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Commonwealth of Virginia
Department of Medical Assistance Services

FAMIS and FAMIS Moms Data Book and Capitation Rates Contract Year 2018

Rates Effective July 1, 2017 to November 30, 2018

REVISED May 2017

Submitted by:

PricewaterhouseCoopers LLP

Three Embarcadero Center

San Francisco, CA 94111

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

May 25, 2017

Dear Bill:

Re: REVISED: Contract Year 2018 FAMIS and FAMIS MOMS Data Book and Capitation Rates: Effective: July 1, 2017 through November 30, 2018

The enclosed report provides a detailed description of the methodology used for calculating capitation rates for the Virginia Medicaid FAMIS and FAMIS MOMS programs for Contract Year 2018. The methods used for calculating these costs are consistent with Centers for Medicare and Medicaid Services and State Children's Health Insurance Program requirements.

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

Very Truly Yours,

PricewaterhouseCoopers LLP

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FAMIS and FAMIS MOMS Data Book and Capitation Rates Prepared by PricewaterhouseCoopers LLP

REVISED May 2017

PricewaterhouseCoopers LLP (PwC) has calculated capitation rates for the Virginia Family Access to Medical Insurance Security (FAMIS) program and for the FAMIS MOMS program, for Contract Year 2018. We used data submitted by the contracting health plans to estimate the cost of providing services. The development of these rates is discussed in this report and shown in the attached exhibits.

Virginia DMAS is in the process of modifying the structure of the Medicaid managed care programs and changes will take place over the 17 month time period, July 1, 2017 to November 30, 2018. At the end of Contract Year 2018, the FAMIS and FAMIS MOMS populations, as well as the Medallion 3.0 LIFC, AA, and FC populations, will transition to the new Medallion 4.0 Medicaid managed care program. This will occur in regional phases over the period July 1, 2018 and November 30, 2018. The 12 month of FY 2018 plus the transition period to Medallion 4.0 is referred to as the Contract Year. The methodology used for FAMIS is consistent with the actuarial soundness requirements for Medicaid managed care and is similar to the steps described in the Medallion 3.0 Data Book and Capitation Rates Contract Year 2018 (the "Medallion 3.0 report"). Please refer to that document for a complete description of the methodology. We have included in the report for the FAMIS and FAMIS MOMS Data Book and Capitation Rates Contract Year 2018 only information specific to the FAMIS and FAMIS MOMS programs and rate setting. However, the exhibits accompanying the report are complete.

I. FAMIS program rate development

I.A. Introduction

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

The development of the FAMIS rates is shown in the attached spreadsheets, with Contract Year 2018 base capitation rates shown in Exhibit I.5b.1 and the associated member months as of February 2017 in Exhibit I.5c. Capitation rate cells for FAMIS are statewide and vary based on the following criteria:

- **Age/Gender.** Capitation rates are paid separately for the following age/gender groups: Under 1, 1-5, 6-14, 15-18 Female, and 15-18 Male.

- **Income Level.** FAMIS includes member co-payment requirements based on income level. There are separate rates for those under and over 150% of the Federal Poverty Level.

I.B. FAMIS program description

The State Children's Health Insurance Program (SCHIP) was promulgated under Title XXI of the Social Security Act through the Balanced Budget Act of 1997. This federal legislation authorized states to expand child health insurance to uninsured, low-income children through either or both a Medicaid expansion and a commercial-like health plan with comprehensive benefits. The 2009 federal reauthorization legislation changed the name to Children's Health Insurance Program (CHIP) and the Affordable Care Act extended CHIP funding through FY 2015. Recent legislation extended funding for two years , through FY 2017, and increased the federal enhanced match rate by 23%, with passage of the *Medicare Access and CHIP Reauthorization Act of 2015* (HR 2, also known as MACRA). The Federal Budget proposes an additional two-year extension of CHIP, through FY 2019.

The Contract Year 2018 FAMIS rates have been developed under the assumption that CHIP program funding will be renewed.

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

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

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

There were limited changes in the program until the past few years.

As of January 1, 2014, the Affordable Care Act (ACA) required state Medicaid agencies to expand Medicaid eligibility to legal resident children up to 138% of the Federal Poverty Level. The child eligibility expansion is required even if the state does not expand Medicaid eligibility to low income adults.

This results in a shift of children in families with incomes between 133% and 138% of FPL from FAMIS into Medicaid. Starting October 2013, DMAS implemented this change by evaluating eligibility applications under the new standard. One effect is that more children qualify for Medicaid and enroll in the Medallion 3.0 program rather than into FAMIS. Then, as of March 2014, DMAS began to assess and move the lower income FAMIS children into the Medallion 3.0 program.

The decision to halt new enrollment in the FAMIS MOMS program as of December 31, 2013 also affected the FAMIS population distribution. DMAS policy is that infants born to FAMIS MOMS are eligible for FAMIS for the first year of life, and may be eligible for Medicaid under Medallion 3.0. The FAMIS MOMS program was reinstituted effective December 1, 2014.

Due to the combination of these factors, the number of FAMIS children <150% FPL has dropped more than 70% since March 2014. In the same period, the number of FAMIS Children >150% FPL has increased. As of February 2017, FAMIS children <150% FPL are approximately 5.6% of the total FAMIS population.

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

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

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

Table I.1

FAMIS cost sharing requirements by service

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

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

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

I.C. Data book

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

The rate developed is a statewide rate based upon MCO encounter data for FY 2015 and FY 2016 and data used to evaluate contract period trend is MCO encounter data for July 1, 2013 to February 28, 2017 with run out through February 2017. Any new FAMIS enrollees throughout the state will be paid the rates described in this report.

In the FAMIS rate setting process, historical claims data for the total population, both the <=150% FPL and the >150% FPL, are combined, adjusted, and trended. We first present the MCO FAMIS encounter summary in Exhibits I.1. All babies born to mothers enrolled in FAMIS MOMS are deemed eligible for FAMIS without having to file an application. All data used in the FY 2018 rate setting for the Under Age 1 rate cell reflects enrollment under this policy.

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

I.D. Capitation rate calculations

The capitation rates for Contract Year 2018 are calculated based on the historical data shown in Exhibits I.1 adjusted to reflect changes in payment rates and covered services. Each adjustment to the historical data is described in the following section. The adjustments are applied to the historical data and resulting capitation rates are presented in Exhibits I.5a.1 and I.5b.1.

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

1. The combined FY 2015 and FY 2016 historical data for each age-gender rate cell and service category are brought forward to Exhibit I.4 from the corresponding rate cell in Exhibit I.1. This information serves as the starting point for the capitation rate calculation.
2. A number of changes in covered services and payment levels have been mandated by the Virginia General Assembly. Each of these adjustments, as well as adjustments for other services not included in the source data, is described in detail below under Section I.E, and is shown in Exhibits I.2a to I.2i.
3. The claims data are adjusted to reflect the expected value of Incurred But Not Reported (IBNR) claims and to update the data to the Contract Year 2018. These adjustments are described in Section I.F and are shown in Exhibit I.3. The resulting claims are shown in Exhibit I.4 under the column "Completed & Trended Claims."
4. The adjusted claims costs from Step 3 are divided by the count of member months for each rate cell (from Exhibit I.1) to arrive at preliminary PMPM costs by service category.
5. The PMPM costs are summarized by rate cell across all service categories to arrive at the cost for each rate cell.
6. An adjustment is made to reflect the differences in the co-payment schedule applicable to FAMIS members below and above 150% of the Federal Poverty Level in Exhibit I.5a.1 and I.5a.2. Co-payment adjustments are made for major service categories; they are not added across all individual claims as health plans may require different collection of co-payments.
7. An adjustment is also made in Exhibit I.5 to reflect average health plan administrative costs plus a 1.5% provision for margin. The derivation of this value is included in the Adjustments described in Section I.E.
8. An adjustment for projected high cost member drug reinsurance is presented in Exhibit I.6a.
9. An adjustment for Addiction and Recovery Treatment Services (ARTS) adjustment is presented in Exhibit I.6b.
10. The drug reinsurance adjustment is subtracted from the base rates and the ARTS adjustment is added to the base rates presented in Exhibit I.5b.1. The final Contract Year 2018 FAMIS rates are shown in Exhibit I.7.

I.E. FAMIS legislative and program adjustments

Legislation and policy changes in the FAMIS program for FY 2016, FY 2017, and Contract Year 2018 must be reflected in the development of per capita rates, as the data used to develop rates do not fully include the effect of those changes.

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

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

Pharmacy adjustment

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

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

The same pharmacy rebates are not available to the state for the FAMIS program. However, the size and drug utilization of the FAMIS population is not, by itself, considered sufficient to allow the plans to negotiate comparable levels of rebate that were contracted for the Medicaid managed care population. Based on plan submitted data, we estimate the effective pharmacy rebate will not change from the amount projected by the health plans, or 2.1%.

The final pharmacy adjustment factors are shown in Exhibit I.2a. It is applied to the full base period Pharmacy service line in ExhibitI.4 under the column labeled "Policy and Program Adjustments."

Exempt infant formula carveout adjustment

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

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

Hospital inpatient adjustments

The hospital capital percentage averaged 8.7% during the FY 2015- FY 2016 base period. The percentage was decreased to 8.43% in FY 2017 and remains at that value through FY 2018. There are no unit cost adjustments for either FY 2015 or FY 2016. The Virginia General Assembly authorized a unit cost adjustment for FY 2017 equal to half the regulatory inflation of 2.1%, a value of, 1.05%.

Hospital inpatient reimbursement rates were rebased for FY 2017. For inpatient medical/surgical, the rebasing is a negative adjustment of 2.65%. For inpatient psychiatric in acute care hospitals, the positive adjustment is 27%.

These adjustments are applied to the total inpatient hospital claims in the base period, excluding inpatient payments to Children's Hospital of the King's Daughters (CHKD). The inpatient psychiatric factor is applied to mental health claims that are submitted with FFS payment detail and the allocated inpatient mental health subcapitation dollars, but exclude payments to freestanding psychiatric hospitals.

These adjustment factors are shown in Exhibit I.2c.1 and applied to all hospital inpatient service categories in Exhibit I.4 under the column labeled "Policy and Program Adjustments."

The FY 2017 unit cost adjustment is different for CHKD, a hospital that serves children primarily in the Rural and Tidewater regions. The hospital has a higher inpatient capital percentage than the statewide average, 10.4% in the

base period, and it increases to 11.52% for FY 2017 and FY 2018. The Virginia General Assembly authorized a unit cost adjustment for FY 2017 equal to the full value of the regulatory inflation, 2.1%, for CHKD. For FY 2018, CKD is the only hospital authorized to receive a unit cost adjustment, an increase of 2.8%. Because FAMIS rates are statewide, the proportion of claims for CHKD was calculated compared to total hospital inpatient payments. The 2.1% and 2.8% unit cost increases are applied to the CHKD total FAMIS inpatient hospital claims. This is then decreased by the value of the FY 2017 hospital rebasing factor.

The adjustment factor shown in Exhibit I.2c.2 and is applied to all hospital inpatient service categories in Exhibit I.4 under the column labeled "Policy and Program Adjustments."

Outpatient hospital adjustment

There were three adjustment to outpatient hospital for FY 2017. DMAS used to pay outpatient hospital as a percent of cost and rate setting used the outpatient hospital trend based on the historical trend. As of January 1, 2014, DMAS FFS started reimbursing outpatient hospital using Enhanced Ambulatory Patient Groups (EAPGs). Inflation adjustments will now be applied to outpatient hospital rates in the same manner as inpatient hospital. FY 2017 is the first year that outpatient hospital inflation has been modified. Outpatient hospital rates are going to be adjusted by 50% of inflation, 1.05%.

The outpatient hospital adjustment is structured similarly to the inpatient hospital adjustment. The adjustments are applied to the total outpatient hospital claims in the base period, excluding inpatient payments to CHKD.

There also is a FY 2017 MCO outpatient hospital rebasing adjustment of 0.1%. The outpatient hospital percentage remains flat in FY 2018.

These adjustment factors are shown in Exhibit I.2d.1 and applied to all hospital inpatient service categories in Exhibit I.4 under the column labeled "Policy and Program Adjustments."

The third outpatient adjustment is to apply the full inflation amount, an additional 1.05% inflation, for CHKD, similar to the inpatient adjustment, and will be subject to the rebasing adjustment.

The CHKD adjustment factors are shown in Exhibit I.2d.2 with separate factors for Emergency Room and for Other Outpatient. The factors are applied to all hospital outpatient service categories in Exhibit I.4 under the column labeled "Policy and Program Adjustments."

Provider incentive adjustment

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

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS incentive is $1.35 PMPM and is presented as the percentage of the weighted average of the medical cost of the FAMIS base rates. This percentage is shown in Exhibit I.2e and is presented as the dollar value applicable to the rate cell in the service line labeled Provider Incentive Payment Adjustment in Exhibit I.4.

Hepatitis C treatment adjustment

With the recent approval of new drugs for the treatment of Hepatitis C over the past few years, standards of treatment for Hepatitis C are evolving rapidly. The initial breakthrough drugs, Sovaldi, Olysio, Harvoni, and Viekira Pak have fewer adverse side effects, are predicted to attain the desired sustained virological response levels in 90% of patients, and are much more expensive than earlier treatments. In late January 2016, the FDA approved Zepatier, another drug that can be used for treatment of Hepatitis C and does not require concurrent treatment with interferon. And Epclusa, the first all oral single pill treatment appropriate for all genotypes, was approved in June 2016. The FY 2015-FY 2016 base period now fully includes Hepatitis C treatment experience since the approval of Sovaldi in early December 2013.

Both the Centers for Disease Control and CMS have recommended protocols that increase the proportion of individuals being treated with drug therapies. The DMAS Pharmacy and Therapeutics (P&T) Committee first established a treatment protocol after new drugs were available for treating Hepatitis C effective July 1, 2014. The P&T Committee met in April and October 2016 and revised the state Medicaid Hepatitis C treatment protocols. The revised treatment protocol applies to patients 18 years or older. Under the original treatment protocol and the protocol approved effective July 1, 2016, the patient must be evaluated for current history of substance and alcohol abuse and level of kidney and liver impairment. Between July 1, 2014 and June 30, 2016, those with Metavir score of F3 or greater were approved for drug therapy. Starting July 1, 2016, those with a Metavir score of F2 or greater may be approved for drug therapy. Such documentation is not required if the patient 1) has a comorbid disease including HIV, hepatitis B or serious extra hepatic manifestations, 2) has renal failure, is on dialysis or has a liver transplant or 3) is diagnosed with Genotype 3 hepatitis C. If patient's life expectancy is less than a year, they do not qualify for hepatitis C drug therapy treatment. Under the most recent protocol effective January 1, 2017, Hepatitis C drug treatment is available for all individuals with a diagnosis of the disease.

The Hepatitis C Drug treatment adjustment uses the historical base data for those diagnosed and treated for Hepatitis C and applies estimates of increases in Hepatitis C testing, identification of new cases, and increases in the frequency of drug treatment using the new drug regimens. The claims runout through February 2017 and data supplied by DMAS through March 2017 were evaluated to assess changes in cost due to the newer treatment drugs and changes in the number of people starting treatment. Analysis of the historical data indicated that approximately 0.2% of the FAMIS population was tested for the disease, approximately 0.01%, or 11 FAMIS children, have a diagnosis of Hepatitis C, and of those, no individuals have undergone drug therapy.

Based on the more recent actual experience, the adjustment assumes a lower cost for a course of treatment and an increase in utilization due to the new protocols. Specifically, the treatment data indicates that approximately half of new treatment eligibles are prescribed the lower cost Epclusa or Zepatier while the remaining 50% are prescribed Harvoni. The data for July to December 2016 indicate about a 30% increase in people starting treatment in the six months after the first change in protocol. Data after January 2017, following the second change in protocol, are limited and vary significantly by month, but indicate an additional increase in the number of people receiving treatment.

