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Commonwealth of Virginia

FINAL Fiscal Year 2027 Cardinal Care Managed Care Rate Report

Acute, FAMIS, and MLTSS Populations

Rates Effective July 1, 2026

Contents

Section 1

Introduction

In partnership with the Commonwealth of Virginia (Commonwealth) Department of Medical Assistance Services (DMAS), Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, has developed actuarially sound[1] capitation rates for the Commonwealth's Cardinal Care Managed Care (CCMC) Acute population (hence forward referred to as Acute), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS populations, and Managed Long-Term Services and Supports population (hence forward referred to as MLTSS) for the 12-month period from July 1, 2026 through June 30, 2027 (fiscal year [FY] 2027).

Per 42 CFR §438.4, the Centers for Medicare & Medicaid Services (CMS) requires that actuarially sound rates meet several criteria for approval, including the following:

- Have been developed in accordance with generally accepted actuarial principles and practices.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Have been certified by actuaries who meet qualification standards established by the American Academy of Actuaries and the Actuarial Standards Board.

The following report provides an overview of the analyses and methodologies used to develop the FY2027 CCMC program capitation rates for purposes of satisfying these requirements. This report follows the currently available outline of the CMS July 2026 through June 2027 Medicaid Managed Care Rate Development Guide (RDG), which is applicable to contract periods beginning on or after July 1, 2026. The final base capitation rates by rate cell are included in Exhibit 6.

This report is the result of collaboration between DMAS and Mercer. It should be read in its entirety and has been prepared under the direction of Brad Diaz, FSA, MAAA; Roger Figueroa, FSA, MAAA; and Selina Gilbertson, FSA, MAAA, who are members of the American Academy of Actuaries and meet its US Qualification Standard for issuing the statements of actuarial opinion herein.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use.

[1] Actuarially sound/actuarial soundness — Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees and taxes.

Section 2

General Information

Program Background

The Virginia Medicaid managed care program has provided health care coverage to Medicaid recipients since 1992. The CCMC program is a fully capitated, risk-based Medicaid managed care program that is mandatory statewide for the Acute, FAMIS, and MLTSS populations.

As of the date of this report, there will be five managed care organizations (MCOs) operating in the managed care program: Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Humana Healthy Horizons in Virginia, Sentara Health Plans, and UnitedHealthcare of the Mid-Atlantic, Inc.

Covered Populations

To be eligible for enrollment within the Acute population covered by a CCMC MCO, individuals must be Non-Dual eligible (i.e., Medicaid only) and meet the criteria defined in the contract[2] between the Commonwealth and the MCOs. The Acute population covered by the CCMC program includes those who are:

- Low-Income Families and Children (LIFC)
- Adoption Assistance (AA)
- Foster Care (FC)
- Members with comprehensive private insurance or third-party liability (TPL) as a primary payer (Major TPL)

The CCMC program includes coverage for Modified Adjusted Gross Income Adult Medicaid Expansion population with income levels up to 138% of the federal poverty level (FPL). New adult enrollees who are eligible for managed care are assigned to one of two existing managed care cohorts based on their medical complexity. The Commonwealth has developed an MCO Member Health Screening tool that identifies new entrants who are determined to be non-Medically Complex. These members are enrolled in the Acute population and all others are enrolled in MLTSS population.

Individuals who do not qualify for the CCMC program, due to higher FPL requirements, may be eligible for enrollment in the FAMIS and FAMIS MOMS program.

To be eligible for enrollment within the MLTSS population covered by a CCMC MCO, individuals must be either Dual-eligible or Non-Dual eligible (i.e., Medicaid only), and must

[2] https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/

meet the criteria defined in the contract between the Commonwealth and the MCOs. The MLTSS populations covered by the CCMC program include those who:

- Receive Medicare benefits and full Medicaid benefits (Dual-eligible).
- Receive Medicaid Long-Term Services and Supports (LTSS) in a facility or through one of the following home- and community-based waivers: Building Independence, MLTSS, Community Living, or Family and Individual Supports. The Community Living, the Family and Individual Supports, and Building Independence waivers are collectively known as the developmental disabilities (DD) waivers. Populations in intermediate care facilities for the intellectually disabled and state government owned nursing homes (NHs) are currently excluded.
- Are eligible in the aged, blind, and disabled (ABD) Medicaid coverage groups. Individuals in psychiatric residential treatment facilities are currently excluded.
- Any of the populations listed above with comprehensive private insurance or Major TPL are also included.

Dual-eligible members enrolled in the MLTSS population may receive their Medicare benefits from the Contractor's companion Dual-Eligible Special Needs Plan, Medicare Fee-for-Service (FFS), or through another Medicare Advantage Plan. The providers for the MLTSS population are required to submit claims directly to Medicare for services that are covered by Medicare FFS, otherwise these claims are submitted to the Medicare managed care plan. Costs for services that are covered by Medicare are included in the plans' separate Medicare premium and are not included in the rates described in this rate report. These MLTSS rates do reflect costs for any member cost sharing related to these Medicare-covered services, as applicable.

Covered Services

The CCMC program covers acute, behavioral health, and pharmacy services for the Acute, FAMIS, and MLTSS populations, as well as institutional and community-based LTSS services exclusively for the MLTSS population. For a full list of covered services, please refer to the *Covered Services* section of the approved managed care contract.

Services Excluded

Any State Plan services that are not included in the CCMC program benefit package and are provided to enrollees on a FFS basis have been excluded from this rate report. Excluded services are primarily dental services, school-based services, therapeutic group home services, and treatment foster care case management.

MLTSS individuals enrolled in the DD waivers are enrolled for their non-waiver services only. DD waiver services will continue to be covered through Medicaid FFS.

Rate Structure

The rates paid to the CCMC MCOs vary depending on the member's rate cell and/or region. There is a separate one-time kick payment for delivery events. The FY2027 reimbursement structure pays a combined Non-TPL/Major TPL rate for all rate cells.

The following table outlines the rate cells and reimbursement structure effective during FY2027.

Rate Cell Structure

Population	Rate Cell	Description	TPL Category	Age	Geography
Acute	LIFC		Non-TPL/ Major TPL blended	Age Under 1, Child (Ages 1–20), Adult (Age 21+)	Regional Capitation
Acute	AA		Non-TPL/ Major TPL blended	Children Under Age 21	Statewide Capitation
Acute	FC		Non-TPL/ Major TPL blended	Children Under Age 21	Statewide Capitation
Acute	Expansion Medically Non-Complex		Non-TPL/ Major TPL blended	Ages 19–64	Regional Capitation
Acute and FAMIS	Maternity Kick – Acute		Non-TPL/ Major TPL blended	All Ages	Statewide Delivery Payment
FAMIS	FAMIS Under 1		Non-TPL/ Major TPL blended	Age Under 1	Statewide Capitation
FAMIS	FAMIS Child		Non-TPL/ Major TPL blended	Ages 1–18	Statewide Capitation
FAMIS	FAMIS MOMS		Non-TPL/ Major TPL blended	Pregnant Women of Any Age	Statewide Capitation
MLTSS	Blended NH/Home- and Community-Based Services (HCBS) waiver	Nursing facility (NF) and waiver HCBS subpopulation (Meet nursing facility level of care [NF LOC])	Dual (includes Medicare Part A or B)	All Ages	Regional Capitation
			Non-Dual (includes Major, Minor or No TPL)		

Population	Rate Cell	Description	TPL Category	Age	Geography
MLTSS	DD waiver	DD waiver population	Dual (includes Medicare Part A or B)	All Ages	Statewide Capitation
			Non-Dual (includes Major, Minor or No TPL)		
MLTSS	HCBS with Private Duty Nursing (PDN) waiver	Waiver HCBS with PDN (Meet Specialized NF LOC for Technology Dependent)	Dual and Non-Dual	All Ages	Statewide Capitation
MLTSS	Community No LTSS	ABD population	Dual (includes Medicare Part A or B)	Age Under 65	Regional Risk-Adjusted Capitation
				Age 65 and Over	
			Non-Dual (includes Major, Minor or No TPL)	Age Under 1	Statewide Capitation
				Age 1 and Over	Regional Risk-Adjusted Capitation
MLTSS	Expansion Medically Complex	Expansion No LTSS population	Non-TPL/ Major TPL blended	Ages 19–64	Regional Capitation
MLTSS	Maternity Kick – MLTSS		All	All Ages	Statewide Delivery Payment

Maternity Kick payments are separate from the monthly capitation rates paid for non-maternity services. The Maternity Kick payment reimburses the MCOs for their inpatient and professional benefits associated with a live birth. A delivery event is defined based on the following surgical procedure codes:

- 10D00Z0: Classical C-Section
- 10D00Z1: Low Cervical C-Section
- 10D00Z2: Extraperitoneal C-Section
- 10D07Z3: Low Forceps Vaginal Delivery
- 10D07Z4: Mid-Forceps Vaginal Delivery

- 10D07Z5: High Forceps Vaginal Delivery
- 10D07Z6: Vacuum Vaginal Delivery
- 10D07Z7: Internal Version for Vaginal Delivery
- 10D07Z8: Other Vaginal Delivery
- 10E0XZZ: Delivery, products of conception, external, no device, no qualifier

The Maternity Kick payment is developed on a statewide basis for the Acute/FAMIS populations and separately for the MLTSS population.

Regional Groups

The CCMC program includes six separate regions. The FY2027 region groups are consistent with the Program of All-Inclusive Care for the Elderly managed care program. Counties and cities that make up the rate regions displayed below represent region mappings in effect for July 1, 2026.

Region/County Mapping

Region	Counties
Central Virginia	Amelia, Brunswick, Caroline, Charles City, Chesterfield, Colonial Heights, Cumberland, Dinwiddie, Emporia, Essex, Franklin City, Fredericksburg, Goochland, Greensville, Hanover, Henrico, Hopewell, King and Queen, King George, King William, Lancaster, Lunenburg, Matthews, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Powhatan, Prince Edward, Prince George, Richmond City, Richmond County, Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland
Charlottesville/Western	Albemarle, Amherst, Appomattox, Augusta, Buckingham, Campbell, Charlotte, Charlottesville, Danville, Fluvanna, Greene, Halifax, Harrisonburg, Louisa, Lynchburg, Madison, Nelson, Orange, Pittsylvania, Rockingham, Staunton, Waynesboro
Northern/Winchester	Alexandria, Arlington, Clarke, Culpeper, Fairfax City, Fairfax County, Falls Church, Fauquier, Frederick, Loudoun, Manassas City, Manassas Park City, Page, Prince William, Rappahannock, Shenandoah, Warren, Winchester
Roanoke/Alleghany	Alleghany, Bath, Bedford County, Botetourt, Buena Vista, Covington, Craig, Floyd, Franklin County, Giles, Henry, Highland, Lexington, Martinsville, Montgomery, Patrick, Pulaski, Radford, Roanoke City, Roanoke County, Rockbridge, Salem, Wythe

Region	Counties
Southwest	Bland, Bristol, Buchanan, Carroll, Dickenson, Galax, Grayson, Lee, Norton, Russell, Scott, Smyth, Tazewell, Washington, Wise
Tidewater	Accomack, Chesapeake, Gloucester, Hampton, Isle of Wight, James City County, Newport News, Norfolk, Northampton, Poquoson, Portsmouth, Suffolk, Virginia Beach, Williamsburg, York

Services Eligible for Different Federal Medical Assistance Percentage

There are specific services and populations for which DMAS receives a different Federal Medical Assistance Percentage (FMAP) than the regular state FMAP, including:

- Family Planning services meeting the definition of family planning in accordance with the authority for the program and provided to enrollees who can receive such services.
- Mobile Crisis Intervention services meeting the definition of community-based mobile crisis intervention services in accordance with the authority for the program and provided to enrollees who can receive such services.
- Affordable Care Act Medicaid Expansion population.
- FAMIS and FAMIS MOMS.

