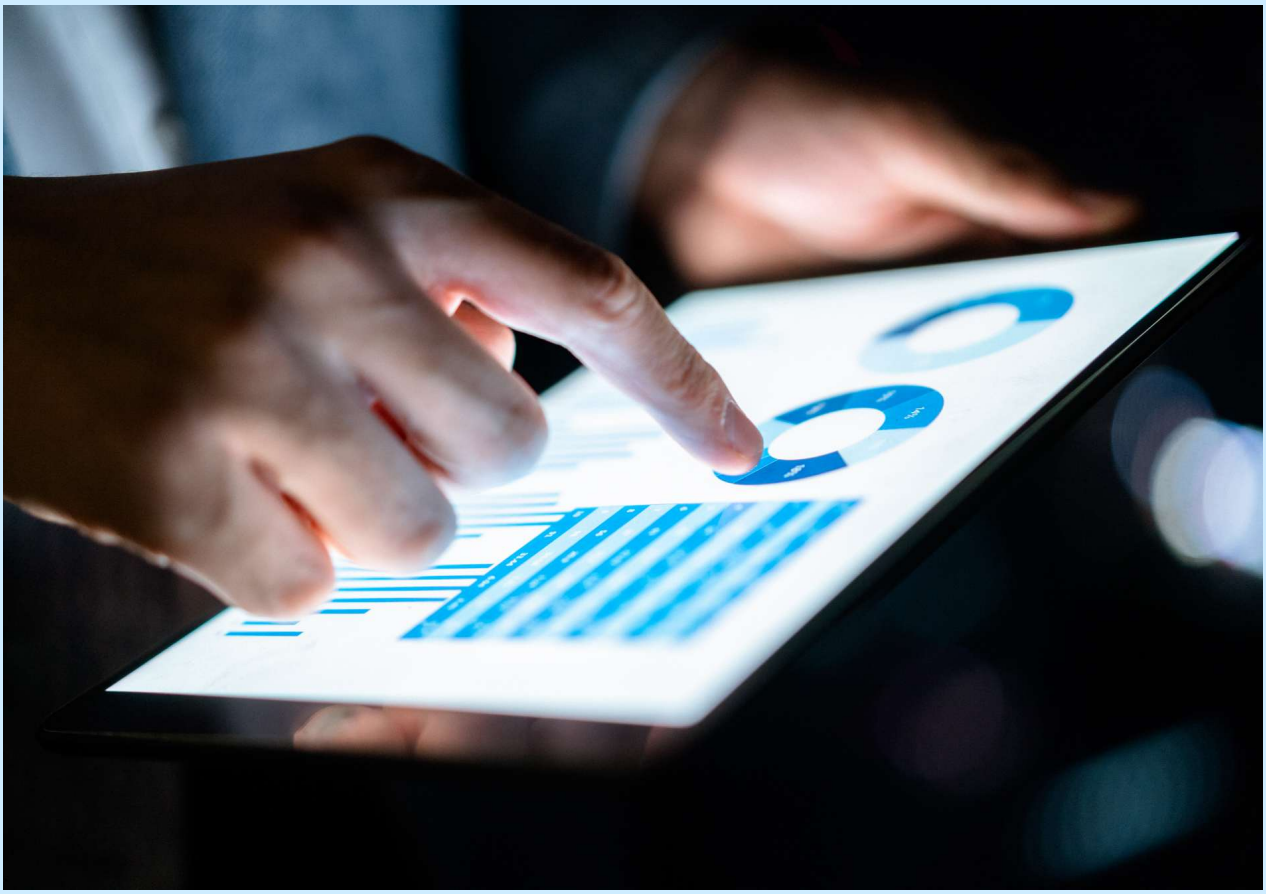
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August 19, 2026
Commonwealth of Virginia