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

ER Triage adjustment

The 2015 General Assembly final Budget conference report eliminated ER triage for physician services. Current DMAS FFS policy applies ER Triage review only to Level III ER claims. If a case is determined to have insufficient

documentation of medical necessity for an emergency, DMAS may reduce the physician payment to an all-inclusive rate of $21.62 for the code 99283 instead of paying the physician fee of $43.20 plus ancillaries. Eliminating the ER Triage review would increase the Level III ER payment to physicians by the difference in the physician fee plus the average amount of ancillary services billed on those claims.

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

The ER Triage adjustment reflects the additional amount estimated to cover the cost of discontinuing Level III Triage review and paying such claims at the average fee for CPT code 99283, plus the average of the ancillary payments that are associated with the claim. The historical base data was analyzed by health plan to identify the number of Level III ER claims paid at the ER Triage level and was re-priced to reflect each plan's average cost of a Level III professional claim paid in full. Level III claims for FAMIS was approximately $61,000 per year. Plan payment of the physician fee varied and the average of $43.20 is slightly lower than the DMAS Medicaid fee schedule.

Approximately 3.4% of the Level III claims paid as ER Triage were for services to the FAMIS population. The paid amount of these claims is increased to the weighted average of the plan professional fee payment and then calculated as a percentage of the Professional Evaluation and Management service line.

This adjustment is applied to the FY 2015 period of the base data and the calculation of the additional cost is presented in Exhibit I.2g. The adjustment is added in Exhibit I.4 under the column labeled "Policy and Program Adjustments.

RBRVS rebasing adjustment

Each year DMAS adjusts physician rates consistent with the Medicare RBRVS update in a budget neutral manner based on funding and uses both FFS and MCO encounter data, as re priced to the DMAS fee schedule. Claims cover all professional providers, including physicians, nurse practitioners, psychologists, therapists, opticians, and federally qualified health centers and the full range of CPT codes from 10000 to 99499. J codes for drugs administered in an office setting and anesthesia-related codes that are grouped in the professional service categories are excluded from the adjustment.

The FAMIS rates use the FY 2018 RBRVS adjustment of -0.21%. This is a single factor provided by DMAS and is applied to all Medallion 3.0 populations. The calculation of the RBRVS adjustment is shown in Exhibit I.2h**.** The adjustment is added in Exhibit I.4 under the column labeled "Policy and Program Adjustments."

Plan administration adjustment

The FAMIS plan administrative adjustment is calculated using the same methodology described for the LIFC and ABAD populations in the Medallion 3.0 report. The FAMIS program is included when the CY 2016 average administrative dollar PMPM is apportioned across the eligibility groups enrolled in the Virginia DMAS managed care programs and described in Medallion 3.0, Section II under the same subheading.

The resulting CY 2016 administrative cost of $10.42 PMPM for FAMIS is the sum of lines 1 and 2 of the administrative adjustment exhibit. Trending the separate administrative expense and salary components increases the value to $10.75 PMPM. To reflect an estimate of administrative activity rather than just differences in base costs, the administrative dollars PMPM were reallocated based on weighting by claims volume PMPM for each eligibility group on line 5b. The $11.96 PMPM reallocated administrative costs are compared to the weighted average of the medical component of the FY 2018 FAMIS base rates to determine separate administrative allowances as a percentage of the base capitation rate.

This percentage is then increased by a 1.50% provision for margin. Based on a Society of Actuaries report titled "Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting, the provision for margin in most states' capitation rates range from 0.5%to 2.5%. Virginia Medicaid's provision for margin of 1.5% is based on a DMAS analysis of risk-based capital reports for CY2013, and is within other states' Medicaid margin range.

The allowance for a contribution to margin is the same as in last year's rate setting. The trended value of the administrative factor is 8.8% for FAMIS.

As with LIFC and ABAD, a rate adjustment for the health insurance premium excise tax is not included in the administrative cost adjustment presented here. The Consolidated Appropriations Act of 2016, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers, suspends collection of the health insurance provider fee for the 2017 calendar year and applies to fee year 2017. Therefore, no fee will be due in fee year 2017 based on the 2016 data year. If the moratorium is not extended, an aggregated retrospective adjustment process will be used to pay the health insurer fee adjustment for the FY 2017 rates in the fall of 2018 and a similar adjustment will be calculated for these Contract Year 2018 rates in the fall of 2019.

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

I.F. FAMIS Trend and IBNR Adjustments

Trend and IBNR adjustment factors use FAMIS encounter data and apply the same methodology described in the Medallion 3.0 report. We used the monthly historical health plan expenditures for FY 2015 and FY 2016 with run-out through October 2016 to develop the historical data period trend and monthly historical health plan expenditures from July 2013, the beginning of FY 2014, through December 2016 with run-out through February 2017 to develop the contract period trend. One change is that Inpatient Hospital Med/Surg and Inpatient Hospital-Psych experience is combined for the trend evaluation.

We observed age-gender mix changes in the FAMIS population. Up through the first quarter of FY 2014, there was an increase in the proportion of higher cost FAMIS children, particularly the Under Age 1, likely due to the policy change which made children born to FAMIS MOMS eligible for FAMIS without an application. This has been followed by a decrease in the number and proportion of Under 1 and Age 1-5. This decrease is consistent with the end of new enrollment in FAMIS MOMS, the major source of newborns for the FAMIS program, at the end of 2013. This is also when DMAS began to assess new applicants for Medicaid eligibility under the 138% FPL family income criteria that was effective January 1, 2014. At the same time, we observe an increase in the proportion in Age 6-14 and both the male and females Age 15 to 20 rate cells.

Because of the changes in program policy and the small number in Under Age 1, this age group is excluded from the trend development and the calculation of the age-gender adjustment. Also, because of the substantial decrease in the proportion of FAMIS <150% of FPL, the contract period trend uses only data for the FAMIS >150% FPL.

With Under Age 1 excluded, the age gender adjustment factors applied to the contract period service trend models is shown in Table I.2.

Table I.2.

Estimated Change in Age-Gender Mix : July 2013 to February 2017

AID Group	IP Med/Surg & Psych	OP/HH	Prof	Pharmacy	Other	All Services
FAMIS	-0.6%	-0.5%	-1.1%	1.7%	0.5%	-0.2%

In addition to the age-gender adjustments, the trend models apply an adjustment to remove the impact of increases or decreases to services that are already reflected in the adjustment Exhibits I.2a to I.2i. For FY 2018, the adjustment is applied to inpatient hospital and is the same values as for LIFC Child, LIFC Adult and ABAD. It is presented in the following table.

Table I.3 Summary of Adjustments to Trend		
Service	**Time Period**	**Adjustment**
Inpatient Hospital	July 2014 – June 2016 July 2016 – October 2016	1.000 .990

Incurred But Not Reported (IBNR) completion factors in the first column of Exhibit I.3 are based on the FAMIS historical data and are applied to the total claims in the first column of Exhibit I.4, with the dollar value of the IBNR completion factors shown in the second column of that exhibit. The data used in this analysis has run-out through October 2016 or four months past the end of the data period, and the resulting IBNR factors are generally small. IBNR factors for Outpatient Hospital, Inpatient Psychiatric, Inpatient Hospital, Practitioner, Prescription Drug and Other services are all calculated to be 1.4% or less. The second column of Exhibit I.3.1 provides information on the cumulative impact of the policy and program adjustments in Exhibits I.2a - I.2h. This is for informational purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. Overall, the data period trend, using the adjusted FAMIS trend factors and weighted by the service distribution in the FAMIS population, has a weighted average of 9.8%, primarily driven by unit cost increases. Because of changes in the proportion of FAMIS under and over 150% FPL, the contract period trend is developed using the experience of the FAMIS >150% FPL population. The contract period trend is positive with a weighted average of 6.5%.

The resulting trend factors are shown in Exhibit I.3.1. The last two columns show two total trans factors; one based on 18 months of contract trend to project a FY 2018 capitation rate and a second with 22.7 months of contract trend to project to the midpoint of the longer 17 month Contract Year 2018. Only the Contract Year 2018 trend and IBNR factors are applied to the historical data in Exhibit I.4 by applicable service category. The Exhibit I.4.1 includes an additional column "Base Claims Redistribution FY15-16" which represents the redistributed value of individual annual inpatient claims costs above $250,000. Approximately $233,000, or 1.1% of the inpatient dollars, was redistributed across the inpatient hospital service lines. IBNR is applied to the Total Base Claims excluding the redistributed dollars.

I.G. Base capitation rates for FAMIS – FY 2018 and Contract Year 2018

Adjustment for FAMIS co-payment schedule

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

The final step in developing the capitation rates for FAMIS is to adjust the combined base rates for the under 150% FPL and over 150% FPL. This was done through a factor that valued the differences in the co-payment amount for separate categories relative to the average utilization of the entire FAMIS population. The separate under 150% FPL and over 150% FPL co-payment adjustment values for medical services for each age-gender cell is shown under the columns Copay Value FAMIS<=150% and Copay Value FAMIS >150% in Exhibit I.5a.1 for FY 2018 and Exhibit I.5b.1 for Contract Year 2018. The co-payment adjustments for 2018 are similar to those that were applied to the FY 2017 FAMIS rate setting for both those under 150% and those over 150% FPL. These values are subtracted from the medical component of the base rate.

The administrative factor is then applied to the medical component of the capitation rate to produce the statewide FAMIS rates. The resulting values are shown in the last two columns of Exhibit I.5a.1 and Exhibit I.5b.1.

The comparison of the FY 2018 and the Contract Year 2018 FAMIS rates to FY 2017 rates are shown in Exhibit I.5a.2 for FY 2018 and Exhibit I.5b.2 for Contract Year 2018.

I.H. Post base capitation rates adjustments

Drug reinsurance adjustment

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

Exhibit I.6a presents the steps in the reinsurance calculation and information on the number of people who met the threshold in each of the base years.

Beginning FY 2015, DMAS established a program to reinsurance 90% of drug costs above $150,000 per member per year. For FY 2018, the threshold will be increased from $150,000 to $175,000. Because FAMIS program transitions during Contract Year 2018, the $175,000 threshold is pro-rated to the nearest $25,000 for the expected length of FAMIS enrollment to $225, 000. The trended drug costs amount is reduced by $225,000 per person plus the additional 10% of risk that will be retained by the health plans. This is the estimate of the 90% reinsurance pool for that year.

Continuance tables using FY 2015 and FY 2016 base data were analyzed to determine the total dollars and the number of members with drug costs in increments of $25,000. This was supplemented with health plan reinsurance claims submissions for FY 2017 through March 2017 (3Q). The FAMIS continuance tables used 15 month accumulation period and a threshold of $225,000.

Data was first examined to identify people who met the drug reinsurance threshold in FY 2016 and by the FY 2017 3Q. The “persistent” members who met drug reinsurance attachment points in both FY 2016 and by FY2017 3Q consistently utilized more expensive drugs with higher cost trends. Based on that data, drug claims for persistent members were trended at 20%. Drug claims costs for the non-persistent members who met the attachment point in one of the years (either FY 2016 or by FY 2017 3Q) were trended at 15%. This 15% unit cost trend is supported by an analysis of the contract trend for specialty drugs, defined as all outpatient prescription drugs where MCO plans pay $500 or more per prescription.

Because of the uncertainty, the number of people estimated to reach the threshold is increased by 20% and the reinsurance pool is increased by the number of additional individuals multiplied by the average cost with the applied specialty trend. Because analysis of actual reinsurance payouts for FY 2015, FY 2016 and the first three quarters of FY 2017 showed actual reinsurance payouts higher than projected by the prior years’ methodology, the drug reinsurance adjustment applies a higher number of projected claimants.

The reinsurance amount is $6.11 PMPM for FAMIS. This amount will be subtracted from the health plan capitation payment for each rate cell to fund a drug reinsurance pool.

Addiction and Recovery Treatment Services (ARTS) adjustment

The 2016 Virginia budget authorized DMAS to restructure its Addiction and Recovery Treatment Services to more effectively address the opioid epidemic. This initiative includes adding inpatient services for Substance Use Disorder and increasing rates significantly for key services. DMAS is implementing this initiative April 1, 2017 and is working closely with MCOs and providers to build a provider network for ARTS and to increase utilization. ARTS services will be available to members in all of the DMAS managed care programs, including Medallion 3.0, FAMIS, FAMIS Moms, CCC Duals and CCC Plus.

The Virginia budget appropriated additional funds for FY 2017 and Contract Year 2018 for the new services, higher rates and care coordination by MCOs and also assumed some increase in utilization. DMAS expects additional utilization growth in future fiscal years. The FY 2018 budget allocation is $16.7 million, with approximately $16.3 million allocated across all DMAS managed care programs for ARTS services and administration.

The starting point for the medical component of the adjustment for Med 3.0 for the FY 2018 rates is the $16 million appropriation for FY 2018 that is allocated across all managed care populations with enrollees eligible for the ARTS services. The administrative component is calculated based on the FY 2018 ARTS allocation of $700,000 for the FY 2018 period.

DMAS provided a list of diagnosis codes to identify the target population. The potentially eligible population includes individuals in managed care and those currently in Medicaid FFS who will be enrolled in CCC Plus, but excludes individuals in the Technology Assisted waivers. ARTS eligible members were identified as those who incur claims with any of the substance abuse disorder diagnoses. After the prevalence was determined by population group, that percentage was adjusted for the estimated ARTS utilization factor for each population. The utilization factors were developed by DMAS program staff and varied by age and population group,

Multiplying the prevalence and the expected utilization rates produced an estimate of the ARTS participation factor for each eligible population. These values were used to allocate the medical and the administrative components of the funding per ARTS participant. In addition to the new budget allocation, the ARTS adjustment includes the cost of substance abuse services currently paid under Fee for Service that will now be covered in Medallion 3.0. The estimated annual expenditure for these medical services is approximately $2.6 million for all managed care program populations. A full description of the calculation of the ARTS adjustment across all DMAS managed care programs is described in a separate memo dated April 25, 2017 that was distributed to the health plans.

Exhibit I.6b presents the FY 2018 ARTS adjustment factors for the FAMIS rates effective July 1, 2017.

Given the uncertainty in utilization growth, there is concern that costs could exceed the funding in the rate cells. DMAS is implementing a stop loss insurance program such that if costs for ARTS exceed the funding by more than 20%, DMAS will assume 100% of the costs. The stop loss will be based on experience over the 15 month period April 2017 to June 2018 and will be determined for each plan based on the combined utilization across all managed care programs (Medallion 3.0, FAMIS/FAMIS Moms, CCC Duals and CCC Plus) the plan participates in.

Performance Incentive Award

As with the Medallion 3.o program, beginning FY 2016, the FAMIS program is included in the DMAS Performance Incentive Award (PIA) program. This builds upon a pilot program established in FY 2015 and the Contract Year 2018 Performance Incentive Award will be based upon criteria established by DMAS using three HEDIS 2018 measures and three FY 2018 administrative measures designed to measure managed care quality. The Performance Incentive Award, or penalty, will be relative to performance among the contracting health plans. The

maximum amount at risk for each Contractor is 0.15% of the PMPM capitation rate and the maximum award is 0.15% of the PMPM capitation rate. Total awards for all Contractors will equal total penalties for all Contractors.

The structure of the PIA follows the HEDIS reporting year time frame. HEDIS 2018, for instance, reflects services provided in the calendar year 2017. The three administrative measures are based on the monthly reporting deliverables received by the Department from July 1 to June 30 of each measurement year.

DMAS anticipates that report cards for each health plan will be completed by December 31, 2018 for FY 2018. Payment or penalties pursuant to the PIA will be distributed by March 2019. This process and the schedule will recur in the following years. Therefore, the FY 2019 PIA will be complete by December 31, 2019 and payment or penalties will be distributed by March 2020.

