Commonwealth Coordinated Care
CY 2017 Medicaid Medicare Rate Report
Revised January 19, 2017

The Commonwealth of Virginia, in conjunction with the Centers for Medicare and Medicaid Services (CMS), is releasing the Medicare component of the CY 2017 rates for the Commonwealth Coordinated Care program.

The general principles of the rate development process for the Demonstration have been outlined in the three-way contract between CMS, the Commonwealth of Virginia, and the Participating Plans (Medicare-Medicaid Plans). The components of the capitation rates are based on estimates of what Medicare and Medicaid would have spent on behalf of the enrollees absent the Demonstration, with the agreed upon savings percentage subsequently applied.

Included in this report are CY 2017 Medicare county base rates. The Virginia Medicaid component of the rate will be released at a later date. An updated report will be provided when the rates are finalized.

I. Components of the Capitation Rate

CMS and Virginia will each contribute to the global capitation payment. CMS and Virginia will each make monthly payments to Participating Plans for their components of the capitated rate. Participating Plans will receive three monthly payments for each enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services, one amount from CMS reflecting coverage of Medicare Part D services, and a third amount from Virginia reflecting coverage of Medicaid services.

The Medicare Parts A/B rate component will be risk adjusted using the prevailing Medicare Advantage CMS-HCC and CMS HCC-ESRD models. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. To adjust the Medicaid component, Virginia's methodology assigns each enrollee to a rating category (RC) according to the individual enrollee's nursing facility level of care status, age, and region.

Section II of this document includes information on the Medicaid component of the rate. Section III includes information on the Medicare Parts A/B and Medicare Part D components of the rate. Section IV includes information on the savings percentages and quality withholds.

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II. Virginia Medicaid Component of the Rate – CY 2017

This section presents the development of the capitation rates for the Medicaid portion of the Virginia Medicare-Medicaid Financial Alignment Demonstration (Dual Demonstration) for Calendar Year 2017 effective January 1, 2017 as prepared by the Virginia Department of Medical Assistance Services (DMAS). This content includes description of historical base data production details, adjustments applied to the historical base data, and trend factors used to project historical base data forward to the contract period.

The full report titled "Commonwealth of Virginia Department of Medical Assistance Services Dual Demonstration Data Book and Capitation Rates: Medicaid Component Calendar Year 2017 is available for download on the DMAS website for Integrated Care for Medicare-Medicaid Enrollees at http://www.dmas.virginia.gov/content_pgs/capitation.aspx.

Medicaid capitation rate cells for the Dual Demonstration are as follows:

- **Nursing Home Eligible (NHE) Age 21-64**. Single rate cell for all enrollees age 21-64 meeting Nursing Facility Level of Care criteria and enrolled in the EDCD waiver or residing in a nursing facility for 20 or more consecutive days; rates will vary for the five CCC Demonstration regions. Rates are developed separately for subpopulations in nursing home institutions (NHE-I) and HCBS waivers (NHE-W) and the final NHE rate blends the rates for the two subpopulations.

- **Nursing Home Eligible (NHE) Age 65 and over.** Single rate cell for all enrollees age 65 and over meeting Nursing Facility Level of Care criteria and enrolled in the EDCD waiver or residing in a nursing facility for 20 or more consecutive days; rates will vary for the five CCC Demonstration regions. Rates are developed separately for subpopulations in nursing home institutions (NHE-I) and HCBS waivers (NHE-W) and the final NHE rate blends the rates for the two subpopulations.

- **Community Well (CW) Age 21-64.** Enrollees age 21-64 who do not meet Nursing Facility Level of Care criteria; rates will vary for the five CCC Demonstration regions.

- **Community Well (CW) Age 65 and over.** Enrollees age 65 and over that do not meet Nursing Facility Level of Care criteria; rates will vary for the five CCC Demonstration regions.

Data Sources

PwC obtained detailed Medicaid historical fee-for-service claims and eligibility data from DMAS' Medicaid Management Information System (MMIS) for services incurred and months of enrollment during state fiscal years 2013 and 2014 with claims paid through July 2015. The claims in the historical database include Medicaid paid amounts net of any third party insurance payments, which are primarily Medicare payments, and the amounts for which patients are personally responsible for nursing facility and home and community base care services, termed the *patient pay amount*.

Individuals in the base data eligible for the CCC were matched to two other data sets. These are 1) mental and behavioral health claims managed by Magellan under an administrative services

arrangement that began December 1, 2013, and 2) claims associated with consumer-directed personal care services received under the EDCD waiver that are paid through a separate vendor.

All claims, non-claims payment data, and eligibility data for members who are not eligible for the Demonstration were excluded from the historical data used in these calculations. Individuals who meet at least one of the criteria listed below are excluded from the CCC:

- Required to "spend down" in order to meet Medicaid eligibility requirements;
- In aid categories which Virginia only pays a limited amount each month toward their cost of care, including non-full benefit Medicaid beneficiaries such as Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLMBs), Qualified Disabled Working Individuals (QDWIs) or Qualifying Individuals (QIs);
- Inpatients in state mental hospitals;
- Residents of State Hospitals, , State Veterans Nursing Facilities, ICF/MR facilities, Residential Treatment Facilities, or long stay hospitals;
- Participate in federal Home and Community Based Services waivers other than the EDCD Waiver, such as Individual and Family Developmental Disability Support, Intellectual Disabilities, Day Support, Technology Assisted Waiver, and Alzheimer's Assisted Living waivers;
- Enrolled in a hospice program;
- Receive the end stage renal disease (ESRD) Medicare benefit prior to enrollment into the Demonstration;
- Have other comprehensive group or individual health insurance coverage, other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP);
- Have a Medicare supplemental policy to cover traditional Medicare deductible and copayment requirements;
- Have a Medicaid eligibility period that is only retroactive;
- Enrolled in the Virginia Birth-Related Neurological Injury Compensation Program;
- Enrolled in the Money Follows the Person (MFP) Program;
- Reside outside of the CCC Demonstration areas;
- Enrolled in a Program of All-Inclusive Care for the Elderly (PACE)[1];
- Participate in the CMS Independence at Home (IAH) demonstration identified in the CMS/Infocrossing files.

[1] Individuals enrolled in a PACE program may voluntarily elect to disenroll from PACE and enroll in the Demonstration, but they will not be passively enrolled.

