psych	\$322,717	\$7,977	\$330,694	\$2.64	654	63	\$505.65
Lab and X-ray Services	\$17,986	\$0	\$17,986	\$0.14	1,116	107	\$16.12
Medicare Xover - IP	\$3,292,342	\$0	\$3,292,342	\$26.26	3,354	321	\$981.62
Medicare Xover - Nursing Facility	\$1,764,033	\$92,179	\$1,856,212	\$14.80	127,636	12,216	\$14.54
Medicare Xover - OP	\$1,207,063	\$1	\$1,207,064	\$9.63	10,819	1,035	\$111.57
Medicare Xover - Other	\$1,070,878	\$388	\$1,071,266	\$8.54	51,460	4,925	\$20.82
Medicare Xover - Physician	\$2,867,263	\$65	\$2,867,328	\$22.87	125,250	11,987	\$22.89
Nursing Facility	\$292,328,089	\$68,136,331	\$360,464,420	\$2,874.89	2,400,997	229,791	\$150.13
Outpatient - Other	\$83,522	\$0	\$83,522	\$0.67	534	51	\$156.41
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$29,212,797	\$221,278	\$29,434,074	\$234.75	515,097	49,298	\$57.14
Physician - Clinic	\$3,528	\$0	\$3,528	\$0.03	1,588	152	\$2.22
Physician - IP Mental Health	\$214	\$0	\$214	\$0.00	2	0	\$106.82
Physician - OP Mental Health	\$8,533,600	\$815	\$8,534,414	\$68.07	579,640	55,475	\$14.72
Physician - Other Practitioner	\$656,393	\$138	\$656,532	\$5.24	12,338	1,181	\$53.21
Physician - PCP	\$73,102	\$928	\$74,030	\$0.59	1,582	151	\$46.80
Physician - Specialist	\$42,301	\$944	\$43,245	\$0.34	1,147	110	\$37.70
Pharmacy	\$2,334,348	\$0	\$2,334,348	\$18.62	321,359	30,756	\$7.26
Transportation - Emergency	\$29,840	\$0	\$29,840	\$0.24	513	49	\$58.17
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$367,320,859	\$68,837,692	\$436,158,551	\$3,478.60	6,161,442		

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 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	125,347						
Service Type							
Adult Day Care	\$2,992,518	\$38,868	\$3,031,386	\$24.18	68,369	6,545	\$44.34
Ambulatory Surgery Center	\$1,404	\$0	\$1,404	\$0.01	2	0	\$702.10
Case Management Services	\$75	\$0	\$75	\$0.00	1	0	\$75.00
Consumer Directed Services	\$24,172,498	\$360,943	\$24,533,441	\$195.72	2,494,174	238,777	\$9.84
DME/Supplies	\$3,228,083	\$1,347	\$3,229,430	\$25.76	40,959	3,921	\$78.85
Emergency	\$6,742	\$0	\$6,742	\$0.05	12	1	\$561.81
FQHC	\$927	\$128	\$1,055	\$0.01	16	2	\$65.92
Home Health Services	\$11,126	\$0	\$11,126	\$0.09	64	6	\$173.85
Inpatient - Medical/Surgical	\$2,204,398	\$108,783	\$2,313,181	\$18.45	662	63	\$3,494.23
Inpatient - Psych	\$116,283	\$372	\$116,655	\$0.93	231	22	\$505.00
Lab and X-ray Services	\$10,884	\$0	\$10,884	\$0.09	731	70	\$14.89
Medicare Xover - IP	\$3,935,213	\$0	\$3,935,213	\$31.39	3,830	367	\$1,027.47
Medicare Xover - Nursing Facility	\$2,130,111	\$64,599	\$2,194,710	\$17.51	147,458	14,117	\$14.88
Medicare Xover - OP	\$1,280,085	\$0	\$1,280,085	\$10.21	14,186	1,358	\$90.24
Medicare Xover - Other	\$1,306,976	\$443	\$1,307,419	\$10.43	57,613	5,516	\$22.69
Medicare Xover - Physician	\$3,269,936	\$97	\$3,270,033	\$26.09	126,176	12,079	\$25.92
Nursing Facility	\$241,797,415	\$62,068,382	\$303,865,797	\$2,424.19	1,959,546	187,595	\$155.07
Outpatient - Other	\$254,163	\$0	\$254,163	\$2.03	147	14	\$1,729.00
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$56,674,046	\$690,552	\$57,364,598	\$457.65	877,028	83,961	\$65.41
Physician - Clinic	\$22,301	\$0	\$22,301	\$0.18	11,202	1,072	\$1.99
Physician - IP Mental Health	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Physician - OP Mental Health	\$13,690,504	\$2,337	\$13,692,841	\$109.24	1,022,738	97,911	\$13.39
Physician - Other Practitioner	\$752,924	\$268	\$753,192	\$6.01	13,073	1,252	\$57.61
Physician - PCP	\$83,050	\$296	\$83,345	\$0.66	1,748	167	\$47.68
Physician - Specialist	\$53,927	\$283	\$54,210	\$0.43	1,224	117	\$44.29
Pharmacy	\$1,549,084	\$0	\$1,549,084	\$12.36	212,173	20,312	\$7.30
Transportation - Emergency	\$60,305	\$0	\$60,305	\$0.48	1,011	97	\$59.65
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$359,604,979	\$63,337,697	\$422,942,676	\$3,374.17	7,054,374		

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 2013 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Rural	Medicaid Payments FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	187,999						
Service Type							
Adult Day Care	\$694,641	\$3,143	\$697,785	\$3.71	15,228	972	\$45.82
Ambulatory Surgery Center	\$1,496	\$466	\$1,962	\$0.01	3	0	\$654.00
Case Management Services	\$75,529	\$0	\$75,529	\$0.40	22,689	1,448	\$3.33
Consumer Directed Services	\$37,993,113	\$415,753	\$38,408,865	\$204.30	3,913,914	249,826	\$9.81
DME/Supplies	\$4,096,313	\$5,800	\$4,102,113	\$21.82	59,278	3,784	\$69.20
Emergency	\$14,155	\$0	\$14,155	\$0.08	40	3	\$353.87
FQHC	\$2,306	\$3	\$2,309	\$0.01	35	2	\$65.96
Home Health Services	\$36,772	\$0	\$36,772	\$0.20	106	7	\$346.90
Inpatient - Medical/Surgical	\$3,107,276	\$123,131	\$3,230,407	\$17.18	834	53	\$3,873.39
Inpatient - Psych	\$247,161	\$26,293	\$273,454	\$1.45	519	33	\$526.89
Lab and X-ray Services	\$15,062	\$0	\$15,062	\$0.08	1,351	86	\$11.15
Medicare Xover - IP	\$5,555,533	\$0	\$5,555,533	\$29.55	5,523	353	\$1,005.89
Medicare Xover - Nursing Facility	\$3,475,310	\$95,981	\$3,571,291	\$19.00	246,765	15,751	\$14.47
Medicare Xover - OP	\$2,543,746	\$402	\$2,544,148	\$13.53	26,952	1,720	\$94.40
Medicare Xover - Other	\$2,285,050	\$895	\$2,285,944	\$12.16	105,625	6,742	\$21.64
Medicare Xover - Physician	\$4,451,812	\$329	\$4,452,141	\$23.68	208,292	13,295	\$21.37
Nursing Facility	\$326,893,953	\$69,736,534	\$396,630,488	\$2,109.75	2,864,540	182,844	\$138.46
Outpatient - Other	\$81,903	\$0	\$81,903	\$0.44	617	39	\$132.74
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$69,275,343	\$705,832	\$69,981,175	\$372.24	1,280,843	81,757	\$54.64
Physician - Clinic	\$172	\$0	\$172	\$0.00	15	1	\$11.46
Physician - IP Mental Health	\$39	\$0	\$39	\$0.00	1	0	\$39.00
Physician - OP Mental Health	\$16,952,651	\$3,496	\$16,956,147	\$90.19	1,247,845	79,650	\$13.59
Physician - Other Practitioner	\$1,301,998	\$1,139	\$1,303,136	\$6.93	22,431	1,432	\$58.10
Physician - PCP	\$109,219	\$2,046	\$111,265	\$0.59	5,708	364	\$19.49
Physician - Specialist	\$68,882	\$1,206	\$70,087	\$0.37	2,036	130	\$34.42
Pharmacy	\$3,087,762	\$0	\$3,087,762	\$16.42	397,359	25,364	\$7.77
Transportation - Emergency	\$44,135	\$0	\$44,135	\$0.23	546	35	\$80.83
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$482,411,332	\$71,122,448	\$553,533,780	\$2,944.35	10,429,095		

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 2013 PACE Capitation Rate Development
Historical Eligibility, Fee-For-Service Claims, and Utilization Data
Dual Population

Exhibit 1a

Age 55 and Over							
Tidewater	Medicaid Payments FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	124,875						
Service Type							
Adult Day Care	\$386,332	\$3,638	\$389,970	\$3.12	8,550	822	\$45.61
Ambulatory Surgery Center	\$6,919	\$0	\$6,919	\$0.06	17	2	\$406.99
Case Management Services	\$2,743	\$0	\$2,743	\$0.02	824	79	\$3.33
Consumer Directed Services	\$10,796,236	\$134,802	\$10,931,038	\$87.54	1,113,905	107,042	\$9.81
DME/Supplies	\$3,630,089	\$1,870	\$3,631,959	\$29.08	41,384	3,977	\$87.76
Emergency	\$10,961	\$0	\$10,961	\$0.09	38	4	\$288.44
FQHC	\$520	\$0	\$520	\$0.00	9	1	\$57.76
Home Health Services	\$36,177	\$0	\$36,177	\$0.29	109	10	\$331.90
Inpatient - Medical/Surgical	\$2,473,721	\$97,709	\$2,571,429	\$20.59	553	53	\$4,649.96
Inpatient - Psych	\$49,143	\$3,973	\$53,116	\$0.43	98	9	\$542.00
Lab and X-ray Services	\$19,616	\$0	\$19,616	\$0.16	1,965	189	\$9.98
Medicare Xover - IP	\$3,387,133	\$533	\$3,387,666	\$27.13	3,233	311	\$1,047.84
Medicare Xover - Nursing Facility	\$1,687,456	\$167,584	\$1,855,040	\$14.86	123,118	11,831	\$15.07
Medicare Xover - OP	\$1,232,950	\$180	\$1,233,130	\$9.87	13,073	1,256	\$94.33
Medicare Xover - Other	\$1,356,854	\$209	\$1,357,063	\$10.87	59,498	5,718	\$22.81
Medicare Xover - Physician	\$3,641,876	\$67	\$3,641,943	\$29.16	148,615	14,281	\$24.51
Nursing Facility	\$237,121,396	\$68,039,283	\$305,160,678	\$2,443.73	2,045,264	196,542	\$149.20
Outpatient - Other	\$172,744	\$0	\$172,744	\$1.38	132	13	\$1,308.66
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$70,138,232	\$526,873	\$70,665,105	\$565.89	1,067,535	102,586	\$66.19
Physician - Clinic	\$57,783	\$0	\$57,783	\$0.46	19,453	1,869	\$2.97
Physician - IP Mental Health	\$386	\$0	\$386	\$0.00	8	1	\$48.22
Physician - OP Mental Health	\$19,879,461	\$3,673	\$19,883,134	\$159.22	1,521,871	146,246	\$13.06
Physician - Other Practitioner	\$481,051	\$337	\$481,387	\$3.85	10,223	982	\$47.09
Physician - PCP	\$116,146	\$1,087	\$117,233	\$0.94	2,876	276	\$40.76
Physician - Specialist	\$65,043	\$985	\$66,028	\$0.53	1,906	183	\$34.64
Pharmacy	\$1,871,526	\$0	\$1,871,526	\$14.99	237,484	22,821	\$7.88
Transportation - Emergency	\$35,654	\$0	\$35,654	\$0.29	606	58	\$58.83
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$358,658,147	\$68,982,801	\$427,640,948	\$3,424.55	6,422,347		