The value of the 0.15% maximum Performance Incentive award or penalty is not reflected in the Contract Year 2018 capitation rates because total awards for all Contractors will equal total penalties for all Contractors.

The adjusted FAMIS rates, net of drug reinsurance, and with the ARTS adjustment for rate cells age 6-14 and female and male age 15-18, are presented in Exhibit I.7.

I.I. Contract Year 2018 Capitation rates for FAMIS –Effective July 1, 2017 to November 30, 2018

Virginia DMAS is in the process of modifying the structure of the Medicaid managed care programs and changes will take place over the 17 month time period. At the end of FY 2018, the FAMIS and FAMIS MOMS populations, as well as the Medallion 3.0 LIFC, AA, and FC populations, will transition to the new Medallion 4.0 Medicaid managed care program. This will occur in regional phases over the period August 1, 2018 to November 30, 2018.

Medallion 4.0 will use different regions with different county configurations. While the Medallion 3.0 and Medallion 4.0 region definition for Roanoke/Alleghany, Far Southwest, and Tidewater are similar, the new Central Virginia, Charlottesville/Western and Northern/Winchester are not aligned. For example, the Medallion 4.0 Central Virginia region is composed of 40 counties that are currently assigned to four of the Medallion 3.0 regions.

The Contract Year 2018 FAMIS, rates net of Drug reinsurance and with the ARTS adjustment, are presented in Exhibit I.7

II. FAMIS MOMS program rate development

II.A. Introduction

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

II.B. FAMIS MOMS program description

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

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

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

Table II.1
FAMIS MOMS income eligibility

Federal poverty level	Effective date
133-150% FPL	August 1, 2005
133-166% FPL	September 1, 2007
133-185% FPL	July 1, 2008
133-200% FPL	July 1, 2009
New Enrollment Discontinued	December 31, 2013
New Enrollment Reinstated 133- 200% FPL	December 1, 2014

The FAMIS MOMS program was discontinued for most of CY 2014. DMAS halted new enrollment into the FAMIS MOMS program on December 31, 2013. This decision by the General Assembly was based on the assumption that these higher income pregnant women were eligible to enroll in the Qualified Health Plans available through the Federal Health Benefits Exchange. The program was reinstated with the first FAMIS MOMS enrollment effective December 1, 2014 for pregnant women up to 200% of the Federal Poverty Level. In 2016, this was an annual income up to $23,540 for a single person.

Eligibility begins with a determination of pregnancy and income verification and continues through the month of delivery, plus an additional two months. One important difference between Medicaid for pregnant women (under either FFS or Medallion 3.0) and FAMIS MOMS is that Medicaid offers up to three months of retroactive coverage

while the FAMIS MOMS' effective date of coverage is the first of the month that the signed application was received. There is no retroactive coverage for FAMIS MOMS enrollees. Based on a policy change dating back to July 1, 2010, babies born to FAMIS MOMS are automatically covered for the birth month plus two additional months but not beyond the first three months. The baby is eligible for additional coverage through the first year of life, and may be determined eligible for either FAMIS or the Medicaid Medallion 3.0 program, FAMIS Plus.

Eligible women are enrolled in managed care plans wherever possible. If a woman's FFS OB-GYN participates with one of the available managed care organizations, DMAS will transition her into that MCO to provide continuity of care. However, similar to Medicaid rules, a woman can opt out of an MCO if she is in her last trimester and her regular OB-GYN does not participate with the MCO. Beginning March 1, 2015, pregnant women enrolled in FAMIS MOMS received dental benefits during the pregnancy and for 60 days following the birth of the child. However, services are administered through the Smiles for Children program rather than through MCOs. The dental services include: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, bridges, partials and dentures, tooth extractions and other oral surgeries, and other appropriate services.

II.C. Data book

Approach to rate setting for FAMIS MOMS

The Contract Year 2018 FAMIS MOMS rate setting uses MCO data for the one year period October 1, 2015 to September 30, 2016. In developing proposed capitation rates, the method by which women will be enrolled in the health plan and the potential variation in the length of plan enrollment is a key consideration. A small difference in the average length of plan enrollment can have a material difference in the capitation rate, since most of the cost is incurred at the time of delivery and is not evenly spread over the entire pregnancy and eligibility period. After enrollment in FAMIS MOMS was reinstated, enrollment grew slowly and it was not until late 2015 that we observe a leveling off of the enrollment and a similar length of enrollment as existed prior to December 2013.

We believe that the enrollment patterns are now similar to those seen in the program before the halt in new enrollment and future FAMIS MOMs rate development will be able to use a longer base period in the development of the capitation rates.

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

II.D. FAMIS MOMS legislative and program adjustments

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

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

Table II.2

Medallion 3.0 Adjustment Methodology Used in FAMIS MOMS Rates

Medallion Exhibit Number and Adjustment Name	FAMIS MOMS Exhibits	FAMIS MOMS values
2a Pharmacy Adjustment	2a	2a: -1.5% applied to pharmacy services
2b Exempt Infant Formula Carveout	Not applicable	Applies only to children
2c.1 Hospital Inpatient Adjustments	2b	2b: -1.47% Inpatient Medical/Surgical, 25.7% Inpatient Psychiatric
2d Freestanding Psychiatric Hospital	Not applicable	Not a covered FAMIS MOMS service
2e.1 Outpatient Hospital Adjustments	2c	2c: 1.15% applies to OP-ER and related and OP-Other
2g Provider Incentive	2d	2d: $1.31 PMPM and 0.14% of the weighted average PMPM medical cost
2f Hepatitis C Adjustment	2e	2e: 0.1% applied to Pharmacy
2h ER Triage Adjustment	NA	ER triage fully in October 2015 to September 2016 base period.
2i RBRVS Adjustment	2f	2f: -0.21% applied to professional services
2j Administrative Cost	2g	2g: $48.26 PMPM based on reallocation weighted by claims, or 6.2% of base capitation rate with contribution to margin

Pharmacy adjustment

The size and drug utilization of the FAMIS MOMS population is not sufficient to allow the plans to negotiate levels of rebate that were contracted for the Medicaid managed care population. Based on plan submitted data, we do not expect additional reductions to the managed care rebate and use the health plan projection of 2.3%.

The final pharmacy adjustment factors are shown in Exhibit II.2a. The PBM factor is a reduction of 1.5%.

Hospital Inpatient adjustment

The hospital capital percentage averaged 8.7 % during the FY 2015- FY 2016 base period. The percentage was decreased to 8.43% in FY 2016 and is expected to remain at that value in through FY 2018. There are no unit cost adjustments for either FY 2015 or FY 2016. The Virginia General Assembly authorized a unit cost adjustment for FY 2017 equal to half the regulatory inflation, a value of 1.05%.

Hospital reimbursement rates are being rebased for FY 2017. For inpatient medical/surgical, the rebasing is a negative adjustment of 2.65%. For inpatient psychiatric in acute care hospitals, it is a positive adjustment of 27%. The inpatient psychiatric factor is applied to mental health claims that are submitted with FFS payment detail and the allocated inpatient mental health subcapitation dollars

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

Outpatient hospital adjustment

There are two adjustment to outpatient hospital for FY 2017. DMAS used to pay outpatient hospital as a percent of cost and rate setting used the outpatient hospital trend based on the historical trend. As of January 1, 2014, DMAS FFS started reimbursing outpatient hospital using Enhanced Ambulatory Patient Groups (EAPGs). Inflation adjustments will now be applied to outpatient hospital rates in the same manner as inpatient hospital. FY 2017 is the first year that outpatient hospital inflation has been modified. Outpatient hospital rates are going to be adjusted by 50% of inflation, a value of 1.05%.

There also is an MCO outpatient hospital rebasing adjustment. The rebasing adjustment is 0.1%.

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

Provider incentive adjustment

This adjustment represents the percentage value of the case management and provider incentive payments that are paid separately from the encounter data. The value of the FAMIS MOMS incentive is $1.31 PMPM. This translates to a percent of weighted average PMPM medical cost shown in Exhibit II.2d, and is presented as the dollar value applicable to the rate cell in the service line labeled Provider Incentive Payment Adjustment in Exhibit II.4.

Hepatitis C treatment adjustment

The Hepatitis C Drug treatment adjustment is developed by applying estimates of increases in Hepatitis C testing, identification of new cases, and increases in the frequency of drug treatment using the new drug regimens. Based on the more recent actual experience, the adjustment assumes a lower cost for a course of treatment and an increase in utilization due to the new protocols. Specifically, the treatment data indicates that approximately half of new treatment eligibles are prescribed the lower cost Epclusa or Zepatier while the remaining 50% are prescribed Harvoni. The data for July to December 2016 indicate about a 30% increase in people starting treatment in the six months after the first change in protocol. Data after January 2017, following the second change in protocol, are limited and vary significantly by month, but indicate an additional increase in the number of people receiving treatment. Analysis of the historical data indicated that approximately 2.0% of the FAMIS MOMS population was tested for the disease, approximately 0.21%, or 5 FAMIS MOMS, had a diagnosis of Hepatitis C, and of those, none have undergone drug therapy.

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

RBRVS rebasing adjustment

Each year DMAS adjusts physician rates consistent with the Medicare Resource Based Relative Value Scale update in a budget neutral manner based on funding. Up until last year, the update was based solely on DMAS FFS data. Plans have reported that the rebasing is not cost neutral to their operations and that the impact on them varies. Last year the DMAS update used both FFS and MCO data. For the last two years of rate development, the DMAS analysis used both FFS and the MCO data, as repriced to the DMAS physician fee schedule. Claims covered all professional providers, including physicians, nurse practitioners, psychologists, therapists, opticians, and federally qualified health centers and the full range of CPT codes from 10000 to 99499. The new physician rates for FY 2018 resulted in a -0.21 percent reduction to the FAMIS and FAMIS MOMS. This is a single factor provided by DMAS

and is applied to all Medallion 3.0 populations. Other codes, such as J codes for drugs administered in an office setting, that are grouped in the professional service categories, are excluded from the adjustment.

The managed care professional fee adjustment is -0.16% for FAMIS MOMS. The calculation of the RBRVS adjustment is shown in Exhibit II.2f. The adjustment is added in Exhibit II.4 under the column labeled "Policy and Program Adjustments."

Plan administration adjustment

The administrative allowance for FAMIS MOMS is calculated using the same revised approach that was used to develop the administrative allowance for the Medallion 3.0 and FAMIS programs. These administrative dollars were based upon CY 2016 costs PMPM that were then reallocated based on weighting by claims volume PMPM for each eligibility group. The CY 2016 base of $67.09 PMPM value is trended. The reallocation decreases the FAMIS MOMS administrative cost adjustment from $69.21 PMPM to $48.26 PMPM.

The reallocated administrative cost is compared to the medical component of the FY 2018 base rate to determine administrative allowance as a percentage of the base capitation rate, a value of 4.7%. This percentage is then increased by a 1.50% provision for margin. Based on a Society of Actuaries report titled "Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting, the provision for margin in most states' capitation rates range from 0.5%to 2.5%. Virginia Medicaid's provision for margin of 1.5% is based on a DMAS analysis of risk-based capital reports for CY2013 and is within other states' Medicaid margin range. The allowance for a contribution to reserve is the same as in last year's rate setting. With the provision for margin, the final administrative factor is 6.2% for FAMIS MOMS.

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

II.E. FAMIS MOMS trend and IBNR adjustments

Trend and IBNR adjustment factors uses FAMIS MOMS encounter data and applies the same methodology described in the Medallion 3.0 report. The FAMIS MOMS program was restarted December 1, 2014 but has not grown to the enrollment levels observed before the program shut down.

Because of the shortened base period, it is not possible to develop data or contract period trend off of the FAMIS MOMS data. Instead, the unit cost trend for the LIFC Adult population is applied. There is no utilization trend.

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

IBNR factors for Inpatient Medical/Surgical, Inpatient Psychiatric, Outpatient, Practitioner, Prescription Drug and Other services are also set to the LIFC Adult values. The second column of Exhibit II.3 is information on the cumulative impact of the policy and program adjustments in Exhibits II.2a to II.2f. This is for informational purposes and should be evaluated in conjunction with the IBNR and applied trend.

Utilization and cost trend are presented separately for the data period and as a combined trend for the contract period. The weighted average data period trend assigned is an increase of 3.6%. Overall contract period trend is also a weighted average increase of 3.6%.

The resulting trend factors are shown in Exhibit II.3. The last two columns show two total trend factors; one based on 15 months of contract trend to project a FY 2018 capitation rate and a second with 19.6 months of contract trend to project to the midpoint of the longer 17 month Contract Year 2018. Only the Contract Year 2018 trend and IBNR factors are applied to the historical data in Exhibit II.4 by applicable service category.

II.F. Base capitation rates for FAMIS MOMS- FY 2018 and Contract Year 2018

The historical data presented in Exhibit II.1 is adjusted by the factors shown in Exhibits II.2a through II.2i and the Trend and IBNR factors in Exhibit II.3. The administrative adjustment is then added to the completed and adjusted claims. The result of these calculations is shown in Exhibit II.4. The administrative factor is then applied to the medical component of the capitation rate to produce the statewide FAMIS MOMS rate.

The resulting values are shown in Exhibit II.5a for FY 2018 and Exhibit I.5b for Contract Year 2018. These exhibits also present the comparison of the FY 2018 and the Contract Year 2018 FAMIS MOMS rates to the FY 2017 rates.

II.G. Post Base capitation rates adjustments

Addiction and Recovery Treatment Services (ARTS) adjustment

The 2016 Virginia budget authorized DMAS to restructure its Addiction and Recovery Treatment Services to more effectively address the opioid epidemic. This initiative includes adding inpatient services for Substance Use Disorder and increasing rates significantly for key services. DMAS is implementing this initiative April 1, 2017 and is working closely with MCOs and providers to build a provider network for ARTS and to increase utilization. ARTS amenities will be available to members in all of the DMAS managed care programs, including Medallion 3.0, FAMIS, FAMIS Moms, CCC Duals and CCC Plus.

The Virginia budget appropriated additional funds for FY 2017 and FY 2018 for the new services, higher rates and care coordination by MCOs and also assumed some increase in utilization. DMAS expects additional utilization growth in future fiscal years.

The starting point for the medical component of the adjustment for Med 3.0 for the FY 2018 rates is the $16 million appropriation for FY 2018 that is allocated across all managed care populations with enrollees eligible for the ARTS services. The administrative component is calculated based on the FY 2018 ARTS allocation of $700,000.

DMAS provided a list of diagnosis codes to identify the target population. The potentially eligible population includes individuals in managed care and those currently in Medicaid FFS who will be enrolled in CCC Plus, but excludes individuals in the Technology Assisted waivers. ARTS eligible members were identified as those who incur claims with any of the substance abuse disorder diagnoses. After the prevalence was determined by population group, that percentage was adjusted for the estimated ARTS utilization factor for each population. The utilization factors were developed by DMAS program staff and varied by age and population group,

Multiplying the prevalence and the expected utilization rates produced an estimate of the ARTS participation factor for each eligible population. These values were used to allocate the medical and the administrative components of the funding per ARTS participant. In addition to the new budget allocation, the ARTS adjustment includes the cost of substance abuse services currently paid under Fee for Service that will now be covered in Medallion 3.0. The estimated annual expenditure for these medical services is approximately $2.6 million for all managed care program populations. A full description of the calculation of the ARTS adjustment across all DMAS managed care programs is described in a separate memo dated April 25, 2017 that was distributed to the health plans.

Exhibit II.6 presents the Contract Year 2018 ARTS adjustment factors for the FAMIS MOMS rates effective July 1, 2017.

Given the uncertainty in utilization growth, there is concern that costs could exceed the funding in the rate cells. DMAS is implementing a stop loss insurance program such that if costs for ARTS exceed the funding by more than 20%, DMAS will assume 100% of the costs. The stop loss will be based on experience over the 15 month period April 2017 to June 2018 and will be determined for each plan based on the combined utilization across all managed care programs (Medallion 3.0, CCC Duals and CCC Plus) the plan participates in.