FINAL Fiscal Year 2027 Cardinal Care Managed Care Rate Report

Acute, FAMIS, and MLTSS Populations

Rates Effective July 1, 2026



Contents

1. Introduction 1

2. General Information 3

- Rate Development Overview 8
- Rate Change 8
- Known Amendments 10

3. Data 11

4. Projected Benefit Costs and Trends 12

- Base Program Changes 12
- Trend 14
- Prospective Program Changes 15

5. Special Contract Provisions Related to Payment 18

6. Projected Non-Benefit Costs 21

- Administration 21
- Care Management 21
- Underwriting Gain 21

7. Risk Adjustment and Acuity Adjustments 22

- Risk Adjustment 22
- NH/HCBS Mix Adjustment 22
- Risk-Sharing Mechanisms 22

8. Certification of Final Rates 23

Exhibit 2: Base Program Change Summary 25

Exhibit 3: Trend Summary 26

Exhibit 4: Prospective Program Change Summary 27

Exhibit 5: Rate Sheets 28

Exhibit 6: Final Base Capitation Rate Summary 29

Exhibit 7: Directed Payment Estimates 30

Appendix A: Directed Payment Portion of Capitation Rates 31

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).

An overview of the analyses and methodologies used to develop the original FY2027 CCMC program capitation rates was provided in the previous rate report dated May 28, 2026.

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 a certification of the revisions to the original FY2027 CCMC rates to reflect programmatic changes that were not authorized by the Commonwealth at the time of the previous certification. The only changes to these revised rates include:

- Elimination of inflation adjustments for inpatient, outpatient, home health, and nursing facility rates for FY2027 and FY2028, effective July 1, 2026.
- Updated fee schedule changes for personal/respite care, skilled/private duty nursing, and hospice services.
- Requirement of a diagnosis of autism spectrum disorder prior to authorization for applied behavioral analysis (ABA) services, and implementation of 20-hour-per-week cumulative limit per recipient for ABA services unless medically necessary, effective October 1, 2026.

[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.

- Limitation of mobile crisis response services to four hours per incident, and restricting coverage to Virginia's Department of Behavioral Health and Developmental Services (DBHDS)-licensed and approved mobile crisis providers contracted with Community Service Boards, effective October 1, 2026.
- Implementation of the nursing facility per diem add-on of $14.50, effective October 1, 2026.
- Reflecting a maximum underwriting gain of 1.00%.

All other rating adjustments described in the original report dated May 28, 2026, remain unchanged. Additional details related to these legislative updates are included in the following sections.

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.

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

This report provides a certification of revisions effective July 1, 2026, to reflect additional programmatic changes that were not authorized at the time of the previous certification dated May 28, 2026. All other rating assumptions described in the previous rate certification remain unchanged. Additional details related to these revisions are included in the following sections of this report.

The Exhibits and Appendix A attached in this report have been updated from the previous rate report dated May 28, 2026, for only those impacted by the programmatic changes.

Rate Change

The revised FY2027 rates represent an aggregate -1.47% change for total CCMC, -2.44% change for Acute/FAMIS and -0.71% change for MLTSS from the original FY2027 rates effective July 1, 2026. Figures below represent rate change drivers as compared to the original FY2027 rates. For information regarding the magnitude of each adjustment for revised FY2027 rates, please refer to the appropriate section in this report. No changes were made to the assumptions that were utilized in the development of the original FY2027 rates other than those noted in this rate report. Exhibit 6 includes the revised FY2027 rates for each rate cell and region. Key drivers of the rate changes include:

- Due to the removal of inflation adjustments for hospital and nursing facilities effective July 1, 2026, several fee schedule adjustments were updated to remove prior placeholder assumptions from the analysis, contributing -1.02% to the total CCMC rate change, with -0.94% to Acute/FAMIS populations and -1.08% to the MLTSS populations.
- An increase to the reimbursement rates for skilled and private duty nursing services, contributing 0.05% to the total CCMC rate change, with 0.00% to the Acute/FAMIS populations and 0.09% to the MLTSS populations.
- An increase to the reimbursement rates for personal and respite care services adjustment, contributing 0.05% to the total CCMC rate change, with 0.00% to the Acute/FAMIS populations and 0.43% to the MLTSS populations.
- Service provision limits for ABA services were implemented due to legislative mandate, contributing to 0.15% to the total CCMC rate change, with 0.21% to Acute/FAMIS populations and 0.12% to the MLTSS populations.
- Service provision limits for mobile crisis services were implemented due to legislative mandate, contributing to -0.66% to the total CCMC rate change, with -0.89% to Acute/FAMIS populations and -0.48% to the MLTSS populations.
- Inclusion of add-on per diem for nursing and specialized care facility reimbursement rates, included as an add-on payment, contributing 0.38% to the total CCMC rate change; with 0.00% to Acute/FAMIS populations and 0.68% to MLTSS populations.
- A reduction in the underwriting gain load from 1.25% to 1.00%, contributing -0.27% to the total CCMC rate change, with -0.27% to Acute/FAMIS populations and -0.26% to MLTSS populations.

Rate Change Summary

The table below compares the revised FY2027 capitation rates to the final FY2026 rates by rate cell on a statewide basis.

Population	Rate Cell	TPL Category	Age Group	Statewide
Acute Non-Expansion				
Acute	LIFC Under 1	Combined	Age Under 1	4.52%
Acute	LIFC Child	Combined	Ages 1–20	3.31%
Acute	LIFC Adult	Combined	Age 21+	4.16%
Acute	Adoption Assistance	Combined	Age Under 21	1.80%
Acute	Foster Care	Combined	Age Under 21	9.97%
Acute Expansion				
Acute	Expansion Medically Non-Complex	Combined	Ages 19–64	4.80%
Acute Maternity				
Acute and FAMIS	Maternity Kick – Acute	Combined	All Ages	0.95%
FAMIS				

Population	Rate Cell	TPL Category	Age Group	Statewide
FAMIS	FAMIS Under 1	Combined	Age Under 1	4.61%
FAMIS	FAMIS Child	Combined	Ages 1–18	3.11%
FAMIS	FAMIS MOMS	Combined	All Ages	11.12%
MLTSS Non-Expansion				
MLTSS	Blended NH/HCBS waiver	Dual	All Ages	5.29%
		Non-Dual	All Ages	5.81%
MLTSS	DD waivers	Dual	All Ages	-4.96%
		Non-Dual	All Ages	1.37%
MLTSS	HCBS with PDN waiver	Dual and Non-Dual	All Ages	9.51%
MLTSS	Community No LTSS	Dual	Age Under 65	-2.59%
			Age 65 and Over	2.50%
		Non-Dual	Age Under 1	12.31%
			Age 1 and Over	6.78%
MLTSS Expansion LTSS				
MLTSS	Blended NH/HCBS waiver	Major TPL	All Ages	4.99%
		Non-TPL	All Ages	5.17%
MLTSS	DD waivers	Non-TPL	All Ages	1.37%
MLTSS	HCBS with PDN waiver	Combined	All Ages	9.51%
MLTSS Expansion No LTSS				
MLTSS	Expansion Medically Complex	Combined	All Ages	2.28%
MLTSS Maternity				
MLTSS	Maternity Kick – MLTSS	Combined	All Ages	-2.33%

Known Amendments

Mercer anticipates a need to issue an amendment to this certification during the FY2027 contract period due to expected material changes associated with “An act to provide for reconciliation pursuant to title II of H. Con. Res. 14” (H.R.1) and other cost containment measures that were approved by the State legislature after the original FY2027 rates were finalized. Program changes related to H.R.1 are not included in these revised FY2027 rates given the current implementation status the operational changes needed to meet the new requirements. The cost containment measures are pending SPA approvals prior to implementation.