Rate Development Overview

Capitation rates for the CCMC program were developed in accordance with rate-setting guidelines established by CMS. The final rates presented reflect all known benefit changes applicable to the CCMC program.

The FY2027 rates were developed using a rate rebase approach. The calendar year (CY) 2024 base data time period was utilized for rate development. In addition, more recent available enrollment data, encounter data, and MCO financial reports were reviewed and utilized for the development of the FY2027 rates. Please refer to Section 3 of this rate report for further detail on the base data.

Mercer applied the following adjustments to the CY2024 base data:

- Base data adjustments: Adjustments to the base period data that do not reflect changes in MCO requirements (e.g., claims completion factors).
- Base program changes not reflected in the base data: Adjustments to the base period data that reflect changes in MCO requirements (e.g., fee schedule changes).
- Trend: Factors to forecast expenditures and utilization from the base period to the contract period.

- Prospective program changes: Adjustments to the contract period data that reflect changes in MCO requirements (e.g., new covered benefits) and other changes expected to occur between the base period and contract period.

Once the FY2027 projected medical costs are developed, additional adjustments are applied to reflect various non-benefit cost components of the final capitation rates. These adjustments are discussed in more detail in subsequent sections of this report and include:

- Administrative expense
- Underwriting gain

The capitation rates for the NH and HCBS waiver populations are blended utilizing a projected FY2027 enrollment mix.

The capitation rates for the LIFC Child, LIFC Adult, Expansion Medically Non-Complex, Expansion Medically Complex and Community Non-Dual > 1 rate cells are risk-adjusted using the Chronic Illness and Disability Payment System and Medicaid Rx (CDPS+Rx) risk adjustment model. The Community Dual < 65 and Community Dual 65+ rate cells BH categories of services of Addiction and Recovery Treatment Services (ARTS), Case Management Services, Community Behavioral Health (CBH), and Early Intervention Services, are to be risk-adjusted utilizing a risk adjustment model that leverages the Clinical Classification Software Refined (CCSR) diagnostic grouper. All other rate cells are not subject to risk adjustment. Additional detail regarding the risk adjustment process is provided in Section 7.

The rate cell structure for the Expansion LTSS population crosswalks to the existing rate cells as illustrated in the following table.

Expansion LTSS Rate Cell Crosswalk

Expansion LTSS Rate Cell		Rate Cell Proxy	
Rate Cell	**TPL Category**	**Rate Cell**	**TPL Category**
Blended NH/HCBS waiver	TPL and Non-TPL	Blended NH/HCBS waiver	Non-Dual
DD waivers	TPL and Non-TPL	DD waivers	Non-Dual
HCBS with PDN waiver	TPL and Non-TPL	HCBS with PDN waiver	Dual and Non-Dual

The base data, rating adjustments, and FY2027 rates for the Expansion LTSS population are unchanged when compared to the Non-Expansion LTSS population FY2027 rates with the exception of the NH mix.

Rate Change

The FY2027 rates represent an aggregate 6.12% change for total CCMC, 6.77% change for Acute/FAMIS and 5.64% change for MLTSS from the FY2026 rates effective July 1, 2025. The table below compares the FY2027 capitation rates to the FY2026 rates by rate cell on a statewide basis. Exhibit 6 includes the Final FY2027 rates for each rate cell and region. Key drivers of the rate changes include:

- Updated base data to reflect CY2024 as the base data time period, contributing 8.48% to the total CCMC rate change; with 9.28% to Acute/FAMIS populations and 7.86% to MLTSS populations.
  - A significant portion of the base data increase is driven by fee schedule changes as well as previously observed utilization trends that are now reflected in the base.
- The Common Core Formulary was updated to prefer Humira biosimilars over brand, with Humira brand changed to non-preferred status. A lower anticipated spend is estimated, contributing -0.95% to the total CCMC rate change; with -1.58% to Acute/FAMIS populations and -0.46% to MLTSS populations.
- Updated trend adjustments applied to the CY2024 base, contributing 0.06% to the total CCMC rate change; with 0.05% to Acute/FAMIS populations and 0.08% to MLTSS populations.
- Smaller enrollment acuity adjustment as the base data captures a significant amount of redetermination activity, contributing -0.60% to the total CCMC rate change; with -0.80% to Acute/FAMIS populations and -0.44% to MLTSS populations.
- TPL enrollment mix adjustment based on projected TPL/Non-TPL enrollment, contributing -0.18% to the total CCMC rate change; with -0.47% to Acute/FAMIS populations and 0.04% to MLTSS populations.
- Multi-state eligibility adjustment, reflecting the impact due to removing members enrolled in multiple state Medicaid programs, contributing 0.24% to the total CCMC rate; with 0.42% to Acute/FAMIS populations and 0.11% to MLTSS populations.
- Updated administrative load, contributing 0.22% to the total CCMC rate change; with 0.98% to Acute/FAMIS populations and -0.37% to MLTSS populations.

Figures above represent rate change drivers as compared to prior year assumptions. For information regarding the magnitude of each adjustment for FY2027 rates, please refer to the appropriate section in this report.

Rate Change Summary

Population	Rate Cell	TPL Category	Age Group	Statewide
Acute Non-Expansion				
Acute	LIFC Under 1	Combined	Age Under 1	7.26%
Acute	LIFC Child	Combined	Ages 1–20	5.39%
Acute	LIFC Adult	Combined	Age 21+	7.44%
Acute	Adoption Assistance	Combined	Age Under 21	4.71%
Acute	Foster Care	Combined	Age Under 21	12.40%
Acute Expansion				
Acute	Expansion Medically Non-Complex	Combined	Ages 19–64	7.52%

Acute Maternity				
Acute and FAMIS	Maternity Kick – Acute	Combined	All Ages	3.67%
FAMIS				
FAMIS	FAMIS Under 1	Combined	Age Under 1	6.91%
FAMIS	FAMIS Child	Combined	Ages 1–18	4.74%
FAMIS	FAMIS MOMS	Combined	All Ages	12.77%
MLTSS Non-Expansion				
MLTSS	Blended NH/HCBS waiver	Dual	All Ages	4.60%
		Non-Dual	All Ages	5.78%
MLTSS	DD waivers	Dual	All Ages	-4.10%
		Non-Dual	All Ages	3.17%
MLTSS	HCBS with PDN waiver	Dual and Non-Dual	All Ages	6.50%
MLTSS	Community No LTSS	Dual	Age Under 65	0.16%
			Age 65 and Over	3.44%
		Non-Dual	Age Under 1	11.75%
			Age 1 and Over	9.19%
MLTSS Expansion LTSS				
MLTSS	Blended NH/HCBS waiver	Major TPL	All Ages	5.34%
		Non-TPL	All Ages	5.53%
MLTSS	DD waivers	Non-TPL	All Ages	3.17%
MLTSS	HCBS with PDN waiver	Combined	All Ages	6.50%
MLTSS Expansion No LTSS				
MLTSS	Expansion Medically Complex	Combined	All Ages	5.28%
MLTSS Maternity				
MLTSS	Maternity Kick – MLTSS	Combined	All Ages	0.40%

Known Amendments

Mercer anticipates a need to issue an amendment to this certification during the FY2027 contract period due to material changes associated with “An act to provide for reconciliation pursuant to title II of H. Con. Res. 14” (H.R.1). Program changes related to H.R.1 are not

currently included in the FY2027 Rates Effective July 2026–June 2027 given the current implementation status of the program changes.

Mercer also anticipates that there may be a need to issue an amendment to this report and certification during the FY2027 time period due to material program changes to be potentially included in the Commonwealth's FY2027 budget, which would take effect on or after July 1, 2026. Mercer will work with the Commonwealth to identify any such program changes that necessitate a rate update and will issue the amendment as timely as possible.

Section 3

Data

The most recent and complete three years of experience available at the time of rate development were 2022, 2023, and 2024. In reviewing the CY2024 data, Mercer determined that the CY2024 data was appropriate to use as the basis for FY2027 rate development.

The encounter data reflects actual medical expense for the eligible population enrolled in CCMC program. The base data for the Acute, FAMIS, and Medically Complex (Community No LTSS) population includes both TPL and Non-TPL members. The Expansion LTSS populations will continue to use proxy logic consistent with historical rate development given the small nature of these populations and observed volatility in the emerging experience.

Mercer assessed the quality and completeness of the data per Actuarial Standards of Practice 23 (Data Quality) in order to deem the data sufficient to support rate setting. Mercer provided the MCOs with data summaries and collected feedback on any reconciliation to reported financial statements. Additional validation efforts included reviews of the data for changes year-over-year, errors in reporting including missing or duplicated data, and overall reasonableness/consistency across data sources to ensure it was reasonable to develop the rates. While this data may be impacted by the unwinding of the maintenance of effort, Mercer considers this data is suitable as a basis for rate development. Mercer considered various adjustments to the base data to account for anticipated cost changes when projecting FY2027 rates.

Along with describing the underlying base experience as reported above, each of the base data adjustments that was applied to the encounter base data source are described in this section.

Encounter Base Data Source

As stated above, the CY2024 time period serves as the basis for FY2027 rate development. Mercer received and validated actual encounter data submitted through the Encounter Processing System for claims submitted through June 2025. Mercer validated the data and selected the CY2024 time period as the base for FY2027 rate development.

Base Data Adjustments

Mercer reviewed the encounter data to ensure they were appropriate for the populations and services covered in the CCMC program. This review included comparisons of the encounter data results at a rate cell and category of service (COS) level to the previous base data utilized in the FY2026 rate development and to the MCO-reported financials for CY2024. Additionally, Mercer provided summaries to each of the MCOs to allow them an opportunity to review and validate the data used for rate setting. The following items were not included in the encounter data costs; therefore, no adjustment was necessary:

- Graduate Medical Education payments.

- Disproportionate Share Hospital payments.
- Wraparound payments made to Federally Qualified Health Centers/Rural Health Clinics such that total reimbursement is at the level authorized in the State Plan.
- Recovery of payments due to subrogation.