Performance Incentive Award

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

II.H. Contract Year 2018 capitation rates for FAMIS MOMS: Effective July 1, 2017 to November 30, 2018

FAMIS MOMS will transition to new Medallion 4.0 regions under the same in regional phases as LIFC and FAMIS over the period August 1, 2018 to November 30, 2018.

Because it is a single statewide rate, the FAMIS MOMS transition rates that will be effective for the period August 1, 2018 to November 30, 2018 will not reflect the impact of decreasing enrollment as members move to new Medallion 4.0 regions.

The Contract Year 2018 FAMIS MOMS rate with ARTS adjustment is $1,036.04 and is presented in Exhibit II.7. The comparison of this FAMIS MOMS rate to the FY 2017 FAMIS MOMS rate is also shown and is a decrease of 9.17%.

Virginia Medicaid

Section I

Contract Year 2018 Capitation Rate Development for the FAMIS Program

Exhibit 1

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

Historical Eligibility, Claims, and Utilization Data

Age Under 1												
MCO Statewide	Raw Claims FY15	Raw Claims FY16	Capitation FY15	Capitation FY16	Unadjusted PMPM 15	Unadjusted PMPM 16	Units FY15	Units FY16	Units/1000 FY15	Units/1000 FY16	Cost/Unit FY15	Cost/Unit FY16
Member Months	19,730	18,880										
Service Type												
DME/Supplies	$75,680	$74,923	$0	$0	$3.84	$3.97	1,010	1,009	614	641	$74.93	$74.25
FQHC / RHC	$19,452	$28,620	$0	$0	$0.99	$1.52	377	486	229	309	$51.60	$58.89
Home Health	$4,178	$6,918	$0	$0	$0.21	$0.37	13	13	8	8	$321.42	$532.17
IP - Maternity	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Newborn	$908,258	$1,628,570	$0	$0	$46.03	$86.26	222	208	135	132	$4,091.25	$7,829.67
IP - Other	$360,460	$2,453,700	$0	$0	$18.27	$129.96	46	712	28	453	$7,836.09	$3,446.21
IP - Psych	$0	$0	$8,570	$7,481	$0.43	$0.40	0	0	-	-	-	-
Lab	$36,230	$24,379	$11,312	$10,968	$2.41	$1.87	3,098	2,298	1,884	1,461	$15.35	$15.38
OP - Emergency Room & Related	$238,708	$208,087	$0	$0	$12.10	$11.02	1,294	1,196	787	760	$184.47	$173.99
OP - Other	$327,802	$314,405	$0	$0	$16.61	$16.65	945	1,102	575	700	$346.88	$285.30
Pharmacy	$262,171	$265,135	$0	$0	$13.29	$14.04	4,605	4,622	2,801	2,938	$56.93	$57.36
Prof - Anesthesia	$17,797	$19,612	$0	$0	$0.90	$1.04	100	142	61	90	$177.97	$138.11
Prof - Child EPSDT	$358,525	$354,630	$0	$0	$18.17	$18.78	8,121	8,268	4,939	5,255	$44.15	$42.89
Prof - Evaluation & Management	$1,186,965	$1,962,219	$10,250	$11,487	$60.68	$104.54	16,876	22,342	10,264	14,200	$70.94	$88.34
Prof - Maternity	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
Prof - Other	$1,035,728	$1,134,373	$1,410	$1,378	$52.57	$60.16	18,184	19,254	11,060	12,238	$57.04	$58.99
Prof - Psych	$0	$0	$8,168	$7,129	$0.41	$0.38	0	0	-	-	-	-
Prof - Specialist	$66,078	$133,559	$0	$0	$3.35	$7.07	849	1,033	516	657	$77.83	$129.29
Prof - Vision	$7,749	$9,653	$22,815	$21,029	$1.55	$1.63	118	154	72	98	$259.02	$199.23
Radiology	$15,501	$29,534	$1,069	$989	$0.84	$1.62	917	1,910	558	1,214	$18.07	$15.98
Transportation/Ambulance	$12,672	$18,049	$8,209	$8,868	$1.06	$1.43	110	109	67	69	$189.83	$246.94
Total	$4,933,954	$8,666,366	$71,804	$69,329	$253.71	$462.70	56,885	64,858				

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

Age 1-5												
MCO Statewide	Raw Claims FY15	Raw Claims FY16	Capitation FY15	Capitation FY16	Unadjusted PMPM 15	Unadjusted PMPM 16	Units FY15	Units FY16	Units/1000 FY15	Units/1000 FY16	Cost/Unit FY15	Cost/Unit FY16
Member Months	203,157	186,227										
Service Type												
DME/Supplies	$289,743	$298,346	$0	$0	$1.43	$1.60	3,859	3,337	228	215	$75.08	$89.41
FQHC / RHC	$101,750	$74,823	$0	$0	$0.50	$0.40	2,365	1,797	140	116	$43.02	$41.64
Home Health	$7,857	$49,074	$0	$0	$0.04	$0.26	70	44	4	3	$112.24	$1,115.32
IP - Maternity	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Newborn	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Other	$3,791,132	$1,385,070	$0	$0	$18.66	$7.44	270	180	16	12	$14,041.23	$7,694.84
IP - Psych	$9,686	$0	$85,472	$68,883	$0.47	$0.37	12	0	1	-	$7,929.90	-
Lab	$366,126	$312,365	$121,174	$111,420	$2.40	$2.28	31,590	26,288	1,866	1,694	$15.43	$16.12
OP - Emergency Room & Related	$1,747,281	$1,601,775	$0	$0	$8.60	$8.60	9,886	8,817	584	568	$176.74	$181.67
OP - Other	$3,149,312	$3,022,669	$0	$0	$15.50	$16.23	7,049	6,655	416	429	$446.77	$454.20
Pharmacy	$3,239,493	$3,458,263	$0	$0	$15.95	$18.57	53,820	48,672	3,179	3,136	$60.19	$71.05
Prof - Anesthesia	$176,222	$151,957	$0	$0	$0.87	$0.82	1,427	1,416	84	91	$123.49	$107.31
Prof - Child EPSDT	$670,563	$634,658	$0	$0	$3.30	$3.41	19,609	17,401	1,158	1,121	$34.20	$36.47
Prof - Evaluation & Management	$5,606,817	$5,329,981	$110,056	$127,463	$28.14	$29.31	85,937	79,950	5,076	5,152	$66.52	$68.26
Prof - Maternity	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
Prof - Other	$2,242,892	$4,135,777	$15,226	$14,737	$11.12	$22.29	56,918	56,240	3,362	3,624	$39.67	$73.80
Prof - Psych	$45,396	$44,257	$81,459	$65,649	$0.62	$0.59	950	840	56	54	$133.53	$130.84
Prof - Specialist	$598,569	$432,862	$0	$0	$2.95	$2.32	5,458	4,252	322	274	$109.67	$101.80
Prof - Vision	$132,045	$121,693	$243,142	$217,971	$1.85	$1.82	1,979	1,802	117	116	$189.58	$188.49
Radiology	$91,916	$91,809	$11,502	$10,873	$0.51	$0.55	6,067	5,744	358	370	$17.05	$17.88
Transportation/Ambulance	$82,946	$51,450	$76,346	$73,674	$0.78	$0.67	613	519	36	33	$259.86	$241.09
Total	$22,349,745	$21,196,830	$744,377	$690,671	$113.68	$117.53	287,879	263,954				

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

Age 6-14												
MCO Statewide	Raw Claims FY15	Raw Claims FY16	Capitation FY15	Capitation FY16	Unadjusted PMPM 15	Unadjusted PMPM 16	Units FY15	Units FY16	Units/1000 FY15	Units/1000 FY16	Cost/Unit FY15	Cost/Unit FY16
Member Months	362,257	336,965										
Service Type												
DME/Supplies	518,498	$495,586	$0	$0	$1.43	$1.47	4,475	4,416	148	157	$115.87	$112.23
FQHC / RHC	$110,436	$108,745	$0	$0	$0.30	$0.32	2,550	2,521	84	90	$43.31	$43.14
Home Health	$58,638	$184,047	$0	$0	$0.16	$0.55	74	105	2	4	$792.41	$1,752.83
IP - Maternity	$8,752	$0	$0	$0	$0.02	$0.00	3	0	0	-	$2,917.20	-
IP - Newborn	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Other	$2,224,418	$2,322,672	$0	$0	$6.14	$6.89	260	255	9	9	$8,555.45	$9,108.52
IP - Psych	$475,041	$368,176	$161,165	$134,682	$1.76	$1.49	921	775	31	28	$690.78	$648.85
Lab	$480,267	$428,703	$224,836	$209,298	$1.95	$1.89	41,666	34,773	1,380	1,238	$16.92	$18.35
OP - Emergency Room & Related	$2,233,544	$2,101,540	$0	$0	$6.17	$6.24	9,995	9,182	331	327	$223.47	$228.88
OP - Other	$3,747,124	$3,696,170	$0	$0	$10.34	$10.97	9,784	9,663	324	344	$382.98	$382.51
Pharmacy	$10,454,947	$9,950,174	$0	$0	$28.86	$29.53	105,053	97,665	3,480	3,478	$99.52	$101.88
Prof - Anesthesia	$130,711	$127,692	$0	$0	$0.36	$0.38	1,072	1,202	36	43	$121.93	$106.23
Prof - Child EPSDT	$123,987	$86,880	$0	$0	$0.34	$0.26	4,861	3,411	161	121	$25.51	$25.47
Prof - Evaluation & Management	$6,741,709	$6,670,164	$176,671	$214,604	$19.10	$20.43	102,411	98,279	3,392	3,500	$67.56	$70.05
Prof - Maternity	$2,527	$0	$0	$0	$0.01	$0.00	10	0	0	-	$252.74	-
Prof - Other	$3,348,783	$3,237,761	$27,594	$27,215	$9.32	$9.69	73,163	71,429	2,424	2,544	$46.15	$45.71
Prof - Psych	$543,704	$572,813	$153,598	$128,359	$1.92	$2.08	11,263	11,728	373	418	$61.91	$59.79
Prof - Specialist	$806,402	$805,807	$0	$0	$2.23	$2.39	7,437	6,508	246	232	$108.43	$123.82
Prof - Vision	$340,429	$323,241	$437,206	$400,336	$2.15	$2.15	5,368	5,124	178	182	$144.86	$141.21
Radiology	$294,383	$274,367	$19,280	$18,872	$0.87	$0.87	13,090	12,785	434	455	$23.96	$22.94
Transportation/Ambulance	$93,015	$107,274	$132,572	$127,477	$0.62	$0.70	959	904	32	32	$235.23	$259.68
Total	$32,737,314	$31,861,813	$1,332,922	$1,260,842	$94.05	$98.30	394,415	370,725				

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

Age 15-18 Female												
MCO Statewide	Raw Claims FY15	Raw Claims FY16	Capitation FY15	Capitation FY16	Unadjusted PMPM 15	Unadjusted PMPM 16	Units FY15	Units FY16	Units/1000 FY15	Units/1000 FY16	Cost/Unit FY15	Cost/Unit FY16
Member Months	62,585	58,553										
Service Type												
DME/Supplies	$100,924	$131,068	$0	$0	$1.61	$2.24	791	714	152	146	$127.59	$183.57
FQHC / RHC	$38,473	$29,129	$0	$0	$0.61	$0.50	782	712	150	146	$49.20	$40.91
Home Health	$8,715	$2,605	$0	$0	$0.14	$0.04	15	11	3	2	$580.99	$236.77
IP - Maternity	$271,456	$124,642	$0	$0	$4.34	$2.13	96	46	18	9	$2,827.66	$2,709.61
IP - Newborn	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Other	$519,780	$478,321	$0	$0	$8.31	$8.17	81	55	16	11	$6,417.03	$8,696.75
IP - Psych	$299,063	$246,139	$30,788	$26,724	$5.27	$4.66	485	457	93	94	$680.11	$597.07
Lab	$181,449	$153,472	$39,210	$36,565	$3.53	$3.25	12,806	10,316	2,455	2,114	$17.23	$18.42
OP - Emergency Room & Related	$759,563	$756,589	$0	$0	$12.14	$12.92	2,661	2,380	510	488	$285.44	$317.89
OP - Other	$1,055,687	$1,151,045	$0	$0	$16.87	$19.66	2,827	2,748	542	563	$373.43	$418.87
Pharmacy	$1,755,491	$2,199,164	$0	$0	$28.05	$37.56	26,669	24,958	5,113	5,115	$65.83	$88.11
Prof - Anesthesia	$50,648	$37,397	$0	$0	$0.81	$0.64	371	345	71	71	$136.52	$108.40
Prof - Child EPSDT	$39,572	$31,600	$0	$0	$0.63	$0.54	1,313	974	252	200	$30.14	$32.44
Prof - Evaluation & Management	$1,405,047	$1,394,781	$29,295	$36,177	$22.92	$24.44	20,853	20,055	3,998	4,110	$68.78	$71.35
Prof - Maternity	$167,033	$82,534	$0	$0	$2.67	$1.41	355	146	68	30	$470.51	$565.30
Prof - Other	$624,149	$620,845	$4,902	$4,802	$10.05	$10.69	11,930	11,845	2,287	2,428	$52.73	$52.82
Prof - Psych	$159,856	$160,061	$29,343	$25,469	$3.02	$3.17	3,065	3,130	588	641	$61.73	$59.27
Prof - Specialist	$213,248	$228,769	$0	$0	$3.41	$3.91	2,315	2,117	444	434	$92.12	$108.06
Prof - Vision	$55,755	$54,703	$75,796	$69,401	$2.10	$2.12	915	870	175	178	$143.77	$142.65
Radiology	$161,957	$149,655	$3,381	$3,313	$2.64	$2.61	4,197	3,992	805	818	$39.39	$38.32
Transportation/Ambulance	$38,420	$35,681	$25,322	$24,200	$1.02	$1.02	367	317	70	65	$173.68	$188.90
Total	$7,906,284	$8,068,201	$238,037	$226,650	$130.13	$141.66	92,894	86,188				

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

Age 15-18 Male												
MCO Statewide	Raw Claims FY15	Raw Claims FY16	Capitation FY15	Capitation FY16	Unadjusted PMPM 15	Unadjusted PMPM 16	Units FY15	Units FY16	Units/1000 FY15	Units/1000 FY16	Cost/Unit FY15	Cost/Unit FY16
Member Months	61,353	57,871										
Service Type												
DME/Supplies	134,079	$126,448	$0	$0	$2.19	$2.19	939	892	184	185	$142.79	$141.76
FQHC / RHC	$16,342	$16,230	$0	$0	$0.27	$0.28	386	407	75	84	$42.34	$39.88
Home Health	$2,466	$7,811	$0	$0	$0.04	$0.13	8	20	2	4	$308.30	$390.55
IP - Maternity	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Newborn	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
IP - Other	$1,431,805	$563,374	$0	$0	$23.34	$9.73	65	59	13	12	$22,027.77	$9,548.71
IP - Psych	$149,199	$225,443	$29,579	$25,994	$2.91	$4.34	290	399	57	83	$616.48	$630.17
Lab	$65,061	$67,709	$38,494	$36,277	$1.69	$1.80	5,403	4,748	1,057	985	$19.17	$21.90
OP - Emergency Room & Related	$531,713	$504,252	$0	$0	$8.67	$8.71	1,771	1,738	346	360	$300.23	$290.13
OP - Other	$1,006,320	$949,369	$0	$0	$16.40	$16.40	1,922	1,864	376	387	$523.58	$509.32
Pharmacy	$2,130,443	$2,280,190	$0	$0	$34.72	$39.40	16,339	15,938	3,196	3,305	$130.39	$143.07
Prof - Anesthesia	$35,579	$28,118	$0	$0	$0.58	$0.49	272	240	53	50	$130.81	$117.16
Prof - Child EPSDT	$24,373	$21,162	$0	$0	$0.40	$0.37	896	694	175	144	$27.20	$30.49
Prof - Evaluation & Management	$1,009,238	$1,023,979	$29,367	$36,278	$16.93	$18.32	14,712	14,613	2,878	3,030	$70.60	$72.56
Prof - Maternity	$0	$0	$0	$0	$0.00	$0.00	0	0	-	-	-	-
Prof - Other	$586,374	$947,131	$4,769	$4,832	$9.64	$16.45	10,672	10,481	2,087	2,173	$55.39	$90.83
Prof - Psych	$95,924	$128,523	$28,190	$24,774	$2.02	$2.65	2,204	2,581	431	535	$56.31	$59.39
Prof - Specialist	$237,560	$212,947	$0	$0	$3.87	$3.68	1,636	1,548	320	321	$145.21	$137.56
Prof - Vision	$44,419	$40,112	$74,585	$69,038	$1.94	$1.89	735	659	144	137	$161.91	$165.63
Radiology	$86,883	$77,547	$3,331	$3,331	$1.47	$1.40	3,412	3,173	667	658	$26.44	$25.49
Transportation/Ambulance	$36,608	$29,924	$24,171	$24,369	$0.99	$0.94	307	303	60	63	$197.98	$179.18
Total	$7,624,389	$7,250,267	$232,484	$224,893	$128.06	$129.17	61,969	60,357				