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Claims are limited to those services covered in the approved State Plan and EDCD waiver services. The following is the list of services not covered in the State Plan or EDCD waiver:

- Abortions, induced
- Case management services for participants of Auxiliary Grants
- Case management services for the elderly
- Chiropractic services
- Christian Science nurses and Christian Science Sanatoria
- Dental
- Experimental and investigational procedures
- Regular assisted living services provided to residents of assisted living families

The following services are in the State Plan but carved out of the CCC Demonstration or are covered in waivers that are not part of the Demonstration:

- Community Mental Retardation Services
- Hospice Care
- Inpatient mental health services rendered in a state psychiatric hospital
- Private duty nursing
- Targeted case management

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Programmatic and Legislative Adjustments

As outlined in the Memorandum of Understanding (MOU), rates have been developed based on expected costs for the eligible population had the CCC Demonstration not been implemented. If a member opts out of the CCC program, he/she returns to the FFS program. The rate setting methodology for this time period uses the expected costs for the FFS program. A number of changes in covered services and payment levels have been mandated by the Virginia Legislature or by changes to the Medicaid State Plan or waivers. The adjustments included below have been made to the historical base data to reflect the benefits and costs that will apply in CY 2017 to fee-for-service dual eligible individuals.

The following table summarizes the adjustment percentages applied to the base data by major service category for each sub-population, with the exception of the administrative adjustment. A more detailed description of each adjustment and the accompanying adjustment value are provided below. This reflects program and policy changes based on actions by the General Assembly.

Table 1. Summary of Programmatic and Legislative Adjustments to Medicaid Base Year Expenditures

Category of Service	NHE - Institutional	NHE - Waiver	Community Well
Inpatient	-3.4%	-3.5%	-1.9%
Outpatient/ER	0.6%	1.0%	0.8%
Physician/Professional	0.7%	0.7%	1.0%
Pharmacy	-3.8%	-3.8%	-4.0%
Nursing Facility	11.4%	11.4%	11.4%
HCBS/Home Health Care	3.8%	--	4.0%
HCBS/Home Health Care – CD Only	--	4.0%	--
HCBS/Home Health Care – without CD	--	4.2%	--
Mental Health/ Substance Abuse	-10.4%	0.6%	-2.0%
Ancillary/Other	-9.4%	-19.9%	-16.9%
Medicare Crossover	0.0%	0.0%	0.0%
Weighted Average	**11.1%**	**3.3%**	**-0.1%**

Prescription drug co-pay adjustment

This adjustment is developed to take into consideration differences in pharmacy payment policy for FFS Medicaid and the dual eligible population. For the CCC population, most prescriptions are covered under the Medicare Part D drug benefit. The Virginia Medicaid program continues to cover the prescription drugs for which federal matching funds remain available but which are specifically excluded by law from Medicare Part D and to cover DMAS approved over-the-counter (OTC) drugs, which are also excluded from Part D. For the Medicare Part B covered drugs, DMAS continues to pay for coinsurance and deductibles.

The Medicaid paid pharmacy component is approximately $15 PMPM for the NHE-I and less than $5PMPM for NHE-W and CW. A 4% rebate to reflect the high proportion of generic and over the counter medicines that are paid by DMAS was applied. As mandated by Federal law, co-payments are not imposed on recipients in nursing homes or in community-based waivers, although a small amount of co-payment was reported in the FFS data and is included in the adjustment for the NHE population. The Demonstration imposes limited cost-sharing for pharmacy services on the CW population. These copayments are excluded from the CW pharmacy base data and there is not any further co-payment adjustment.

This produces an adjustment of -3.8% for the NHE population and -4.0% for the CW population and is applied to the pharmacy claims.

Hospital inpatient adjustment

There are a number of changes in DMAS hospital inpatient payment policy between the FY 2013 and FY 2014 base period and the current rate year.

Effective FY 2014, there was no explicit unit cost increase, but hospital reimbursement rates were rebased resulting in a weighted average cost per unit change of 4.7% for inpatient medical/surgical and -7.4% for inpatient psychiatric. FY 2014 unit cost change is applied to the operating cost component. For both FY 2015 and FY 2016, the Virginia General Assembly did not provide a budget regulatory increase so there is no unit cost increase.

Effective FY 2017, there are updates to the unit cost and FFS rebasing for CY 2017 CCC Duals. 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 reimbursements rates are rebased for FY 2017. For inpatient medical/surgical, the FFS rebasing is a negative adjustment of 7.25%. For inpatient psychiatric in acute care hospitals, the FFS rebasing is a positive adjustment of 27.00%.

For inpatient medical/surgical, the negative adjustment is 3.6%. For inpatient psychiatric in acute care hospitals, the positive adjustment is 24.2%. The inpatient psychiatric factor is applied to Inpatient-Psych service line.

Hospital outpatient adjustment

There are three adjustments 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 is now applied to outpatient

hospital rates in the same manner as inpatient hospital. FY 2017 is the first year that outpatient hospital inflation adjustment has been modified.

Outpatient hospital rates are adjusted by half of the regulatory inflation, a 1.05% unit cost increase. The outpatient hospital adjustment is structured similarly to the inpatient hospital adjustment. There also is a FFS outpatient hospital rebasing adjustment of 0.1%. The adjustment value of 1.2% is calculated uniformly across CCC Duals eligible populations.

Nursing facility adjustment

Effective FY 2015, DMAS implemented a fully prospective nursing facility payment system. The prospective per diem amount includes adjustments for cost settlement, unit cost inflation and any policy changes. This nursing facility reimbursement change produced a substantial increase in the unit cost amount in the claims run out beginning July 2014 compared to the FY 2013 – FY 2014 base period. The FY 2013 to FY 2015 capital and operating cost factor changes and the FY 2014 occupancy requirement change are incorporated in the prospective rate. The revised nursing facility adjustment is a unit cost adjustment that increases the CY 2013-CY2014 base period nursing facility unit cost to the FY 2015 nursing facility prospective unit cost.

The adjustment increase of 10.5% is calculated as the ratio of the average of the prospective payment unit cost in the last six months of historical data in FY 2015 (January to June 2015) to the base data FY2013 and FY2014. There was no nursing facility fee increase for FY 2016.

Effective July 1, 2016, there is a 0.9% nursing facility fee increase for FY 2017 that is applied to the full FY 2013 – FY 2014 base period for on the non-capital portion of the claims.

The cumulative calculation is a positive 11.4% adjustment applied to nursing facility claims.

Adult day care fee adjustment

This adjustment incorporates a fee increase of $10 per day effective July 1, 2013, the beginning of FY 2014. Northern Virginia rates are higher than the rest of the state, therefore the value of the increase is calculated separately for that region. Effective FY 2017, there is an additional 2.5% rate increase across all regions.

The calculation results in a 9.7% adjustment for Northern Virginia and a 13.5% adjustment for the other regions and is applied to adult day care service claims.

Personal Care and Respite Care adjustment

The 2015 Virginia Appropriation Act increased personal care and respite care rates by 2% effective July 1, 2015. Under the contract, the plans are required to pay at least the Medicaid personal care and respite care rates. As a result, the FY 2016 fee change applies to relevant claims in the consumer directed services and personal care services categories. Effective July 1, 2016, there was an additional 2% rate increase to personal care and respite care.