After processing the data, Mercer identified adjustments within the data set and the impacts across the CCMC program are as follows:

- Duplicate claims removal. The impact of this step was a reduction of approximately $8.9 million for Acute and FAMIS combined and $5.1 million for MLTSS.
- Claims not matched to individuals in the enrollment roster. The impact of removing these claims was a reduction of approximately $15.8 million for Acute and FAMIS combined and $7.1 million for MLTSS.
- Removal of services typically covered through waivers such as NF, Adult Day Care, and Respite Care incurred by Acute population members. The impact of this step was a reduction of approximately $4.3 million.

Mercer subsequently considered the following adjustments when forming the rate base. The impacts of these adjustments at the region, rating group, and COS level are shown in Exhibit 1.

- Incurred but not Reported (IBNR) Claims
- Provider Incentives
- Pharmacy Efficiencies
- Institution for Mental Disease (IMD)
- Non-State Plan Services Removal
- Coronavirus disease 2019 (COVID-19) Vaccine Cost Removal adjustment
- NH Per Diem Add-On Removal

IBNR Claims

The base period includes encounter data from the historical CCMC populations for the period of January 2024–December 2024, paid through June 2025. To account for any outstanding claim liabilities that would not have been reflected in the base encounter data, Mercer developed completion factors to apply to the base data. Claims payment triangles using monthly Encounter Data Warehouse System (EDWS) data from January 2024–June 2025 were analyzed to estimate the amount of outstanding claim liabilities due to claim payment lags for the EDWS data.

The statewide aggregate adjustment for IBNR claims is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	2.34%	0.89%	0.84%	0.91%	1.20%	0.88%	2.44%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	2.09%	0.85%	0.94%

MLTSS/ Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.60%	0.42%	0.95%	0.50%	0.80%	0.80%	1.99%
Non-Dual	0.80%	0.62%	0.77%	0.50%	0.84%	0.80%	1.99%

Provider Incentives

The MCOs continue to provide incentive payments to providers for coordinating care, ensuring access, and improving quality. These payments were not included in the encounter data. Mercer relied on financial data submitted by the MCOs and worked with the MCOs to gain feedback on the populations and services affected by these arrangements in order to account for the impact of these payments.

The statewide aggregate adjustment for provider incentives is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.64%	0.60%	0.41%	0.35%	0.37%	0.34%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.63%	0.62%	0.55%

MLTSS/ Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.02%	0.03%	0.73%	0.07%	0.32%	0.59%	0.00%
Non-Dual	0.33%	0.19%	0.58%	0.07%	0.57%	0.59%	0.00%

Pharmacy Efficiency Adjustments

After the base data was adjusted to reflect the populations and benefits expected to be covered for FY2027, Mercer applied various efficiency adjustments based on a review of the base period encounter claims. These adjustments are intended to reflect efficient provision of services in the pharmacy settings and are consistent with the Commonwealth's goals, Joint Legislative Audit Review Commission recommendations and requirements included in the

biennial budget that the Virginia Medicaid managed care program be operated in an efficient, high-quality manner.

The final impacts by COS and rate cell for the combined pharmacy efficiency adjustments are included in Exhibit 1. The data, methodologies, and assumptions for each adjustment are described in further detail below.

The statewide aggregate adjustment for combined pharmacy efficiency adjustments is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	-0.17%	-1.15%	-1.70%	-2.03%	-0.90%	-1.91%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	-0.25%	-1.09%	-0.65%

MLTSS/ Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	-0.01%	-0.19%	-0.30%	-0.03%	-1.70%	N/A
Non-Dual	-0.58%	-0.66%	-4.86%	-0.30%	-1.93%	-1.70%	N/A

Pharmacy Clinical Edits

Mercer performed a retrospective analysis of the CY2024 pharmacy encounter data to identify potentially inappropriate prescribing and/or dispensing patterns using a customized series of clinical rules-based pharmacy utilization management edits. These edits were developed by Mercer's Managed Pharmacy Practice based on published literature, industry standard practices, clinical appropriateness review, professional expertise, and information gathered during the review of several MCO pharmacy programs across the country. Mercer's clinical resources update the set of customized edits each year to incorporate new drugs introduced during the base data time period. These updates address changes in industry standards and incorporate new edits that address changes in medical practice or emerging clinical issues.

The customized edits reviewed individual pharmacy claims to identify issues related to inappropriate dosage limits and quantity limits, therapeutic duplication issues, long- and short-acting opioid polypharmacy, excessive opioid use based on morphine equivalent doses per day thresholds, excessive use of acetaminophen, and age- and pregnancy-related issues. Existing edits were updated to include appropriate medications for the corresponding base time period. Edits are separated into pediatric and adult, in order to accommodate differing limits in each population. Each edit was assigned a priority ranking based on order of highest clinical importance (e.g., adverse drug events and patient safety), clinical standards of practice and professional judgment to ensure that each claim was only counted once. For example, if a pharmacy claim met the criteria for a dosage limit edit and a

therapeutic duplication edit, the claim and the associated dollars would only be counted as inefficient for the highest priority edit, which in this case would be the therapeutic duplication edit.

Although the criteria associated with each edit is clinically sound, it is expected that situations exist in which clinical or operational rationale support the payment of a claim that did not meet the initial criteria. Therefore, each custom pharmacy edit was assigned an adjustment factor that varies by edit. Such rationale includes, but is not limited to, clinical practice guidelines, eligibility data issues, off-label prescribing practices, medication titration issues, individual patient response to therapy, and professional judgment.

The analysis also took into consideration the probability that a certain percentage of the pharmacy claims that met the edit criteria could have been modified and appropriately treated in another manner (e.g., prescribed as a different medication or resolved with a different treatment modality). Mercer considers these “cost offsets”, which will be directly applied to offset the avoidable dollars quantified for each edit.

The final adjustment applied a 100% target efficiency level (TEL) to the results. The overall amount removed from the base data for the clinical edits pharmacy efficiency adjustment is $20.3 million, with $9.9 million coming from the Acute/FAMIS populations and $10.4 million coming from the MLTSS population.

Drug-Disease Matching

Mercer also reviewed the pharmacy claims for select medications to determine if clinically appropriate diagnosis codes appeared in the medical claims data. The select list of medications included those medications for which off-label use is associated with the potential for misuse/abuse, are relatively high cost and/or carry safety concerns. Mercer clinicians developed a list of clinically appropriate diagnosis codes based on peer-reviewed literature, FDA-approved indications and clinically accepted off-label use.

Mercer reviewed CY2024 pharmacy and medical claims data and looked back 24 months and looked forward six months from the pharmacy claim date of service to identify pharmacy claims that did not have a corresponding, clinically appropriate diagnosis present in the medical claims (ICD-10 diagnosis code). Each pharmacy claim that did not have an appropriate diagnosis in the medical data was considered potentially inappropriate (or avoidable).

Although the diagnosis-drug (DxRx) pairings are clinically sound, it is expected that situations exist in which clinical rationale support the lack of corresponding medical diagnosis. As such, adjustment factors were applied to the results for each medication ultimately included in the analysis. The adjustment value for this analysis took into consideration the probability that a certain percentage of the pharmacy claims that did not have corresponding diagnosis could have been prescribed a different medication or treated through a different modality. Such considerations are quantified as cost offsets, which reduced the final adjustment value.

The final adjustment applied a 100% TEL to the results. The overall amount removed from the base data for the DxRx efficiency is $36.2 million, with $24.6 million coming from the Acute/FAMIS populations and $11.6 million coming from the MLTSS population.

Maximum Allowable Cost

Mercer performed an evaluation of CY2024 pharmacy encounter data to evaluate efficient payment for generic products in addition to identifying potential for generic substitution when brands drugs were dispensed. This analysis is performed by benchmarking MCO payment for drugs against a Medicaid industry standard maximum allowable cost (MAC).

The benchmark is a MAC list used in a FFS Medicaid program, which is comparable to the commercial MAC programs commonly used by MCOs or their subcontracted pharmacy benefit managers (PBMs). MAC rates are set at a drug grouping of active ingredient, route of administration, dosage form and drug strength, using the First Databank Hierarchical Formulation ID. Rates are established and updated on a monthly and quarterly basis to incorporate periodic updates resulting from provider inquiries. The historical MAC rates are matched to the date of service for each individual claim in the analysis to calculate ingredient reimbursement differences between the benchmark MAC and plan reported payment. Mercer made two adjustments to account for appropriately dispensed brand drugs in the analysis. These adjustments include:

- **Dispense as Written (DAW):** Brand drugs may be dispensed to members when directed by the prescriber or provider. As such, claims for brand prescription drugs received with a DAW code of 1, 7, or 8 were removed from the efficiency analysis.
- **Virginia Common Core Formulary (CCF):** Brands that are preferred on the CCF are removed from the MAC analysis. Mercer also removed from the analysis generic prescriptions that were anticipated to switch to branded medications due to the CCF. To accomplish this, Mercer estimated the percent of generic claims that would shift to brand for each brand preferred drug. Calculated inefficient generic dollars were reduced by the percent of claims anticipated to switch to brands.

The final adjustment applied a 100% TEL to the results. The overall amount removed from the base data for the MAC efficiency is $102.7 million, with $63.1 million coming from the Acute/FAMIS populations and $39.6 million coming from the MLTSS population.

Physician-Administered Drugs

The final pharmacy-related adjustment Mercer completed was to identify potentially avoidable costs due to reimbursement inefficiencies for physician-administered medications. Mercer reviewed the MCO CY2024 professional encounter data to identify the drug-related health care common procedure coding system (HCPCS) codes with the highest reimbursement expense.

To identify the potentially avoidable costs, Mercer compared the MCO per unit reimbursement rate to an industry benchmark. For the industry benchmark, Mercer used the CMS average sales price (ASP) plus 6% per unit reimbursement rate for a similar time

period. Prior to calculating the avoidable dollars, Mercer reviewed any cost outliers relative to the Medicare benchmark rate. In these instances, high outliers were repriced at 120% of ASP and low outliers were repriced at the benchmark. Mercer also removed from the analysis claims from outpatient services where the Enhanced Ambulatory Patient Group payment methodology incorporated physician-administered drugs.

Mercer excluded claims with zero or negative paid amounts or administered quantities and any claim for which a third party contributed any portion of the claim payment. Blood factor products, vaccines, and other non-drug items were also excluded from potentially avoidable cost calculations.

The final adjustment applied a 100% TEL to the results. The overall amount removed from the base data for the HCPCS pharmacy efficiency is $5.2 million, with $3.1 million coming from the Acute/FAMIS populations and $2.1 million coming from the MLTSS population.

IMD

CMS published the Managed Care Final Rule on May 6, 2016, that included provisions regarding the treatment of utilization at IMDs in capitation payment and rate setting. Specifically, the Final Rule outlines that states, "[…] may make a monthly capitation payment to an MCO or PIHP [prepaid inpatient health plan] for an enrollee ages 21–64 receiving inpatient treatment in an Institution for Mental Diseases, as defined in §435.1010 of this chapter, so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay of no more than 15 days during the period of the monthly capitation payment." As a result of this provision, Mercer incorporated an adjustment to the capitation rates that reflects the appropriate cost and utilization of allowable stays in an IMD facility.