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 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	654,012						
Service Type							
Adult Day Care	\$8,472,262	\$74,958	\$8,547,220	\$13.07	282,608	5,185	\$30.24
Ambulatory Surgery Center	\$12,759	\$466	\$13,225	\$0.02	102	2	\$129.66
Case Management Services	\$99,821	\$0	\$99,821	\$0.15	30,016	551	\$3.33
Consumer Directed Services	\$115,396,705	\$1,342,801	\$116,739,506	\$178.50	11,354,112	208,329	\$10.28
DME/Supplies	\$14,778,537	\$14,223	\$14,792,760	\$22.62	190,816	3,501	\$77.52
Emergency	\$38,780	\$0	\$38,780	\$0.06	106	2	\$365.85
FQHC	\$4,761	\$1,033	\$5,794	\$0.01	83	2	\$69.81
Home Health Services	\$135,254	\$0	\$135,254	\$0.21	397	7	\$340.69
Inpatient - Medical/Surgical	\$15,554,155	\$607,616	\$16,161,771	\$24.71	3,660	67	\$4,415.78
Inpatient - Psych	\$1,514,199	\$71,842	\$1,586,041	\$2.43	3,128	57	\$507.05
Lab and X-ray Services	\$72,559	\$0	\$72,559	\$0.11	5,819	107	\$12.47
Medicare Xover - IP	\$18,268,491	\$533	\$18,269,024	\$27.93	17,895	328	\$1,020.90
Medicare Xover - Nursing Facility	\$10,426,112	\$439,964	\$10,866,076	\$16.61	732,075	13,432	\$14.84
Medicare Xover - OP	\$7,248,359	\$697	\$7,249,056	\$11.08	74,407	1,365	\$97.42
Medicare Xover - Other	\$6,740,569	\$2,549	\$6,743,118	\$10.31	304,679	5,590	\$22.13
Medicare Xover - Physician	\$16,533,974	\$611	\$16,534,585	\$25.28	676,426	12,411	\$24.44
Nursing Facility	\$1,307,138,592	\$313,150,953	\$1,620,289,545	\$2,477.46	10,669,759	195,772	\$151.86
Outpatient - Other	\$1,302,284	\$0	\$1,302,284	\$1.99	1,644	30	\$792.14
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$283,305,400	\$2,511,552	\$285,816,952	\$437.02	4,354,803	79,903	\$65.63
Physician - Clinic	\$105,409	\$0	\$105,409	\$0.16	39,364	722	\$2.68
Physician - IP Mental Health	\$638	\$0	\$638	\$0.00	11	0	\$58.03
Physician - OP Mental Health	\$72,573,339	\$15,217	\$72,588,557	\$110.99	5,257,100	96,459	\$13.81
Physician - Other Practitioner	\$3,837,027	\$2,139	\$3,839,166	\$5.87	66,881	1,227	\$57.40
Physician - PCP	\$519,163	\$5,073	\$524,236	\$0.80	14,466	265	\$36.24
Physician - Specialist	\$311,020	\$3,948	\$314,967	\$0.48	8,480	156	\$37.14
Pharmacy	\$10,119,659	\$0	\$10,119,659	\$15.47	1,338,231	24,554	\$7.56
Transportation - Emergency	\$180,949	\$0	\$180,949	\$0.28	2,862	53	\$63.22
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$1,894,690,776	\$318,246,175	\$2,212,936,952	\$3,383.63	35,429,930		

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 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	10,694						
Service Type							
Adult Day Care	\$148,842	\$0	\$148,842	\$13.92	6,279	7,046	\$23.70
Ambulatory Surgery Center	\$11,148	\$0	\$11,148	\$1.04	14	16	\$796.28
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$4,398,929	\$17,672	\$4,416,601	\$412.99	352,456	395,495	\$12.53
DME/Supplies	\$867,417	\$19	\$867,436	\$81.11	6,964	7,814	\$124.56
Emergency	\$388,140	\$0	\$388,140	\$36.29	558	626	\$695.59
FQHC	\$4,834	\$0	\$4,834	\$0.45	152	171	\$31.80
Home Health Services	\$416,722	\$0	\$416,722	\$38.97	923	1,036	\$451.49
Inpatient - Medical/Surgical	\$7,725,282	\$5,814	\$7,731,096	\$722.93	660	741	\$11,713.78
Inpatient - Psych	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Lab and X-ray Services	\$280,027	\$0	\$280,027	\$26.19	19,132	21,468	\$14.64
Medicare Xover - IP	\$33,709	\$0	\$33,709	\$3.15	38	43	\$887.07
Medicare Xover - Nursing Facility	\$11,649	\$0	\$11,649	\$1.09	1,014	1,138	\$11.49
Medicare Xover - OP	\$19,921	\$0	\$19,921	\$1.86	245	275	\$81.31
Medicare Xover - Other	\$20,362	\$0	\$20,362	\$1.90	744	835	\$27.37
Medicare Xover - Physician	\$58,298	\$1	\$58,299	\$5.45	1,790	2,009	\$32.57
Nursing Facility	\$23,747,240	\$1,961,132	\$25,708,372	\$2,403.97	141,636	158,931	\$181.51
Outpatient - Other	\$1,298,611	\$0	\$1,298,611	\$121.43	1,379	1,547	\$941.70
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$8,627,370	\$17,484	\$8,644,855	\$808.37	93,346	104,744	\$92.61
Physician - Clinic	\$869,440	\$0	\$869,440	\$81.30	250,077	280,614	\$3.48
Physician - IP Mental Health	\$315	\$0	\$315	\$0.03	4	4	\$78.82
Physician - OP Mental Health	\$2,305,234	\$91	\$2,305,326	\$215.57	139,953	157,043	\$16.47
Physician - Other Practitioner	\$383,649	\$100	\$383,748	\$35.88	5,964	6,692	\$64.34
Physician - PCP	\$954,020	\$36	\$954,056	\$89.21	16,234	18,216	\$58.77
Physician - Specialist	\$691,773	\$321	\$692,094	\$64.72	22,680	25,449	\$30.52
Pharmacy	\$5,047,326	\$0	\$5,047,326	\$471.97	88,282	99,062	\$57.17
Transportation - Emergency	\$64,500	\$0	\$64,500	\$6.03	1,089	1,222	\$59.23
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$58,374,757	\$2,002,670	\$60,377,428	\$5,645.84	1,151,613		

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.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	7,981						
Service Type							
Adult Day Care	\$49,031	\$0	\$49,031	\$6.14	1,071	1,610	\$45.78
Ambulatory Surgery Center	\$20,587	\$0	\$20,587	\$2.58	31	47	\$664.09
Case Management Services	\$1,588	\$0	\$1,588	\$0.20	477	717	\$3.33
Consumer Directed Services	\$2,148,779	\$7,822	\$2,156,601	\$270.21	220,937	332,186	\$9.76
DME/Supplies	\$682,268	\$290	\$682,557	\$85.52	6,570	9,878	\$103.89
Emergency	\$222,694	\$0	\$222,694	\$27.90	504	758	\$441.85
FQHC	\$45,561	\$92	\$45,653	\$5.72	605	910	\$75.46
Home Health Services	\$284,947	\$0	\$284,947	\$35.70	1,054	1,585	\$270.35
Inpatient - Medical/Surgical	\$5,909,109	\$1,071	\$5,910,180	\$740.51	556	836	\$10,629.82
Inpatient - Psych	\$38,963	\$0	\$38,963	\$4.88	50	75	\$779.27
Lab and X-ray Services	\$245,894	\$0	\$245,894	\$30.81	16,933	25,459	\$14.52
Medicare Xover - IP	\$26,160	\$0	\$26,160	\$3.28	27	41	\$968.90
Medicare Xover - Nursing Facility	\$6,991	\$0	\$6,991	\$0.88	605	910	\$11.55
Medicare Xover - OP	\$20,038	\$0	\$20,038	\$2.51	126	189	\$159.03
Medicare Xover - Other	\$17,183	\$0	\$17,183	\$2.15	762	1,146	\$22.55
Medicare Xover - Physician	\$70,949	\$6	\$70,955	\$8.89	1,227	1,845	\$57.83
Nursing Facility	\$17,743,382	\$1,011,125	\$18,754,507	\$2,349.84	126,104	189,602	\$148.72
Outpatient - Other	\$1,253,599	\$0	\$1,253,599	\$157.07	1,605	2,413	\$781.06
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$2,573,283	\$10,366	\$2,583,649	\$323.72	46,335	69,666	\$55.76
Physician - Clinic	\$273,013	\$0	\$273,013	\$34.21	49,433	74,324	\$5.52
Physician - IP Mental Health	\$2,112	\$0	\$2,112	\$0.26	31	47	\$68.14
Physician - OP Mental Health	\$995,022	\$84	\$995,106	\$124.68	45,983	69,137	\$21.64
Physician - Other Practitioner	\$271,987	\$5	\$271,992	\$34.08	6,680	10,044	\$40.72
Physician - PCP	\$691,166	(\$23)	\$691,143	\$86.60	22,118	33,255	\$31.25
Physician - Specialist	\$486,074	\$98	\$486,172	\$60.91	10,815	16,261	\$44.95
Pharmacy	\$4,394,642	\$0	\$4,394,642	\$550.62	88,062	132,404	\$49.90
Transportation - Emergency	\$110,090	\$0	\$110,090	\$13.79	1,863	2,801	\$59.09
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$38,585,115	\$1,030,935	\$39,616,049	\$4,963.68	650,564		

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.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	11,424						
Service Type							
Adult Day Care	\$452,855	\$2,635	\$455,490	\$39.87	10,086	10,594	\$45.16
Ambulatory Surgery Center	\$25,330	\$0	\$25,330	\$2.22	45	47	\$562.89
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$3,518,201	\$3,223	\$3,521,424	\$308.24	363,366	381,680	\$9.69
DME/Supplies	\$1,491,567	\$25	\$1,491,592	\$130.56	11,299	11,868	\$132.01
Emergency	\$582,966	\$0	\$582,966	\$51.03	881	925	\$661.71
FQHC	\$51,949	\$45	\$51,994	\$4.55	518	544	\$100.37
Home Health Services	\$513,706	\$0	\$513,706	\$44.97	1,851	1,944	\$277.53
Inpatient - Medical/Surgical	\$10,646,171	\$490	\$10,646,662	\$931.94	871	915	\$12,223.49
Inpatient - Psych	\$24,347	\$0	\$24,347	\$2.13	29	30	\$839.57
Lab and X-ray Services	\$338,461	\$0	\$338,461	\$29.63	21,571	22,658	\$15.69
Medicare Xover - IP	\$35,098	\$0	\$35,098	\$3.07	58	61	\$605.14
Medicare Xover - Nursing Facility	\$11,727	\$910	\$12,637	\$1.11	973	1,022	\$12.99
Medicare Xover - OP	\$17,757	\$0	\$17,757	\$1.55	207	217	\$85.78
Medicare Xover - Other	\$27,426	\$0	\$27,426	\$2.40	1,023	1,075	\$26.81
Medicare Xover - Physician	\$70,252	\$0	\$70,252	\$6.15	1,617	1,698	\$43.45
Nursing Facility	\$20,992,052	\$1,319,947	\$22,311,999	\$1,953.04	142,352	149,527	\$156.74
Outpatient - Other	\$2,489,488	\$0	\$2,489,488	\$217.91	3,286	3,452	\$757.60
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$6,133,577	\$12,082	\$6,145,659	\$537.95	97,692	102,616	\$62.91
Physician - Clinic	\$892,208	\$4	\$892,212	\$78.10	210,782	221,406	\$4.23
Physician - IP Mental Health	\$1,941	\$0	\$1,941	\$0.17	32	34	\$60.66
Physician - OP Mental Health	\$2,035,146	\$0	\$2,035,147	\$178.14	125,286	131,600	\$16.24
Physician - Other Practitioner	\$575,630	\$57	\$575,687	\$50.39	8,087	8,495	\$71.19
Physician - PCP	\$922,474	\$52	\$922,526	\$80.75	16,091	16,902	\$57.33
Physician - Specialist	\$750,963	\$4	\$750,967	\$65.73	13,371	14,045	\$56.16
Pharmacy	\$4,961,370	\$0	\$4,961,370	\$434.29	99,512	104,527	\$49.86
Transportation - Emergency	\$161,849	\$0	\$161,849	\$14.17	2,807	2,948	\$57.66
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$57,724,512	\$1,339,475	\$59,063,987	\$5,170.07	1,133,693		

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.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	12,958						
Service Type							
Adult Day Care	\$18,257	\$0	\$18,257	\$1.41	399	370	\$45.76
Ambulatory Surgery Center	\$31,641	\$0	\$31,641	\$2.44	55	51	\$575.29
Case Management Services	\$8,778	\$0	\$8,778	\$0.68	2,636	2,441	\$3.33
Consumer Directed Services	\$3,905,941	\$10,216	\$3,916,157	\$302.23	400,663	371,051	\$9.77
DME/Supplies	\$1,533,696	\$1,262	\$1,534,958	\$118.46	14,296	13,239	\$107.37
Emergency	\$458,630	\$0	\$458,630	\$35.39	1,233	1,142	\$371.96
FQHC	\$254,893	\$291	\$255,184	\$19.69	3,426	3,173	\$74.48
Home Health Services	\$843,801	\$0	\$843,801	\$65.12	2,183	2,022	\$386.53
Inpatient - Medical/Surgical	\$9,563,809	\$3,379	\$9,567,188	\$738.34	976	904	\$9,802.45
Inpatient - Psych	\$22,477	\$0	\$22,477	\$1.73	33	31	\$681.13
Lab and X-ray Services	\$416,490	\$0	\$416,490	\$32.14	28,981	26,839	\$14.37
Medicare Xover - IP	\$65,862	\$0	\$65,862	\$5.08	70	65	\$940.89
Medicare Xover - Nursing Facility	\$15,555	\$0	\$15,555	\$1.20	1,395	1,292	\$11.15
Medicare Xover - OP	\$59,351	\$0	\$59,351	\$4.58	504	467	\$117.76
Medicare Xover - Other	\$68,978	\$10	\$68,988	\$5.32	2,620	2,426	\$26.33
Medicare Xover - Physician	\$115,050	\$12	\$115,062	\$8.88	3,627	3,359	\$31.72
Nursing Facility	\$19,918,924	\$715,573	\$20,634,497	\$1,592.45	149,227	138,198	\$138.28
Outpatient - Other	\$1,860,493	\$133	\$1,860,627	\$143.59	3,140	2,908	\$592.56
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$6,511,193	\$31,362	\$6,542,555	\$504.92	124,238	115,056	\$52.66
Physician - Clinic	\$739,685	\$17	\$739,702	\$57.09	200,360	185,552	\$3.69
Physician - IP Mental Health	\$1,296	\$0	\$1,296	\$0.10	20	19	\$64.80
Physician - OP Mental Health	\$2,267,142	\$99	\$2,267,241	\$174.97	120,687	111,767	\$18.79
Physician - Other Practitioner	\$356,667	\$132	\$356,799	\$27.54	7,594	7,033	\$46.98
Physician - PCP	\$1,270,056	\$194	\$1,270,251	\$98.03	31,716	29,372	\$40.05
Physician - Specialist	\$734,966	\$316	\$735,282	\$56.74	15,450	14,308	\$47.59
Pharmacy	\$7,328,778	\$0	\$7,328,778	\$565.59	136,332	126,256	\$53.76
Transportation - Emergency	\$228,088	\$0	\$228,088	\$17.60	2,765	2,561	\$82.49
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$58,600,498	\$762,997	\$59,363,494	\$4,581.34	1,254,626		