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

All Age Categories												
MCO Statewide	Raw Claims FY15	Raw Claims FY16	Capitation FY15	Capitation FY16	Unadjusted PMPM 15	Unadjusted PMPM 16	Units FY15	Units FY16	Units/1000 FY15	Units/1000 FY16	Cost/Unit FY15	Cost/Unit FY16
Member Months	709,082	658,496										
Service Type												
DME/Supplies	$1,118,924	$1,126,371	$0	$0	$1.58	$1.71	11,074	10,368	187	189	$101.04	$108.64
FQHC / RHC	$286,453	$257,547	$0	$0	$0.40	$0.39	6,460	5,923	109	108	$44.34	$43.48
Home Health	$81,855	$250,455	$0	$0	$0.12	$0.38	180	193	3	4	$454.75	$1,297.70
IP - Maternity	$280,207	$124,642	$0	$0	$0.40	$0.19	99	46	2	1	$2,830.37	$2,709.61
IP - Newborn	$908,258	$1,628,570	$0	$0	$1.28	$2.47	222	208	4	4	$4,091.25	$7,829.67
IP - Other	$8,327,595	$7,203,138	$0	$0	$11.74	$10.94	722	1,261	12	23	$11,534.06	$5,712.24
IP - Psych	$932,990	$839,757	$315,575	$263,764	$1.76	$1.68	1,708	1,631	29	30	$731.01	$676.59
Lab	$1,129,132	$986,630	$435,025	$404,528	$2.21	$2.11	94,563	78,423	1,600	1,429	$16.54	$17.74
OP - Emergency Room & Related	$5,510,810	$5,172,243	$0	$0	$7.77	$7.85	25,607	23,313	433	425	$215.21	$221.86
OP - Other	$9,286,246	$9,133,658	$0	$0	$13.10	$13.87	22,527	22,032	381	401	$412.23	$414.56
Pharmacy	$17,842,546	$18,152,926	$0	$0	$25.16	$27.57	206,486	191,855	3,494	3,496	$86.41	$94.62
Prof - Anesthesia	$410,957	$364,776	$0	$0	$0.58	$0.55	3,242	3,345	55	61	$126.76	$109.05
Prof - Child EPSDT	$1,217,019	$1,128,930	$0	$0	$1.72	$1.71	34,800	30,748	589	560	$34.97	$36.72
Prof - Evaluation & Management	$15,949,777	$16,381,124	$355,638	$426,009	$23.00	$25.52	240,789	235,239	4,075	4,287	$67.72	$71.45
Prof - Maternity	$169,560	$82,534	$0	$0	$0.24	$0.13	365	146	6	3	$464.55	$565.30
Prof - Other	$7,837,926	$10,075,887	$53,901	$52,964	$11.13	$15.38	170,867	169,249	2,892	3,084	$46.19	$59.85
Prof - Psych	$844,879	$905,654	$300,758	$251,380	$1.62	$1.76	17,482	18,279	296	333	$65.53	$63.30
Prof - Specialist	$1,921,857	$1,813,944	$0	$0	$2.71	$2.75	17,695	15,458	299	282	$108.61	$117.35
Prof - Vision	$580,398	$549,401	$853,544	$777,775	$2.02	$2.02	9,115	8,609	154	157	$157.32	$154.16
Radiology	$650,639	$622,913	$38,562	$37,377	$0.97	$1.00	27,683	27,604	468	503	$24.90	$23.92
Transportation/Ambulance	$263,660	$242,378	$266,620	$258,587	$0.75	$0.76	2,356	2,152	40	39	$225.08	$232.79
Total	$75,551,685	$77,043,477	$2,619,624	$2,472,385	$110.24	$120.75	894,042	846,082				

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

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Pharmacy Adjustment

Section I
Exhibit 2a

		FAMIS	Source
1.	Health Plan Total Drug Cost PMPM	$26.32	FY15-16 Health Plan Encounter Data
2.	Health Plan Drug Ingredient Cost PMPM	$25.95	Health Plan Encounter Analysis
3.	Change in Average Managed Care Discount	0.3%	From Plan Data
4.	Current Average Managed Care Rebate	2.1%	From Plan Data
5.	FY18 Managed Care Dispensing Fee PMPM	$0.37	From Plan Data
6.	Average PBM Admin Cost PMPM	$0.16	From Plan Data
7.	Adjusted PMPM with FY18 Pharmacy Pricing Arrangements	$25.85	= (2.) * (1 - (3.)) * (1 - (4.)) + (5.) + (6.)
8.	**Pharmacy Adjustment**	**-1.8%**	= (7.) / (1.) - 1

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

Exempt Infant Formula Carveout Adjustment

Section I
Exhibit 2b

		FAMIS Age 0-5	FAMIS Age 6-18	Source
1.	Claims Associated with Exempt Infant Formula	$18,768	$12,185	FY15-16 Health Plan Encounter Data
2.	Total Claims in DME/Supplies Service Category	$738,691	$1,506,604	FY15-16 Health Plan Encounter Data
3.	**Exempt Infant Formula Carveout Adjustment**	**-2.5%**	**-0.8%**	= - (1.) / (2.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Hospital Inpatient Adjustments

Section I
Exhibit 2c.1

		Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1a.	FY15 Total Claims in IP Service Categories	$9,516,060	$932,990	FY15 Health Plan Encounter Data
1b.	FY16 Total Claims in IP Service Categories	$8,956,350	$839,757	FY16 Health Plan Encounter Data
1c.	FY15 Children's Hospital of The King's Daughters IP Claims	$1,091,062	$0	FY15 Health Plan Encounter Data
1d.	FY16 Children's Hospital of The King's Daughters IP Claims	$680,625	$0	FY16 Health Plan Encounter Data
2.	FY15-16 Hospital Capital Percentage Adjusted	8.70%	8.70%	Provided by DMAS
3.	FY17 Capital Reimbursement Increase	-3.10%	-3.10%	= ((4.)-(2.))/(2.)
4.	FY17 & FY18 Hospital Capital Percentage	8.43%	8.43%	Provided by DMAS
5a.	FY17 Hospital Rate Change - Unit Cost	1.05%	1.05%	Provided by DMAS
5b.	FY18 Hospital Rate Change - Unit Cost	0.00%	0.00%	Provided by DMAS
5c.	Dollar Change	$160,575	$17,045	=[((1a.)+(1b.))-((1c.)+(1d.))]* (1 - (4.)) * [(1 + (5a.)) * (1 + (5b.)) - 1]
6a.	FY17 Hospital Rate Change - Rebasing	-2.65%	27.00%	Provided by DMAS
6b.	FY18 Hospital Rate Change - Rebasing	0.00%	0.00%	Provided by DMAS
6c.	Dollar Change	($405,261)	$438,292	=[((1a.)+(1b.))-((1c.)+(1d.))]* (1 - (4.)) * [(1 + (6a.)) * (1 + (6b.)) - 1]
7.	**Hospital Inpatient Adjustment**	**-1.32%**	**25.69%**	= ((5c.)+(6c.)) / ((1a.) + (1b.))

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Hospital Inpatient Adjustments For Children Hospital of The King's Daughter

		IP - Med/Surg	Source
1a.	FY15-16 Total Claims in IP Service Categories (for age 0-18)		
	Statewide	$18,472,410	FY15-16 Health Plan Encounter Data
2.	FY15-16 Children Hospital King's Daughter IP Claims		
	Statewide	$1,771,687	FY15-16 Health Plan Encounter Data
3.	FY15-16 Hospital Capital Percentage	10.40%	Provided by DMAS
4.	FY17 Capital Reimbursement Increase	10.77%	= ((5.)-(3.))/(3.)
5.	FY17 & FY18 Hospital Capital Percentage	11.52%	Provided by DMAS
6.	% Excluded Claims from Freestanding Psych Hospitals	0.00%	FY15-16 Health Plan Encounter Data
7a.	FY17 Hospital Rate Change - Unit Cost	2.10%	Provided by DMAS
7b.	FY18 Hospital Rate Change - Unit Cost	2.80%	Provided by DMAS
7c.	Dollar Change		
	Statewide	$77,734	= ((2.) * (1 - (5.)) * (1 - (6.)) * [(1 + (7a.)) * (1 + (7b.)) - 1]
8a.	FY17 Hospital Rate Change - Rebasing	-2.65%	Provided by DMAS
8b.	FY18 Hospital Rate Change - Rebasing	0.00%	Provided by DMAS
8c.	Dollar Change		
	Statewide	($41,541)	= ((2.) * (1 - (5.)) * (1 - (6.)) * [(1 + (8a.)) * (1 + (8b.)) - 1]
9.	**Hospital Inpatient Adjustment**		
	Statewide	**0.196%**	= ((7c.) + (8c.))/ (1a.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Hospital Outpatient Adjustments

Section I
Exhibit 2d.1

		OP - Emergency Room & Related	OP - Other	Source
1a.	FY15 Total Claims in OP Service Categories	$5,510,810	$9,286,246	FY15 Health Plan Encounter Data
1b.	FY16 Total Claims in OP Service Categories	$5,172,243	$9,133,658	FY16 Health Plan Encounter Data
1c.	FY15 Children's Hospital of The King's Daughters OP Claims	$155,213	$1,006,301	FY15 Health Plan Encounter Data
1d.	FY16 Children's Hospital of The King's Daughters OP Claims	$156,037	$1,012,765	FY16 Health Plan Encounter Data
2a.	FY17 Hospital Rate Change - Unit Cost	1.05%	1.05%	Provided by DMAS
2b.	FY18 Hospital Rate Change - Unit Cost	0.00%	0.00%	Provided by DMAS
2c.	Dollar Change	$108,904	$172,209	= [((1a.)+(1b.))-((1c.)+(1d.))] * [(1 + (2a.)) * (1 + (2b.)) - 1]
3a.	FY17 Hospital Rate Change - Rebasing	0.10%	0.10%	Provided by DMAS
3b.	FY18 Hospital Rate Change - Rebasing	0.00%	0.00%	Provided by DMAS
3c.	Dollar Change	$10,372	$16,401	= [((1a.)+(1b.))-((1c.)+(1d.))] * [(1 + (3a.)) * (1 + (3b.)) - 1]
3.	**Hospital Outpatient Adjustment**	**1.12%**	**1.02%**	= ((2c.)+(3c.)) / ((1a.) + (1b.))

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Hospital Outpatient Adjustments for Children's Hospital of The King's Daughters

	OP - Emergency Room & Related	OP - Other	Source
1. FY15-16 Total Claims in OP Service Categories (For Age 0-18)			
Statewide	$10,683,053	$18,419,903	FY15-16 Health Plan Encounter Data
2. FY15-16 Children Hospital King's Daughter OP Claims			
Statewide	$311,249	$2,019,066	FY15-16 Health Plan Encounter Data
3a. FY17 Hospital Rate Change - Unit Cost	2.10%	2.10%	Provided by DMAS
3b. FY18 Hospital Rate Change - Unit Cost	2.80%	2.80%	Provided by DMAS
3c. Dollar Change			
Statewide	$15,434	$100,121	= ((2.) * [(1 + (3a.)) * (1 + (3b.)) - 1]
4a. FY17 Hospital Rate Change - Rebasing	0.10%	0.10%	Provided by DMAS
4b. FY18 Hospital Rate Change - Rebasing	0.00%	0.00%	Provided by DMAS
4c. Dollar Change			
Statewide	$311	$2,019	= ((2.) * [(1 + (4a.)) * (1 + (4b.)) - 1]
5. Hospital Outpatient Adjustment			
Statewide	**0.15%**	**0.55%**	= ((3c.)+(4c.))/ (1.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Provider Incentive Payment Adjustment

Section I
Exhibit 2e

	Adjustment Value	Source
Provider Incentive Payment Adjustment	**0.9%**	From Plan Data

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

Hepatitis C Treatment Adjustment

Section I
Exhibit 2f

		FAMIS	Source
1.	Total Claims in Pharmacy Service Categories	$35,995,472	FY15-16 Health Plan Encounter Data
2.	Unique Individuals in Base Period	90,799	FY15-16 Health Plan Encounter Data
3a.	Proportion of Population Being Tested for Hepatitis C	0.2%	FY15-16 Health Plan Encounter Data
3b.	Number of Individuals Being Tested	170	FY15-16 Health Plan Encounter Data
3c.	Projected Testing Change in FY18	15%	Estimate
3d.	Additional Number of People Being Tested	26	= (3b.) * (3c.)
3e.	Average Cost Per Test Per Person	$42	FY15-16 Health Plan Encounter Data
4a.	Proportion of Population Diagnosed With Hepatitis C	0.01%	FY15-16 Health Plan Encounter Data
4b.	Number of Individuals Diagnosed With Hepatitis C	11	FY15-16 Health Plan Encounter Data
4c.	Projected Increase in People Diagnosed With Hepatitis C	5%	Estimate
4d.	Projected Number of People With Hepatitis C	12	= (4b.) * (1 + (4c.))
5a.	Proportion of People With Hepatitis C With Drug Therapy	0.0%	FY15-16 Health Plan Encounter Data
5b.	Number of Individuals With Hepatitis C With Drug Therapy in Base Period	0	FY15-16 Health Plan Encounter Data
5c.	Expected Percentage Increase of Hepatitis C Receiving Drug Therapy - Current Protocol In The Base Period	0%	Estimate
5d.	Expected Percentage Increase of Hepatitis C Receiving Drug Therapy - New Protocols (Eff. Jul 2016 and Eff. Jan 2017; both protocols combined)	100%	Estimate
5e.	Projected Number of Additional People Going Through Drug Therapy	0	= (4d.) * (5a.) * (1 + (5c.)) * (1 + (5d.)) - (5b.)
5f.	Base Period Average Cost of Drug Therapy	$88,345	FY15-16 Health Plan Encounter Data
5g.	Projected Average Cost of Drug Therapy	$70,000	Estimate
6.	Additional Cost of Hepatitis C Treatment	$1,071	= ((3d.) * (3e.)) + ((5g.) - (5f.)) * (5b.) + (5e.) * (5g.)
7.	**Hepatitis C Treatment Adjustment**	**0.0%**	= (6.) / (1.)