The combined adjustment (removal of costs associated with IMD long stays and adjustment to reprice IMD short stays) resulted in a downward adjustment of approximately $0.7 million to the CY2024 time period. The statewide aggregate IMD adjustment is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	0.00%	0.01%	0.00%	0.00%	-0.02%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	0.00%	0.00%

MLTSS/ Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.10%	0.00%	0.06%	0.01%	0.00%

MLTSS/ Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Non-Dual	0.00%	0.00%	-0.01%	0.00%	-0.01%	0.01%	0.00%

Non-State Plan Services Removal

Mercer included an adjustment to remove services provided to members beyond those identified in the MCO contract. The costs associated with these services were excluded from the base data for the applicable populations. The excluded services include home-delivered meals, adult vision, adult hearing, diabetic footcare, and environment modifications in excess of $5,000 per calendar year per individual for the MLTSS population.

The adjustment resulted in the removal of approximately $25.6 million in costs from the CY2024 time period. The statewide aggregate non-State Plan services adjustment is summarized below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	0.00%	-0.44%	0.00%	0.00%	-0.38%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	0.00%	-0.84%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	-0.02%	-0.05%	-1.15%	0.00%	-0.55%	-0.22%	0.00%
Non-Dual	-0.08%	-0.04%	-0.20%	0.00%	-0.19%	-0.22%	0.00%

COVID-19 Vaccine Cost Removal

Mercer included an adjustment to remove costs related to the COVID-19 vaccine administration from the CY2024 base period. During the CY2024 time period, the costs directly associated with the COVID-19 vaccine administration were paid directly to the MCOs on a non-risk basis, and that payment was separate from the monthly capitation payments during that time period. Changes to this arrangement during the FY2027 contract period are reflected as a prospective program change documented later in this report.

The statewide aggregate adjustment for the COVID-19 vaccine cost removal adjustment is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	-0.02%	-0.06%	-0.07%	-0.05%	-0.02%	-0.12%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	-0.05%	-0.13%	-0.17%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	-0.04%	0.00%	-0.02%	-0.06%	0.00%
Non-Dual	-0.01%	-0.01%	-0.11%	0.00%	-0.06%	-0.06%	0.00%

NH Per Diem Add-On Removal

In FY2024, this per diem add-on was set at $6.13. Effective FY2025, this add-on payment was removed due to the Nursing Facility Value-Based Purchasing (NF VBP) separate payment term directed payment. Mercer developed a base data adjustment to calculate the removal of the increased unit cost for the NF COS utilization during the second half of FY2024.

The statewide aggregate adjustment for the NH Per Diem Add-on removal adjustment is summarized in the table below and only applicable to the MLTSS population.

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	-0.98%	0.00%	-0.01%	0.00%	-0.10%	0.00%	0.00%
Non-Dual	-0.67%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

In-Lieu-of Services

In-lieu-of services (ILOS) are defined under 42 CFR §438.3(e)(2) as “a medically appropriate and cost-effective substitute for the covered service or setting under the State plan.” This includes stays at an IMD for individuals age 21 to 64 who are receiving inpatient psychiatric or substance use disorder treatment, in lieu of receiving these services in an acute care hospital (psychiatric unit), as long as the length of stay is no longer than 15 days during the period of monthly capitation payment. As of the date of this report, there are no other ILOS authorized under CCMC, nor are there expected to be any others authorized for FY2027.

Changes to Covered Benefits

There are no changes to the State Plan covered benefits for FY2027.

Section 4

Projected Benefit Costs and Trends

Program change adjustments recognize the impact of benefit or eligibility changes occurring during and after the base data period. CMS requires that the rate-setting methodology used to determine actuarially sound rates incorporate the results of any program changes that have taken place, or are anticipated to take place, between the start of the base period and the conclusion of the contract period.

It is also necessary to recognize the impact of medical trend patterns in the development of prospective rates. The impact is applied through the prospective trend factors described below.

Base Program Changes

Historical program change adjustments recognize the impact of benefit or eligibility changes occurring prior to the beginning of the contract period. Adjustments for historical base program changes were applied to bring the base data period to a consistent time period. Final adjustments by rate cell and COS for each of the items listed below are provided in Exhibit 2.

Fee Schedule Changes

Mercer understands that the participating MCOs align their provider contracting as an amount related to the FFS fee schedule for many services. Therefore, the same fee schedule changes applicable in FFS will be implemented in the managed care program as noted in Section 12.1.9 of the CCMC MCO contract.

- **Inpatient Hospital Reimbursement Changes:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, inflation adjustments of 6.40%, 4.19%, and 3.20%, respectively, were made to reimbursement for inpatient hospital services due to FFS fee schedule changes.
- **Outpatient Hospital Reimbursement Changes:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, inflation adjustments of 4.60%, 4.19%, and 3.20%, respectively, were made to reimbursement for outpatient hospital services due to FFS fee schedule changes.
- **Inpatient Hospital — Children of the King's Daughters (CHKD) Reimbursement Changes:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, inflation adjustments of 6.40%, 4.19%, and 3.20%, respectively, were made to reimbursement for inpatient CHKD services due to FFS fee schedule changes.
- **Outpatient Hospital — CHKD Reimbursement Changes:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, inflation adjustments of 4.60%, 4.19% and 3.20%,

respectively, were made to reimbursement for outpatient CHKD services due to FFS fee schedule changes.

- **Freestanding Inpatient Psychiatric Hospital Reimbursement Changes:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, inflation adjustments of 14.80%, 4.19%, and 3.20%, respectively, were made to reimbursement for freestanding inpatient psychiatric hospital services due to FFS fee schedule changes. DMAS provided a list of freestanding psychiatric hospitals.
- **Critical Access Hospitals (CAHs):** Effective July 1, 2024, July 1, 2025, and July 1, 2026, increases of 17.20%, 4.19%, and 3.20% were made to inpatient services, respectively, and increases of 6.00%, 4.19%, and 3.20%, were made to outpatient services, respectively, to account for inflation and hospital rebasing changes. DMAS provided a list of the CAH impacted by this adjustment.
- **Type One Hospitals:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, increases of 5.70%, 4.19%, and 3.20% were made to inpatient services, respectively, and increases of -37.40%, 4.19% and 3.20% were made to outpatient services, respectively, to account for inflation and hospital rebasing changes. DMAS provided a list of type one hospitals subject to this adjustment.
- **Acute Inpatient Psychiatric Hospital Reimbursement Changes:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, inflation adjustments of 17.40%, 4.19%, and 3.20%, respectively, were made to reimbursement for inpatient psychiatric services provided at acute hospitals due to FFS fee schedule changes.
- **Hospice:** Effective July 1, 2025, and July 1, 2026, increases of 2.90% and 2.90%, respectively were made due to FFS fee schedule changes.
- **Skilled and Private Duty Nursing:** Effective July 1, 2024, an increase of 3.00%, was made to reimbursement due to FFS fee schedule changes.
- **Home Health Adjustment:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, increases of 4.00%, 3.70%, and 3.40%, respectively, were made to reimbursement for home health services due to FFS fee schedule changes. Mercer made no change to the draft inflation adjustment of 3.50% for July 1, 2025, that was already included in rate development, due to the immateriality between the assumed and actual inflation adjustments.
- **Personal Care and Respite Care Adjustment:** Effective July 1, 2024 and July 1, 2025, increases of 2.00% and 2.00%, respectively, were made to reimbursement for personal care and respite care services.
- **NF Adjustment:** Effective July 1, 2024, July 1, 2025, and July 1, 2026, increases of 3.34%, 3.98%, and 3.30%, respectively, were made to reimbursement for NF services due to FFS fee schedule changes. Effective July 1, 2024, July 1, 2025, and July 1, 2026, increases of 3.83%, 3.98%, and 3.30%, respectively, were made to reimbursement for specialized care in NF settings.
- **Consumer-Directed Facilitation Services:** Effective July 1, 2024, DMAS added funds to increase the rates for consumer-directed management training, initial comprehensive visits, routine visits, and reassessment visits.

- **Durable Medical Equipment (DME) Enteral Supplies:** Effective July 1, 2024, the DME rate for enteral products increased to 100% of the Medicare rural rate or non-rural rate if rural rate does not exist.
- **Substance Use Disorder Services:** Effective July 1, 2025, a 6.50% increase was effective for substance use disorder services. DMAS provided a list of procedure codes subject to this adjustment.

For all adjustments above, considerations were made in the trend analysis to ensure that projected changes in costs due to fee schedule changes were accounted for only once in rate development.

The statewide aggregate adjustment for these program changes is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	7.68%	1.77%	2.53%	1.61%	3.11%	2.82%	7.81%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	6.29%	1.62%	1.88%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	8.92%	2.86%	1.34%	2.01%	2.26%	2.90%	7.35%
Non-Dual	8.12%	2.87%	2.14%	2.01%	2.88%	2.90%	7.35%

Common Core Formulary

Effective January 1, 2026, a change was made to the Common Core Formulary including the addition of Humira biosimilar to preferred status; Humira brand was changed to non-preferred status. Members will be transitioned to one of the preferred biosimilars by the effective date of this change. The Common Core Formulary adjustment reflects the cost savings of switching to required biosimilars.

The statewide aggregate adjustment for the Common Core Formulary adjustment is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	-1.30%	-2.66%	-0.13%	-0.07%	-2.75%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	-1.35%	-0.30%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.00%	0.00%	-0.05%	-1.85%	0.00%
Non-Dual	-0.02%	-0.27%	-0.89%	0.00%	-1.07%	-1.85%	0.00%

Trend

As part of the FY2027 rate development process, Mercer reviewed detailed historical encounter data summarized by month of service and grouped by major COS and population type. Mercer reviewed 42 months of historical encounter data from January 2022 to June 2025, with runout through December 2025. The analysis included a review of the utilization per 1,000, unit cost, and per member per month (PMPM) statistics. The historical experience for the populations and services that are covered under the CCMC program was the primary data source used for the trend analysis, as it reflects the Commonwealth's specific Medicaid environment, including medical management practices, network construction, and population risk.

Mercer's trend analysis also takes into account the impact of other rating adjustments that may be addressed elsewhere in the rate development to prevent any duplication of their impact in trend development. Therefore, Mercer has normalized the claims data underlying the trend analysis to reflect fee schedule changes and other applicable programmatic changes.

Mercer recognizes the impact of fluctuating population acuity on program experience stemming from non-standard disenrollment volumes. An additional analysis was conducted to examine the historical trends with claims/eligibility data removed for members who lost managed care eligibility during the redetermination period of April 2023 to September 2025. Trend assumptions were adjusted for certain categories of service and populations where utilization patterns under the modified experience differed significantly from trends without the modified experience.