Section 3

Data

As previously stated, Mercer performed a rate update to develop the revised FY2027 rates. 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.

For more information regarding the development of the original FY2027 rates, please refer to the previous rate report letter dated May 28, 2026.

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. For the revised FY2027 rate development, certain program changes were updated to reflect relevant items from the final approved Virginia State budget and are outlined below. All other program changes remain consistent with the original FY2027 rate development and can be found in the previous rate report dated May 28, 2026. While the values of the adjustments may have changed, the same methodology was maintained.

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, and July 1, 2025, inflation adjustments of 6.40% and 4.19%, respectively, were made to reimbursement for inpatient hospital services due to FFS fee schedule changes. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Outpatient Hospital Reimbursement Changes:** Effective July 1, 2024, and July 1, 2025, inflation adjustments of 4.60% and 4.19%, respectively, were made to reimbursement for outpatient hospital services due to FFS fee schedule changes. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.

- **Inpatient Hospital — Children of the King's Daughters (CHKD) Reimbursement Changes:** Effective July 1, 2024, and July 1, 2025, inflation adjustments of 6.40% and 4.19%, respectively, were made to reimbursement for inpatient CHKD services due to FFS fee schedule changes. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Outpatient Hospital — CHKD Reimbursement Changes:** Effective July 1, 2024, and July 1, 2025, inflation adjustments of 4.60% and 4.19%, respectively, were made to reimbursement for outpatient CHKD services due to FFS fee schedule changes. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Freestanding Inpatient Psychiatric Hospital Reimbursement Changes:** Effective July 1, 2024, and July 1, 2025, inflation adjustments of 14.80% and 4.19%, 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. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Critical Access Hospitals (CAHs):** Effective July 1, 2024, and July 1, 2025, increases of 17.20% and 4.19% were made to inpatient services, respectively, and increases of 6.00% and 4.19%, 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. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Type One Hospitals:** Effective July 1, 2024, and July 1, 2025, increases of 5.70% and 4.19%, were made to inpatient services, respectively, and changes of -37.40% and 4.19% 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. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Acute Inpatient Psychiatric Hospital Reimbursement Changes:** Effective July 1, 2024, and July 1, 2025, inflation adjustments of 17.40% and 4.19%, respectively, were made to reimbursement for inpatient psychiatric services provided at acute hospitals due to FFS fee schedule changes. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.
- **Hospice:** Effective July 1, 2025, and July 1, 2026, increases of 2.90% and 2.30%, respectively were made due to FFS fee schedule changes.
- **Skilled and Private Duty Nursing:** Effective July 1, 2024, and July 1, 2026, increases of 3.00% and 4.32%, respectively, were made to reimbursement due to FFS fee schedule changes.
- **Home Health Adjustment:** Effective July 1, 2024, and July 1, 2025, increases of 4.00% and 3.70%, 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. In accordance with

the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.

- **Personal and Respite Care Adjustment:** Effective July 1, 2024, July 1, 2025, and January 1, 2027, increases of 2.00%, 2.00%, and 4.00%, respectively, were made to reimbursement for personal and respite care services.
- **NF Adjustment:** Effective July 1, 2024, and July 1, 2025, increases of 3.34% and 3.98%, respectively, were made to reimbursement for NF services due to FFS fee schedule changes. Effective July 1, 2024, and July 1, 2025, increases of 3.83% and 3.98%, respectively, were made to reimbursement for specialized care in NF settings. In accordance with the 2026 Appropriations Act, Item 291.PPPPP, no inflation adjustments were effective July 1, 2026.

All other fee schedule changes remain consistent with the original FY2027 rate development and can be found in the previous rate report dated May 28, 2026.

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	5.02%	0.78%	1.43%	0.79%	1.97%	1.68%	5.11%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	4.09%	0.61%	0.63%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	5.54%	4.61%	0.95%	5.15%	1.56%	1.77%	4.59%
Non-Dual	5.07%	3.71%	1.24%	5.15%	1.86%	1.77%	4.59%

Trend

All trend assumptions remain consistent with the original FY2027 rate development and can be found in the previous rate report dated May 28, 2026.