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.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	14,038						
Service Type							
Adult Day Care	\$17,524	\$0	\$17,524	\$1.25	390	333	\$44.93
Ambulatory Surgery Center	\$18,421	\$0	\$18,421	\$1.31	26	22	\$708.51
Case Management Services	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Consumer Directed Services	\$1,184,708	\$2,055	\$1,186,763	\$84.54	122,223	104,482	\$9.71
DME/Supplies	\$1,479,356	\$1,046	\$1,480,402	\$105.46	11,225	9,596	\$131.88
Emergency	\$630,909	\$0	\$630,909	\$44.94	1,189	1,016	\$530.62
FQHC	\$13,426	\$0	\$13,426	\$0.96	191	163	\$70.30
Home Health Services	\$737,213	\$0	\$737,213	\$52.52	2,366	2,023	\$311.59
Inpatient - Medical/Surgical	\$11,690,545	\$3,384	\$11,693,929	\$833.04	980	838	\$11,932.58
Inpatient - Psych	\$23,872	\$0	\$23,872	\$1.70	33	28	\$723.39
Lab and X-ray Services	\$396,129	\$0	\$396,129	\$28.22	30,096	25,727	\$13.16
Medicare Xover - IP	\$37,999	\$0	\$37,999	\$2.71	39	33	\$974.34
Medicare Xover - Nursing Facility	\$729	\$0	\$729	\$0.05	67	57	\$10.87
Medicare Xover - OP	\$26,475	\$0	\$26,475	\$1.89	260	222	\$101.83
Medicare Xover - Other	\$48,091	\$0	\$48,091	\$3.43	964	824	\$49.89
Medicare Xover - Physician	\$85,042	\$18	\$85,060	\$6.06	2,083	1,781	\$40.84
Nursing Facility	\$28,916,716	\$2,387,328	\$31,304,044	\$2,230.01	207,552	177,425	\$150.83
Outpatient - Other	\$2,053,351	\$0	\$2,053,351	\$146.27	2,589	2,213	\$793.11
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$9,693,675	\$11,052	\$9,704,727	\$691.34	152,956	130,754	\$63.45
Physician - Clinic	\$1,314,094	\$0	\$1,314,094	\$93.61	390,050	333,432	\$3.37
Physician - IP Mental Health	\$2,341	\$0	\$2,341	\$0.17	34	29	\$68.86
Physician - OP Mental Health	\$3,171,210	\$359	\$3,171,569	\$225.93	221,472	189,324	\$14.32
Physician - Other Practitioner	\$641,411	\$51	\$641,462	\$45.70	9,140	7,813	\$70.18
Physician - PCP	\$1,353,573	\$76	\$1,353,649	\$96.43	29,526	25,240	\$45.85
Physician - Specialist	\$895,361	\$131	\$895,492	\$63.79	19,062	16,295	\$46.98
Pharmacy	\$7,362,345	\$0	\$7,362,345	\$524.47	125,987	107,699	\$58.44
Transportation - Emergency	\$188,345	\$0	\$188,345	\$13.42	3,033	2,593	\$62.10
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$71,982,864	\$2,405,500	\$74,388,364	\$5,299.21	1,333,533		

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.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

VIRGINIA MEDICAID
FY 2013 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 FY10 - FY11	Patient Payments FY10 - FY11	Total Payments FY10 - FY11	Unadjusted PMPM	Units FY10 - FY11	Units/1000 FY10 - FY11	Cost/Unit FY10 - FY11
Member Months	57,095						
Service Type							
Adult Day Care	\$686,508	\$2,635	\$689,143	\$12.07	18,225	3,830	\$37.81
Ambulatory Surgery Center	\$107,127	\$0	\$107,127	\$1.88	171	36	\$626.47
Case Management Services	\$10,366	\$0	\$10,366	\$0.18	3,113	654	\$3.33
Consumer Directed Services	\$15,156,558	\$40,988	\$15,197,546	\$266.18	1,459,646	306,783	\$10.41
DME/Supplies	\$6,054,304	\$2,641	\$6,056,945	\$106.09	50,354	10,583	\$120.29
Emergency	\$2,283,339	\$0	\$2,283,339	\$39.99	4,365	917	\$523.10
FQHC	\$370,664	\$428	\$371,091	\$6.50	4,892	1,028	\$75.86
Home Health Services	\$2,796,389	\$0	\$2,796,389	\$48.98	8,377	1,761	\$333.82
Inpatient - Medical/Surgical	\$45,534,916	\$14,139	\$45,549,055	\$797.78	4,043	850	\$11,266.15
Inpatient - Psych	\$109,660	\$0	\$109,660	\$1.92	145	30	\$756.28
Lab and X-ray Services	\$1,677,001	\$0	\$1,677,001	\$29.37	116,713	24,530	\$14.37
Medicare Xover - IP	\$198,829	\$0	\$198,829	\$3.48	232	49	\$857.02
Medicare Xover - Nursing Facility	\$46,650	\$910	\$47,560	\$0.83	4,054	852	\$11.73
Medicare Xover - OP	\$143,542	\$0	\$143,542	\$2.51	1,342	282	\$106.96
Medicare Xover - Other	\$182,041	\$10	\$182,051	\$3.19	6,113	1,285	\$29.78
Medicare Xover - Physician	\$399,592	\$37	\$399,629	\$7.00	10,344	2,174	\$38.63
Nursing Facility	\$111,318,314	\$7,395,105	\$118,713,419	\$2,079.23	766,871	161,178	\$154.80
Outpatient - Other	\$8,955,542	\$133	\$8,955,675	\$156.86	11,999	2,522	\$746.37
Outpatient - Psychological	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Personal Care Services	\$33,539,099	\$82,346	\$33,621,445	\$588.87	514,567	108,150	\$65.34
Physician - Clinic	\$4,088,440	\$22	\$4,088,462	\$71.61	1,100,702	231,342	\$3.71
Physician - IP Mental Health	\$8,006	\$0	\$8,006	\$0.14	121	25	\$66.17
Physician - OP Mental Health	\$10,773,755	\$633	\$10,774,388	\$188.71	653,381	137,325	\$16.49
Physician - Other Practitioner	\$2,229,344	\$345	\$2,229,689	\$39.05	37,465	7,874	\$59.51
Physician - PCP	\$5,191,289	\$336	\$5,191,625	\$90.93	115,685	24,314	\$44.88
Physician - Specialist	\$3,559,138	\$870	\$3,560,007	\$62.35	81,378	17,104	\$43.75
Pharmacy	\$29,094,462	\$0	\$29,094,462	\$509.58	538,175	113,112	\$54.06
Transportation - Emergency	\$752,871	\$0	\$752,871	\$13.19	11,557	2,429	\$65.14
Transportation - Non-Emergency	\$0	\$0	\$0	\$0.00	0	0	\$0.00
Total	\$285,267,746	\$7,541,576	\$292,809,322	\$5,128.47	5,524,030		

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.

Acute care costs for the ALTC population are obtained from health plan reported encounter data.

**Virginia Medicaid
 FY 2013 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	\$15.47	\$509.58	DMAS FY10-FY11 FFS Invoices
2. Fee-for-Service Net Cost per Script	\$7.56	\$54.06	DMAS FY10-FY11 FFS Invoices
3. Average Fee-for-Service Copayment per Script	\$0.02	\$0.05	DMAS FY10-FY11 FFS Invoices
4. Fee-for-Service Gross Cost per Script	\$7.58	\$54.11	= (2.) + (3.)
5. Average Fee-for-Service Dispensing Fees	\$2.73	\$2.98	DMAS FY10-FY11 FFS Invoices
6. Fee-for-Service Ingredient Cost per Script	\$4.85	\$51.14	= (4.) - (5.)
7. Average Fee-for-Service Rebate	11%	36%	Provided by DMAS
8. Fee-for-Service Cost per Script with Rebate	\$4.32	\$32.72	= (6.) * (1 - (7.))
9. Brand-Generic Improvement Adjustment	1.000	0.995	VA Claims Analysis
10. Adjusted Cost PMPM with Brand-Generic Improvement Adjustment	\$4.32	\$32.55	= (8.) * (9.)
11. Average Fee-for-Service Dispensing Fees	\$2.73	\$2.98	= (5.)
12. Adjusted Cost per Script	\$7.05	\$35.53	= (10.) + (11.)
13. Adjusted Cost PMPM	\$14.42	\$334.92	= (12.) * scripts / MM
14. Pharmacy Adjustment Factor	-6.8%	-34.3%	= (13.) / (1.) -1

Virginia Medicaid
FY 2013 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Non-Emergency Transportation Adjustment

	Adjustment Values	Source
Non-ER Transportation Rate	\$27.38	Non-Emergency Transportation Rate - Service Cost Component Only

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Emergency Transportation Adjustment**

Exhibit 2c

	Dual Eligibles	Non-Dual Eligibles	Source
1. Total claims in Transportation - Emergency Service Category	\$180,949	\$752,871	DMAS FY10-FY11 FFS Invoices
2a. % FFS Claims	100%	65%	DMAS FY10-FY11 FFS Invoices
2b. % MCO Claims	0%	35%	FY10-FY11 ALTC Health Plan Encounter Data
3a. FFS Increase to 40% of Medicare	38.4%	38.4%	Provided by DMAS
3b. MCO Increase to 40% of Medicare	0.5%	0.5%	Estimate based on Medallion II ABAD population
4. Emergency Transportation Adjustment	38.4%	25.3%	$= ((1.) * (2a.) * (3a.) + (1.) * (2b.) * (3b.)) / (1.)$

Virginia Medicaid
FY 2013 PACE Capitation Rate Development
Historical Fee-for-Service Claims
DME/Supplies Fee Reduction Adjustment

Exhibit 2d

	Adjustment Value	Source
1. Total claims in DME/Supplies Service Category	\$20,832,841	DMAS FY10-FY11 FFS Invoices
2. % Fee Reduction Effective FY11	10.0%	Provided by DMAS
3. % Claims Associated with DME HCPCs	34.8%	Estimate based on Medallion II ABAD population
4. DME/Supplies Fee Reduction Adjustment	-3.5%	= - (2.) * (3.)

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Clinical Lab Fee Reduction Adjustment**

	Adjustment Value	Source
1. Total claims in Lab Service Category	\$1,749,560	DMAS FY10-FY11 FFS Invoices
2. % Fee Reduction Effective February 1, 2010*	5.0%	Provided by DMAS
3. % Claims Associated with Clinical Lab Procedure	76.3%	Estimate based on Medallion II ABAD population
4. Clinical Lab Fee Reduction Adjustment	-1.1%	= - (7 / 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 2013 PACE Capitation Rate Development
Historical Fee-for-Service Claims
Home and Community-Based Care Fee Adjustment

Exhibit 2f

		Adjustment Value	Source
1. Total Claims in Service Categories	a. Adult Day Care	\$9,158,771	DMAS FY10-FY11 FFS Invoices
	b. Consumer Directed Services	\$130,553,263	
	c. Personal Care Services	\$316,844,499	
2a. FY12 Fee Decrease		1.0%	Provided by DMAS
2b. FY13 Fee Increase		1.0%	Provided by DMAS
3. Claims associated with FY12 Fee Decrease	a. Adult Day Care	\$9,158,771	DMAS FY10-FY11 FFS Invoices
HCBC Procedure Codes	b. Consumer Directed Services	\$130,546,512	
	c. Personal Care Services	\$316,844,499	
4. Claims associated with FY13 Fee Increase	a. Adult Day Care	\$0	DMAS FY10-FY11 FFS Invoices
HCBC Procedure Codes	b. Consumer Directed Services	\$130,546,512	
	c. Personal Care Services	\$316,844,499	
5. HCBC Fee Adjustment	a. Adult Day Care	-1.0%	= ((3.) * (-2a.) + (4.) * (2b.)) / (1.)
	b. Consumer Directed Services	0.0%	
	c. Personal Care Services	0.0%	

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Hospital Inpatient Adjustment**

Exhibit 2g

	Inpatient Medical/Surgical	Inpatient - Psych	Source
1. Total Claims in IP Service Categories	\$61,089,071	\$1,623,859	DMAS FY10-FY11 FFS Invoices
2. FY10-11 Hospital Capital Percentage*	9.4%	9.3%	Provided by DMAS
3a. FY12 Capital Reimbursement Reduction	5.3%	5.3%	Provided by DMAS
3b. Dollar Change	(\$307,796)	(\$8,095)	= - (1.) * (2.) * (3a.)
4a. FY13 Hospital Rate Increase	2.6%	2.6%	Provided by DMAS
4b. Dollar Change	\$1,438,265	\$38,274	= (1.) * ((1 + (4a.)) * (1 - (2.)) + (2.) - 1) * (1 - (3.))
5. Hospital Inpatient Adjustment	1.9%	1.9%	= ((3b.) + (4b.)) / (1.)