Mercer's review of historical and emerging encounter data had indicated continued elevated expenditures in certain categories of service, including CBH, ARTS, and Other Professional services, specifically for Applied Behavioral Analysis services. To support the development of trend assumptions for these services, Mercer conducted comprehensive analyses to identify and understand the key drivers. This includes evaluating the utilization of relevant procedure codes and recognizing shifting patterns of utilization across different service groups. In some instances, Mercer projected trends for services separately before blending with trends of other services observed within the respective broader categories of service. Trends represented in the appendices reflect a blended COS total.

Mercer's pharmacy trend development process incorporated marketplace intelligence into overall expected pharmacy trends for broad therapeutic categories based on the combination of the expectations for new traditional and specialty drug price fluctuations and new generics and biosimilar introductions that are routinely monitored. As an additional step in the review process when developing the pharmacy trend assumptions, Mercer compared the forecasted pharmacy trend assumptions to the historical monthly program data, which reflects past experience with new high-cost drugs as well as cost reductions due to generics or increased

competition to ensure the forecast is reasonable compared to this historical experience. Mercer also evaluates impacts on utilization associated with programmatic changes such as stricter authorization criteria on GLP-1 weight management agents and other marketplace changes.

To further supplement the trend analysis, Mercer reviewed information from proprietary work with other states' Medicaid programs, publicly available reports on general health expenditure trend and Medicaid trends, and Bureau of Labor Statistics Consumer Price Index medical trend information. These sources provide a cross-section of information pertaining to the dynamics of the health care marketplace that help inform the process of developing prospective trend assumptions. This information combined with professional actuarial opinion was used to develop the final trend assumptions used in the FY2027 rates.

Trends are comprised of changes in unit cost and utilization, which lead to an ultimate change in the PMPM trend. Final PMPM trend assumptions can be seen in Exhibit 3 and Exhibit 5.

The statewide aggregate adjustment for trend (not annualized) is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.60%	9.74%	16.33%	11.33%	12.57%	17.72%	7.18%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.70%	10.54%	10.39%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.69%	5.88%	0.70%	7.83%	8.00%	16.33%	5.59%
Non-Dual	3.86%	11.89%	12.66%	7.83%	15.69%	16.33%	5.59%

Prospective Program Changes

The Commonwealth and Mercer reviewed program changes that would have a material impact on the cost and utilization that occur during the FY2027 contract period.

The impact of the individual adjustments described below by region, rate cell, and COS can be found in Exhibit 4.

Enrollment Acuity Adjustment

During the Medicaid unwinding period and following its conclusion, the Cardinal Care Managed Care program has experienced member disenrollments exceeding what is expected in the contract period. To address the impact of these additional disenrollments on

population acuity, Mercer developed an enrollment acuity adjustment that quantifies changes in the base PMPM costs attributable to shifts in member composition resulting from disenrollments beyond standard eligibility redeterminations such as death, relocation, or annual eligibility verification. Mercer's methodology involved analyzing claim cost and enrollment data from April 2023 through September 2025, focusing specifically on Non-TPL members. Mercer recognizes that observed disenrollments during this study period include both standard and non-standard leavers and that the adjustment should reflect only non-standard leavers.

Using enrollment data sourced from the DMAS enrollment dashboards, Mercer distinguished the portion of members undergoing standard periodic eligibility redeterminations from the cases that are identified to be non-standard enrollment closures. Within the portion of members estimated to be disenrolled for standard reasons, Mercer used calendar year 2022 data as a proxy to approximate the magnitude of higher acuity members losing eligibility due to death, relocation, or voluntary termination. Mercer used this information alongside all terminated members observed between April 2023 through September 2025 to determine the volume of disenrollment due to non-standard reasons.

The final adjustment was calculated by comparing base PMPM costs before and after excluding the estimated average cost profile attributed to the portion of non-standard closures. Note that this enrollment acuity adjustment is distinct and mutually exclusive from a separate adjustment that Mercer calculates to capture the impact of eligibility redeterminations on the mix between TPL and Non-TPL members.

HCBS Eligibility Redetermination Impacts

Separate from the enrollment acuity adjustment, due to the resumption of eligibility redetermination for Medicaid recipients, DMAS identified specific HCBS members who had not utilized LTSS waiver services for at least two consecutive months. As a result, these members were reassigned from the HCBS rate cell and subsequently enrolled within the Community rate cells.

Mercer utilized eligibility and encounter data to identify redetermined HCBS members and their historical experience. Mercer noted that the observed PMPM experience for these redetermined HCBS were higher than the PMPM experience observed for Community rate cells and lower than the PMPM experience observed for the HCBS rate cells. As such, an adjustment was made to the Community and HCBS rate cells to reflect the impact to their respective acuity levels as a result of the incoming/outgoing HCBS members. This adjustment has been reduced from previous years as the impact of these transitions is now partially reflected in the base.

The statewide aggregate adjustment for the combined enrollment acuity and HCBS eligibility redetermination adjustments is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	3.86%	6.36%	0.90%	0.90%	8.67%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	4.31%	0.00%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	1.13%	0.00%	0.00%	4.12%	6.30%	0.00%
Non-Dual	0.00%	1.15%	0.00%	0.00%	3.90%	6.30%	0.00%

Multi-State Eligibility Removal Adjustment

In collaboration with other state Medicaid agencies, DMAS identified a number of covered members that are currently receiving Medicaid benefits in the Commonwealth of Virginia, as well as other states. These members will receive written notices from the Commonwealth requesting confirmation of their current residence. Any responses indicating that they no longer reside in Virginia or a non-response will result in closure of their Medicaid eligibility in CCMC. Any planned closures are expected to occur effective June 30, 2026.

Mercer utilized a list of these identified members to summarize their historical claims and eligibility for the base period. Mercer noted that the aggregate PMPM experience for this group of members was lower than their overall respective rate cells. Based on the review of member utilization, Mercer assumed that roughly half of these members will lose coverage, with the loss of these lower costing members resulting in a higher overall acuity and increasing medical PMPM for the remaining CCMC population.

The statewide aggregate adjustment for the multi-state eligibility removal adjustment is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	0.51%	0.50%	0.83%	0.83%	0.49%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	0.30%	0.00%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.00%	0.00%	0.02%	0.37%	0.00%
Non-Dual	0.00%	0.00%	0.00%	0.00%	0.27%	0.37%	0.00%

Pharmacy Rebates Adjustment

The CCMC MCOs continue to negotiate competitive rebate agreements with their PBM even though the Commonwealth is also receiving rebates for the MCO pharmacy expenditures. Therefore, it was necessary to make an adjustment to account for these rebates, which will be retained by the MCOs. The rebate assumptions applied to the FY2027 rates were based on industry intelligence and professional assessment of marketplace competition and rebating activity. Consideration was also given for the impact the CCF contractual requirements will have on the future of rebates that are available.

The statewide aggregate adjustment for pharmacy rebates is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	-0.12%	-0.10%	-0.04%	-0.06%	-0.09%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	-0.14%	-0.14%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.00%	0.00%	0.00%	-0.11%	0.00%
Non-Dual	0.00%	-0.03%	-0.06%	0.00%	-0.10%	-0.11%	0.00%

Third Party Liability Mix Adjustment

The CCMC program covers members with comprehensive private insurance as the primary payer. These members typically have lower plan expenditures than members with little-to-no TPL arrangements. As Mercer is using a combined Non-TPL and TPL base dataset to project a combined rate, an explicit program change is necessary to reflect any anticipated change in the Non-TPL and TPL enrollment distribution.

To develop the adjustment, Mercer calculated historical PMPM relativities between Non-TPL and TPL using base CY2024 experience and analyzed the Non-TPL and TPL enrollment distribution through September 2025 to project the mix of Non-TPL and TPL members in the forecast period. Mercer notes that this adjustment is separate and mutually exclusive from the Enrollment Acuity Adjustment discussed previously.

In aggregate, the statewide impact by rate cell can be seen in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.87%	0.40%	0.58%	1.04%	0.51%	1.35%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	1.50%	0.84%	1.24%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.00%	0.00%	0.00%	0.44%	0.00%
Non-Dual	0.00%	0.00%	0.00%	0.00%	0.00%	0.44%	0.00%

COVID-19 Vaccine Inclusion

Effective October 1, 2024, COVID-19 vaccine-related services that were previously covered under non-risk arrangements will be carved into managed care. The MCOs will be responsible for the cost to administer COVID-19 vaccines in addition to the ingredient cost of the COVID-19 vaccine itself. The ingredient cost of the vaccines for children will continue to be covered under the Vaccines for Children program, while the cost of the vaccines for Non-Duals adults will be paid for by the MCOs. The cost of the vaccine and the administration of the vaccine for Dual populations in the MLTSS program is covered by Medicare, therefore they are excluded from the adjustment buildup.

Mercer leveraged historical utilization of COVID-19 vaccination rates, along with clinical and pharmacy review, to develop vaccination ingredient cost and utilization projections expected for FY2027. The statewide aggregate adjustment for the COVID-19 Vaccine Inclusion is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	0.00%	0.03%	0.01%	0.00%	0.05%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	0.01%	0.04%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.00%	0.00%	0.00%	0.04%	0.00%
Non-Dual	0.01%	0.01%	0.06%	0.00%	0.04%	0.04%	0.00%

High-Cost Drug Adjustment

Additional considerations were made to account for potential utilization of gene therapies in FY2027 that were not captured in the base spend. An adjustment was applied to account for the potential utilization of one or more of the following gene therapies: Zynteglo™ (Transfusion-Dependent β-Thalassemia), Lyfgenia™ (Sickle Cell Disease), Elevidys

(Duchene Muscular Dystrophy), Itvisma™ (Spinal Muscular Atrophy), Zevaskyn™ (Recessive Dystrophic Epidermolysis Bullosa), and Encelto™ (Macular Telangiectasia Type 2).

These high-cost gene therapies are less likely to be billed and paid through the pharmacy benefit and additional adjustments beyond pharmacy trend were considered to capture the full potential cost. These adjustments were developed based on anticipated utilization and unit cost information from the marketplace. Anticipated utilization was informed by reviewing historical medical and pharmacy claims data for members identified as being diagnosed with the indicated conditions. Where appropriate, the cost for these high-cost drugs was offset by anticipated cost offsets in drug expenditures as a result of the new therapy.

The statewide aggregate adjustment for high-cost drugs is summarized below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	0.36%	0.00%	0.00%	0.00%	0.01%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	0.99%	0.00%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	0.00%	0.00%	0.00%	0.00%	0.20%	0.00%
Non-Dual	0.00%	0.61%	0.00%	0.00%	0.51%	0.20%	0.00%

Section 5

Special Contract Provisions Related to Payment

This section describes contract provisions for delivery system and payment initiatives under 42 CFR §438.6 that impact the final net payments to the MCOs for reasons other than risk adjustment under the MCO contract.