The calculation results in adjustment factors of 3.28% on the NHE-I, 4.01% on NHE-W and 4.03% on CW applied to consumer directed services claims and 4.00% on the NHE-I, 4.01% on NHE-W and 4.03% on CW applied to personal care services claims.

Mental health skill-building services adjustment

DMAS implemented a new policy for Mental Health Skill-Building Services (MHSS) effective December 1, 2013. This is described in the October 31, 2013 DMAS Medicaid Memo to Providers.

Because of this policy change, DMAS expected an overall 20% reduction in utilization among the FFS population for Mental Health Skill Building Services. Members enrolled in CCC now receive MH services through the Medicare Medicaid Plans. Review of the DMAS FFS and the Magellan data after the new policy was implemented showed different levels of reduction across the CCC subpopulations.

The adjustments are: -20% for NHE-I, no savings for NHE-W and -3.9% for CW. These reductions are applied to service code H0046 (Mental Health Services, not otherwise specified). The H0046 code was 55% of the NHE I OP Mental Health base dollars, 62.4% of the NHE-W OP Mental Health and 51.8% of the CW OP Mental Health base dollars.

The MHSS adjustment is -11.1% on the NHE-I, 0.0% on NHE-W and -2.0% on CW and is applied to the Physician – OP Mental Health service.

Durable medical equipment fee adjustment

The 2014 General Assembly session reduced Medicaid fees for the products covered under the Medicare DME competitive bid program to a level based on the average of the competitive bid prices in the three areas of the state in the Medicare DME competitive bid program effective July 1, 2014. This was estimated to result in $4.9 million in total savings. DMAS estimated that the Medicare competitive bid rates for the targeted DME services are 33% lower than the DMAS FFS Medicaid rates. DMAS provided a list of DME HCPCS codes subject to the Medicare competitive bid program and the average Medicare bid payment rate for the three areas in Virginia that participate in the program. These were used to calculate the dollar cost savings per unit and a savings percentage per affected DME code. This information was applied to the historical claims to determine the proportion of DME claims subject to the fee reduction and the average savings percentage based on the mix of DME codes subject to the savings. Overall, 8.7% of NHE and 6.2% of CW DME claims dollars were for codes subject to the reduction. Savings on this subset are 33.4% and 31.2% respectively.

This results in an adjustment factor reduction of 2.9% for NHE and 1.9% for CW.

Incontinence supplies fee adjustment

DMAS solicited bids for the cost of high volume incontinence supplies, primarily adult diapers and protection pads. The prices offered by the winning bidder were implemented January 1, 2014. When compared to prior DMAS payment rates, the new prices were estimated to produce nearly $2.7 million in savings, or 33% of the cost of the mix of those supplies. DMAS provided a list of DME incontinence supplies HCPCS codes subject to the bid program and the bid rate for the items. These were used to calculate the dollar cost savings per unit and a savings percentage per affected DME code. This information was applied to the historical claims to determine the proportion of DME claims subject to the incontinence supplies fee reduction and the average savings percentage based on the mix of DME codes subject to the savings. Overall, 21.6% of NHE-I and over half of the NHE-W and CW DME claims dollars were for incontinence supply codes subject to the reduction. Savings on this subset are 30.4% to 33.8%%

This results in adjustment factor reduction that ranges from 6.6% to 17.0%.

Lab fee adjustment

The Virginia General Assembly approved budget includes a 12% reduction to lab fees ($2.1 million in FFS savings) effective July 1, 2014. The 12% reduction was chosen to match the payment rates

already in place for the Medallion 3.0 plans. Therefore, this adjustment is applied to any rates based on FFS claims data, including the CCC dual population.

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 could reduce the physician payment to an all-inclusive rate of $22.06 for the code 99283 instead of paying the physician fee of $43.57 plus ancillaries. Eliminating the ER Triage review will increase the Level III ER payment to physicians by the difference in the triage amount and the physician fee for 99283plus the average amount of ancillary services billed on those claims.

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 FFS data was analyzed in order to identify the number of Level III ER claims paid at the ER Triage level and was re-priced to reflect DMAS FFS average cost of a Level III professional claim paid in full at $43.57. Triage claims repriced to Level III claims for CW is approximately $12,691. There were very few triage claims for NHE-W and NHE-I. When repriced to Level III, the estimated increase is $1,100. The adjustment is very small because Medicare is the primary payer for the vast majority of ER claims.

The ER Triage adjustment is 0.07% on the NHE-I, 0.01% on NHE-W and 0.45% on CW and is applied to the Physician – Other Practitioner, Physician - PCP, and Physician – Specialist claims.

RBRVS rebasing adjustment

Each year DMAS adjusts physician rates consistent with the Medicare RBRVS update in a budget neutral manner based on funding. Up until recently, the update was based solely on DMAS FFS data. Plans reported that the rebasing is not cost neutral to their operations and that the impact on them varies. Therefore, the analysis was revised and the DMAS update now uses both FFS and MCO data. The FY 2017 DMAS analysis used 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 FY17 result in a 0.6% increase to the FFS experience. Other codes, such as 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 FFS professional fee adjustment is approximately 0.6% for NHE-I, NHE-W and CW.

Home Health and Rehab adjustment

Effective July 1, 2016, there is an increase to the fee schedule for home health care and outpatient rehabilitation agencies. The inflation adjustments are a 1.7% increase to home health care and a 2.1% increase to outpatient rehabilitative agency. DMAS provided a list of outpatient rehabilitative procedure codes and the provider class subject to the fee schedule inflation adjustment. The identified claims are under Physician – Other practitioner service line.

The calculation results in adjustment factors of 0.0% on the NHE-I, 0.9% on NHE-W and 0.8% on CW applied to home health services claims and 0.02% on the NHE-I, 0.01% on NHE-W and 0.03% on CW applied to Physician – Other Practitioner claims.

Non-emergency transportation adjustment

Non-emergency transportation (NET) services were contracted to a broker during the historical data period under a capitated payment methodology, and utilization is not captured in the DMAS FFS claims. The non-emergency transportation adjustment is based on the full cost, including both the service and administrative costs, of the accepted transportation vendor bid that was effective January 1, 2016. The non-emergency transportation adjustment is calculated separately for the Nursing Home Eligible – Institutional (NHE-I), Nursing Home Eligible – Waiver (NHE-W) and Community Well (CW) populations.

The accepted bid for the ABAD nursing home population who reside in the nursing facility (NHE-I) is a statewide rate of $82.46 PMPM and the bid for the ABAD age over 21 population (NHE-W and CW) is a statewide rate of $31.80 PMPM. These rates are added to the overall cost for each sub-population.