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

**Virginia Medicaid
 FY 2013 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	\$38,780	\$2,283,339	DMAS FY10-FY11 FFS Invoices
	b. Outpatient - Other	\$1,302,284	\$8,955,542	
2.	% ER Triage of Total Outpatient	0.0%	6.0%	Provided by DMAS
3.	% Emergency of Total Outpatient	2.9%	20.3%	= (1a.) / ((1a.) + (1b.))
4.	% of Claims Exempt from Fee Reduction	0.0%	29.5%	= (2.) / (3.)
5.	FY12 Hospital Rate Reduction	5.0%	5.0%	Provided by DMAS
6.	Dollar Decrease			
	a. Emergency	\$1,939	\$80,450	= (1a.) * (1 - (4.)) * (5.)
	b. Outpatient - Other	\$65,114	\$447,777	= (1b.) * (5.)
7.	Hospital Outpatient Adjustment			
	a. Emergency	-5.0%	-3.5%	= (6.) / (1.)
	b. Outpatient - Other	-5.0%	-5.0%	= (6.) / (1.)

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Nursing Facility Adjustment**

Exhibit 2i

	Adjustment Value	Source
1. Total Claims in Nursing Facility Service Category	\$1,418,456,907	DMAS FY10-FY11 FFS Invoices
2. FY12 Nursing Facility Capital Rental Rate Percentage	10.0%	Provided by DMAS
3a. FY12 Nursing Facility Capital Rental Rate Reduction	11.1%	Provided by DMAS
3b. FY13 Nursing Facility Capital Rental Rate Increase	6.3%	Provided by DMAS
3c. Dollar Change	(\$7,880,316)	= (1.) * (2.) * ((1 - (3a.)) * (1 + (3b.)) -1)
4a. FY13 Nursing Facility Operating Rate Increase	2.8%	Provided by DMAS
4b. Dollar Change	\$35,745,114	= (1.) * (1 - (2.)) * (4a.)
5a. Nursing Facility Cost Settlement Adjustment	4.5%	Provided by DMAS
5b. Dollar Change	\$63,830,561	= (1.) * (5a.)
6. Nursing Facility Adjustment	6.5%	= ((3c.) + (4b.) + (5b.)) / (6.)

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 Other Adjustments**

	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 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 IBNR, Policy/Program, and 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%	6.5%	6.5%	2.7%	-4.1%	-1.5%	0.3%	0.9899
Adult Day Care	0.0%	-1.0%	-1.0%	-3.8%	6.5%	2.4%	4.2%	1.0886
Personal Care	0.1%	0.0%	0.1%	-8.5%	22.2%	11.8%	12.3%	1.3298
Consumer Directed Services	0.1%	0.0%	0.1%	-8.5%	22.2%	11.8%	12.3%	1.3298
IP Medical/Surgical - DRG Services	1.7%	1.9%	3.6%	-4.0%	5.1%	0.9%	0.0%	1.0090
IP Psych - Per Diem Services	0.0%	1.9%	1.9%	-4.0%	5.1%	0.9%	0.0%	1.0090
Outpatient Hospital	0.3%	-4.5%	-4.3%	-14.9%	-4.6%	-18.8%	0.0%	0.8120
Practitioner	0.2%	0.0%	0.2%	0.8%	10.1%	10.9%	14.1%	1.3508
Prescription Drug	0.0%	-6.8%	-6.8%	-13.6%	-9.3%	-21.6%	0.0%	0.7820
Other	0.3%	-3.0%	-2.6%	-10.4%	7.0%	-4.1%	0.0%	0.9590
Weighted Average*	0.1%	4.9%	5.0%	0.4%	1.3%	1.2%	3.0%	1.0574
Medicare Crossovers								
Inpatient	0.1%	0.0%	0.1%	0.7%	-3.2%	-2.5%	0.0%	0.9750
Nursing Facility	0.1%	0.0%	0.1%	0.7%	-3.2%	-2.5%	0.0%	0.9750
Outpatient	0.1%	0.0%	0.1%	0.7%	-3.2%	-2.5%	0.0%	0.9750
Professional	0.1%	0.0%	0.1%	0.7%	-3.2%	-2.5%	0.0%	0.9750
Other	0.1%	0.0%	0.1%	0.7%	-3.2%	-2.5%	0.0%	0.9750
Weighted Average*	0.1%	0.0%	0.1%	0.7%	-3.2%	-2.5%	0.0%	0.9750
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 2010-2011 Claims)

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 IBNR, Policy/Program, and 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%	6.5%	6.6%	3.1%	-4.9%	-1.9%	0.0%	0.9814
Adult Day Care	0.0%	-1.0%	-1.0%	-3.8%	6.5%	2.4%	4.2%	1.0886
Personal Care	0.1%	0.0%	0.1%	-8.5%	22.2%	11.8%	12.3%	1.3298
Consumer Directed Services	0.1%	0.0%	0.1%	-8.5%	22.2%	11.8%	12.3%	1.3298
IP Medical/Surgical - DRG Services	0.2%	1.9%	2.0%	-5.8%	6.7%	0.5%	0.0%	1.0050
IP Psych - Per Diem Services	0.0%	1.9%	1.9%	-5.8%	6.7%	0.5%	0.0%	1.0050
Outpatient Hospital	0.4%	-3.8%	-3.4%	-2.3%	14.3%	11.7%	13.5%	1.3509
Practitioner	0.3%	0.0%	0.3%	20.0%	-5.5%	13.4%	10.8%	1.3235
Prescription Drug	0.0%	-34.3%	-34.3%	5.6%	0.0%	5.6%	3.7%	1.1151
Other	0.3%	-0.5%	-0.1%	-0.6%	4.8%	4.1%	5.4%	1.1262
Weighted Average*	0.1%	0.0%	0.2%	1.1%	3.0%	3.5%	4.1%	1.0999
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 2010-2011 Claims)

**Virginia Medicaid
FY 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Northern Virginia	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$3,807,958	\$216	\$22,954	(\$38,311)	\$3,792,816	1.089	\$4,128,711	\$45.67	0.78	\$35.62
Ambulatory Surgery Center	\$2,019	\$3			\$2,023	1.351	\$2,732	\$0.03	0.78	\$0.02
Case Management Services	\$12,506	\$20			\$12,526	1.351	\$16,920	\$0.19	0.78	\$0.15
Consumer Directed Services	\$23,410,553	\$19,014	\$215,932		\$23,645,499	1.330	\$31,443,003	\$347.79	0.78	\$271.28
DME/Supplies	\$1,902,442	\$6,312		(\$66,378)	\$1,842,376	0.959	\$1,766,838	\$19.54	0.78	\$15.24
Emergency	\$6,176	\$17		(\$310)	\$5,883	0.812	\$4,777	\$0.05	0.78	\$0.04
FQHC	\$287	\$0			\$287	1.351	\$388	\$0.00	0.78	\$0.00
Home Health Services	\$41,174	\$111			\$41,285	0.812	\$33,523	\$0.37	0.78	\$0.29
Inpatient - Medical/Surgical	\$5,846,008	\$98,483		\$110,004	\$6,054,496	1.009	\$6,108,986	\$67.57	0.78	\$52.71
Inpatient - Psych	\$778,895	\$0		\$14,475	\$793,370	1.009	\$800,510	\$8.85	0.78	\$6.91
Lab and X-ray Services	\$9,010	\$30		(\$101)	\$8,940	0.959	\$8,573	\$0.09	0.78	\$0.07
Medicare Xover - IP	\$2,098,270	\$2,243			\$2,100,512	0.975	\$2,047,999	\$22.65	0.78	\$17.67
Medicare Xover - Nursing Facility	\$1,369,201	\$1,463	\$19,621		\$1,390,286	0.975	\$1,355,528	\$14.99	0.78	\$11.69
Medicare Xover - OP	\$984,514	\$1,052			\$985,566	0.975	\$960,927	\$10.63	0.78	\$8.29
Medicare Xover - Other	\$720,811	\$770			\$721,582	0.975	\$703,542	\$7.78	0.78	\$6.07
Medicare Xover - Physician	\$2,303,088	\$2,461			\$2,305,549	0.975	\$2,247,910	\$24.86	0.78	\$19.39
Nursing Facility	\$208,997,740	\$113,206	\$45,170,423	\$13,517,861	\$267,799,230	0.990	\$265,083,244	\$2,932.09	0.78	\$2,287.03
Outpatient - Other	\$709,953	\$1,914		(\$35,593)	\$676,273	0.812	\$549,134	\$6.07	0.78	\$4.74
Outpatient - Psychological	\$0	\$0			\$0	0.812	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$58,004,981	\$47,111	\$367,017	\$0	\$58,419,110	1.330	\$77,683,803	\$859.26	0.78	\$670.23
Physician - Clinic	\$21,625	\$34			\$21,660	1.351	\$29,257	\$0.32	0.78	\$0.25
Physician - IP Mental Health	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$13,517,122	\$21,516			\$13,538,639	1.351	\$18,287,620	\$202.28	0.78	\$157.78
Physician - Other Practitioner	\$644,660	\$1,026			\$645,687	1.351	\$872,176	\$9.65	0.78	\$7.52
Physician - PCP	\$137,645	\$219			\$137,864	1.351	\$186,224	\$2.06	0.78	\$1.61
Physician - Specialist	\$80,866	\$129			\$80,995	1.351	\$109,406	\$1.21	0.78	\$0.94
Pharmacy	\$1,276,939	\$215		(\$86,652)	\$1,190,501	0.782	\$930,972	\$10.32	1.00	\$10.32
Transportation - Emergency	\$11,015	\$37		\$4,242	\$15,293	0.959	\$14,666	\$0.16	0.78	\$0.13
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$326,695,459	\$317,603	\$45,795,948	\$13,419,237	\$386,228,246			\$4,621.91		\$3,613.38
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$4,716.23		\$4,251.04

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Other MSA	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$590,813	\$33	\$6,355	(\$5,972)	\$591,230	1.089	\$643,589	\$5.13	0.78	\$4.00
Ambulatory Surgery Center	\$921	\$1			\$922	1.351	\$1,246	\$0.01	0.78	\$0.01
Case Management Services	\$8,968	\$14			\$8,982	1.351	\$12,133	\$0.10	0.78	\$0.08
Consumer Directed Services	\$19,024,305	\$15,451	\$215,372		\$19,255,128	1.330	\$25,604,833	\$204.21	0.78	\$159.29
DME/Supplies	\$1,921,610	\$6,375		(\$67,047)	\$1,860,938	0.959	\$1,784,639	\$14.23	0.78	\$11.10
Emergency	\$747	\$2		(\$37)	\$712	0.812	\$578	\$0.00	0.78	\$0.00
FQHC	\$722	\$1			\$723	1.351	\$976	\$0.01	0.78	\$0.01
Home Health Services	\$10,006	\$27			\$10,033	0.812	\$8,147	\$0.06	0.78	\$0.05
Inpatient - Medical/Surgical	\$1,922,753	\$32,391		\$36,180	\$1,991,325	1.009	\$2,009,247	\$16.02	0.78	\$12.50
Inpatient - Psych	\$322,717	\$0		\$5,997	\$328,714	1.009	\$331,673	\$2.65	0.78	\$2.06
Lab and X-ray Services	\$17,986	\$60		(\$201)	\$17,845	0.959	\$17,114	\$0.14	0.78	\$0.11
Medicare Xover - IP	\$3,292,342	\$3,519			\$3,295,860	0.975	\$3,213,464	\$25.63	0.78	\$19.99
Medicare Xover - Nursing Facility	\$1,764,033	\$1,885	\$92,179		\$1,858,098	0.975	\$1,811,645	\$14.45	0.78	\$11.27
Medicare Xover - OP	\$1,207,063	\$1,290			\$1,208,353	0.975	\$1,178,144	\$9.40	0.78	\$7.33
Medicare Xover - Other	\$1,070,878	\$1,145			\$1,072,022	0.975	\$1,045,222	\$8.34	0.78	\$6.50
Medicare Xover - Physician	\$2,867,263	\$3,064			\$2,870,327	0.975	\$2,798,569	\$22.32	0.78	\$17.41
Nursing Facility	\$292,328,089	\$158,343	\$68,136,331	\$18,907,623	\$379,530,385	0.990	\$375,681,235	\$2,996.26	0.78	\$2,337.08
Outpatient - Other	\$83,522	\$225		(\$4,187)	\$79,560	0.812	\$64,602	\$0.52	0.78	\$0.40
Outpatient - Psychological	\$0	\$0			\$0	0.812	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$29,212,797	\$23,726	\$221,278	\$0	\$29,457,801	1.330	\$39,172,011	\$312.42	0.78	\$243.69
Physician - Clinic	\$3,528	\$6			\$3,533	1.351	\$4,773	\$0.04	0.78	\$0.03
Physician - IP Mental Health	\$214	\$0			\$214	1.351	\$289	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$8,533,600	\$13,584			\$8,547,184	1.351	\$11,545,300	\$92.08	0.78	\$71.82
Physician - Other Practitioner	\$656,393	\$1,045			\$657,438	1.351	\$888,050	\$7.08	0.78	\$5.52
Physician - PCP	\$73,102	\$116			\$73,219	1.351	\$98,902	\$0.79	0.78	\$0.62
Physician - Specialist	\$42,301	\$67			\$42,369	1.351	\$57,230	\$0.46	0.78	\$0.36
Pharmacy	\$2,334,348	\$393		(\$158,407)	\$2,176,333	0.782	\$1,701,892	\$13.61	1.00	\$13.61
Transportation - Emergency	\$29,840	\$99		\$11,490	\$41,429	0.959	\$39,731	\$0.32	0.78	\$0.25
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$367,320,859	\$262,864	\$68,671,514	\$18,725,439	\$454,980,676			\$3,773.64		\$2,952.46
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,850.66		\$3,473.48