Incentive Arrangements

Incentive arrangements are defined under 42 CFR §438.6(a) as "any payment mechanism under which an MCO may receive additional funds over and above the capitation rate it was paid for meeting targets specified in the contract." Payments under these arrangements must not exceed 105% of the approved capitation payment. The Commonwealth implemented the Discrete Incentive Transition program on July 1, 2019, and is still in effect. The Discrete Incentive Transition Program provides financial rewards for MCOs that successfully transition complex members residing in a NF to a home- and community-based setting for a sustained period. DMAS will reward MCOs when these transitions result in better care outcomes and quality of life for members. MCOs will receive a one-time payment of $7,500 for each successful transition accomplished under the program. Based on historic transitions and achieved payments, this incentive program is not expected to exceed 105% of the approved capitation payment as required under 42 CFR §438.6(a).

Withhold Arrangements

Withhold arrangements are defined under 42 CFR §438.6(a) as "any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or prepaid ambulatory health plan (PAHP) and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract." The CCMC program includes provisions for the Performance Withhold Program (PWP) and the Clinical Efficiency (CE) Performance Withhold during the FY2027 contract period.

As of the date of this report, Mercer has reviewed DMAS's proposed PWP and CE performance measures and have determined the performance targets to be reasonably achievable for the FY2027 contract period.

PWP

The PWP is established using a 1.00% withhold applied to the capitation payments made to the MCOs to incentivize health outcomes and quality of care. For the FY2027 PWP, MCO performance will be evaluated on seven National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures (14 measure indicators), one Agency for Healthcare Research and Quality and Pediatric Quality Indicator

(AHRQ PDI) measure (one measure indicator), and two CMS Core Set of Adult Health Care Quality Measures for Medicaid (CMS Adult Core Set) measures (two measure indicators). The measures will be evaluated across the CCMC Acute and MLTSS programs. The MCOs will earn back withheld funds based on performance in accordance with the methodology established by the DMAS External Quality Review Organization.

Mercer reviewed the PWP design specifications and terms that dictate how the MCOs can earn back the withhold. Based on review of available data that showed historical MCO performance on the HEDIS measures and improvement bonus criteria, Mercer determined the PWP metrics provide the MCOs the opportunity to earn back the full withhold during the contract period. DMAS has indicated that the improvement bonus criteria will be adapted in a way that provides a new MCO the opportunity to achieve the withhold. As a result, no adjustments to the capitation rates have been made for a portion of the withhold that is not reasonably attainable.

CE Performance Withhold

An additional CE performance withhold is established using a 0.25% withhold applied to the capitation payments made to the MCOs to address performance improvements in potentially preventable ER visits, acute inpatient 30-day readmissions, and potentially preventable admissions. The goal of the CE policy is to incentivize MCOs to direct resources and care support efforts to avoid these events and reduce associated utilization and costs. The withhold for FY2027 will be evaluated based on actual FY2027 performance as compared to the FY2025 baseline year across both CCMC programs, considering both the MCO's achievement of the target value and percent improvement from their baseline rate.

Mercer worked with DMAS on the withhold design specifications and terms that dictate how the MCOs earn back the withhold. Mercer reviewed the FY2027 targets established by DMAS with consideration for historical and more recent MCO experience. After review and discussions with DMAS, Mercer determined the FY2027 targets established were reasonable and achievable for an effectively managed MCO. As a result, no adjustments to the capitation rates have been made for a portion of the withhold that is not reasonably achievable.

Delivery System Provider Payment Initiatives

The CMS RDG defines provider payment initiatives as those that require managed care plans to:

- "Implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services;
- Participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative;
- Adopt a minimum fee schedule for network providers that provide a particular service under the contract;
- Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract; or

- Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the MCO retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract."

The following items address the Commonwealth's provider payment initiatives that are either under CMS review, have been approved or will be submitted to CMS for approval. There are not any requirements regarding the reimbursement rates the MCOs must pay to any providers beyond those specified in the rate report as a directed payment or authorized under applicable law, regulation, or waiver.

The initiatives related to hospitals, physician services, and NF VBP changes are funded separately from the capitation rates and **are not** included in the final rates provided in Exhibit 6. The directed payment estimates for each of the separate payment term arrangements noted below will be included in the final estimates for the populations in the CCMC program.

The table below addresses item I.4.D.ii.a.i in the 2025–2026 RDG.

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the payment included as a rate adjustment or separate payment term?	Page #
Private Hospital VA_Fee_IPH.OPH_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia based on an analysis of the FFS upper payment limit (UPL) with adjustments for consideration of managed care reimbursement.	Separate payment term	42
Non-State Government VA_Fee_IPH.OPH2_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia based on the UPL gap for each type of provider.	Separate payment term	42 & 43
UVA, VCU, and EVMS VA_Fee_AMC_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia based on the UPL gap for each type of provider.	Separate payment term	43
State Government Owned NFs	Uniform Percentage Increase	Uniform increase is determined by Virginia based on the UPL gap	Separate payment term	43 & 44

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the payment included as a rate adjustment or separate payment term?	Page #
VA_Fee_Oth3_Renewal_20260701-20270630		for each type of provider.		
CRMC VA_Fee_Oth2_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia based on the FFS average commercial rate (ACR) analysis.	Separate payment term	44
CHKD VA_Fee_SP_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia based on the fixed pool of funding each year.	Separate payment term	44 & 45
Riverside VA_Fee_AMC.PC.SP_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia.	Separate payment term	45
Sentara VA_Fee_AMC.PC.SP3_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia.	Separate payment term	45 & 46
Valley VA_Fee_AMC.PC.SP2_Renewal_20260701-20270630	Uniform Percentage Increase	Uniform increase is determined by Virginia.	Separate payment term	46
NF VBP VA_VBP_NF_Renewal_20260701-20270630	Value-Based Payment	Facility payments based on how facilities perform against set thresholds on six performance measures.	Separate payment term	46 & 47

Control Name of the State Directed Payment	Type of Payment	Brief Description	Is the payment included as a rate adjustment or separate payment term?	Page #
LTSS Services, Community Mental Health Services, ARTS, and Early Intervention Services *No CMS Control Number as this is a minimum fee schedule based on State Plan Approved Rates and does not require a preprint	Minimum Fee Schedule	The CCMC contract includes a minimum fee schedule for LTSS Services, Community Mental Health Services, ARTS, and Early Intervention Services. MCOs must pay no less than the DMAS fee schedule for these services.	No rate adjustment as managed care experience utilized in rate development already reflected these minimum fee schedule requirements.	47
VA_Fee_Oth_Renewal_20260701-20270630	Minimum Fee Schedule	The CCMC contract includes a minimum fee schedule for DME. MCOs must pay no less than 90% of the DMAS fee schedule for these services effective July 1, 2021.	No rate adjustment as managed care experience utilized in rate development already reflected these minimum fee schedule requirements.	23 & 47
Personal Care and Respite Care Services *No CMS Control Number as this is a minimum fee schedule based on State Plan Approved Rates and does not require a preprint	Minimum Fee Schedule	The CCMC contract includes a minimum fee schedule for Personal Care and Respite Care services. MCOs must pay no less than the DMAS fee schedule for these services effective July 1, 2021.	No rate adjustment as managed care experience utilized in rate development already reflected these minimum fee schedule requirements.	22 & 47

The table below addresses item I.4.D.ii.a.ii in the 2025–2026 RDG.

Control Name of the State Directed Payment	Rate Cells Affected	Magnitude of the Adjustment	Description of the Adjustment	Confirmation the Rates are Consistent with the Preprint	For Maximum Fee Schedules, Provide the Information Requested in (E) Below
VA_Fee_Oth_Renewal_20260701-20270630	All	Please see Exhibit 2 of the certification	MCOs must pay no less than 90% of the DMAS fee schedule for these services effective July 1, 2021.	Confirmed	N/A

The table below addresses item I.4.D.ii.a.iii in the 2025–2026 RDG.

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
Private Hospital VA_Fee_IPH.OPH_Renewal_20260701-20270630	Acute — $3,172,378,476 MLTSS — $1,815,597,002 Total — $4,987,975,478	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $24.96 and $13,003.39 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	The development of the estimates is consistent with the preprint which was submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
					this arrangement.
Non-State Government VA_Fee_IPH.OPH2_Renewal_20260701-20270630	Acute — $36,008,848 MLTSS — $38,601,213 Total — $74,610,061	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $303.17 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	The development of the estimates is consistent with the preprint which was submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under this arrangement.
UVA, VCU, and EVMS VA_Fee_AMC_Renewal_20260701-20270630	Acute — $180,214,346 MLTSS — $93,885,654 Total — $274,100,000	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.12 and $1,093.16 by rate cell. Please see Exhibit 7 for the estimated PMPM impact.	The development of the estimates is consistent with the preprint which was submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under this arrangement.
State Government Owned NFs	MLTSS — $3,589,920	Mercer certifies to the estimates shown in Exhibit 7 of	The PMPM estimate varies between $0.00 and	The development of the estimates is consistent	A final rate certification will be completed following the

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
VA_Fee_Oth3_Renewal_20260701-20270630		the rate report.	$83.66 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	with the preprint which was submitted to CMS for approval.	end of the contract period to document final payments made to the MCOs under this arrangement.
CRMC VA_Fee_Oth2_Renewal_20260701-20270630	Acute — $625,920 MLTSS — 324,080 Total — $950,000	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $3.81 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	The development of the estimates is consistent with the preprint which was submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under this arrangement.
CHKD VA_Fee_SP_Renewal_20260701-20270630	Acute — $8,715,886 MLTSS — $2,334,114 Total — $11,050,000	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $51.85 by rate cell. Please see Exhibit 7 for the estimated PMPM impact	The development of the estimates is consistent with the preprint which was submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
			on each rate cell.		this arrangement.
Riverside VA_Fee_AMC.PC.SP_Renewal_20260701-20270630	Acute — $6,194,472 MLTSS — $2,373,452 Total — $8,567,924	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $32.54 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	The development of the estimates is consistent with the preprint which will be submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under this arrangement.
Sentara VA_Fee_AMC.PC.SP3_Renewal_20260701-20270630	Acute — $13,739,208 MLTSS — $7,309,098 Total — $21,048,306	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $12.27 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	The development of the estimates is consistent with the preprint which will be submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under this arrangement.
Valley VA_Fee_AMC.PC.SP2_Renewal	Acute — $3,857,433 MLTSS — $1,241,562	Mercer certifies to the estimates shown in Exhibit 7 of	The PMPM estimate varies between $0.00 and	The development of the estimates is consistent	A final rate certification will be completed following the

Control Name of the State Directed Payment	Aggregate Amount Included in the Certification	Statement that the Actuary is Certifying the Separate Payment Term	The Magnitude on a PMPM Basis	Confirmation the Rate Development is Consistent with the Preprint	Confirmation that the State and Actuary will Submit Required Documentation at the End of the Rating Period (as applicable)
_20260701-20270630	Total — $5,098,995	the rate report.	$5.40 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	with the preprint which will be submitted to CMS for approval.	end of the contract period to document final payments made to the MCOs under this arrangement.
NF VBP VA_VBP_NF_Renewal_20260701-20270630	MLTSS — $184,900,000	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $859.72 by rate cell. Please see Exhibit 7 for the estimated PMPM impact on each rate cell.	The development of the estimates is consistent with the preprint which was submitted to CMS for approval.	A final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under this arrangement.