Note: Based on analysis of FY15 - FY16 base data experience

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Emergency Room Triage Adjustment

Section I
Exhibit 2g

		FAMIS	Source
1.	Total FY15-16 Claims in Prof - Evaluation & Management	$32,330,901	FY15-16 Health Plan Encounter Data
2	FY15 Number of Claims in ER Triage Level 3	2,907	FY15-16 Health Plan Encounter Data
3.	ER Cost No Triage Level 3	$43.20	FY15-16 Health Plan Encounter Data
4.	ER Triage Cost	$22.06	Provided by DMAS
5.	FY16 ER Triage Financial Impact (1 year)	$61,461	= (2.) * ((3.) - (4.))
6.	**FY16 ER Triage Adjustment**	**0.2%**	= (5.) / (1.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Resource Based Relative Value Scale Adjustment

Section I
Exhibit 2h

		FAMIS	
1.	Professional Fee Adjustment - Effective FY18	-0.21%	Provided by DMAS
2.	Proportion of claims subject to fee adjustment	92%	FY15-16 Health Plan Encounter Data
3.	**Final Professional Fee Adjustment**	**-0.19%**	= (1.) * (2.)

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

Administrative Cost Adjustment

Section I
Exhibit 2i

		FAMIS	Source
1.	Claims Adjustment Expense PMPM	$3.99	Expense from CY2016 BOI Reports; CY2016 Member months from capitation payment files
2.	General Admin Expense PMPM	$6.43	Expense from CY2016 BOI Reports; CY2016 Member months from capitation payment files
3.	Claims Adjustment Expense Increase %	2.1%	BLS CPI-U
4.	General Admin Expense Increase %	2.1%	Weighted average of BLS Compensation Trend and CPI
5a.	Administrative PMPM*	$10.75	= (1.) * (1+ (3.)) ^ (18 months/12) + (2.) * (1+ (4.)) ^ (18 months/12)
5b.	Administrative PMPM Weighted by Claims	$11.96	Reallocation of administrative costs weighted by claims
6.	Adjusted and Trended Base PMPM	$148.67	Weighted average of medical component of FY2018 FAMIS Base Rates
7.	Administrative allowance as % of Base Capitation Rate	7.3%	= (5b.) / (((5b.) + (6.)) / (1 - (8.)))
8.	Provision for Margin as % of Base Capitation Rate	1.50%	Provided by DMAS
9.	**Administrative Factor as % of Base Capitation Rate**	**8.8%**	= (7.) + (8.)

*Note:

Administrative increases are applied from midpoint of CY2016 to the midpoint of the contract period (18 months) using compound interest calculations.

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Incurred But Not Reported (IBNR), Policy/Program, and Trend Adjustments

Section I
Exhibit 3

	FAMIS								
	Completion and Policy/Program Adjustments			Data Period Trend					
Category of Service	IBNR	Policy/ Program[1]	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend	Contract Period Cost and Utilization Trend	FY 18 Total Trend Factor	Contract Year Total Trend Factor
Inpatient Medical/Surgical	0.3%	-1.1%	-0.8%	5.4%	-10.0%	-5.2%	-0.7%	0.9388	0.9363
Inpatient Psychiatric	0.3%	25.7%	26.1%	5.4%	-10.0%	-5.2%	-0.7%	0.9388	0.9363
Outpatient Hospital	1.4%	1.4%	2.9%	1.9%	5.9%	7.9%	3.7%	1.1399	1.1563
Practitioner	1.0%	-0.1%	1.0%	13.9%	2.3%	16.5%	10.4%	1.3522	1.4056
Prescription Drug	0.0%	-1.8%	-1.8%	7.0%	1.4%	8.5%	8.9%	1.2326	1.2740
Other	0.9%	-0.4%	0.5%	8.3%	-7.3%	0.4%	3.8%	1.0611	1.0766
Weighted Average[2]	**1.0%**	**0.6%**	**1.6%**	**9.2%**	**0.5%**	**9.8%**	**6.5%**	**1.2074**	**1.2376**

Months of FY Trend Applied	12	12	12	18
Months of Contract Year Trend Applied	12	12	12	22.7

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

[2] Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims FY15-16), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted FY15-16 Claims)

Trend rates for managed care plans are calculated based on regression studies of historical health plan data.
Trend rates have been calculated separately for the broad service categories shown above. Utilization trend is based on service units per thousand.

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations; includes FY15-16 incurred claims paid through Oct 2016.
Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations; includes FY14-16 incurred claims paid through Feb 2017.

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

Age Under 1										
Statewide	Total Base Claims FY15-16	Base Claims Redistribution FY15-16	Total Redistributed Base Claims FY15-16	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Patient Copay	Completed and Adjusted Claims FY15-16	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type										
DME/Supplies	$150,602		$150,602	$1,315	($3,860)	$681	$148,739	1.077	$160,131	$4.15
FQHC / RHC	$48,072		$48,072	$504		$1,212	$49,787	1.406	$69,979	$1.81
Home Health	$11,097		$11,097	$158		$92	$11,347	1.156	$13,121	$0.34
IP - Maternity	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Newborn	$2,536,828	$201,456	$2,738,284	$8,127	($30,998)	$7,115	$2,722,528	0.936	$2,549,063	$66.02
IP - Other	$2,814,160	$221,520	$3,035,680	$9,016	($34,365)	$12,984	$3,023,315	0.936	$2,830,686	$73.31
IP - Psych	$16,051		$16,051		$4,123	$0	$20,174	0.936	$18,888	$0.49
Lab	$82,889		$82,889	$529		$1,303	$84,721	1.077	$91,210	$2.36
OP - Emergency Room	$446,795		$446,795	$6,376	$5,728	$40,917	$499,815	1.156	$577,959	$14.97
OP - Other	$642,206		$642,206	$9,164	$10,282	$7,285	$668,937	1.156	$773,522	$20.03
Pharmacy	$527,306		$527,306	$1	($9,317)	$32,306	$550,296	1.274	$701,097	$18.16
Prof - Anesthesia	$37,409		$37,409	$392		$133	$37,934	1.406	$53,319	$1.38
Prof - Child EPSDT	$713,155		$713,155	$7,473	($1,390)	$0	$719,237	1.406	$1,010,941	$26.18
Prof - Evaluation & Management	$3,170,921		$3,170,921	$32,998	($91)	$128,367	$3,332,195	1.406	$4,683,646	$121.31
Prof - Maternity	$0		$0			$0	$0	1.406	$0	$0.00
Prof - Other	$2,172,889		$2,172,889	$22,739	($4,236)	$51,889	$2,243,281	1.406	$3,153,097	$81.67
Prof - Psych	$15,297		$15,297		($30)	$0	$15,268	1.406	$21,460	$0.56
Prof - Specialist	$199,637		$199,637	$2,092	($389)	$6,277	$207,616	1.406	$291,820	$7.56
Prof - Vision	$61,246		$61,246	$182	($119)	$634	$61,944	1.406	$87,067	$2.26
Radiology	$47,093		$47,093	$393		$8,734	$56,221	1.077	$60,527	$1.57
Transportation/Ambulance	$47,798		$47,798	$268		$28	$48,095	1.077	$51,779	$1.34
Provider Incentive Payment Adjustment										$3.96
Total	$13,741,453	$422,975	$14,164,428	$101,729	($64,662)	$299,956	$14,501,451		$17,199,312	$449.43

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

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

Age 1-5										
Statewide	Total Base Claims FY15-16	Base Claims Redistribution FY15-16	Total Redistributed Base Claims FY15-16	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Patient Copay	Completed and Adjusted Claims FY15-16	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type										
DME/Supplies	$588,089		$588,089	$5,135	($15,072)	$3,209	$581,361	1.077	$625,888	$1.61
FQHC / RHC	$176,573		$176,573	$1,850		$8,001	$186,425	1.406	$262,033	$0.67
Home Health	$56,931		$56,931	$812		$523	$58,266	1.156	$67,376	$0.17
IP - Maternity	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Newborn	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Other	$5,176,202	($526,802)	$4,649,400	$16,583	($52,664)	$9,998	$4,623,317	0.936	$4,328,744	$11.12
IP - Psych	$164,042		$164,042	$31	$42,143	$47	$206,262	0.936	$193,120	$0.50
Lab	$911,085		$911,085	$5,925		$17,568	$934,578	1.077	$1,006,158	$2.58
OP - Emergency Room	$3,349,056		$3,349,056	$47,792	$42,932	$382,429	$3,822,209	1.156	$4,419,790	$11.35
OP - Other	$6,171,982		$6,171,982	$88,076	$98,812	$59,924	$6,418,793	1.156	$7,422,336	$19.06
Pharmacy	$6,697,756		$6,697,756	$14	($118,338)	$440,159	$7,019,591	1.274	$8,943,208	$22.97
Prof - Anesthesia	$328,179		$328,179	$3,439		$2,014	$333,632	1.406	$468,944	$1.20
Prof - Child EPSDT	$1,305,221		$1,305,221	$13,677	($2,545)	$0	$1,316,353	1.406	$1,850,231	$4.75
Prof - Evaluation & Management	$11,174,316		$11,174,316	$114,600	($321)	$711,210	$11,999,806	1.406	$16,866,613	$43.32
Prof - Maternity	$0		$0			$0	$0	1.406	$0	$0.00
Prof - Other	$6,408,632		$6,408,632	$66,838	($12,494)	$264,835	$6,727,812	1.406	$9,456,436	$24.29
Prof - Psych	$236,761		$236,761	$939	($459)	$5,320	$242,562	1.406	$340,939	$0.88
Prof - Specialist	$1,031,432		$1,031,432	$10,808	($2,011)	$39,595	$1,079,824	1.406	$1,517,772	$3.90
Prof - Vision	$714,851		$714,851	$2,659	($1,384)	$8,899	$725,024	1.406	$1,019,075	$2.62
Radiology	$206,099		$206,099	$1,604		$47,335	$255,039	1.077	$274,572	$0.71
Transportation/Ambulance	$284,416		$284,416	$1,174		$187	$285,777	1.077	$307,665	$0.79
Provider Incentive Payment Adjustment										$1.36
Total	$44,981,623	($526,802)	$44,454,821	$381,955	($21,399)	$2,001,254	$46,816,630		$59,370,902	$153.83

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Age 6-14										
Statewide	Total Base Claims FY15-16	Base Claims Redistribution FY15-16	Total Redistributed Base Claims FY15-16	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Patient Copay	Completed and Adjusted Claims FY15-16	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type										
DME/Supplies	$1,014,083		$1,014,083	$8,855	($8,273)	$4,732	$1,019,398	1.077	$1,097,475	$1.57
FQHC / RHC	$219,181		$219,181	$2,297		$12,876	$234,354	1.406	$329,402	$0.47
Home Health	$242,686		$242,686	$3,463		$842	$246,990	1.156	$285,606	$0.41
IP - Maternity	$8,752	$520	$9,272	$28	($105)	$72	$9,267	0.936	$8,676	$0.01
IP - Newborn	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Other	$4,547,090	$271,761	$4,818,852	$14,567	($54,554)	$12,081	$4,790,946	0.936	$4,485,693	$6.42
IP - Psych	$1,139,064		$1,139,064	$2,701	$293,267	$3,763	$1,438,794	0.936	$1,347,122	$1.93
Lab	$1,343,104		$1,343,104	$7,937		$22,928	$1,373,969	1.077	$1,479,203	$2.12
OP - Emergency Room	$4,335,084		$4,335,084	$61,863	$55,572	$411,562	$4,864,081	1.156	$5,624,553	$8.04
OP - Other	$7,443,294		$7,443,294	$106,217	$119,166	$89,340	$7,758,018	1.156	$8,970,941	$12.83
Pharmacy	$20,405,121		$20,405,121	$41	($360,524)	$910,781	$20,955,420	1.274	$26,697,948	$38.18
Prof - Anesthesia	$258,403		$258,403	$2,708		$1,707	$262,817	1.406	$369,409	$0.53
Prof - Child EPSDT	$210,867		$210,867	$2,210	($411)	$0	$212,665	1.406	$298,917	$0.43
Prof - Evaluation & Management	$13,803,148		$13,803,148	$140,535	($396)	$895,208	$14,838,494	1.406	$20,856,598	$29.83
Prof - Maternity	$2,527		$2,527	$26	($5)	$1	$2,550	1.406	$3,584	$0.01
Prof - Other	$6,641,353		$6,641,353	$69,016	($12,947)	$389,373	$7,086,796	1.406	$9,961,014	$14.25
Prof - Psych	$1,398,473		$1,398,473	$11,699	($2,721)	$70,840	$1,478,291	1.406	$2,077,848	$2.97
Prof - Specialist	$1,612,209		$1,612,209	$16,893	($3,143)	$59,892	$1,685,852	1.406	$2,369,589	$3.39
Prof - Vision	$1,501,212		$1,501,212	$6,954	($2,910)	$23,426	$1,528,683	1.406	$2,148,676	$3.07
Radiology	$606,902		$606,902	$4,966		$105,136	$717,004	1.077	$771,920	$1.10
Transportation/Ambulance	$460,338		$460,338	$1,749		$315	$462,402	1.077	$497,818	$0.71
Provider Incentive Payment Adjustment										$1.14
Total	$67,192,891	$272,282	$67,465,173	$464,727	$22,017	$3,014,872	$70,966,789		$89,681,991	$129.40

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Age 15-18 Female										
Statewide	Total Base Claims FY15-16	Base Claims Redistribution FY15-16	Total Redistributed Base Claims FY15-16	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Patient Copay	Completed and Adjusted Claims FY15-16	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type										
DME/Supplies	$231,992		$231,992	$2,026	($1,893)	$847	$232,973	1.077	$250,816	$2.07
FQHC / RHC	$67,602		$67,602	$708		$3,476	$71,787	1.406	$100,901	$0.83
Home Health	$11,319		$11,319	$162		$121	$11,602	1.156	$13,416	$0.11
IP - Maternity	$396,098	$31,322	$427,420	$1,269	($4,838)	$3,240	$427,091	0.936	$399,879	$3.30
IP - Newborn	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Other	$998,101	$78,512	$1,076,613	$3,198	($12,188)	$3,161	$1,070,784	0.936	$1,002,559	$8.28
IP - Psych	$602,714		$602,714	$1,747	$155,258	$2,652	$762,370	0.936	$713,796	$5.89
Lab	$410,696		$410,696	$2,925		$5,957	$419,578	1.077	$451,714	$3.73
OP - Emergency Room	$1,516,152		$1,516,152	$21,636	$19,436	$107,890	$1,665,114	1.156	$1,925,445	$15.89
OP - Other	$2,206,731		$2,206,731	$31,491	$35,329	$25,606	$2,299,157	1.156	$2,658,618	$21.95
Pharmacy	$3,954,655		$3,954,655	$8	($69,872)	$231,165	$4,115,956	1.274	$5,243,875	$43.29
Prof - Anesthesia	$88,045		$88,045	$923		$532	$89,500	1.406	$125,798	$1.04
Prof - Child EPSDT	$71,171		$71,171	$746	($139)	$0	$71,778	1.406	$100,890	$0.83
Prof - Evaluation & Management	$2,865,300		$2,865,300	$29,338	($82)	$183,157	$3,077,713	1.406	$4,325,953	$35.71
Prof - Maternity	$249,567		$249,567	$2,615	($487)	$39	$251,734	1.406	$353,831	$2.92
Prof - Other	$1,254,698		$1,254,698	$13,046	($2,446)	$69,754	$1,335,052	1.406	$1,876,514	$15.49
Prof - Psych	$374,729		$374,729	$3,352	($729)	$20,432	$397,784	1.406	$559,115	$4.62
Prof - Specialist	$442,016		$442,016	$4,632	($862)	$19,227	$465,013	1.406	$653,610	$5.40
Prof - Vision	$255,655		$255,655	$1,157	($495)	$3,789	$260,107	1.406	$365,599	$3.02
Radiology	$318,306		$318,306	$2,721		$31,870	$352,897	1.077	$379,925	$3.14
Transportation/Ambulance	$123,622		$123,622	$647		$120	$124,389	1.077	$133,916	$1.11
Provider Incentive Payment Adjustment										$1.59
Total	$16,439,172	$109,834	$16,549,006	$124,344	$115,992	$713,036	$17,502,378		$21,636,171	$180.20