DMAS FFS administrative adjustment

The 0.49% administrative factor is the estimated cost of DMAS staff and monitoring activities for the existing FFS programs that will be transferred to the participating health plans. The percentage is based on the estimated percentage cost of Medicare claims processing included in the Medicare standardized FFS county rates as a proxy for DMAS claims processing costs and the DMAS estimate of Medicaid administrative cost for prior authorizations attributed to the dual eligibles who participate in the Demonstration. Because Demonstration requirements mandate that only current Medicaid expenditures related to the eligible population may be included in the capitation payments, there is no adjustment for costs related to administrative functions that the health plans will perform but are not currently performed by DMAS.

Trend Adjustments

The data used for the incurred by not reported (IBNR) and trend calculations reflect experience for the period FY 2012 through FY 2014. Data for FY 2013 to FY 2014 are used to evaluate the base period trend and an additional year of data, FY 2012 with run out through FY 2015, are used to develop contract period projected trend.

For services with fee increases reflected in the adjustments described in the previous section, the contract period trend is in addition to the planned cost per unit increase. The trend rates used reflect utilization and rate increases when additional legislative cost increases or decreases have been applied and represent PMPM increases otherwise. Specifically, the trend models are adjusted for the fee increases or decreases that occurred during the historical base period. Adjustments to the historical data before the analysis of trend were applied to both the Nursing Home Eligible and the Community Well trends and are presented in the following table.

Table 2. Summary of Adjustments to Trend		
Category of Service	**Time Period**	**Adjustment**
HCBS	Jul 2012 – Jun 2013	0.990 ALL
	Jul 2013 – Jul 2015	0.990 NHE-I 0.987 NHE-W 0.990 CW
Mental Health / Substance Abuse	Dec 2013 – Jul 2015	1.239 NHE-I 1.000 NHE-W 1.043 CW
Ancillary/Other	Jul 2012 – Dec 2013	0.988 NHE-I 1.000 NHE-W 0.996 CW
	Jan 2014 – June 2014	1.038 NHE-I 1.273 NHE-W 1.264 CW
	Jul 2014 – Jul 2015	1.072 NHE-I 1.303 NHE-W 1.295 CW

Annual trend rates must be applied to move the historical data from the midpoint of the data period (July 1, 2013) to the midpoint of the contract period (June 30, 2016), for a total trend of 48 months.

The following tables show the IBNR and trend factors that have been applied to the adjusted historical base data for the data and contract phases and separately for each sub-population. Calculation of applied trend incorporates patient payments for nursing facility and HCBS services. The cost and utilization of drugs that are now covered under Medicare Part D were removed from the pharmacy contract period trend development. Review of the residual Medicaid only Inpatient, Outpatient/ER, showed substantial fluctuation on a small utilization base for all the sub-populations. These Medicaid only data and contract period trends have been set to equal the trends developed for the ABAD population in the Medallion 3.0 program. All other data period and contract period trend values use the CCC Duals data.

The data used for the CY 2017 CCC trend calculations is the same as the data used for the second year of the Duals Demonstration. Therefore, the months of contract period trend applied was extended from 24 months to 36 months.

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Table 3. Summary of IBNR Adjustments			
Category of Service	**NHE - Institutional**	**NHE - Waiver**	**Community Well**
Inpatient	0.1%	0.0%	0.3%
Outpatient/ER	0.0%	0.0%	0.5%
Physician/Professional	0.0%	0.0%	0.0%
Pharmacy	0.0%	0.0%	0.0%
Nursing Facility	0.0%	0.0%	0.0%
HCBS/Home Health Care	0.0%	n/a	0.0%
HCBS/Home Health Care – CD Only	n/a	0.0%	n/a
HCBS/Home Health Care - without CD	n/a	0.0%	n/a
Mental Health/ Substance Abuse	0.0%	0.0%	0.0%
Ancillary/Other	0.0%	0.0%	0.0%
Medicare Crossover	-0.2%	0.0%	0.0%
Weighted Average	**0.0%**	**0.0%**	**0.0%**

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Table 4. Summary of Trend Adjustments			
	NHE - Institutional	**NHE - Waiver**	**Community Well**
Category of Service	Total Trend Factor	Total Trend Factor	Total Trend Factor
Inpatient	1.1218	1.1218	1.1218
Outpatient/ER	1.0909	1.0909	1.0909
Physician/ Professional	1.4211	1.5524	0.8480
Pharmacy	0.9390	0.9610	0.8640
Nursing Facility	1.0075	1.0075	0.9590
HCBS/ Home Health Care	1.1456	n/a	0.9396
HCBS/Home Health Care – CD only	n/a	1.6318	n/a
HCBS/Home Health Care - without CD	n/a	0.9890	n/a
Mental Health/ Substance Abuse	0.9710	1.3057	1.1583
Ancillary/Other	0.8810	1.0660	1.1503
Medicare Crossover	1.0683	1.0118	1.2173
Weighted Average	**1.0086**	**1.1382**	**1.1353**

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Blended Nursing Home Eligible Medicaid Capitation Rates and the Member Enrollment Mix Adjustment

The NHE population is a combination of the NHE-Institutional and the NHE-Waiver populations. The adjusted and trended rates for these two populations are blended using the eligible member month distribution for June 2016 of 40% NHE-I and 60% NHE-W.

Table 5 presents the NHE blended rates effective January 1, 2017 – December 31, 2017. The blended NHE rates will be revised over the period of the Demonstration to pay health plan specific rates within each region that reflect the actual proportion of NHE-I and NHE-W members enrolled in each plan. This Member Enrollment Mix Adjustment (MEMA) adjustment is intended to minimize the risk due to actual plan enrollment that diverges from the Demonstration population average mix for any one plan and to adjust to the changes in enrollment mix over the course of the Demonstration. DMAS has adopted the MEMA policy recommendations described in a memo dated September 30, 2013. It is available on the DMAS website at http://www.dmas.virginia.gov/Content_atchs/altc/cntct-mmfa_cr3.pdf.

Table 5. CY 2017 Blended Nursing Home Eligible-Institutional and Nursing Home Eligible-Waiver

Sub-Population	**Age Group**	Central Virginia	Northern Virginia	Southwest/ Roanoke	Tidewater	Western/ Charlottes-ville	**CY 2017 Average**
Nursing Home Eligible-Institutional	Age 21-64	$5,127.91	$6,363.09	$5,255.47	$5,165.31	$4,668.12	$5,308.65
	Age 65+	$5,195.17	$6,237.49	$5,004.60	$5,010.85	$5,035.80	$5,249.15
Nursing Home Eligible-Waiver	Age 21-64	$2,694.24	$3,461.16	$2,566.86	$2,661.89	$2,646.53	$2,749.99
	Age 65+	$2,508.27	$3,453.64	$2,330.71	$2,457.68	$2,256.99	$2,753.78
Nursing Home Eligible	Age 21-64	$3,240.85	$4,290.76	$3,196.67	$3,237.42	$3,133.74	$3,357.14
	Age 65+	$3,773.78	$4,213.63	$3,962.93	$3,578.42	$3,737.81	$3,865.72
	Average	$3,648.70	$4,223.71	$3,778.60	$3,493.61	$3,594.70	$3,755.53

Note: Weighted Averages are based on June 2016 Member Month Distribution.