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 2013 PACE Capitation Rate Development
 Capitation Rate Calculations
 Dual Population**

Exhibit 4a

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$2,992,518	\$170	\$38,868	(\$30,316)	\$3,001,240	1.089	\$3,267,033	\$26.06	0.78	\$20.33
Ambulatory Surgery Center	\$1,404	\$2			\$1,406	1.351	\$1,900	\$0.02	0.78	\$0.01
Case Management Services	\$75	\$0			\$75	1.351	\$101	\$0.00	0.78	\$0.00
Consumer Directed Services	\$24,172,498	\$19,633	\$360,943		\$24,553,074	1.330	\$32,649,867	\$260.48	0.78	\$203.17
DME/Supplies	\$3,228,083	\$10,710		(\$112,631)	\$3,126,161	0.959	\$2,997,988	\$23.92	0.78	\$18.66
Emergency	\$6,742	\$18		(\$338)	\$6,422	0.812	\$5,215	\$0.04	0.78	\$0.03
FQHC	\$927	\$1			\$928	1.351	\$1,254	\$0.01	0.78	\$0.01
Home Health Services	\$11,126	\$30			\$11,156	0.812	\$9,059	\$0.07	0.78	\$0.06
Inpatient - Medical/Surgical	\$2,204,398	\$37,136		\$41,480	\$2,283,014	1.009	\$2,303,561	\$18.38	0.78	\$14.33
Inpatient - Psych	\$116,283	\$0		\$2,161	\$118,444	1.009	\$119,510	\$0.95	0.78	\$0.74
Lab and X-ray Services	\$10,884	\$36		(\$121)	\$10,798	0.959	\$10,356	\$0.08	0.78	\$0.06
Medicare Xover - IP	\$3,935,213	\$4,206			\$3,939,419	0.975	\$3,840,933	\$30.64	0.78	\$23.90
Medicare Xover - Nursing Facility	\$2,130,111	\$2,277	\$64,599		\$2,196,987	0.975	\$2,142,062	\$17.09	0.78	\$13.33
Medicare Xover - OP	\$1,280,085	\$1,368			\$1,281,453	0.975	\$1,249,417	\$9.97	0.78	\$7.77
Medicare Xover - Other	\$1,306,976	\$1,397			\$1,308,373	0.975	\$1,275,664	\$10.18	0.78	\$7.94
Medicare Xover - Physician	\$3,269,936	\$3,495			\$3,273,430	0.975	\$3,191,595	\$25.46	0.78	\$19.86
Nursing Facility	\$241,797,415	\$130,972	\$62,068,382	\$15,639,326	\$319,636,095	0.990	\$316,394,386	\$2,524.14	0.78	\$1,968.83
Outpatient - Other	\$254,163	\$685		(\$12,742)	\$242,106	0.812	\$196,590	\$1.57	0.78	\$1.22
Outpatient - Psychological	\$0	\$0			\$0	0.812	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$56,674,046	\$46,030	\$690,552	\$0	\$57,410,628	1.330	\$76,342,758	\$609.05	0.78	\$475.06
Physician - Clinic	\$22,301	\$35			\$22,336	1.351	\$30,171	\$0.24	0.78	\$0.19
Physician - IP Mental Health	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$13,690,504	\$21,792			\$13,712,297	1.351	\$18,522,192	\$147.77	0.78	\$115.26
Physician - Other Practitioner	\$752,924	\$1,198			\$754,123	1.351	\$1,018,649	\$8.13	0.78	\$6.34
Physician - PCP	\$83,050	\$132			\$83,182	1.351	\$112,360	\$0.90	0.78	\$0.70
Physician - Specialist	\$53,927	\$86			\$54,013	1.351	\$72,960	\$0.58	0.78	\$0.45
Pharmacy	\$1,549,084	\$261		(\$105,120)	\$1,444,224	0.782	\$1,129,383	\$9.03	1.00	\$9.03
Transportation - Emergency	\$60,305	\$200		\$23,221	\$83,727	0.959	\$80,294	\$0.64	0.78	\$0.50
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$359,604,979	\$281,871	\$63,223,343	\$15,444,920	\$438,555,113			\$3,752.78		\$2,935.18
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,829.36		\$3,453.15

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Rural	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$694,641	\$39	\$3,143	(\$6,978)	\$690,846	1.089	\$752,028	\$4.00	0.78	\$3.12
Ambulatory Surgery Center	\$1,496	\$2			\$1,499	1.351	\$2,025	\$0.01	0.78	\$0.01
Case Management Services	\$75,529	\$120			\$75,649	1.351	\$102,184	\$0.54	0.78	\$0.42
Consumer Directed Services	\$37,993,113	\$30,858	\$415,753		\$38,439,723	1.330	\$51,115,874	\$271.89	0.78	\$212.08
DME/Supplies	\$4,096,313	\$13,590		(\$142,925)	\$3,966,978	0.959	\$3,804,332	\$20.24	0.78	\$15.78
Emergency	\$14,155	\$38		(\$710)	\$13,483	0.812	\$10,948	\$0.06	0.78	\$0.05
FQHC	\$2,306	\$4			\$2,309	1.351	\$3,119	\$0.02	0.78	\$0.01
Home Health Services	\$36,772	\$99			\$36,871	0.812	\$29,939	\$0.16	0.78	\$0.12
Inpatient - Medical/Surgical	\$3,107,276	\$52,346		\$58,470	\$3,218,091	1.009	\$3,247,054	\$17.27	0.78	\$13.47
Inpatient - Psych	\$247,161	\$0		\$4,593	\$251,755	1.009	\$254,020	\$1.35	0.78	\$1.05
Lab and X-ray Services	\$15,062	\$50		(\$168)	\$14,944	0.959	\$14,331	\$0.08	0.78	\$0.06
Medicare Xover - IP	\$5,555,533	\$5,937			\$5,561,471	0.975	\$5,422,434	\$28.84	0.78	\$22.50
Medicare Xover - Nursing Facility	\$3,475,310	\$3,714	\$95,981		\$3,575,005	0.975	\$3,485,630	\$18.54	0.78	\$14.46
Medicare Xover - OP	\$2,543,746	\$2,719			\$2,546,465	0.975	\$2,482,803	\$13.21	0.78	\$10.30
Medicare Xover - Other	\$2,285,050	\$2,442			\$2,287,492	0.975	\$2,230,304	\$11.86	0.78	\$9.25
Medicare Xover - Physician	\$4,451,812	\$4,758			\$4,456,570	0.975	\$4,345,156	\$23.11	0.78	\$18.03
Nursing Facility	\$326,893,953	\$177,066	\$69,736,534	\$21,143,324	\$417,950,878	0.990	\$413,712,072	\$2,200.61	0.78	\$1,716.48
Outpatient - Other	\$81,903	\$221		(\$4,106)	\$78,018	0.812	\$63,350	\$0.34	0.78	\$0.26
Outpatient - Psychological	\$0	\$0			\$0	0.812	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$69,275,343	\$56,265	\$705,832	\$0	\$70,037,440	1.330	\$93,133,475	\$495.39	0.78	\$386.41
Physician - Clinic	\$172	\$0			\$172	1.351	\$233	\$0.00	0.78	\$0.00
Physician - IP Mental Health	\$39	\$0			\$39	1.351	\$53	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$16,952,651	\$26,985			\$16,979,636	1.351	\$22,935,625	\$122.00	0.78	\$95.16
Physician - Other Practitioner	\$1,301,998	\$2,072			\$1,304,070	1.351	\$1,761,502	\$9.37	0.78	\$7.31
Physician - PCP	\$109,219	\$174			\$109,393	1.351	\$147,765	\$0.79	0.78	\$0.61
Physician - Specialist	\$68,882	\$110			\$68,991	1.351	\$93,191	\$0.50	0.78	\$0.39
Pharmacy	\$3,087,762	\$519		(\$209,534)	\$2,878,748	0.782	\$2,251,181	\$12.01	1.00	\$12.01
Transportation - Emergency	\$44,135	\$146		\$16,995	\$61,276	0.959	\$58,764	\$0.31	0.78	\$0.24
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$482,411,332	\$380,276	\$70,957,243	\$20,858,961	\$574,607,813			\$3,279.88		\$2,566.97
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,346.81		\$3,019.96

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Tidewater	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$386,332	\$22	\$3,638	(\$3,900)	\$386,092	1.089	\$420,284	\$3.37	0.78	\$2.63
Ambulatory Surgery Center	\$6,919	\$11			\$6,930	1.351	\$9,361	\$0.07	0.78	\$0.06
Case Management Services	\$2,743	\$4			\$2,747	1.351	\$3,711	\$0.03	0.78	\$0.02
Consumer Directed Services	\$10,796,236	\$8,769	\$134,802		\$10,939,807	1.330	\$14,547,394	\$116.50	0.78	\$90.87
DME/Supplies	\$3,630,089	\$12,043		(\$126,658)	\$3,515,475	0.959	\$3,371,340	\$27.00	0.78	\$21.06
Emergency	\$10,961	\$30		(\$550)	\$10,441	0.812	\$8,478	\$0.07	0.78	\$0.05
FQHC	\$520	\$1			\$521	1.351	\$703	\$0.01	0.78	\$0.00
Home Health Services	\$36,177	\$98			\$36,274	0.812	\$29,455	\$0.24	0.78	\$0.18
Inpatient - Medical/Surgical	\$2,473,721	\$41,673		\$46,548	\$2,561,942	1.009	\$2,584,999	\$20.70	0.78	\$16.15
Inpatient - Psych	\$49,143	\$0		\$913	\$50,056	1.009	\$50,507	\$0.40	0.78	\$0.32
Lab and X-ray Services	\$19,616	\$65		(\$219)	\$19,463	0.959	\$18,665	\$0.15	0.78	\$0.12
Medicare Xover - IP	\$3,387,133	\$3,620			\$3,390,753	0.975	\$3,305,984	\$26.47	0.78	\$20.65
Medicare Xover - Nursing Facility	\$1,687,456	\$1,803	\$167,584		\$1,856,844	0.975	\$1,810,422	\$14.50	0.78	\$11.31
Medicare Xover - OP	\$1,232,950	\$1,318			\$1,234,268	0.975	\$1,203,411	\$9.64	0.78	\$7.52
Medicare Xover - Other	\$1,356,854	\$1,450			\$1,358,304	0.975	\$1,324,346	\$10.61	0.78	\$8.27
Medicare Xover - Physician	\$3,641,876	\$3,892			\$3,645,768	0.975	\$3,554,624	\$28.47	0.78	\$22.20
Nursing Facility	\$237,121,396	\$128,439	\$68,039,283	\$15,336,884	\$320,626,002	0.990	\$317,374,253	\$2,541.54	0.78	\$1,982.40
Outpatient - Other	\$172,744	\$466		(\$8,660)	\$164,549	0.812	\$133,614	\$1.07	0.78	\$0.83
Outpatient - Psychological	\$0	\$0			\$0	0.812	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$70,138,232	\$56,966	\$526,873	\$0	\$70,722,071	1.330	\$94,043,874	\$753.10	0.78	\$587.42
Physician - Clinic	\$57,783	\$92			\$57,875	1.351	\$78,176	\$0.63	0.78	\$0.49
Physician - IP Mental Health	\$386	\$1			\$386	1.351	\$522	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$19,879,461	\$31,644			\$19,911,105	1.351	\$26,895,372	\$215.38	0.78	\$168.00
Physician - Other Practitioner	\$481,051	\$766			\$481,816	1.351	\$650,824	\$5.21	0.78	\$4.07
Physician - PCP	\$116,146	\$185			\$116,331	1.351	\$157,137	\$1.26	0.78	\$0.98
Physician - Specialist	\$65,043	\$104			\$65,147	1.351	\$87,998	\$0.70	0.78	\$0.55
Pharmacy	\$1,871,526	\$315		(\$127,001)	\$1,744,840	0.782	\$1,364,465	\$10.95	1.00	\$10.95
Transportation - Emergency	\$35,654	\$118		\$13,729	\$49,501	0.959	\$47,472	\$0.38	0.78	\$0.30
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$358,658,147	\$293,893	\$68,872,180	\$15,131,087	\$442,955,307			\$3,815.82		\$2,984.77
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,893.69		\$3,511.49