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Age 15-18 Male										
Statewide	Total Base Claims FY15-16	Base Claims Redistribution FY15-16	Total Redistributed Base Claims FY15-16	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Patient Copay	Completed and Adjusted Claims FY15-16	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type										
DME/Supplies	$260,528		$260,528	$2,275	($2,125)	$1,032	$261,710	1.077	$281,755	$2.36
FQHC / RHC	$32,571		$32,571	$341		$1,888	$34,801	1.406	$48,915	$0.41
Home Health	$10,277		$10,277	$147		$125	$10,549	1.156	$12,199	$0.10
IP - Maternity	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Newborn	$0	$0	$0			$0	$0	0.936	$0	$0.00
IP - Other	$1,995,179	($278,290)	$1,716,889	$6,392	($19,450)	$2,928	$1,706,759	0.936	$1,598,014	$13.40
IP - Psych	$430,215		$430,215	$1,200	$110,811	$1,929	$544,155	0.936	$509,485	$4.27
Lab	$207,541		$207,541	$1,159		$2,588	$211,288	1.077	$227,471	$1.91
OP - Emergency Room	$1,035,966		$1,035,966	$14,783	$13,280	$74,877	$1,138,906	1.156	$1,316,968	$11.05
OP - Other	$1,955,690		$1,955,690	$27,908	$31,310	$17,481	$2,032,390	1.156	$2,350,142	$19.71
Pharmacy	$4,410,633		$4,410,633	$9	($77,928)	$144,541	$4,477,254	1.274	$5,704,180	$47.84
Prof - Anesthesia	$63,697		$63,697	$667		$388	$64,752	1.406	$91,014	$0.76
Prof - Child EPSDT	$45,535		$45,535	$477	($89)	$0	$45,923	1.406	$64,549	$0.54
Prof - Evaluation & Management	$2,098,862		$2,098,862	$21,305	($60)	$129,807	$2,249,914	1.406	$3,162,420	$26.53
Prof - Maternity	$0		$0			$0	$0	1.406	$0	$0.00
Prof - Other	$1,543,105		$1,543,105	$16,069	($3,008)	$56,081	$1,612,246	1.406	$2,266,131	$19.01
Prof - Psych	$277,411		$277,411	$2,352	($540)	$14,887	$294,111	1.406	$413,394	$3.47
Prof - Specialist	$450,506		$450,506	$4,721	($878)	$13,356	$467,704	1.406	$657,393	$5.51
Prof - Vision	$228,154		$228,154	$886	($442)	$3,043	$231,641	1.406	$325,589	$2.73
Radiology	$171,092		$171,092	$1,436		$26,247	$198,775	1.077	$213,999	$1.79
Transportation/Ambulance	$115,071		$115,071	$581		$105	$115,757	1.077	$124,623	$1.05
Provider Incentive Payment Adjustment										$1.45
Total	$15,332,034	($278,290)	$15,053,744	$102,708	$50,880	$491,305	$15,698,637		$19,368,241	$163.90

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

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

All Age Categories										
Statewide	Total Base Claims FY15-16	Base Claims Redistribution FY15-16	Total Redistributed Base Claims FY15-16	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Patient Copay	Completed and Adjusted Claims FY15-16	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type										
DME/Supplies	$2,245,295	$0	$2,245,295	$19,606	($31,223)	$10,501	$2,244,180	1.077	$2,416,065	$1.77
FQHC / RHC	$544,000	$0	$544,000	$5,700	$0	$27,453	$577,153	1.406	$811,231	$0.59
Home Health	$332,310	$0	$332,310	$4,742	$0	$1,703	$338,755	1.156	$391,717	$0.29
IP - Maternity	$404,849	$31,843	$436,692	$1,297	($4,943)	$3,312	$436,357	0.936	$408,555	$0.30
IP - Newborn	$2,536,828	$201,456	$2,738,284	$8,127	($30,998)	$7,115	$2,722,528	0.936	$2,549,063	$1.86
IP - Other	$15,530,732	($233,298)	$15,297,434	$49,755	($173,220)	$41,151	$15,215,121	0.936	$14,245,696	$10.42
IP - Psych	$2,352,086	$0	$2,352,086	$5,679	$605,601	$8,390	$2,971,756	0.936	$2,782,412	$2.03
Lab	$2,955,315	$0	$2,955,315	$18,475	$0	$50,344	$3,024,134	1.077	$3,255,756	$2.38
OP - Emergency Room	$10,683,053	$0	$10,683,053	$152,449	$136,948	$1,017,675	$11,990,125	1.156	$13,864,715	$10.14
OP - Other	$18,419,903	$0	$18,419,903	$262,856	$294,899	$199,637	$19,177,295	1.156	$22,175,559	$16.22
Pharmacy	$35,995,472	$0	$35,995,472	$73	($635,979)	$1,758,952	$37,118,518	1.274	$47,290,308	$34.58
Prof - Anesthesia	$775,732	$0	$775,732	$8,128	$0	$4,774	$788,635	1.406	$1,108,485	$0.81
Prof - Child EPSDT	$2,345,949	$0	$2,345,949	$24,582	($4,574)	$0	$2,365,957	1.406	$3,325,527	$2.43
Prof - Evaluation & Management	$33,112,548	$0	$33,112,548	$338,776	($950)	$2,047,749	$35,498,122	1.406	$49,895,231	$36.48
Prof - Maternity	$252,094	$0	$252,094	$2,642	($491)	$40	$254,284	1.406	$357,415	$0.26
Prof - Other	$18,020,678	$0	$18,020,678	$187,708	($35,131)	$831,931	$19,005,186	1.406	$26,713,192	$19.53
Prof - Psych	$2,302,672	$0	$2,302,672	$18,343	($4,478)	$111,480	$2,428,016	1.406	$3,412,756	$2.50
Prof - Specialist	$3,735,801	$0	$3,735,801	$39,145	($7,283)	$138,347	$3,906,009	1.406	$5,490,184	$4.01
Prof - Vision	$2,761,118	$0	$2,761,118	$11,838	($5,350)	$39,793	$2,807,399	1.406	$3,946,007	$2.89
Radiology	$1,349,492	$0	$1,349,492	$11,121	$0	$219,322	$1,579,935	1.077	$1,700,944	$1.24
Transportation/Ambulance	$1,031,246	$0	$1,031,246	$4,419	$0	$755	$1,036,420	1.077	$1,115,800	$0.82
Provider Incentive Payment Adjustment										$1.35
Total	$157,687,173	$0	$157,687,173	$1,175,462	$102,827	$6,520,423	$165,485,885		$207,256,617	$152.90

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

Summary of FY 2018 Base Capitation Rates Below & Above 150% Federal Poverty Level

Section I

Exhibit 5a.1

Age Group	Combined Base Rates	Copay Value PMPM FAMIS <=150%	Copay Value PMPM FAMIS >150%	Admin Cost Adjustment	Statewide FAMIS <=150% Total with Admin	Statewide FAMIS >150% Total with Admin
Under 1	$439.26	$2.13	$4.95	8.83%	$479.49	$476.40
1-5	$149.46	$2.15	$5.09	8.83%	$161.58	$158.36
6-14	$125.68	$2.13	$5.10	8.83%	$135.52	$132.26
Female 15-18	$175.46	$2.16	$5.14	8.83%	$190.09	$186.82
Male 15-18	$159.57	$2.22	$5.27	8.83%	$172.60	$169.25

	Statewide FAMIS <=150% Total with Admin	Statewide FAMIS >150% Total with Admin	Overall FAMIS
Average	$155.37	$158.19	$158.04

Note:
Average is weighted by health plan enrollment distribution as of February 2017

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

Comparison of FY 2017 and FY 2018 Capitation Rates

		Statewide					
	Aid Category	FAMIS <=150%			FAMIS >150%		
	Age Group	FY 2017	FY 2018	% Change	FY 2017	FY 2018	% Change
FAMIS	Under 1	$461.64	$479.49	3.87%	$458.54	$476.40	3.89%
	1-5	$128.43	$161.58	25.81%	$125.30	$158.36	26.39%
	6-14	$115.52	$135.52	17.32%	$112.29	$132.26	17.79%
	Female 15-18	$168.72	$190.09	12.67%	$165.50	$186.82	12.88%
	Male 15-18	$143.92	$172.60	19.93%	$140.64	$169.25	20.35%
	Average	$130.74	$155.37	18.83%	$133.76	$158.19	18.26%

Overall FAMIS Average		
FY 2017	FY 2018	% Difference
$133.59	$158.04	18.29%

Note:
Average is weighted by health plan enrollment distribution as of February 2017

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

Summary of Contract Year 2018 Base Capitation Rates Below & Above 150% Federal Poverty Level

Section I

Exhibit 5b.1

Age Group	Combined Base Rates	Copay Value PMPM FAMIS <=150%	Copay Value PMPM FAMIS >150%	Admin Cost Adjustment	Statewide FAMIS <=150% Total with Admin	Statewide FAMIS >150% Total with Admin
Under 1	$449.43	$2.13	$4.95	8.83%	$490.63	$487.54
1-5	$153.83	$2.15	$5.09	8.83%	$166.37	$163.16
6-14	$129.40	$2.13	$5.10	8.83%	$139.60	$136.34
Female 15-18	$180.20	$2.16	$5.14	8.83%	$195.29	$192.02
Male 15-18	$163.90	$2.22	$5.27	8.83%	$177.35	$174.00

			Overall FAMIS
Average	$159.89	$162.84	$162.68

Note:
Average is weighted by health plan enrollment distribution as of February 2017

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS)
Comparison of FY 2017 and Contract Year 2018 Capitation Rates

		Statewide					
	Aid Category	FAMIS <=150%			FAMIS >150%		
	Age Group	FY 2017	Contract Year	% Change	FY 2017	Contract Year	% Change
FAMIS	Under 1	$461.64	$490.63	6.28%	$458.54	$487.54	6.32%
	1-5	$128.43	$166.37	29.54%	$125.30	$163.16	30.21%
	6-14	$115.52	$139.60	20.85%	$112.29	$136.34	21.42%
	Female 15-18	$168.72	$195.29	15.75%	$165.50	$192.02	16.03%
	Male 15-18	$143.92	$177.35	23.22%	$140.64	$174.00	23.72%
	Average	$130.74	$159.89	22.30%	$133.76	$162.84	21.74%

Overall FAMIS Average		
FY 2017	Contract Year	% Difference
$133.59	$162.68	21.77%

Note:
Average is weighted by health plan enrollment distribution as of February 2017

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

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

February 2017 Member Month Distribution

Section I

Exhibit 5c

Aid Category	Age Group	Statewide
FAMIS <= 150%	Under 1	37
	1-5	872
	6-14	1,616
	Female 15-18	278
	Male 15-18	290
Aid Category Total		3,093
FAMIS >150%	Under 1	1,637
	1-5	14,901
	6-14	27,657
	Female 15-18	4,859
	Male 15-18	4,918
Aid Category Total		53,972

Total	57,065

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Drug Reinsurance Adjustment

Section I
Exhibit 6a

		FAMIS	Source
	Attachment Point	**$225,000**	
1a.	Contract Year Base Period Number of Individuals Exceeding the Threshold	12	Contract Year Base Period Health Plan Encounter Data
1b.	Contract Year Base Period Additional Individuals	2	20% Increase of People who Exceed the Threshold
1c.	Contract Year Base Period Average Cost After Specialty Cost Trend	$615,340	Contract Year Base Period Health Plan Encounter Data
1d.	Contract Year Base Period Total Dollars Including Additional Individuals	$8,860,901	= 1c. * (1a.+1b.)
1e.	Contract Year Base Period Amount of Reinsurance	$5,058,811	= ((1d.) - ((1a.+1b.) * Attachment Point)) * 90%
2.	Historical Member Months (Contract Year Base Period)	827,900	Health Plan Encounter Data
3.	**Estimated PMPM**	**$6.11**	**= (1e.) / (2.)**

Note:
Discounted threshold is based upon Contract Year Base Period reinsurance threshold of attachment points per person per year discounted by
1) 20 % drug unit cost trend per year for persistent members; (2) 15% drug unit cost trend per year for non-persistent members

Health Plan Encounter Data - Family Access to Medical Insurance Security (FAMIS) Addiction and Recovery Treatment Services (ARTS) Adjustment

		Age 6-14	Age 15-18 Male	Age 15-18 Female	Source
1a.	ARTS Medical PMPM (Per Participant)	$100.62	$100.62	$100.62	Estimated for FY18
1b.	ARTS Admin PMPM (Per Participant)	$4.72	$4.72	$4.72	Estimated for FY18
1c.	Medical PMPM For New Carve-In Services (Per Participant)	$17.64	$17.64	$17.64	Estimated for FY18
2a.	ARTS Participants	4	15	11	Dec 2016 snapshot
2b.	Other Members	29,390	5,162	5,175	Dec 2016 snapshot
3a.	**ARTS Medical PMPM (Rate Adjustment)**	$0.02	$0.34	$0.26	= ((1a.) + (1c.)) * (2a.) / ((2a.) + (2b.))
3b.	**ARTS Admin PMPM (Rate Adjustment)**	$0.00	$0.01	$0.01	= (1b.) * (2a.) / ((2a.) + (2b.))
3c.	**ARTS Total PMPM (Rate Adjustment)**	$0.02	$0.36	$0.27	= (3a.) + (3b.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
FAMIS Capitation Rates Net of Drug Reinsurance Adjustment and With ARTS Adjustment
Summary of Contract Year 2018 Base Capitation Rates Below & Above 150% Federal Poverty Level

	Statewide		
Age Group	**FAMIS <=150% Total with Admin**	**FAMIS >150% Total with Admin**	
Under 1	$484.52	$481.43	
1-5	$160.26	$157.05	
6-14	$133.51	$130.25	
15-18 Female	$189.45	$186.18	
15-18 Male	$171.60	$168.24	
			Overall FAMIS
Average	$153.85	$156.80	$156.64

Note:
Average is weighted by health plan enrollment distribution as of February 2017

Age 10 and Over Female						
Statewide	Raw Claims Oct 2015 - Sep 2016	Capitation Oct 2015 - Sep 2016	Unadjusted PMPM Oct 2015 - Sep 2016	Units Oct 2015 - Sep 2016	Units/1000 Oct 2015 - Sep 2016	Cost/Unit Oct 2015 - Sep 2016
Member Months	10,979					
Service Type						
DME/Supplies	$82,832	$0	$7.54	540	590	$153.39
FQHC / RHC	$16,524	$0	$1.51	134	146	$123.32
Home Health	$6,825	$0	$0.62	21	23	$324.98
IP - Maternity	$3,800,735	$0	$346.18	1,126	1,231	$3,375.43
IP - Newborn	$0	$0	$0.00	0	0	-
IP - Other	$452,258	$0	$41.19	78	85	$5,798.18
IP - Psych	$41,136	$9,052	$4.57	62	68	$809.48
Lab	$220,612	$6,328	$20.67	8,483	9,272	$26.75
OP - Emergency Room & Related	$283,891	$0	$25.86	935	1,022	$303.63
OP - Other	$636,913	$0	$58.01	2,511	2,745	$253.65
Pharmacy	$391,152	$0	$35.63	8,379	9,158	$46.68
Prof - Anesthesia	$217,759	$0	$19.83	1,341	1,466	$162.39
Prof - Child EPSDT	$10,006	$0	$0.91	220	240	$45.48
Prof - Evaluation & Management	$436,484	$7,290	$40.42	6,675	7,296	$66.48
Prof - Maternity	$1,978,905	$0	$180.24	3,201	3,499	$618.21
Prof - Other	$212,197	$506	$19.37	2,753	3,009	$77.26
Prof - Psych	$6,673	$1,759	$0.77	111	121	$75.96
Prof - Specialist	$85,481	$0	$7.79	1,607	1,756	$53.19
Prof - Vision	$5,690	$8,902	$1.33	88	96	$165.82
Radiology	$457,522	$639	$41.73	5,823	6,365	$78.68
Transportation/Ambulance	$17,238	$35,147	$4.77	202	221	$259.33
Total	$9,360,831	$69,624	$858.95	44,290		