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Base Medicaid Capitation Rates

The CY17 base capitation rates for the blended NHE and CW prior to the third year savings adjustment are presented in Table 6.

Table 6. CY 2017 Dual Demonstration Base Capitation Rates Prior to 2% Savings and 3% Quality Withhold

Sub-Population	Age Group	Central Virginia	Northern Virginia	Southwest/ Roanoke	Tidewater	Western/ Charlottes-ville	**CY 2017 Average**
Nursing Home Eligible*	Age 21-64	$3,240.85	$4,290.76	$3,196.67	$3,237.42	$3,133.74	$3,357.14
	Age 65+	$3,773.78	$4,213.63	$3,962.93	$3,578.42	$3,737.81	$3,865.72
	Average	$3,648.70	$4,223.71	$3,778.60	$3,493.61	$3,594.70	$3,755.53
Community Well	Age 21-64	$415.54	$340.72	$429.64	$346.85	$269.84	$377.40
	Age 65+	$237.06	$150.11	$291.04	$219.63	$234.51	$199.62
	Average	$328.90	$184.02	$373.84	$284.21	$253.48	$273.98
Weighted Average		**$1,768.51**	**$1,405.93**	**$1,883.34**	**$1,582.36**	**$1,745.69**	**$1,643.24**

Note: Weighted Averages are based on June 2016 Member Month Distribution

*NHE rates will be adjusted by MEMA calculations over the time period of the Demonstration.

MOU Savings Adjustment

The MOU signed by the Commonwealth of Virginia and the Centers for Medicare and Medicaid Services establishes annual savings assumptions for the Virginia Medicare-Medicaid Financial Alignment Demonstration. First year savings, to cover the period CY 2014 and CY 2015, were 1%. The original MOU established CY 2016 savings at 2% and CY 2017 savings at 4%. However, DMAS submitted a request to CMS that the CY 2016 savings adjustment remain at 1% rather than increase to 2%, as in the terms of the original MOU. In early January 2016, CMS notified DMAS that it approved the reduction to the savings adjustment. As a result, the CY 2016 savings adjustment remained at 1% and is 2% for CY 2017.

The third year MOU savings of 2% is included in the Medicaid component of the capitation rates.

Quality Withhold adjustment

The actual rates paid monthly to the health plans equal the final rates minus a quality withhold. Plans may earn back the "withheld" amount if they fully meet the quality criteria. There are two additional exhibits to reflect the quality withhold adjustment and the monthly rates that will actually be paid to the MMPs. The quality withhold was 1% in Demonstration Year One (2014-2015), 2% in Demonstration Year Two (2016) and will be 3% in Demonstration Year Three (2017).

The quality withhold adjustment for 2017 of 3% is included in the Medicaid component of the capitation rates

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Summary Capitation Rates

The resulting Medicaid capitation rates for CY 2017 are presented in Table 7. These incorporate the 2% third year savings and the 3% quality withhold. All averages are weighted by the distribution of member months in June 2016.

The NHE Age 21-64 and Age 65 and Over regional blended rates will be revised during the year. DMAS will apply the MEMA as measured by enrollment effective January and July 2017. These MEMA adjustments will be health plan specific by region and establish rates for the remainder of the calendar year.

Table 7. CY 2017 Dual Demonstration Capitation Rates with 2% Savings and 3% Quality Withhold

Sub-Population	**Age Group**	Central Virginia	Northern Virginia	Southwest/ Roanoke	Tidewater	Western/ Charlottes-ville	**CY 2017 Average**
Nursing Home Eligible*	Age 21-64	$3,080.75	$4,078.80	$3,038.75	$3,077.50	$2,978.94	$3,191.30
	Age 65+	$3,587.36	$4,005.48	$3,767.16	$3,401.65	$3,553.17	$3,674.75
	Average	$3,468.46	$4,015.06	$3,591.94	$3,321.02	$3,417.12	$3,570.01
Community Well	Age 21-64	$395.01	$323.89	$408.42	$329.71	$256.51	$358.75
	Age 65+	$225.35	$142.70	$276.66	$208.78	$222.93	$189.76
	Average	$312.65	$174.93	$355.38	$270.17	$240.96	$260.44
Weighted Average		**$1,681.15**	**$1,336.48**	**$1,790.30**	**$1,504.20**	**$1,659.46**	**$1,562.06**

Note: *NHE rates will be adjusted by MEMA calculations over the time period of the Demonstration.

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A list of the Demonstration counties by region follows in Table 8.

Table 8. Dual Demonstration County Listing by Region

Phase	Region	County		
Phase I	Central Virginia	Amelia County Brunswick County Caroline County Charles City County Chesterfield County Colonial Heights City Cumberland County Dinwiddie County Emporia City Essex County Franklin City Fredericksburg City Goochland County	Greensville County Hanover County Henrico County Hopewell City King George County King William County King and Queen County Lancaster County Lunenburg County Mecklenburg County Middlesex County New Kent County	Northumberland County Nottoway County Petersburg City Powhatan County Prince Edward County Prince George County Richmond City Richmond County Southampton County Spotsylvania County Stafford County Surry County Sussex County Westmoreland County
	Tidewater	Accomack County Chesapeake City Gloucester County Hampton City Isle of Wight County James City County	Matthews County Newport News City Norfolk City Northampton County Poquoson City Portsmouth City	Suffolk City Virginia Beach City Williamsburg City York County
Phase II	Northern Virginia	Alexandria City Arlington County Culpeper County Fairfax City	Fairfax County Falls Church City Fauquier County Loudoun County	Manassas City Manassas Park City Prince William County
	Southwest/ Roanoke	Alleghany County Bath County Bedford City Bedford County Botetourt County Buena Vista City Covington City Craig County	Floyd County Franklin County Giles County Henry County Highland County Lexington City Martinsville City Montgomery County	Patrick County Pulaski County Radford City Roanoke City Roanoke County Rockbridge County Salem City Wythe County
	Western/ Charlottesville	Albemarle County Augusta County Buckingham County Charlottesville City Fluvanna County	Greene County Harrisonburg City Louisa County Madison County Nelson County	Orange County Rockingham County Staunton City Waynesboro City

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III. Medicare Components of the Rate – CY 2017

Medicare A/B Services

CMS has developed baseline spending (costs absent the Demonstration) for Medicare A and B services using estimates of what Medicare would have spent on behalf of the enrollees absent the Demonstration. With the exception of specific subsets of enrollees as noted below, the Medicare baseline for A/B services is a blend of the Medicare Fee-for-Service (FFS) Standardized County Rates, as adjusted below, and the Medicare Advantage projected payment rates for each year, weighted by the proportion of the target population that would otherwise be enrolled in each program in the absence of the Demonstration. The Medicare Advantage baseline spending includes costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans.