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%	9.81%	16.38%	11.41%	12.69%	17.78%	7.20%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.70%	10.61%	10.39%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.72%	5.89%	0.69%	7.84%	8.05%	16.45%	5.68%
Non-Dual	3.93%	11.92%	12.75%	7.84%	15.78%	16.45%	5.68%

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 and were not originally accounted for in the original FY2027 rates. All other prospective program changes remain consistent with the original FY2027 rate development and can be found in the previous rate report dated May 28, 2026. While the values of the adjustments may have changed, the same methodology was maintained.

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

NF Per Diem Add-On

In accordance with the 2026 Appropriations Act, Item 291.LLL.1.b approved on June 29, 2026, DMAS will distribute approximately $70 million in additional funding across all NF services through a per diem add-on payment for FY2027. DMAS estimated a per diem add-on amount of $14.50 based off the Medicaid managed care portion of the appropriation to be incorporated into the indirect rate of the nursing facility rates, effective October 1, 2026.

The statewide aggregate adjustment for the NF Per Diem Add-On is summarized in the table below.

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	3.31%	0.01%	0.03%	0.00%	0.37%	0.01%	0.00%
Non-Dual	2.19%	0.00%	0.00%	0.00%	0.01%	0.01%	0.00%

Applied Behavioral Analysis

In accordance with the 2026 Appropriations Act, Item 291.WW.2 approved on June 29, 2026, DMAS will limit ABA services to 20 hours per week per member except in the case of medical necessity. In addition, ABA services will only be authorized for members with an autism spectrum disorder (ASD) diagnosis. Children aged five and younger may receive a provisional diagnosis for up to one year before an ASD diagnosis is required. As CMS approval for these service-criteria restrictions is still pending, Mercer assumed an October 1, 2026 effective date at DMAS's direction.

Mercer analyzed the ABA service utilization underlying the CY2024 base data. Any claims for members without an ASD diagnosis were excluded, except for members under age six. It was assumed 10% of the currently undiagnosed members receiving ABA services would obtain an ASD diagnosis once the restrictions are implemented. Per DMAS's direction, members between the ages of eight and fourteen were assumed to have lower levels of medical necessity for ABA services; experience for these members were limited to 20 hours per week unless their utilization currently exceeded 40 hours per week, indicating high-level medical necessity. For all other members currently with an ASD diagnosis, claims totaling between 20 and 25 hours per week were limited to 20 hours. All other ABA experience was left unaltered. The expected value of the removed or repriced ABA utilization was then trended to the rating period using ABA-specific trend factors and prorated to reflect the assumed effective date.

The statewide aggregate adjustment for the ABA service provision criteria change is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	-0.91%	0.00%	-1.82%	-0.80%	0.00%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	-0.57%	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%	0.00%	0.00%
Non-Dual	-0.01%	-0.36%	-0.69%	0.00%	-0.27%	0.00%	0.00%

Mobile Crisis

In accordance with the 2026 Appropriations Act, Item 291.KKKKK approved on June 29, 2026, DMAS will limit mobile crisis response services to four hours per incident and restrict coverage to DBHDS-licensed and approved mobile crisis providers contracted with Community Services Boards (CSBs). As CMS approval for four-hour limit is still pending, Mercer assumed an October 1, 2026 effective date at DMAS's direction. Separately, DMAS

has already implemented changes to limit mobile crisis services to approved providers; accordingly, the portion of the adjustment attributable to provider restrictions is assumed to have taken effect prior to the start of the contract period.