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - FAMIS MOMS
Pharmacy Adjustment

Section II
Exhibit 2a

		FAMIS MOMS	Source
1.	Health Plan Total Drug Cost PMPM	$35.63	Oct 2015 - Sep 2016 Health Plan Encounter Data
2.	Health Plan Drug Ingredient Cost PMPM	$34.63	Health Plan Encounter Analysis
3.	Change in Average Managed Care Discount	0.4%	From Plan Data
4.	Current Average Managed Care Rebate	2.3%	From Plan Data
5.	FY18 Managed Care Dispensing Fee PMPM	$0.99	From Plan Data
6.	Average PBM Admin Cost PMPM	$0.36	From Plan Data
7.	Adjusted PMPM with FY18 Pharmacy Pricing Arrangements	$35.08	= (2.) * (1 - (3.)) * (1 - (4.)) + (5.) + (6.)
8.	**Pharmacy Adjustment**	**-1.5%**	= (7.) / (1.) - 1

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - FAMIS MOMS
Hospital Inpatient Adjustments

Section II
Exhibit 2b

		Inpatient Medical/Surgical	Inpatient Psychiatric	Source
1.	Total Claims in IP Service Categories	$4,252,993	$41,136	Oct 2015 - Sep 2016 Health Plan Encounter Data
2.	FY15-16 Hospital Capital Percentage	8.70%	8.70%	Provided by DMAS
3.	FY17 Capital Reimbursement Increase	-3.10%	-3.10%	= ((4.)-(2.))/(2.)
4.	FY17 & FY18 Hospital Capital Percentage	8.43%	8.43%	Provided by DMAS
5a.	FY17 Hospital Rate Change - Unit Cost	1.05%	1.05%	Provided by DMAS
5b.	FY18 Hospital Rate Change - Unit Cost	0.00%	0.00%	Provided by DMAS
5c.	Dollar Change	$40,892	$396	= (1.) * (1 - (4.)) * [(1 + (5a.)) * (1 + (5b.)) - 1]
6a.	FY17 Hospital Rate Change - Rebasing	-2.65%	27.00%	Provided by DMAS
6b.	FY18 Hospital Rate Change - Rebasing	0.00%	0.00%	Provided by DMAS
6c.	Dollar Change	($103,203)	$10,170	= (1.) * (1 - (4.)) * [(1 + (6a.)) * (1 + (6b.)) - 1]
7.	**Hospital Inpatient Adjustment**	**-1.47%**	**25.69%**	= ((5c.) + (6c.)) / (1.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - FAMIS MOMS
Hospital Outpatient Adjustments

Section II
Exhibit 2c

		OP - Emergency Room & Related	OP - Other	Source
1.	Total Claims in OP Service Categories	$283,891	$636,913	Oct 2015 - Sep 2016 Health Plan Encounter Data
2a.	FY17 Hospital Rate Change - Unit Cost	1.05%	1.05%	Provided by DMAS
2b.	FY18 Hospital Rate Change - Unit Cost	0.00%	0.00%	Provided by DMAS
2c.	Dollar Change	$2,981	$6,688	= (1.) * [(1 + (2a.)) * (1 + (2b.)) - 1]
3a.	FY17 Hospital Rate Change - Rebasing	0.10%	0.10%	Provided by DMAS
3b.	FY18 Hospital Rate Change - Rebasing	0.00%	0.00%	Provided by DMAS
3c.	Dollar Change	$284	$637	= (1.) * [(1 + (3a.)) * (1 + (3b.)) - 1]
4.	**Hospital Outpatient Adjustment**	**1.15%**	**1.15%**	= ((2c.) + (3c.)) / (1.)

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - FAMIS MOMS
Provider Incentive Payment Adjustment

Section II
Exhibit 2d

	Adjustment Value	Source
Provider Incentive Payment Adjustment	**0.14%**	From Plan Data

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - FAMIS MOMS
Hepatitis C Treatment Adjustment

Section II
Exhibit 2e

		FAMIS MOMS	Source
1.	Total Claims in Pharmacy Service Categories	$391,152	Oct 2015 - Sep 2016 Health Plan Encounter Data
2.	Unique Individuals in Base Period	2,383	Oct 2015 - Sep 2016 Health Plan Encounter Data
3a.	Proportion of Population Being Tested for Hepatitis C	2.0%	Oct 2015 - Sep 2016 Health Plan Encounter Data
3b.	Number of Individuals Being Tested	48	Oct 2015 - Sep 2016 Health Plan Encounter Data
3c.	Projected Testing Change in FY18	15%	Estimate
3d.	Additional Number of People Being Tested	7	= (3b.) * (3c.)
3e.	Average Cost Per Test Per Person	$42	Oct 2015 - Sep 2016 Health Plan Encounter Data
4a.	Proportion of Population Diagnosed With Hepatitis C	0.21%	Oct 2015 - Sep 2016 Health Plan Encounter Data
4b.	Number of Individuals Diagnosed With Hepatitis C	5	Oct 2015 - Sep 2016 Health Plan Encounter Data
4c.	Projected Increase in People Diagnosed With Hepatitis C	5%	Estimate
4d.	Projected Number of People With Hepatitis C	5	= (4b.) * (1 + (4c.))
5a.	Proportion of People With Hepatitis C With Drug Therapy	0.0%	Oct 2015 - Sep 2016 Health Plan Encounter Data
5b.	Number of Individuals With Hepatitis C With Drug Therapy in Base Period	0	Oct 2015 - Sep 2016 Health Plan Encounter Data
5c.	Expected Percentage Increase of Hepatitis C Receiving Drug Therapy - Current Protocol In The Base Period	0%	Estimate
5d.	Expected Percentage Increase of Hepatitis C Receiving Drug Therapy - New Protocols (Eff. Jul 2016 and Eff. Jan 2017; both protocols combined)	100%	Estimate
5e.	Projected Number of Additional People Going Through Drug Therapy	0	= (4d.) * (5a.) * (1 + (5c.)) * (1 + (5d.)) - (5b.)
5f.	Base Period Average Cost of Drug Therapy	$88,345	Oct 2015 - Sep 2016 Health Plan Encounter Data
5g.	Projected Average Cost of Drug Therapy	$70,000	Estimate
6.	Additional Cost of Hepatitis C Treatment	$302	= ((3d.) * (3e.)) + ((5g.) - (5f.)) * (5b.) + (5e.) * (5g.)
7.	**Hepatitis C Treatment Adjustment**	**0.1%**	= (6.) / (1.)

Note: Based on analysis of Oct 2015 - Sep 2016 base data experience

Virginia Medicaid
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Health Plan Encounter Data - FAMIS MOMS
Resource Based Relative Value Scale Adjustment

Section II
Exhibit 2f

		FAMIS MOMS	Source
1.	Professional Fee Adjustment - Effective FY18	-0.21%	Provided by DMAS
2.	Proportion of claims subject to fee adjustment	88.4%	Oct 2015 - Sep 2016 Health Plan Encounter Data
3.	**Final Professional Fee Adjustment**	**-0.19%**	= (1.) * (2.)

Virginia Medicaid
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Health Plan Encounter Data - FAMIS MOMS
Administrative Cost Adjustment

Section II
Exhibit 2g

		FAMIS MOMS	Source
1.	Claims Adjustment Expense PMPM	$25.70	Expense from CY2016 BOI Reports; CY2016 Member months from capitation payment files
2.	General Admin Expense PMPM	$41.39	Expense from CY2016 BOI Reports; CY2016 Member months from capitation payment files
3.	Claims Adjustment Expense Increase %	2.1%	BLS CPI-U
4.	General Admin Expense Increase %	2.1%	Weighted average of BLS Compensation Trend and CPI
5a.	Administrative PMPM*	$69.21	= (1.) * (1+ (3.)) ^ (18 months/12) + (2.) * (1+ (4.)) ^ (18 months/12)
5b.	Administrative PMPM Weighted by Claims	$48.26	Reallocation of administrative costs weighted by claims
6.	Adjusted and Trended Base PMPM	$956.94	Weighted average of med component of FY2018 FAMIS Moms Base Rates
7.	Administrative allowance as % of Base Capitation Rate	4.73%	= (5b.) / (((5b.) + (6.)) / (1 - (8.)))
8.	Provision for Margin as % of Base Capitation Rate	1.5%	Provided by DMAS
9.	**Administrative Factor as % of Base Capitation Rate**	**6.2%**	= (7.) + (8.)

*Note:

Administrative increases are applied from midpoint of CY2016 to the midpoint of the contract period (18 months) using compound interest calculations

Uses LIFC Adult Contract Period Unit Cost Trend

	FAMIS MOMS								
	Completion and Policy/Program Adjustments			Data Period Trend					
Category of Service	IBNR	Policy/ Program[1]	Total Base Data Adjustments	Cost Trend	Utilization Trend	Cost and Utilization Trend	Contract Period Cost and Utilization Trend	FY 18 Total Trend Factor	Contract Year Total Trend Factor
Inpatient Medical/Surgical	5.7%	-1.5%	4.1%	5.6%	0.0%	5.6%	5.6%	1.0992	1.1223
Inpatient Psychiatric	5.7%	31.0%	38.5%	5.6%	0.0%	5.6%	5.6%	1.0992	1.1223
Outpatient Hospital	7.8%	1.1%	9.1%	3.2%	0.0%	3.2%	3.2%	1.0562	1.0690
Practitioner	4.3%	-0.2%	4.1%	1.3%	0.0%	1.3%	1.3%	1.0220	1.0270
Prescription Drug	0.0%	-1.5%	-1.4%	8.1%	0.0%	8.1%	8.1%	1.1466	1.1816
Other	5.1%	0.0%	5.1%	0.1%	0.0%	0.1%	0.1%	1.0017	1.0021
Weighted Average[2]	**5.2%**	**-0.5%**	**4.6%**	**3.6%**	**0.0%**	**3.6%**	**3.6%**	**1.0635**	**1.0780**

Months of FY Trend Applied	6	6	6	15
Months of Contract Year Trend Applied	6	6	6	19.6

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

[2] Weighted averages for Completion and Program Adjustments are calculated using a distribution by Service Type, before Trend and Adjustments (Total Claims Oct 2015 - Sep 2016), whereas weighted averages for Trends are calculated using a distribution by Service Type, before Trend (Adjusted Oct 2015 - Sep 2016 Claims)

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

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

Data period trends are applied from the midpoint of the data period to the end of the data period using compound interest calculations; includes FY15-16 incurred claims paid through Oct 2016.

Contract period trends are applied from the end of the data period to the midpoint of the contract period using compound interest calculations; includes FY14-16 incurred claims paid through Feb 2017.

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

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

Age 10 and Over Female							
Statewide	Total Base Claims Oct 2015 - Sep 2016	Completion Factor Adjustments[1]	Policy and Program Adjustments[2]	Completed and Adjusted Claims Oct 2015 - Sep 2016	Trend Adjustment	Completed & Trended Claims Contract Year	PMPM Contract Year
Service Type							
DME/Supplies	$82,832	$4,256		$87,088	1.002	$87,271	$7.95
FQHC / RHC	$16,524	$704		$17,228	1.027	$17,692	$1.61
Home Health	$6,825	$535		$7,360	1.069	$7,867	$0.72
IP - Maternity	$3,800,735	$216,420	($58,856)	$3,958,299	1.122	$4,442,512	$404.64
IP - Newborn	$0	$0		$0	1.122	$0	$0.00
IP - Other	$452,258	$25,752	($7,003)	$471,007	1.122	$528,625	$48.15
IP - Psych	$50,188	$2,342	$13,493	$66,023	1.122	$74,099	$6.75
Lab	$226,940	$11,336		$238,276	1.002	$238,776	$21.75
OP - Emergency Room	$283,891	$22,263	$3,521	$309,675	1.069	$331,030	$30.15
OP - Other	$636,913	$49,947	$7,899	$694,758	1.069	$742,669	$67.64
Pharmacy	$391,152	$15	($5,673)	$385,494	1.182	$455,513	$41.49
Prof - Anesthesia	$217,759	$9,272		$227,031	1.027	$233,150	$21.24
Prof - Child EPSDT	$10,006	$426	($19)	$10,413	1.027	$10,694	$0.97
Prof - Evaluation & Management	$443,774	$18,586	($858)	$461,502	1.027	$473,941	$43.17
Prof - Maternity	$1,978,905	$84,264	($3,828)	$2,059,341	1.027	$2,114,846	$192.63
Prof - Other	$212,703	$9,036	($411)	$221,327	1.027	$227,293	$20.70
Prof - Psych	$8,432	$284	($16)	$8,700	1.027	$8,934	$0.81
Prof - Specialist	$85,481	$3,640	($165)	$88,955	1.027	$91,353	$8.32
Prof - Vision	$14,592	$242	($28)	$14,807	1.027	$15,206	$1.38
Radiology	$458,161	$23,509		$481,670	1.002	$482,681	$43.96
Transportation/Ambulance	$52,385	$886		$53,271	1.002	$53,383	$4.86
Provider Incentive Payment Adjustment							$1.31
Total	$9,430,455	$483,716	($51,947)	$9,862,225		$10,637,535	$970.21
Admin Cost Adjustment							$64.44
FAMIS MOMS Capitation Rate							**$1,034.65**

[1] Completion Factor Adjustment is applied to non-capitated claims only

[2] Policy and Program Adjustments are calculated based on Completed Claims = Total Base Claims + Completion Factor Adjustment.

Virginia Medicaid

Contract Year 2018 Capitation Rate Development

Health Plan Encounter Data - FAMIS MOMS

Comparison of FY 2017 and FY 2018 Base Capitation Rates and Member Months

Section II
Exhibit 5a

	Statewide		
FAMIS MOMS - Age 10 and Over Female	**FY 2017**	**FY 2018**	**% Change**
Capitation Rate	$1,139.21	$1,020.51	-10.42%
February 2017 Member Months		926	

	Statewide		
FAMIS MOMS - Age 10 and Over Female	**FY 2017**	**Contract Year**	**% Change**
Capitation Rate	$1,139.21	$1,034.65	-9.18%
February 2017 Member Months		926	

Virginia Medicaid
Contract Year 2018 Capitation Rate Development
Health Plan Encounter Data - FAMIS MOMS
Addiction and Recovery Treatment Services (ARTS) Adjustment

Section II
Exhibit 6

		FAMIS MOMS	Source
1a.	ARTS Medical PMPM (Per Participant)	$100.62	Estimated for FY18
1b.	ARTS Admin PMPM (Per Participant)	$4.72	Estimated for FY18
1c.	Medical PMPM For New Carve-In Services (Per Participant)	$17.64	Estimated for FY18
2a.	ARTS Participants	9	Dec 2016 snapshot
2b.	Other Members	809	Dec 2016 snapshot
3a.	**ARTS Medical PMPM (Rate Adjustment)**	$1.33	= ((1a.) + (1c.)) * (2a.) / ((2a.) + (2b.))
3b.	**ARTS Admin PMPM (Rate Adjustment)**	$0.05	= (1b.) * (2a.) / ((2a.) + (2b.))
3c.	**ARTS Total PMPM (Rate Adjustment)**	$1.39	= (3a.) + (3b.)

Virginia Medicaid

Contract Year 2018 Capitation Rate Development
FAMIS MOMS Capitation Rates With ARTS Adjustment
Summary of Contract Year 2018 Final Capitation Rates

Section II
Exhibit 7

	Statewide		
FAMIS MOMS - Age 10 and Over Female	**FY 2017**	**Contract Year**	**% Change**
Capitation Rate with ARTS Adjustment	$1,140.67	$1,036.04	-9.17%
February 2017 Member Months		926	