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Dual Population**

Exhibit 4a

Age 55 and Over										
Total	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$8,472,262	\$480	\$74,958	(\$85,477)	\$8,462,223	1.089	\$9,211,646	\$14.08	0.78	\$10.99
Ambulatory Surgery Center	\$12,759	\$20			\$12,780	1.351	\$17,263	\$0.03	0.78	\$0.02
Case Management Services	\$99,821	\$159			\$99,980	1.351	\$135,050	\$0.21	0.78	\$0.16
Consumer Directed Services	\$115,396,705	\$93,724	\$1,342,801		\$116,833,230	1.330	\$155,360,971	\$237.55	0.78	\$185.29
DME/Supplies	\$14,778,537	\$49,030		(\$515,639)	\$14,311,927	0.959	\$13,725,138	\$20.99	0.78	\$16.37
Emergency	\$38,780	\$105		(\$1,944)	\$36,940	0.812	\$29,995	\$0.05	0.78	\$0.04
FQHC	\$4,761	\$8			\$4,769	1.351	\$6,441	\$0.01	0.78	\$0.01
Home Health Services	\$135,254	\$365			\$135,619	0.812	\$110,123	\$0.17	0.78	\$0.13
Inpatient - Medical/Surgical	\$15,554,155	\$262,029		\$292,683	\$16,108,867	1.009	\$16,253,847	\$24.85	0.78	\$19.38
Inpatient - Psych	\$1,514,199	\$0		\$28,140	\$1,542,339	1.009	\$1,556,220	\$2.38	0.78	\$1.86
Lab and X-ray Services	\$72,559	\$241		(\$810)	\$71,990	0.959	\$69,038	\$0.11	0.78	\$0.08
Medicare Xover - IP	\$18,268,491	\$19,524			\$18,288,015	0.975	\$17,830,815	\$27.26	0.78	\$21.27
Medicare Xover - Nursing Facility	\$10,426,112	\$11,143	\$439,964		\$10,877,219	0.975	\$10,605,289	\$16.22	0.78	\$12.65
Medicare Xover - OP	\$7,248,359	\$7,747			\$7,256,106	0.975	\$7,074,703	\$10.82	0.78	\$8.44
Medicare Xover - Other	\$6,740,569	\$7,204			\$6,747,773	0.975	\$6,579,079	\$10.06	0.78	\$7.85
Medicare Xover - Physician	\$16,533,974	\$17,671			\$16,551,645	0.975	\$16,137,854	\$24.68	0.78	\$19.25
Nursing Facility	\$1,307,138,592	\$708,026	\$313,150,953	\$84,545,018	\$1,705,542,590	0.990	\$1,688,245,189	\$2,581.37	0.78	\$2,013.47
Outpatient - Other	\$1,302,284	\$3,511		(\$65,290)	\$1,240,505	0.812	\$1,007,290	\$1.54	0.78	\$1.20
Outpatient - Psychological	\$0	\$0			\$0	0.812	\$0	\$0.00	1.00	\$0.00
Personal Care Services	\$283,305,400	\$230,099	\$2,511,552	\$0	\$286,047,051	1.330	\$380,375,921	\$581.60	0.78	\$453.65
Physician - Clinic	\$105,409	\$168			\$105,576	1.351	\$142,610	\$0.22	0.78	\$0.17
Physician - IP Mental Health	\$638	\$1			\$639	1.351	\$864	\$0.00	0.78	\$0.00
Physician - OP Mental Health	\$72,573,339	\$115,521			\$72,688,860	1.351	\$98,186,109	\$150.13	0.78	\$117.10
Physician - Other Practitioner	\$3,837,027	\$6,108			\$3,843,134	1.351	\$5,191,200	\$7.94	0.78	\$6.19
Physician - PCP	\$519,163	\$826			\$519,989	1.351	\$702,387	\$1.07	0.78	\$0.84
Physician - Specialist	\$311,020	\$495			\$311,515	1.351	\$420,785	\$0.64	0.78	\$0.50
Pharmacy	\$10,119,659	\$1,702		(\$686,714)	\$9,434,647	0.782	\$7,377,894	\$11.31	1.00	\$11.31
Transportation - Emergency	\$180,949	\$600		\$69,677	\$251,226	0.959	\$240,926	\$0.37	0.78	\$0.29
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$1,894,690,776	\$1,536,506	\$317,520,228	\$83,579,644	\$2,297,327,155			\$3,753.02		\$2,935.87
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$3,829.61		\$3,453.96

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Northern Virginia	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$148,842	\$8		(\$1,489)	\$147,362	1.089	\$160,413	\$15.00	0.78	\$11.70
Ambulatory Surgery Center	\$11,148	\$28			\$11,176	1.323	\$14,791	\$1.38	0.78	\$1.08
Case Management Services	\$0	\$0			\$0	1.323	\$0	\$0.00	0.78	\$0.00
Consumer Directed Services	\$4,398,929	\$3,573	\$17,672		\$4,420,174	1.330	\$5,877,801	\$549.63	0.78	\$428.71
DME/Supplies	\$867,417	\$2,774		(\$30,262)	\$839,930	1.126	\$945,969	\$88.46	0.78	\$69.00
Emergency	\$388,140	\$1,436		(\$13,726)	\$375,850	1.351	\$507,742	\$47.48	0.78	\$37.03
FQHC	\$4,834	\$12			\$4,846	1.323	\$6,414	\$0.60	0.78	\$0.47
Home Health Services	\$416,722	\$1,542			\$418,264	1.351	\$565,040	\$52.84	0.78	\$41.21
Inpatient - Medical/Surgical	\$7,725,282	\$12,782		\$143,195	\$7,881,258	1.005	\$7,920,665	\$740.65	0.78	\$577.71
Inpatient - Psych	\$0	\$0			\$0	1.005	\$0	\$0.00	0.78	\$0.00
Lab and X-ray Services	\$280,027	\$896		(\$3,124)	\$277,798	1.126	\$312,870	\$29.26	0.78	\$22.82
Medicare Xover - IP	\$33,709	\$0			\$33,709	1.000	\$33,709	\$3.15	1.00	\$3.15
Medicare Xover - Nursing Facility	\$11,649	\$0			\$11,649	1.000	\$11,649	\$1.09	1.00	\$1.09
Medicare Xover - OP	\$19,921	\$0			\$19,921	1.000	\$19,921	\$1.86	1.00	\$1.86
Medicare Xover - Other	\$20,362	\$0			\$20,362	1.000	\$20,362	\$1.90	1.00	\$1.90
Medicare Xover - Physician	\$58,298	\$0			\$58,298	1.000	\$58,298	\$5.45	1.00	\$5.45
Nursing Facility	\$23,747,240	\$27,747	\$1,961,132	\$1,536,921	\$27,273,040	0.981	\$26,765,554	\$2,502.82	0.78	\$1,952.20
Outpatient - Other	\$1,298,611	\$4,805		(\$65,171)	\$1,238,245	1.351	\$1,672,766	\$156.42	0.78	\$122.01
Outpatient - Psychological	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$8,627,370	\$7,007	\$17,484	\$0	\$8,651,862	1.330	\$11,504,960	\$1,075.82	0.78	\$839.14
Physician - Clinic	\$869,440	\$2,208			\$871,648	1.323	\$1,153,592	\$107.87	0.78	\$84.14
Physician - IP Mental Health	\$315	\$1			\$316	1.323	\$418	\$0.04	0.78	\$0.03
Physician - OP Mental Health	\$2,305,234	\$5,855			\$2,311,089	1.323	\$3,058,633	\$286.01	0.78	\$223.09
Physician - Other Practitioner	\$383,649	\$974			\$384,623	1.323	\$509,033	\$47.60	0.78	\$37.13
Physician - PCP	\$954,020	\$2,423			\$956,443	1.323	\$1,265,814	\$118.37	0.78	\$92.32
Physician - Specialist	\$691,773	\$1,757			\$693,530	1.323	\$917,859	\$85.83	0.78	\$66.95
Pharmacy	\$5,047,326	\$646		(\$1,730,215)	\$3,317,756	1.115	\$3,699,694	\$345.96	1.00	\$345.96
Transportation - Emergency	\$64,500	\$206		\$16,340	\$81,046	1.126	\$91,278	\$8.54	0.78	\$6.66
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$58,374,757	\$76,681	\$1,996,289	(\$147,530)	\$60,300,197			\$6,301.40		\$5,000.19
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$6,430.00		\$5,882.57

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Other MSA	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$49,031	\$3		(\$490)	\$48,543	1.089	\$52,842	\$6.62	0.78	\$5.16
Ambulatory Surgery Center	\$20,587	\$52			\$20,639	1.323	\$27,315	\$3.42	0.78	\$2.67
Case Management Services	\$1,588	\$4			\$1,592	1.323	\$2,108	\$0.26	0.78	\$0.21
Consumer Directed Services	\$2,148,779	\$1,745	\$7,822		\$2,158,346	1.330	\$2,870,097	\$359.61	0.78	\$280.49
DME/Supplies	\$682,268	\$2,182		(\$23,802)	\$660,648	1.126	\$744,053	\$93.23	0.78	\$72.72
Emergency	\$222,694	\$824		(\$7,875)	\$215,643	1.351	\$291,316	\$36.50	0.78	\$28.47
FQHC	\$45,561	\$116			\$45,677	1.323	\$60,451	\$7.57	0.78	\$5.91
Home Health Services	\$284,947	\$1,054			\$286,001	1.351	\$386,364	\$48.41	0.78	\$37.76
Inpatient - Medical/Surgical	\$5,909,109	\$9,777		\$109,531	\$6,028,417	1.005	\$6,058,559	\$759.10	0.78	\$592.10
Inpatient - Psych	\$38,963	\$0		\$724	\$39,688	1.005	\$39,886	\$5.00	0.78	\$3.90
Lab and X-ray Services	\$245,894	\$786		(\$2,743)	\$243,938	1.126	\$274,734	\$34.42	0.78	\$26.85
Medicare Xover - IP	\$26,160	\$0			\$26,160	1.000	\$26,160	\$3.28	1.00	\$3.28
Medicare Xover - Nursing Facility	\$6,991	\$0			\$6,991	1.000	\$6,991	\$0.88	1.00	\$0.88
Medicare Xover - OP	\$20,038	\$0			\$20,038	1.000	\$20,038	\$2.51	1.00	\$2.51
Medicare Xover - Other	\$17,183	\$0			\$17,183	1.000	\$17,183	\$2.15	1.00	\$2.15
Medicare Xover - Physician	\$70,949	\$0			\$70,949	1.000	\$70,949	\$8.89	1.00	\$8.89
Nursing Facility	\$17,743,382	\$20,732	\$1,011,125	\$1,148,351	\$19,923,590	0.981	\$19,552,860	\$2,449.87	0.78	\$1,910.90
Outpatient - Other	\$1,253,599	\$4,638		(\$62,912)	\$1,195,326	1.351	\$1,614,786	\$202.32	0.78	\$157.81
Outpatient - Psychological	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$2,573,283	\$2,090	\$10,366	\$0	\$2,585,739	1.330	\$3,438,431	\$430.82	0.78	\$336.04
Physician - Clinic	\$273,013	\$693			\$273,707	1.323	\$362,240	\$45.39	0.78	\$35.40
Physician - IP Mental Health	\$2,112	\$5			\$2,118	1.323	\$2,803	\$0.35	0.78	\$0.27
Physician - OP Mental Health	\$995,022	\$2,527			\$997,549	1.323	\$1,320,216	\$165.42	0.78	\$129.02
Physician - Other Practitioner	\$271,987	\$691			\$272,678	1.323	\$360,879	\$45.22	0.78	\$35.27
Physician - PCP	\$691,166	\$1,755			\$692,922	1.323	\$917,054	\$114.90	0.78	\$89.62
Physician - Specialist	\$486,074	\$1,235			\$487,308	1.323	\$644,933	\$80.81	0.78	\$63.03
Pharmacy	\$4,394,642	\$562		(\$1,506,476)	\$2,888,728	1.115	\$3,221,276	\$403.61	1.00	\$403.61
Transportation - Emergency	\$110,090	\$352		\$27,890	\$138,332	1.126	\$155,797	\$19.52	0.78	\$15.23
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$38,585,115	\$51,825	\$1,029,312	(\$317,803)	\$39,348,449			\$5,357.45		\$4,277.52
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,466.79		\$5,032.38