Both baseline spending and payment rates under the Demonstration for Medicare A/B services are calculated as PMPM standardized amounts for each Demonstration county. Except as otherwise noted, the Medicare A/B portion of the baseline is updated annually based on the annual FFS estimates and benchmarks released each year with the annual Medicare Advantage and Part D rate announcement, and Medicare Advantage bids (for the applicable year or for prior years trended forward to the applicable year) for products in which potential Demonstration enrollees would be enrolled absent the Demonstration.

Medicare A/B Baseline Incorporating Medicare A/B FFS Baseline and Medicare Advantage Component: CY 2017 Medicare A/B Baseline County rates are provided below.

The rates represent the weighted average of the CY 2017 FFS Standardized County Rates, updated to incorporate the adjustments noted below, and the Medicare Advantage projected payment rates for CY 2017, based on the expected enrollment of beneficiaries from Medicare FFS and Medicare Advantage prior to the demonstration start at the county level.

Please Note: *In CY 2016, CMS updated the Medicare A/B baseline rate to better align Commonwealth Coordinated Care program Plan payments with Medicare fee-for-service costs, by offsetting underprediction in the CMS-HCC risk adjustment model for full-benefit dual eligible beneficiaries in the community. In CY 2017 CMS will implement a new HCC risk adjustment model across all of Medicare Advantage, as well as for Medicare-Medicaid Plans, that will increase risk scores for community full-benefit dual eligible beneficiaries in order to address this underprediction issue. As a result, CMS will not be making such an adjustment to the FFS component of the Medicare A/B baseline in 2017. While this means that the standardized (non-risk adjusted) rates generally decline from CY 2016 to CY 2017, we expect these decreases will be offset by implementation of the new risk adjustment model.*

Applying the Savings Percentage: The savings percentage (2% in Demonstration Year Three) described in Section IV is applied to the final Medicare A/B baseline (blending the final Medicare A/B FFS baseline and the Medicare Advantage rate components).

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Medicare A/B Component Payments: CY 2017 Medicare A/B Baseline County rates are provided below.

The FFS component of the CY 2017 Medicare A/B baseline rate has been updated to reflect a 1.74% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS (in the absence of the Demonstration).

Coding Intensity Adjustment: CMS annually applies a coding intensity factor to Medicare Advantage risk scores to account for differences in diagnosis coding patterns between the Medicare Advantage and the Original Fee-for-Service Medicare programs. The adjustment for CY 2017 in Medicare Advantage is 5.66%. For 2017, CMS will apply the full prevailing Medicare Advantage coding intensity adjustment and there is no upward adjustment to the Medicare A/B baseline rates to offset this reduction in the risk scores.

Impact of Sequestration: Under sequestration, for services beginning April 1, 2013, Medicare payments to providers for individual services under Medicare Parts A and B, and non-exempt portions of capitated payments to Part C Medicare Advantage Plans and Part D Medicare Prescription Drug Plans are reduced by 2%. These reductions are also applied to the Medicare components of the integrated rate. Therefore, under this Demonstration CMS will reduce non-exempt portions of the Medicare components of the integrated rate by 2%, as noted in the sections below.

Default Rate: The default rate will be paid when a beneficiary's address on record is outside of the service area. The default rate is specific to each Participating Plan and is calculated using an enrollment-weighted average of the rates for each county in which the Demonstration Plan participates.

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Albemarle	$718.16	$730.66	$731.71	$717.08	$702.74
Alexandria City	798.52	812.41	812.44	796.20	780.28
Alleghany	705.62	717.90	718.50	704.13	690.05
Amelia	849.07	863.84	862.62	845.37	828.46
Arlington	716.06	728.52	729.13	714.55	700.26
Augusta	712.35	724.74	729.32	714.73	700.44
Bath	1023.62	1041.43	1041.43	1020.60	1000.19
Bedford City	712.10	724.49	725.46	710.95	696.73
Bedford	713.35	725.76	726.26	711.74	697.51
Botetourt	712.24	724.63	733.84	719.16	704.78
Brunswick	734.70	747.48	748.72	733.75	719.08
Buckingham	723.43	736.02	737.11	722.37	707.92
Buena Vista City	665.81	677.40	678.69	665.12	651.82
Caroline	782.79	796.41	796.41	780.48	764.87
Charles City	718.98	731.49	735.53	720.83	706.41
Charlottesville City	697.39	709.52	710.51	696.29	682.36
Chesapeake City	761.46	774.71	777.94	762.37	747.12
Chesterfield	770.95	784.36	786.70	770.96	755.54
Colonial Heights City	771.74	785.17	785.83	770.11	754.71
Covington City	727.57	740.23	740.23	725.42	710.91
Craig	726.10	738.73	738.73	723.96	709.48
Culpeper	792.05	805.83	805.83	789.72	773.93
Cumberland	715.13	727.57	733.22	718.56	704.19
Dinwiddie	781.78	795.38	796.03	780.11	764.51
Emporia City	745.80	758.78	760.17	744.96	730.06
Essex	781.91	795.52	795.52	779.61	764.02
Fairfax City	748.60	761.63	761.63	746.40	731.47

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Fairfax	$745.03	$757.99	$758.71	$743.54	$728.67
Falls Church City	758.00	771.19	770.25	754.84	739.74
Fauquier	791.12	804.89	804.89	788.79	773.01
Floyd	693.20	705.26	708.78	694.61	680.72
Fluvanna	711.90	724.29	725.44	710.93	696.71
Franklin City	797.65	811.53	811.07	794.85	778.95
Franklin	708.51	720.84	730.71	716.10	701.78
Fredericksburg City	874.85	890.07	890.07	872.27	854.82
Giles	704.04	716.29	716.29	701.96	687.92
Gloucester	709.66	722.01	728.32	713.75	699.48
Goochland	771.60	785.03	787.14	771.40	755.97
Greene	726.65	739.29	741.13	726.31	711.78
Greensville	791.87	805.65	810.11	793.91	778.03
Hampton City	776.66	790.17	794.64	778.75	763.18
Hanover	780.99	794.58	797.08	781.13	765.51
Harrisonburg City	697.80	709.94	710.21	696.01	682.09
Henrico	790.85	804.61	807.77	791.61	775.78
Henry	716.22	728.68	734.54	719.85	705.45
Highland	745.69	758.67	758.67	743.50	728.63
Hopewell City	826.94	841.33	839.16	822.38	805.93
Isle of Wight	760.97	774.21	783.74	768.06	752.70
James City	736.14	748.95	752.12	737.08	722.34
King and Queen	733.49	746.25	746.25	731.33	716.70
King George	828.38	842.79	842.79	825.94	809.42
King William	786.01	799.69	800.36	784.35	768.66
Lancaster	689.38	701.38	703.37	689.30	675.51
Lexington City	715.64	728.09	728.09	713.53	699.26