Appendix A: Directed Payment Portion of Capitation Rate addresses item I.4.D.ii.a.iv in the 2025–2026 RDG. The table below also addresses item I.4.D.ii.a.iv in the 2025–2026 RDG.

Control Name of the State Directed Payment	Aggregate Amount
Private Hospital VA_Fee_IPH.OPH_Renewal_20260701-20270630	Inpatient — $2,645,112,662 Outpatient — $2,342,862,816 Total — $4,987,975,478
Non-State Government	Inpatient — $41,856,385

Control Name of the State Directed Payment	Aggregate Amount
VA_Fee_IPH.OPH2_Renewal_20260701-20270630	Outpatient — $32,753,676 Total — $74,610,061
UVA, VCU, and EVMS VA_Fee_AMC_ Renewal_20260701-20270630	UVA/VCU — $262,688,391 EVMS — $11,411,609 Total — $274,100,000
State Government Owned NFs VA_Fee_Oth3_Renewal_20260701-20270630	Total — $3,589,920
CRMC VA_Fee_Oth2_ Renewal_20260701-20270630	Total — $950,000
CHKD VA_Fee_SP_Renewal_20260701-20270630	Total — $11,050,000
Riverside VA_Fee_AMC.PC.SP_Renewal_20260701-20270630	Total — $8,567,924
Sentara VA_Fee_AMC.PC.SP3_ Renewal _20260701-20270630	Total — $21,048,306
Valley VA_Fee_AMC.PC.SP2_ Renewal _20260701-20270630	Total — $5,098,995
NF VBP VA_VBP_NF_Renewal_20260701-20270630	Total — $184,900,000
	Total — $5,571,890,684

For each directed payment arrangement, FY2027 estimates were developed by applying the historical proportion of provider utilization to the FY2027 capitation rates and projected enrollment; because projections indicated directed payment–eligible claim payments for FY2027 would be equal to or greater than FY2026, and in accordance with CMS grandfathering guidance, the FY2027 directed payment estimates were therefore held constant at FY2026 levels.

There are no interactions between multiple state directed payments where the aggregate impact differs from the sum of the impact of each individual state directed payment as no two preprints apply to the same provider.

Private Hospitals (VA_Fee_IPH.OPH_Renewal)

Effective October 1, 2018, DMAS established a payment initiative for private acute care hospitals to ensure that certain networks are maintained and reductions in disparity are promoted. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c). Starting July 1, 2024, DMAS added critical access hospitals to the provider class.

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are private hospitals located in the Commonwealth that provide inpatient and/or outpatient services. For purposes of this payment arrangement, private hospitals exclude public hospitals, freestanding psychiatric and rehabilitation hospitals, children’s hospitals, long stay hospitals, and long-term acute care hospitals.

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 169.5% for inpatient services and 238.6% for outpatient services which is to increase total reimbursement levels to the average commercial rate.

Non-State Government Owned Hospitals (VA_Fee_IPH.OPH2_Renewal)

Effective January 1, 2019, DMAS established a payment initiative for Chesapeake Regional Medical Center (non-state government owned acute care hospital) in the form of a uniform percentage increase. Effective July 1, 2021, DMAS identified Lake Taylor Transitional Care Hospital as being eligible for this payment initiative. This will ensure that there is effective management of chronic conditions. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

The provider eligible for enhanced payments for providing managed care services is Chesapeake Regional Medical Center and Lake Taylor Transitional Care Hospital

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 85.19% for inpatient services and 156.00% for all outpatient services. The actual uniform percentage increase will be determined based on the UPL gap. The UPL gap is based on 95% of the FFS ACR analysis for the UPL.

Physicians Affiliated with University of Virginia, Virginia Commonwealth University, and Eastern Virginia Medical School (VA_Fee_AMC_Renewal)

Effective January 1, 2019, DMAS established a payment initiative for physicians affiliated with the practice plans of Virginia's three allopathic medical schools (University of Virginia [UVA], Virginia Commonwealth University [VCU], and Eastern Virginia Medical School [EVMS]) to strengthen access to primary care networks and ensure effective management of chronic conditions. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are physicians affiliated with UVA, VCU, and EVMS.

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 221.00% for physician services provided at UVA/VCU and 97.00% for physician services provided at EVMS. The UPL gap has been based on the FFS ACR analysis for the UPL but will now follow HR1 grandfathering requirements so will not be updated with the FFS ACR analyses in the future.

State Government Owned Nursing Facilities (VA_Fee_Oth3_Renewal)

Effective July 1, 2025, DMAS established a payment initiative for certain government owned NFs. This will ensure quality of life for members with intensive health care needs. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This directed payment arrangement under 42 CFR §438.6(c) is currently under CMS review.

Eligible Providers

Providers eligible for this uniform percentage are type one hospitals that perform NH like services for individuals under age 21. Type one hospitals include VCU's Children Hospital of Richmond (CHOR).

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 23.69% for NH services provided at VCU's CHOR. The estimated uniform rate increase is based on the FY2026 directed payment increase percentages as the FY2027 directed payment increase percentages are not yet available. The actual uniform percentage increase will be determined based on the UPL gap. The gap is based on 100% of Medicare.

Physicians Affiliated Chesapeake Regional Medical Center (VA_Fee_Oth2_Renewal)

Effective July 1, 2022, DMAS established a payment initiative for physicians employed by or contracted with Chesapeake Regional Medical Center (CRMC), the Commonwealth's only non-state government owned general acute care hospital. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are physicians employed by or contracted with CRMC.

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 65.88% for physician services provided by physicians affiliated with CRMC.

For the directed payments noted above, a final rate certification will be completed following the end of the contract period to document final payments made to the MCOs under these arrangements. The capitation rates within this rate report do not include costs for these directed payments. Actual PMPMs will be calculated retroactively and certified after the end of the rating period.

Physicians Affiliated with Children's Hospital of the King's Daughters (VA_Fee_SP_Renewal)

Effective July 1, 2022, DMAS established a payment initiative for physicians employed by or contracted with CHKD. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are physicians employed by or contracted with CHKD.

Payment Amount

The uniform percentage increase is determined quarterly by dividing $11,050,000 by the total payments made by the Commonwealth in the previous quarter but no more than a uniform percentage increase consistent with the ACR as a percentage of Medicare.

Physicians Affiliated with Riverside Health System (VA_Fee_AMC.PC.SP_Renewal)

Effective July 1, 2024, DMAS established a payment initiative for physicians employed by or contracted with Riverside Health System. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are physicians employed by or contracted with Riverside Health System.

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 138.00% for physician services provided by physicians affiliated with CRMC. The estimated uniform rate increase is based on the FY2026 directed payment increase percentages as the FY2027 directed payment increase percentages are not yet available.

Physicians Affiliated with Sentara Health System (VA_Fee_AMC.PC.SP3_Renewal)

Effective July 1, 2024, DMAS established a payment initiative for physicians employed by or contracted with Sentara Health System. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are physicians employed by or contracted with Sentara Health System.

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 174.00% for physician services provided by physicians affiliated with CRMC. The estimated uniform rate increase is based on the FY2026 directed payment increase percentages as the FY2027 directed payment increase percentages are not yet available.

Physicians Affiliated with Valley Health System (VA_Fee_AMC.PC.SP2_Renewal)

Effective July 1, 2024, DMAS established a payment initiative for physicians employed by or contracted with Valley Health. The payment initiative is intended to supplement the base managed care rates negotiated between the MCOs and certain eligible providers. This is an approved directed payment arrangement under 42 CFR §438.6(c).

Eligible Providers

Providers eligible for enhanced payments for providing managed care services are physicians employed by or contracted with Valley Health System.

Payment Amount

The estimated uniform rate increase established by the Commonwealth is 164.00% for physician services provided by physicians affiliated with CRMC. The estimated uniform rate increase is based on the FY2026 directed payment increase percentages as the FY2027 directed payment increase percentages are not yet available.

Distribution Methodology

The payments for the described directed payments based on uniform percentage increases will be made to eligible providers quarterly throughout the contract period based on actual utilization. MCO encounter data will be used to link the enhanced payments to utilization of applicable services as defined above for MCO enrollees. DMAS will calculate each provider’s payment increase by MCO using valid encounters received during the previous quarter. DMAS will then issue an additional payment to each MCO based on the increase calculated for applicable services provided to the MCO's enrollees. Due to the uniform percentage increase being calculated after the encounters have been received, the directed payments will occur retroactively to each MCO.

Nursing Facility Value-Based Purchasing Program (VA_VBP_NF_Renewal)

Effective July 1, 2022, DMAS established a NF VBP program that seeks to improve the quality and outcomes of care furnished to Medicaid members by enhancing performance accountability in the areas of staffing and avoidance of negative care events. The payment initiative is intended to enhance funding for facilities that meet or exceed designated

performance and improvement thresholds associated with the provision of high-quality care to Medicaid members.

Eligible Providers

All NFs participating in Medicaid managed care will be eligible for NF VBP program payments. NFs should be defined as Provider Types 010 (Skilled Nursing Home) or 015 (Intermediate Care Nursing Home).

Payment Amount

The Commonwealth will allot a budgeted amount for payments to facilities based on their performance and improvement in the program's measures for staffing and avoidance of negative care events.

LTSS Services, Community Mental Health Services, ARTS, and Early Intervention Services

The CCMC contract also includes a minimum fee schedule for LTSS Services, Community Mental Health Services, ARTS, and Early Intervention Services. MCOs must pay no less than the DMAS fee schedule for these services. This is a directed payment arrangement under 42 CFR §438.6(c) that does not require approval. The impact of this payment arrangement is included in the capitation rates. Specifically, the managed care experience utilized in rate development already reflected these minimum fee schedule requirements; therefore, no further adjustment was necessary.

Durable Medical Equipment Services

The CCMC contract also includes a minimum fee schedule for DME. MCOs must pay no less than 90.00% of the DMAS fee schedule for these services effective July 1, 2021. The impact of this payment arrangement is included in the capitation rates. Specifically, the managed care experience utilized in rate development already reflected these minimum fee schedule requirements; therefore, no further adjustment was necessary.

Personal Care and Respite Care Services

The CCMC contract also includes a minimum fee schedule for Personal Care and Respite Care services. MCOs must pay no less than the DMAS fee schedule for these services effective July 1, 2021. The impact of this payment arrangement is included in the capitation rates. Specifically, the FFS and managed care experience utilized in rate development already reflected these minimum fee schedule requirements; therefore, no further adjustment was necessary.