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Richmond/Charlottesville	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$452,855	\$26	\$2,635	(\$4,555)	\$450,960	1.089	\$490,898	\$42.97	0.78	\$33.52
Ambulatory Surgery Center	\$25,330	\$64			\$25,395	1.323	\$33,609	\$2.94	0.78	\$2.29
Case Management Services	\$0	\$0			\$0	1.323	\$0	\$0.00	0.78	\$0.00
Consumer Directed Services	\$3,518,201	\$2,857	\$3,223		\$3,524,282	1.330	\$4,686,473	\$410.22	0.78	\$319.97
DME/Supplies	\$1,491,567	\$4,771		(\$52,036)	\$1,444,301	1.126	\$1,626,642	\$142.39	0.78	\$111.06
Emergency	\$582,966	\$2,157		(\$20,616)	\$564,507	1.351	\$762,603	\$66.75	0.78	\$52.07
FQHC	\$51,949	\$132			\$52,081	1.323	\$68,927	\$6.03	0.78	\$4.71
Home Health Services	\$513,706	\$1,901			\$515,606	1.351	\$696,541	\$60.97	0.78	\$47.56
Inpatient - Medical/Surgical	\$10,646,171	\$17,614		\$197,336	\$10,861,122	1.005	\$10,915,428	\$955.46	0.78	\$745.26
Inpatient - Psych	\$24,347	\$0		\$452	\$24,800	1.005	\$24,924	\$2.18	0.78	\$1.70
Lab and X-ray Services	\$338,461	\$1,083		(\$3,776)	\$335,767	1.126	\$378,157	\$33.10	0.78	\$25.82
Medicare Xover - IP	\$35,098	\$0			\$35,098	1.000	\$35,098	\$3.07	1.00	\$3.07
Medicare Xover - Nursing Facility	\$11,727	\$0	\$910		\$12,637	1.000	\$12,637	\$1.11	1.00	\$1.11
Medicare Xover - OP	\$17,757	\$0			\$17,757	1.000	\$17,757	\$1.55	1.00	\$1.55
Medicare Xover - Other	\$27,426	\$0			\$27,426	1.000	\$27,426	\$2.40	1.00	\$2.40
Medicare Xover - Physician	\$70,252	\$0			\$70,252	1.000	\$70,252	\$6.15	1.00	\$6.15
Nursing Facility	\$20,992,052	\$24,528	\$1,319,947	\$1,358,605	\$23,695,132	0.981	\$23,254,222	\$2,035.52	0.78	\$1,587.71
Outpatient - Other	\$2,489,488	\$9,211		(\$124,935)	\$2,373,764	1.351	\$3,206,758	\$280.70	0.78	\$218.94
Outpatient - Psychological	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$6,133,577	\$4,982	\$12,082	\$0	\$6,150,641	1.330	\$8,178,919	\$715.93	0.78	\$558.42
Physician - Clinic	\$892,208	\$2,266			\$894,474	1.323	\$1,183,800	\$103.62	0.78	\$80.83
Physician - IP Mental Health	\$1,941	\$5			\$1,946	1.323	\$2,576	\$0.23	0.78	\$0.18
Physician - OP Mental Health	\$2,035,146	\$5,169			\$2,040,315	1.323	\$2,700,275	\$236.36	0.78	\$184.36
Physician - Other Practitioner	\$575,630	\$1,462			\$577,092	1.323	\$763,758	\$66.85	0.78	\$52.15
Physician - PCP	\$922,474	\$2,343			\$924,817	1.323	\$1,223,958	\$107.14	0.78	\$83.57
Physician - Specialist	\$750,963	\$1,907			\$752,870	1.323	\$996,394	\$87.22	0.78	\$68.03
Pharmacy	\$4,961,370	\$635		(\$1,700,750)	\$3,261,255	1.115	\$3,636,688	\$318.33	1.00	\$318.33
Transportation - Emergency	\$161,849	\$518		\$41,003	\$203,369	1.126	\$229,044	\$20.05	0.78	\$15.64
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$57,724,512	\$83,630	\$1,338,796	(\$309,271)	\$58,837,667			\$5,736.64		\$4,553.77
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,853.71		\$5,357.38

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Rural	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$18,257	\$1		(\$183)	\$18,075	1.089	\$19,676	\$1.52	0.78	\$1.18
Ambulatory Surgery Center	\$31,641	\$80			\$31,721	1.323	\$41,982	\$3.24	0.78	\$2.53
Case Management Services	\$8,778	\$22			\$8,800	1.323	\$11,647	\$0.90	0.78	\$0.70
Consumer Directed Services	\$3,905,941	\$3,172	\$10,216		\$3,919,330	1.330	\$5,211,795	\$402.22	0.78	\$313.73
DME/Supplies	\$1,533,696	\$4,905		(\$53,506)	\$1,485,095	1.126	\$1,672,586	\$129.08	0.78	\$100.68
Emergency	\$458,630	\$1,697		(\$16,219)	\$444,108	1.351	\$599,952	\$46.30	0.78	\$36.11
FQHC	\$254,893	\$647			\$255,540	1.323	\$338,197	\$26.10	0.78	\$20.36
Home Health Services	\$843,801	\$3,122			\$846,924	1.351	\$1,144,123	\$88.30	0.78	\$68.87
Inpatient - Medical/Surgical	\$9,563,809	\$15,824		\$177,274	\$9,756,906	1.005	\$9,805,691	\$756.75	0.78	\$590.26
Inpatient - Psych	\$22,477	\$0		\$418	\$22,895	1.005	\$23,010	\$1.78	0.78	\$1.39
Lab and X-ray Services	\$416,490	\$1,332		(\$4,647)	\$413,176	1.126	\$465,338	\$35.91	0.78	\$28.01
Medicare Xover - IP	\$65,862	\$0			\$65,862	1.000	\$65,862	\$5.08	1.00	\$5.08
Medicare Xover - Nursing Facility	\$15,555	\$0			\$15,555	1.000	\$15,555	\$1.20	1.00	\$1.20
Medicare Xover - OP	\$59,351	\$0			\$59,351	1.000	\$59,351	\$4.58	1.00	\$4.58
Medicare Xover - Other	\$68,978	\$0			\$68,978	1.000	\$68,978	\$5.32	1.00	\$5.32
Medicare Xover - Physician	\$115,050	\$0			\$115,050	1.000	\$115,050	\$8.88	1.00	\$8.88
Nursing Facility	\$19,918,924	\$23,274	\$715,573	\$1,289,152	\$21,946,924	0.981	\$21,538,544	\$1,662.22	0.78	\$1,296.53
Outpatient - Other	\$1,860,493	\$6,884		(\$93,369)	\$1,774,009	1.351	\$2,396,538	\$184.95	0.78	\$144.26
Outpatient - Psychological	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$6,511,193	\$5,288	\$31,362	\$0	\$6,547,843	1.330	\$8,707,105	\$671.96	0.78	\$524.13
Physician - Clinic	\$739,685	\$1,879			\$741,564	1.323	\$981,429	\$75.74	0.78	\$59.08
Physician - IP Mental Health	\$1,296	\$3			\$1,299	1.323	\$1,720	\$0.13	0.78	\$0.10
Physician - OP Mental Health	\$2,267,142	\$5,758			\$2,272,900	1.323	\$3,008,092	\$232.15	0.78	\$181.07
Physician - Other Practitioner	\$356,667	\$906			\$357,573	1.323	\$473,233	\$36.52	0.78	\$28.49
Physician - PCP	\$1,270,056	\$3,226			\$1,273,282	1.323	\$1,685,137	\$130.05	0.78	\$101.44
Physician - Specialist	\$734,966	\$1,867			\$736,833	1.323	\$975,168	\$75.26	0.78	\$58.70
Pharmacy	\$7,328,778	\$937		(\$2,512,293)	\$4,817,422	1.115	\$5,372,000	\$414.58	1.00	\$414.58
Transportation - Emergency	\$228,088	\$730		\$57,784	\$286,602	1.126	\$322,785	\$24.91	0.78	\$19.43
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$58,600,498	\$81,555	\$757,151	(\$1,155,588)	\$58,283,616			\$5,053.01		\$4,044.09
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,156.13		\$4,757.76

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Tidewater	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$17,524	\$1		(\$175)	\$17,350	1.089	\$18,886	\$1.35	0.78	\$1.05
Ambulatory Surgery Center	\$18,421	\$47			\$18,468	1.323	\$24,442	\$1.74	0.78	\$1.36
Case Management Services	\$0	\$0			\$0	1.323	\$0	\$0.00	0.78	\$0.00
Consumer Directed Services	\$1,184,708	\$962	\$2,055		\$1,187,725	1.330	\$1,579,398	\$112.51	0.78	\$87.76
DME/Supplies	\$1,479,356	\$4,732		(\$51,610)	\$1,432,478	1.126	\$1,613,326	\$114.93	0.78	\$89.64
Emergency	\$630,909	\$2,334		(\$22,311)	\$610,932	1.351	\$825,319	\$58.79	0.78	\$45.86
FQHC	\$13,426	\$34			\$13,461	1.323	\$17,814	\$1.27	0.78	\$0.99
Home Health Services	\$737,213	\$2,728			\$739,941	1.351	\$999,599	\$71.21	0.78	\$55.54
Inpatient - Medical/Surgical	\$11,690,545	\$19,342		\$216,695	\$11,926,582	1.005	\$11,986,214	\$853.86	0.78	\$666.01
Inpatient - Psych	\$23,872	\$0		\$444	\$24,316	1.005	\$24,437	\$1.74	0.78	\$1.36
Lab and X-ray Services	\$396,129	\$1,267		(\$4,419)	\$392,977	1.126	\$442,589	\$31.53	0.78	\$24.59
Medicare Xover - IP	\$37,999	\$0			\$37,999	1.000	\$37,999	\$2.71	1.00	\$2.71
Medicare Xover - Nursing Facility	\$729	\$0			\$729	1.000	\$729	\$0.05	1.00	\$0.05
Medicare Xover - OP	\$26,475	\$0			\$26,475	1.000	\$26,475	\$1.89	1.00	\$1.89
Medicare Xover - Other	\$48,091	\$0			\$48,091	1.000	\$48,091	\$3.43	1.00	\$3.43
Medicare Xover - Physician	\$85,042	\$0			\$85,042	1.000	\$85,042	\$6.06	1.00	\$6.06
Nursing Facility	\$28,916,716	\$33,788	\$2,387,328	\$1,871,489	\$33,209,321	0.981	\$32,591,375	\$2,321.71	0.78	\$1,810.94
Outpatient - Other	\$2,053,351	\$7,598		(\$103,047)	\$1,957,901	1.351	\$2,644,962	\$188.42	0.78	\$146.97
Outpatient - Psychological	\$0	\$0			\$0	1.351	\$0	\$0.00	0.78	\$0.00
Personal Care Services	\$9,693,675	\$7,873	\$11,052	\$0	\$9,712,600	1.330	\$12,915,495	\$920.06	0.78	\$717.65
Physician - Clinic	\$1,314,094	\$3,338			\$1,317,432	1.323	\$1,743,568	\$124.21	0.78	\$96.88
Physician - IP Mental Health	\$2,341	\$6			\$2,347	1.323	\$3,106	\$0.22	0.78	\$0.17
Physician - OP Mental Health	\$3,171,210	\$8,054			\$3,179,264	1.323	\$4,207,628	\$299.74	0.78	\$233.80
Physician - Other Practitioner	\$641,411	\$1,629			\$643,040	1.323	\$851,038	\$60.63	0.78	\$47.29
Physician - PCP	\$1,353,573	\$3,438			\$1,357,011	1.323	\$1,795,949	\$127.94	0.78	\$99.79
Physician - Specialist	\$895,361	\$2,274			\$897,635	1.323	\$1,187,984	\$84.63	0.78	\$66.01
Pharmacy	\$7,362,345	\$942		(\$2,523,800)	\$4,839,487	1.115	\$5,396,605	\$384.44	1.00	\$384.44
Transportation - Emergency	\$188,345	\$602		\$47,715	\$236,662	1.126	\$266,541	\$18.99	0.78	\$14.81
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$71,982,864	\$100,988	\$2,400,435	(\$569,021)	\$73,915,266			\$5,821.42		\$4,634.41
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,940.22		\$5,452.25

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 2013 PACE Capitation Rate Development
Capitation Rate Calculations
Non-Dual Population**