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Loudoun	$736.21	$749.02	$749.88	$734.88	$720.18
Louisa	716.29	728.75	734.07	719.39	705.00
Lunenburg	713.09	725.50	725.50	710.99	696.77
Madison	706.38	718.67	718.67	704.30	690.21
Martinsville City	695.94	708.05	714.72	700.42	686.41
Manassas City	728.96	741.64	741.64	726.81	712.27
Manassas Park City	768.86	782.24	782.24	766.60	751.27
Mathews	720.04	732.57	738.43	723.66	709.19
Mecklenburg	715.99	728.45	731.62	716.99	702.65
Middlesex	716.19	728.65	729.72	715.12	700.82
Montgomery	709.02	721.36	724.40	709.91	695.71
Nelson	735.87	748.67	749.02	734.03	719.35
New Kent	777.81	791.34	788.42	772.66	757.21
Newport News City	768.66	782.03	789.00	773.23	757.77
Norfolk City	755.53	768.68	776.70	761.17	745.95
Northampton	722.01	734.57	735.99	721.27	706.84
Northumberland	714.47	726.90	727.87	713.31	699.04
Nottoway	740.21	753.09	755.07	739.97	725.17
Orange	755.23	768.37	768.45	753.08	738.02
Patrick	746.26	759.24	760.76	745.55	730.64
Petersburg City	787.57	801.27	804.77	788.68	772.91
Portsmouth City	705.99	718.27	730.14	715.53	701.22
Poquoson City	777.14	790.66	791.25	775.43	759.92
Powhatan	780.63	794.21	794.89	778.99	763.41
Prince Edward	747.50	760.51	760.85	745.64	730.73
Prince George	813.56	827.72	827.72	811.17	794.95
Prince William	769.18	782.56	783.77	768.10	752.74

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2017 Medicare A/B Baseline PMPM, Non-ESRD Beneficiaries, Standardized 1.0 Risk Score, by Demonstration County[1]					
County	**2017 Published FFS Standardized County Rate**	**2017 Updated Medicare A/B FFS Baseline** (updated by CY 2017 bad debt adjustment)	**2017 Updated Medicare A/B Baseline** (incorporating updated Medicare A/B FFS baseline and Medicare Advantage component)	**2017 Medicare A/B Baseline PMPM, Savings Percentage Applied** (after application of 2% savings percentage)	**2017 Final Medicare A/B PMPM Payment** (2% sequestration reduction applied and prior to quality withhold)
Pulaski	$764.40	$777.70	$777.65	$762.09	$746.85
Radford City	748.57	761.60	762.02	746.79	731.85
Richmond	741.16	754.06	756.00	740.88	726.06
Richmond City	765.77	779.09	787.35	771.60	756.17
Roanoke	747.91	760.92	768.13	752.77	737.71
Roanoke City	714.98	727.42	737.25	722.51	708.06
Rockbridge	673.98	685.71	685.71	671.99	658.55
Rockingham	706.08	718.37	720.39	705.98	691.86
Salem City	710.82	723.19	728.29	713.72	699.45
Southampton	708.64	720.97	726.18	711.65	697.42
Spotsylvania	844.47	859.16	858.91	841.73	824.90
Stafford	853.59	868.44	868.17	850.81	833.79
Staunton City	723.06	735.64	737.46	722.71	708.26
Suffolk City	731.51	744.24	751.53	736.50	721.77
Surry	763.79	777.08	777.08	761.54	746.31
Sussex	758.23	771.42	771.42	756.00	740.88
Virginia Beach City	769.46	782.85	787.33	771.59	756.16
Waynesboro City	718.16	730.66	733.31	718.65	704.28
Westmoreland	797.96	811.84	811.84	795.61	779.70
Williamsburg City	727.74	740.40	740.40	725.59	711.08
Wythe	750.66	763.72	765.11	749.81	734.81
York	761.69	774.94	779.14	763.55	748.28

[1] Rates do not apply to beneficiaries with End-Stage Renal Disease (ESRD) or those electing the Medicare hospice benefit. See Section IV for information on savings percentages.

Note: For CY 2017 CMS will apply the full prevailing Medicare Advantage coding intensity adjustment of 5.66%.

The Medicare A/B PMPMs above will be risk adjusted at the beneficiary level using the prevailing CMS-HCC risk adjustment model.

Beneficiaries with End-Stage Renal Disease (ESRD): Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment are excluded from the Demonstration; however, an individual who develops ESRD while enrolled in the Demonstration will remain in the Demonstration, unless he/she opts out.

Separate Medicare A/B baselines and risk adjustment models apply to enrollees with ESRD. The Medicare A/B baselines for beneficiaries with ESRD vary by the enrollee's ESRD status: dialysis, transplant, and functioning graft, as follows:

- **Dialysis**: For enrollees in the dialysis status phase, the Medicare A/B baseline is the CY 2017 Virginia ESRD dialysis state rate, updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for Virginia is $6,581.56 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,449.93 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.

- **Transplant**: For enrollees in the transplant status phase (inclusive of the 3-months starting with the transplant), the Medicare A/B baseline is the CY 2017 Virginia ESRD dialysis state rate updated to incorporate the impact of sequestration-related rate reductions. The CY 2017 ESRD dialysis state rate for Virginia is $6,581.56 PMPM; the updated CY 2017 ESRD dialysis state rate incorporating a 2% sequestration reduction and prior to the application of the quality withhold is $6,449.93 PMPM. This applies to applicable enrollees in all counties and will be risk adjusted using the prevailing HCC-ESRD risk adjustment model.

- **Functioning Graft:** For enrollees in the functioning graft status phase (beginning at 4 months post-transplant) the Medicare A/B baseline is the Medicare Advantage 3.5% bonus county rate/benchmark (see table below). This Medicare A/B component will be risk adjusted using the prevailing HCC-ESRD functioning graft risk adjustment model.

A savings percentage will not be applied to the Medicare A/B baseline for enrollees with ESRD (inclusive of those enrollees in the dialysis, transplant and functioning graft status phases).