Mercer analyzed mobile crisis service utilization underlying the CY2024 base data. Claims from disallowed providers were removed. The remaining claim dollars and units were capped at four hours per incident. The expected value of removed or repriced services were then trended forward to the rating period using trend factors specific to mobile crisis service utilization. The hour-limit portion of the adjustment was prorated to reflect the expected effective date of October 1, 2026 and then combined with the reduction for disallowed providers for the final mobile crisis adjustment.

The statewide aggregate adjustment for the mobile crisis service provision criteria change is summarized in the table below.

Acute	LIFC <1	LIFC Child	LIFC Adult	AA	FC	Exp Non-Complex	Mat Kick – Acute
Adjustment	0.00%	-0.18%	-1.97%	-0.20%	-0.28%	-1.40%	0.00%

FAMIS	FAMIS Under 1	FAMIS Child	FAMIS MOMS
Adjustment	0.00%	-0.05%	-0.15%

MLTSS Dual Status	NH	HCBS	DD Waiver	HCBS with PDN	COMM No LTSS	Exp Complex	Mat Kick – MLTSS
Dual	0.00%	-0.02%	-0.61%	0.00%	-1.69%	-1.73%	0.00%
Non-Dual	-0.01%	-0.04%	-0.10%	0.00%	-0.87%	-1.73%	0.00%

Section 5

Special Contract Provisions Related to Payment

This report updates the previously certified capitation rates for the FY2027 rating period to incorporate changes to several approved directed payment arrangements under 42 CFR §438.6(c) that were addressed through a separate payment term. The directed payments described in this report are applicable to the Acute and MLTSS rates effective July 1, 2026, through June 30, 2027. The updates from the previous rate report dated May 28, 2026, are as follows:

- Updated Physicians Affiliated with Chesapeake Regional Medical Center directed payment arrangement estimate to match what is in the most recent preprint submitted to CMS.

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 #
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

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)
CRMC VA_Fee_Oth2_Renewal_20260701-20270630	Acute — $773,646 MLTSS — 400,567 Total — $1,174,213	Mercer certifies to the estimates shown in Exhibit 7 of the rate report.	The PMPM estimate varies between $0.00 and $4.71 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
CRMC VA_Fee_Oth2_Renewal_20260701-20270630	Total — $1,174,213

Physicians Affiliated with 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.

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 MCO administration PMPM development remains the same as the original FY2027 rates. For more information regarding the development of the MCO administration assumptions, please refer to the previous rate report dated May 28, 2026.

Care Management

Care management PMPM development remains the same as the original FY2027 rates. For more information regarding the development of the care management assumptions, please refer to the previous rate report dated May 28, 2026.

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 evaluate the adequacy of a range of underwriting gain assumptions. For the original FY2027 rates, Mercer applied an underwriting gain load of 1.25%.

In accordance with the 2026 Appropriations Act, Item 291.RRRRR approved on June 29, 2026, DMAS will select an underwriting gain load of 1.00% in the final reimbursement to the CCMC MCOs. Mercer evaluated the adequacy of this underwriting gain assumption using previously modeled underwriting gain scenarios as well as in the context of broader rate development assumptions. Mercer concluded that an underwriting gain load of 1.00% continues to reflect reasonable provision for adverse deviation and uncertainty within the underlying rating components and assumptions such that the rates, in aggregate, remain actuarially sound.

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

There were no changes to the risk scores for the revised FY2027 rates. For more information regarding the development of the risk adjustment methodology, please refer to the previous rate report dated May 28, 2026.

NH/HCBS Mix Adjustment

There were no changes to the NH/HCBS mix for the revised FY2027 rates. For more information regarding the development of the NH/HCBS mix methodology, please refer to the previous rate report dated May 28, 2026.

Risk-Sharing Mechanisms

Risk-sharing mechanisms include arrangements such as reinsurance, risk corridors, or stop-loss limits. For more information regarding risk-sharing mechanisms and consideration within the FY2027 rates, please refer to the previous rate report letter dated May 28, 2026.

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,
FSA, MAAA
Principal

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

MERCER
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