Exhibit 4b

Age 55 and Over										
Total	Medicaid Payments FY10 - FY11	Completion Factor Adjustment	Patient Payments FY10 - FY11	Policy and Program Adjustments	Completed and Adjusted Claims	Trend Adjustment	Completed & Trended Claims	UPL PMPM FY13	Managed Care Utilization Adjustment	PACE PMPM FY13
Service Type										
Adult Day Care	\$686,508	\$39	\$2,635	(\$6,892)	\$682,291	1.089	\$742,715	\$13.01	0.78	\$10.15
Ambulatory Surgery Center	\$107,127	\$272			\$107,399	1.323	\$142,138	\$2.49	0.78	\$1.94
Case Management Services	\$10,366	\$26			\$10,393	1.323	\$13,754	\$0.24	0.78	\$0.19
Consumer Directed Services	\$15,156,558	\$12,310	\$40,988		\$15,209,856	1.330	\$20,225,565	\$354.24	0.78	\$276.31
DME/Supplies	\$6,054,304	\$19,364		(\$211,216)	\$5,862,452	1.126	\$6,602,576	\$115.64	0.78	\$90.20
Emergency	\$2,283,339	\$8,449		(\$80,748)	\$2,211,040	1.351	\$2,986,931	\$52.32	0.78	\$40.81
FQHC	\$370,664	\$941			\$371,605	1.323	\$491,804	\$8.61	0.78	\$6.72
Home Health Services	\$2,796,389	\$10,347			\$2,806,736	1.351	\$3,791,668	\$66.41	0.78	\$51.80
Inpatient - Medical/Surgical	\$45,534,916	\$75,339		\$844,030	\$46,454,285	1.005	\$46,686,556	\$817.70	0.78	\$637.81
Inpatient - Psych	\$109,660	\$0		\$2,038	\$111,698	1.005	\$112,257	\$1.97	0.78	\$1.53
Lab and X-ray Services	\$1,677,001	\$5,364		(\$18,709)	\$1,663,656	1.126	\$1,873,689	\$32.82	0.78	\$25.60
Medicare Xover - IP	\$198,829	\$0			\$198,829	1.000	\$198,829	\$3.48	1.00	\$3.48
Medicare Xover - Nursing Facility	\$46,650	\$0	\$910		\$47,560	1.000	\$47,560	\$0.83	1.00	\$0.83
Medicare Xover - OP	\$143,542	\$0			\$143,542	1.000	\$143,542	\$2.51	1.00	\$2.51
Medicare Xover - Other	\$182,041	\$0			\$182,041	1.000	\$182,041	\$3.19	1.00	\$3.19
Medicare Xover - Physician	\$399,592	\$0			\$399,592	1.000	\$399,592	\$7.00	1.00	\$7.00
Nursing Facility	\$111,318,314	\$130,069	\$7,395,105	\$7,204,519	\$126,048,007	0.981	\$123,702,555	\$2,166.61	0.78	\$1,689.96
Outpatient - Other	\$8,955,542	\$33,137		(\$449,434)	\$8,539,245	1.351	\$11,535,811	\$202.05	0.78	\$157.60
Outpatient - Psychological	\$0	\$0			\$0	1.351	\$0	\$0.00	1.00	\$0.00
Personal Care Services	\$33,539,099	\$27,240	\$82,346	\$0	\$33,648,685	1.330	\$44,744,910	\$783.69	0.78	\$611.28
Physician - Clinic	\$4,088,440	\$10,384			\$4,098,824	1.323	\$5,424,629	\$95.01	0.78	\$74.11
Physician - IP Mental Health	\$8,006	\$20			\$8,027	1.323	\$10,623	\$0.19	0.78	\$0.15
Physician - OP Mental Health	\$10,773,755	\$27,363			\$10,801,118	1.323	\$14,294,845	\$250.37	0.78	\$195.29
Physician - Other Practitioner	\$2,229,344	\$5,662			\$2,235,006	1.323	\$2,957,940	\$51.81	0.78	\$40.41
Physician - PCP	\$5,191,289	\$13,185			\$5,204,474	1.323	\$6,887,912	\$120.64	0.78	\$94.10
Physician - Specialist	\$3,559,138	\$9,039			\$3,568,177	1.323	\$4,722,339	\$82.71	0.78	\$64.51
Pharmacy	\$29,094,462	\$3,721		(\$9,973,534)	\$19,124,649	1.115	\$21,326,263	\$373.52	1.00	\$373.52
Transportation - Emergency	\$752,871	\$2,408		\$190,733	\$946,012	1.126	\$1,065,444	\$18.66	0.78	\$14.56
Transportation - Non-Emergency	\$0	\$0			\$0	1.000	\$0	\$27.38	1.00	\$27.38
Total	\$285,267,746	\$394,680	\$7,521,984	(\$2,499,213)	\$290,685,196			\$5,655.11		\$4,502.93
Admin Cost Adjustment								2.0%		15.0%
Capitation Rate								\$5,770.52		\$5,297.56

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 2013 PACE Capitation Rate Development
 Summary of FY 2013 Capitation Rates
 Before Nursing vs Non-Nursing Home Blending Factor Adjustment**

Region	Dual Eligibles FY 2013	Non-Dual Eligibles FY 2013	Weighted Average FY 2013	Difference from UPL Rates
PACE Rates				
Northern Virginia	\$4,251.04	\$5,882.57	\$4,423.62	-9.7%
Other MSA	\$3,473.48	\$5,032.38	\$3,566.77	-9.6%
Richmond/Charlottesville	\$3,453.15	\$5,357.38	\$3,612.21	-9.7%
Rural	\$3,019.96	\$4,757.76	\$3,132.02	-9.6%
Tidewater	\$3,511.49	\$5,452.25	\$3,707.61	-9.6%
Statewide Average weighted by PACE Eligibles	\$3,453.96	\$5,313.59	\$3,603.27	-9.6%

Region	Dual Eligibles FY 2013	Non-Dual Eligibles FY 2013	Weighted Average FY 2013
UPL			
Northern Virginia	\$4,716.23	\$6,430.00	\$4,897.51
Other MSA	\$3,850.66	\$5,466.79	\$3,947.37
Richmond/Charlottesville	\$3,829.36	\$5,853.71	\$3,998.45
Rural	\$3,346.81	\$5,156.13	\$3,463.48
Tidewater	\$3,893.69	\$5,940.22	\$4,100.50
Statewide Average weighted by PACE Eligibles	\$3,829.61	\$5,789.64	\$3,986.98

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

**Virginia Medicaid
 FY 2013 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	1.22	0.68	62.1%	1.0185
Other MSA	1.21	0.46	62.1%	0.9268
Richmond/Charlottesville	1.26	0.62	62.1%	1.0182
Rural	1.29	0.57	62.1%	1.0188
Tidewater	1.15	0.75	62.1%	1.0022

Non-Dual Population

Region	Cost		Statewide NH Blending	Blend Factor
	%NH of Avg	%Non-NH of Avg		
Northern Virginia	1.39	0.66	46.7%	1.0033
Other MSA	1.39	0.53	46.7%	0.9333
Richmond/Charlottesville	1.49	0.64	46.7%	1.0340
Rural	1.45	0.69	46.7%	1.0462
Tidewater	1.28	0.71	46.7%	0.9724

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Summary of FY 2013 Capitation Rates
 After Nursing vs Non-Nursing Home Blending Factor Adjustment**

Region	Dual Eligibles FY 2013	Non-Dual Eligibles FY 2013	Weighted Average FY 2013	Difference from UPL Rates
PACE Rates				
Northern Virginia	\$4,329.77	\$5,901.86	\$4,496.05	-9.7%
Other MSA	\$3,219.15	\$4,696.49	\$3,307.56	-9.6%
Richmond/Charlottesville	\$3,516.09	\$5,539.27	\$3,685.08	-9.7%
Rural	\$3,076.59	\$4,977.70	\$3,199.18	-9.6%
Tidewater	\$3,519.10	\$5,302.03	\$3,699.27	-9.6%
Statewide Average weighted by PACE Eligibles	\$3,445.88	\$5,303.60	\$3,595.04	-9.6%
Statewide Average weighted by PACE Enrollees*	\$3,387.61	\$5,300.41	\$3,516.25	-9.6%

Region	Dual Eligibles FY 2013	Non-Dual Eligibles FY 2013	Weighted Average FY 2013
UPL			
Northern Virginia	\$4,803.57	\$6,451.08	\$4,977.84
Other MSA	\$3,568.71	\$5,101.90	\$3,660.47
Richmond/Charlottesville	\$3,899.16	\$6,052.45	\$4,079.02
Rural	\$3,409.57	\$5,394.49	\$3,537.56
Tidewater	\$3,902.12	\$5,776.55	\$4,091.54
Statewide Average weighted by PACE Eligibles	\$3,820.66	\$5,777.08	\$3,977.74
Statewide Average weighted by PACE Enrollees*	\$3,755.88	\$5,775.33	\$3,891.69

Note:
 Percent change and weighted average by region based on historical member months for PACE eligibles.
 *Statewide weighted average based on December 2011 PACE Enrollees. No PACE plan in Northern Virginia until January 2012.

**Virginia Medicaid
 FY 2013 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	\$4,251.04	\$4,329.77	1.9%	\$5,882.57	\$5,901.86	0.3%	\$4,423.62	\$4,496.05	1.6%
Other MSA	\$3,473.48	\$3,219.15	-7.3%	\$5,032.38	\$4,696.49	-6.7%	\$3,566.77	\$3,307.56	-7.3%
Richmond/Charlottesville	\$3,453.15	\$3,516.09	1.8%	\$5,357.38	\$5,539.27	3.4%	\$3,612.21	\$3,685.08	2.0%
Rural	\$3,019.96	\$3,076.59	1.9%	\$4,757.76	\$4,977.70	4.6%	\$3,132.02	\$3,199.18	2.1%
Tidewater	\$3,511.49	\$3,519.10	0.2%	\$5,452.25	\$5,302.03	-2.8%	\$3,707.61	\$3,699.27	-0.2%
Statewide Average weighted by PACE Eligibles	\$3,453.96	\$3,445.88	-0.2%	\$5,313.59	\$5,303.60	-0.2%	\$3,603.27	\$3,595.04	-0.2%
Statewide Average weighted by PACE Enrollees*	\$3,391.79	\$3,387.61	-0.1%	\$5,313.59	\$5,300.41	-0.2%	\$3,521.03	\$3,516.25	-0.1%

Note:

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

*Statewide weighted average based on December 2011 PACE Enrollees. No PACE plan in Northern Virginia until January 2012.

Virginia Medicaid
FY 2013 PACE Capitation Rate Development
Comparison of FY 2012 and FY 2013 Capitation Rates

Exhibit 5e

Region	Dual Eligibles			Non-Dual Eligibles			Weighted Average		
	FY 2012	FY 2013	% Change	FY 2012	FY 2013	% Change	FY 2012	FY 2013	% Change
PACE Rates									
Northern Virginia	\$4,295.12	\$4,329.77	0.8%	\$5,824.73	\$5,901.86	1.3%	\$4,456.92	\$4,496.05	0.9%
Other MSA	\$3,166.46	\$3,219.15	1.7%	\$4,526.80	\$4,696.49	3.7%	\$3,247.87	\$3,307.56	1.8%
Richmond/Charlottesville	\$3,473.84	\$3,516.09	1.2%	\$5,287.17	\$5,539.27	4.8%	\$3,625.30	\$3,685.08	1.6%
Rural	\$3,044.96	\$3,076.59	1.0%	\$4,716.64	\$4,977.70	5.5%	\$3,152.75	\$3,199.18	1.5%
Tidewater	\$3,418.67	\$3,519.10	2.9%	\$4,912.76	\$5,302.03	7.9%	\$3,569.66	\$3,699.27	3.6%
Statewide Average weighted by PACE Eligibles	\$3,394.62	\$3,445.88	1.5%	\$5,060.03	\$5,303.60	4.8%	\$3,528.34	\$3,595.04	1.9%
Statewide Average weighted by PACE Enrollees*	\$3,317.47	\$3,387.61	2.1%	\$4,977.62	\$5,300.41	6.5%	\$3,429.11	\$3,516.25	2.5%

Note:

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

*Statewide weighted average based on December 2011 PACE Enrollees. No PACE plan in Northern Virginia until January 2012.

**Virginia Medicaid
 FY 2013 PACE Capitation Rate Development
 Member Months of Eligibles and Enrollees**

Exhibit 5f

PACE Eligibles, Historical Member Months FY 2010 - FY 2011

Region	Dual Eligibles	Non-Dual Eligibles	Total
Member Months			
Northern Virginia	90,407	10,694	101,102
Other MSA	125,384	7,981	133,365
Richmond/Charlottesville	125,347	11,424	136,771
Rural	187,999	12,958	200,956
Tidewater	124,875	14,038	138,913
Statewide Average	654,012	57,095	711,107

PACE Enrollees, December 2011

Region	Dual Enrollees	Non-Dual Enrollees	Total
Member Months			
Northern Virginia	0	0	0
Other MSA	75	2	77
Richmond/Charlottesville	105	13	118
Rural	134	6	140
Tidewater	310	24	334
Statewide Average	624	45	669

Virginia Medicaid
FY 2013 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 2013 PACE Capitation Rate Development
 Historical Fee-for-Service Claims
 County Listing by Region**

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.
 Bedford County is in Roanoke-Alleghany for Medallion II rate setting, but is retained in Other MSA for PACE rate setting.