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County	**2017 3.5% Bonus County Rate (Benchmark)**	**2017 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Albemarle	$776.22	$760.70
Alexandria City	826.47	809.94
Alleghany	809.70	793.51
Amelia	878.79	861.21
Arlington	848.53	831.56
Augusta	791.22	775.40
Bath	1,008.27	988.10
Bedford City	802.45	786.40
Bedford	799.34	783.35
Botetourt	844.00	827.12
Brunswick	792.34	776.49
Buckingham	775.95	760.43
Buena Vista City	788.98	773.20
Caroline	810.19	793.99
Charles City	851.99	834.95
Charlottesville City	777.27	761.72
Chesapeake City	845.22	828.32
Chesterfield	855.75	838.64
Colonial Heights City	856.63	839.50
Covington City	800.91	784.89
Craig	860.43	843.22
Culpeper	867.85	850.49
Cumberland	847.43	830.48
Dinwiddie	867.78	850.42
Emporia City	796.81	780.87
Essex	802.12	786.08
Fairfax City	885.99	868.27
Fairfax	826.98	810.44
Falls Church City	746.63	731.70
Fauquier	878.14	860.58
Floyd	801.19	785.17
Fluvanna	776.54	761.01
Franklin City	803.49	787.42
Franklin	839.58	822.79
Fredericksburg City	861.73	844.50
Giles	800.76	784.74

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County	**2017 3.5% Bonus County Rate (Benchmark)**	**2017 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Gloucester	$840.95	$824.13
Goochland	856.48	839.35
Greene	775.79	760.27
Greensville	938.37	919.60
Hampton City	889.21	871.43
Hanover	866.90	849.56
Harrisonburg City	799.46	783.47
Henrico	877.84	860.28
Henry	800.42	784.41
Highland	789.93	774.13
Hopewell City	855.88	838.76
Isle of Wight	888.22	870.46
James City	872.33	854.88
King and Queen	841.68	824.85
King George	836.66	819.93
King William	872.47	855.02
Lancaster	802.07	786.03
Lexington City	792.41	776.56
Loudoun	817.19	800.85
Louisa	848.80	831.82
Lunenburg	796.68	780.75
Madison	776.81	761.27
Martinsville City	802.92	786.86
Manassas City	863.82	846.54
Manassas Park City	768.86	753.48
Mathews	853.25	836.19
Mecklenburg	794.44	778.55
Middlesex	802.55	786.50
Montgomery	795.84	779.92
Nelson	775.33	759.82
New Kent	805.03	788.93
Newport News City	882.04	864.40
Norfolk City	883.54	865.87
Northampton	804.48	788.39
Northumberland	803.30	787.23
Nottoway	802.32	786.27
Orange	783.63	767.96

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2017 Medicare A/B Baseline PMPM, Beneficiaries with ESRD Functioning Graft Status, Standardized 1.0 Risk Score, by Demonstration County		
County	**2017 3.5% Bonus County Rate (Benchmark)**	**2017 Sequestration-Adjusted Medicare A/B Baseline** (after application of 2% Sequestration reduction)
Patrick	$796.19	$780.27
Petersburg City	874.20	856.72
Portsmouth City	836.60	819.87
Poquoson City	885.54	867.83
Powhatan	837.23	820.49
Prince Edward	799.06	783.08
Prince George	842.03	825.19
Prince William	853.79	836.71
Pulaski	802.88	786.82
Radford City	801.69	785.66
Richmond	803.94	787.86
Richmond City	882.02	864.38
Roanoke	885.09	867.39
Roanoke City	847.25	830.31
Rockbridge	794.29	778.40
Rockingham	798.21	782.25
Salem City	842.32	825.47
Southampton	803.03	786.97
Spotsylvania	874.03	856.55
Stafford	883.47	865.80
Staunton City	792.71	776.86
Suffolk City	839.41	822.62
Surry	847.81	830.85
Sussex	841.64	824.81
Virginia Beach City	882.96	865.30
Waynesboro City	787.88	772.12
Westmoreland	805.54	789.43
Williamsburg City	862.37	845.12
Wythe	802.05	786.01
York	887.91	870.15

Beneficiaries Electing the Medicare Hospice Benefit: If an enrollee elects to receive the Medicare hospice benefit, the enrollee will be disenrolled from the Demonstration

Medicare Part D Services

The Part D plan payment is the risk adjusted Part D national average monthly bid amount (NAMBA) for the payment year, adjusted for payment reductions resulting from sequestration applied to the non-premium portion of the NAMBA. The non-premium portion is determined by subtracting the applicable regional Low-Income Premium Subsidy Amount from the risk adjusted NAMBA. To illustrate, the NAMBA for CY 2017 is $61.08 and the CY 2017 Low-Income Premium Subsidy Amount for Virginia is $32.52. Thus, the updated Virginia Part D monthly per member per month payment for a beneficiary with a 1.0 RxHCC risk score applicable for CY 2017 is $60.51. This amount incorporates a 2% sequestration reduction to the non-premium portion of the NAMBA.

CMS will pay an average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts; these payments will be 100% cost reconciled after the payment year has ended. These prospective payments will be same for all counties, and are shown below.

- Virginia low income cost-sharing: $178.81 PMPM
- Virginia reinsurance: $103.74 PMPM

The low-income cost sharing and reinsurance subsidy amounts are exempt from mandatory payment reductions under sequestration.

A savings percentage will not be applied to the Part D component of the rate. Part D payments will not be subject to a quality withhold.

Additional Information: More information on the Medicare components of the rate under the Demonstration may be found online at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

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IV. Savings Percentages and Quality Withholds

Savings Percentages

One of the components of the capitated financial alignment model is the application of aggregate savings percentages to reflect savings achievable through the coordination of services across Medicare and Medicaid. This is reflected in the rates through the application of aggregate savings percentages to both the Medicaid and Medicare A/B components of the rates.

CMS and Virginia established composite savings percentages for each year of the Demonstration, as shown in the table below. The savings percentage will be applied to the Medicaid and Medicare A/B components of the rates, uniformly to all population groups, unless otherwise noted in this report. The savings percentage will not be applied to the Part D component of the joint rate.

Year	Calendar dates	Savings percentage
Demonstration Year 1	April 1, 2014 – December 31, 2015	1%
Demonstration Year 2	January 1 – December 31, 2016	1%
Demonstration Year 3	January 1 – December 31, 2017	2%

Quality Withhold

In Demonstration Year 1, a 1% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. In Demonstration Year 2, a 2% quality withhold will be applied to the Medicaid and Medicare A/B components of the rate. The quality withhold will increase to 3% in Demonstration Year 3.

More information about the DY 1 quality withhold methodology is available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf.

More information about the DY 2 and 3 quality withhold methodology is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY2and3QualityWithholdGuidance042916.pdf.