Section 6

Projected Non-Benefit Costs

This section describes the administrative costs, care management, underwriting gain, relevant taxes and how they were incorporated into the rates. The impact of the non-medical expense loads is included in Exhibit 5.

Administration

The starting point for the administrative expense development was the historical administrative expense incurred in the CCMC program. Mercer certified public accountants and financial consultants reviewed the administrative expenses reported in the MCOs' FY2025 financial reports.

These reviews identify administrative expenses that should be excluded for rate development purposes, as well as reporting inconsistencies among MCOs. Mercer also utilized administrative audit report details completed by Myers and Stauffer LC to make adjustments for non-allowable expenses or costs that are accounted for separately. These may include, but are not limited to, premium taxes that are not applicable to Medicaid plans, marketing/lobbying fees, and as a result of this process, reported administrative expenses are adjusted to produce an appropriate baseline for a capitation rate administrative load.

The baseline administrative load for each population group was then trended to the midpoint of the FY2027 contract period for a total of 24 months and adjusted to reflect the impact of changes to enrollment levels between the base and contract period. The final Statewide administrative cost with all adjustments is $44.63 PMPM for the Acute population, $35.05 PMPM for the FAMIS population, and $162.71 PMPM for the MLTSS population.

The statewide administrative cost was then split out by region and rate cell using a fixed and variable cost methodology that is budget neutral overall. For the Maternity Kick payment, a proportionate administrative adjustment is applied to reflect the appropriate variable expense only in a budget-neutral manner. Fixed administrative PMPM continues to apply to the non-maternity PMPMs for each rate cell.

Care Management

Included in the historical administrative expense are costs related to care management which allows MCOs to eliminate unnecessary medical expenses. In addition, strong care management has been proven to improve the quality of care of the individual members and increase efficiencies, thereby reducing overall costs. Mercer reviewed the care management expenses as reported in the financial reports for reasonability and appropriateness as related to the contractual requirements and determined no adjustment to the reported care management expenses were necessary.

Underwriting Gain

Actuarial soundness requires that capitation rates consider all necessary and reasonable costs the MCO incurs to satisfy the terms of the contract. Mercer develops an underwriting gain component expressed as a percentage of the premium rate that provides for the cost of capital and a margin for risk appropriate for the covered populations under the CCMC program. In developing the margin, Mercer considers data such as state and federal taxes and DMAS-MCO reported financials, including statutory annual statements filed with state insurance regulators. Mercer applies assumptions that are consistent with the underlying rate development factors such as enrollment, projected medical costs, and other non-benefit costs, such as administration and care management.

Mercer considered these modeled scenarios to arrive at an underwriting gain assumption of 1.25% to the final premium rates.

Section 7

Risk Adjustment and Acuity Adjustments

This section describes the risk and acuity adjustments the Commonwealth employs for Acute and MLTSS populations and services during the FY2027 contract period.

Risk Adjustment

Within the Acute and MLTSS populations, capitation rates for the LIFC Child, LIFC Adult, Expansion Medically Non-Complex, Expansion Medically Complex and Community Non-Dual > 1 rate cells are subject to risk adjustment utilizing the combined CDPS+Rx risk adjustment model. The CDPS+Rx model utilizes demographic, diagnostic, and pharmacy data to classify individuals into demographic and disease categories that are used to predict the health care expenditures for each individual.

Within the MLTSS populations, the BH portion of the capitation rates for the Community Dual < 65 and Community Dual 65+ rate cells are risk-adjusted. The BH portion of the capitation rates is risk-adjusted using a model that leverages the CCSR diagnostic grouper. For the purposes of the BH risk adjustment process, BH services are defined as the CBH, ARTS, Case Management Services, and Early Intervention COS lines. The model utilizes demographic and diagnostic data from BH records to classify individuals into model categories to predict BH care expenditures for each individual.

Note that both risk adjustment processes described in this document are projected to be budget neutral, such that total projected dollars are the same both prior to and after the application of the risk adjustment processes. Further details will be shared as final decisions are made regarding the specifications. A separate risk adjustment methodology document will also be provided detailing the process.

NH/HCBS Mix Adjustment

The rates effective July 1, 2026 are blended for the NH eligible population based on a weighted average of the capitation rates for enrollees residing in NFs and enrollees in the HCBS waiver subpopulation. The purpose of the NH/HCBS blended rate is to create a financial incentive for MCOs to serve members in a cost-effective community setting, rather than a more costly institutional setting, to the greatest extent appropriate. To develop the blended rates, Mercer first developed the individual NH and HCBS rates by Dual status and then blended the two rates together (separately for Duals and Non-Duals, TPL and Non-TPL) with the projected mix assumptions. The projected mix represents the targeted enrollment mix between NH and HCBS populations that an efficient MCO can reasonably attain for the contract period.

The projected FY2027 NH/HCBS base mix was calculated using actual enrollment through March 2026, with consideration of historical enrollment patterns between the NH/HCBS populations. Overall, Mercer expects NH and HCBS enrollment mix to shift more towards HCBS relative to FY2026, due to higher observed growth in enrollment for the HCBS population relative to the NH population.

The NH/HCBS enrollment mix assumed for FY2027 by region and dual status are displayed in the table below.

Population	Non-Expansion		Expansion	
Region	Dual	Non-Dual	TPL	Non-TPL
Central Virginia	32.96%	12.09%	32.44%	32.44%
Charlottesville/Western	38.95%	9.34%	31.86%	31.86%
Northern/Winchester	21.44%	4.29%	25.35%	25.35%
Roanoke/Alleghany	42.46%	11.62%	39.47%	39.47%
Southwest	55.81%	23.00%	59.74%	59.74%
Tidewater	30.17%	8.79%	29.72%	29.72%

Budget-neutral adjustments to the NH/HCBS blended rates will be calculated for each MCO by region and dual status and provided with the final FY2027 rates. Adjustments to each MCO NH/HCBS mix may be considered during the contract year but will remain budget-neutral to the Statewide capitation rate.

Risk-Sharing Mechanisms

Risk-sharing mechanisms include arrangements such as reinsurance, risk corridors, or stop-loss limits. Acuity-driven plan risk adjustment is not included in these risk-sharing mechanisms and is addressed separately in this report.

The CCMC contract includes a pharmacy reinsurance pool that is intended to mitigate risk associated with excessive pharmacy claims between MCOs. This reinsurance pool is budget-neutral overall, and funds will be redistributed between MCOs after the rating period once 90% of actual pharmacy claims exceeding the $200,000 attachment point are known. Please refer to section 15.5 of the CCMC contract for additional details.

The MCOs are subject to both a minimum medical loss ratio (MLR) and a limit on underwriting gain. These provisions will apply on a combined basis across the Expansion and Non-Expansion populations in the CCMC program and will only include revenue and expense experience applicable to enrolled members included under the CCMC contract. The MLR is calculated first followed by the calculation of the underwriting gain limit. Please refer to the MLR and Limit on Underwriting Gain section of the CCMC contract for additional details.

The MCOs are required to report MLR calculations to DMAS subsequent to the end of the contract period, using a formula and methodology in accordance with 42 CFR §438.8. As further directed by DMAS, the MCOs shall maintain a minimum MLR of 85.00% in aggregate for the MCO's enrollee population. If the MCO does not maintain such minimum, the MCO is

required to remit an amount equal to the deficiency percentage applied to the amount of adjusted premium revenue. Although capitation rates are not directly impacted by the minimum MLR requirement, Mercer's review of historical MCO MLRs indicate that the rates have been developed in such way that the MCOs are reasonably expected to achieve and MLR of at least 85.00% for FY2027.

Finally, the MCOs are subject to a maximum underwriting gain for the contract period. The percentage shall be determined as the ratio of Medicaid underwriting gain to the amount of Medicaid premium income for FY2027.

- If the underwriting gain percentage for FY2027 exceeds 3.00% then the Contractor shall make payment to DMAS equal to 50.00% of the underwriting gain in excess of 3.00% of Medicaid premium income up to 6.00%.
- If the underwriting gain percentage for FY2027 exceeds 6.00% then the Contractor shall make payment to DMAS equal to 75.00% of the underwriting gain in excess of 6.00% of Medicaid premium income up to 8.00%.
- The Contractor shall return 100.00% of the underwriting gain above 8.00%.

Such amount will be remitted to DMAS as a refund of an overpayment. DMAS has implemented the underwriting gain limit as a cost-control strategy. The underwriting gain limit has been developed in accordance with generally accepted actuarial principles and practices. The underwriting gain limit does not have an effect on the development of the capitation rates.

Section 8

Certification of Final Rates

This certification assumes items in the Medicaid State Plan or waiver, as well as the CCMC program MCO contract, have been approved by CMS. In preparing the rates, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement levels, benefit design, financial data and information supplied by the Commonwealth and its vendors. The Commonwealth and its vendors are solely responsible for the validity and completeness of this supplied data and information. We have reviewed the summarized data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended rate-setting purpose. However, if the data and information are incomplete/inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness, appropriateness or attainability of the results for the Medicaid program. Actuarial assumptions may also be changed from one certification period to the next because of changes in mandated requirements, program experience, changes in expectations about the future and other factors. A change in assumptions is not an indication that prior assumptions were unreasonable, inappropriate or unattainable when they were made.

Mercer certifies that the rates shown in Exhibit 6 were developed in accordance with generally accepted actuarial practices and principles and are appropriate for the Medicaid covered populations and services under the CCMC MCO contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates. To the best of Mercer’s knowledge, there are no conflicts of interest in performing this work.

Rates developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely, and potentially wide, range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use. Actual MCO costs will differ from these projections. Mercer has developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR §438.4 and accordance with applicable law and regulations. Use of these rates for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCOs for

any purpose. Mercer recommends that any MCO considering contracting with the Commonwealth should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rates before deciding whether to contract with the Commonwealth.

The Commonwealth understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that the Commonwealth secure the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This report assumes the reader is familiar with the Commonwealth's CCMC program, Medicaid eligibility rules, and financing and actuarial rating techniques. It has been prepared exclusively for the Commonwealth, MCOs, and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results. Mercer is not responsible for, and expressly disclaims liability for, any reliance on this report by third parties.

The Commonwealth agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to the Commonwealth if nothing is received by Mercer within such 30-day period. If there are any questions regarding this report, please contact Brad Diaz at +1 612 642 8756, Roger Figueroa at +1 470 548 8862, or Selina Gilbertson at +1 602 522 6474.

Sincerely,

Brad Diaz,
FSA, MAAA
Principal

Roger Figueroa,
FSA, MAAA
Principal

Selina Gilbertson,
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Principal

Exhibit 1

Base Sheets

Exhibit 2

Base Program Change Summary

Exhibit 3

Trend Summary

Exhibit 4

Prospective Program Change Summary

Exhibit 5

Rate Sheets

Exhibit 6

Final Base Capitation Rate Summary

Exhibit 7

Directed Payment Estimates

Appendix A

Directed Payment Portion of Capitation Rates

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