COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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September 1, 2025

MEMORANDUM

TO: The Honorable Don Scott
Speaker, Virginia House of Delegates

The Honorable Scott A. Surovell
Majority Leader, Senate of Virginia

FROM: Cheryl J. Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Managed Care Spending and Utilization Trends in SFY25

This report is submitted in compliance with item 288.R.3. of the 2025 Appropriations Act, which states:

"The Department of Medical Assistance Services shall report to the General Assembly on spending and utilization trends within Medicaid managed care, with detailed population and service information and include an analysis and report on the underlying reasons for these trends, the agency's and MCOs' initiatives to address undesirable trends, and the impact of those initiatives. The report shall be submitted each year by September 1."

Should you have any questions or need additional information, please feel free to contact me at (804) 664-2660.

CJR/wrf

Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Managed Care Spending and Utilization Trends in SFY25

September 1, 2025

Report Mandate:

Item 288.R.3. of the 2025 Appropriations Act, states, "The Department of Medical Assistance Services shall report to the General Assembly on spending and utilization trends within Medicaid managed care, with detailed population and service information and include an analysis and report on the underlying reasons for these trends, the agency's and MCOs' initiatives to address undesirable trends, and the impact of those initiatives. The report shall be submitted each year by September 1."

Spending and Utilization Trends in SFY25

This report provides a review of overall medical spend and utilization by Virginia's Managed Care Organizations (MCOs) for Fiscal Year (FY) 2025 (July 1, 2024, through March 31, 2025; partial year due to claims lag and runout).

Overall, we see total Medicaid per member per month (PMPM) costs increased 11.5% from FY24 (July 1, 2023, through June 30, 2024) to FY25. The drivers of the increase are a split between cost per claim (+4.5%) and claim volume (+6.7%). When stratifying by program, Acute (formerly known as Medallion 4) PMPM costs increased 10.7% from FY24 to FY25. Similarly, for the Managed Long-Term Services and Supports (MLTSS, formerly known as CCC Plus) program, PMPM increased 9.2% from FY24 to FY25. For additional context, the change between FY23 (July 1, 2022, through June 30, 2023) and FY24 for PMPM was 8.65% for Acute and 10.45% for Managed Long-Term Services & Supports (MLTSS).

By reviewing costs through PMPM, we can standardize enrollment changes and provide better year to year comparisons; this is especially important for these time periods as the Public Health Emergency (PHE) resulted in more Virginians receiving Medicaid coverage beginning in late FY20 and continuing until unwinding efforts began in April 2023 and continued through FY24. Due to the nature of unwinding and redetermining Medicaid member eligibility, we expected to see increases in PMPM and volume of medical claims—referred to as Claims per 12K members (or Utilization)—as both have enrollment in their denominators. When dividing, decreasing the denominator without changing in the numerator, leads to a higher ratio or higher measure. In this case, reducing Medicaid enrollment can and did result in higher per member metrics (PMPM and Utilization) due to this shrinking denominator.

Acute's PMPM increase can be attributed to its 7.1% increase in volume of medical claims and a 3.4% increase in Cost per Claim.

MLTSS's overall PMPM change can be attributed to an increase in average cost and volume with Cost per Claim up 5.5% and Claims per 12K Members up 3.5%. The increase in volume is mostly attributed to Physician Services, which accounts for 70% of

the program's number of medical claims and experienced a 3.3% increase in FY25. It should be noted that for this report, Physician Services also includes Personal Care, Attendant Care Services, and other similar services; this is a noteworthy footnote as Personal Care and Attendant Care specifically are the top two services by cost each year. DMAS is actively working to split these out into a separate category for further reporting and analysis.

Additionally, Acute PMPM cost increases in FY25 were observed in all categories, with a small offset in Outpatient — which had a decrease of 1.6% over the prior State Fiscal Year. Similarly, MLTSS PMPM costs decreased in Outpatient services by 2.4%. This is consistent with the PMPM changes observed from FY23 to FY24 in both programs.

For MLTSS, the main contributor is an upward change in unit cost between FY24 and FY25, seen in all categories except Outpatient. Acute's overall upward change is due to increased utilization, as seen in the ED, Other, and Physician Services categories.

As MCOs reported in their initiatives (detailed below), they focused on decreasing ED utilization, Inpatient Readmissions, and duplicate Pharmacy prescriptions.

Medical expense categories that can be associated with preventative healthcare and therefore help reduce costlier place of service care like Inpatient hospitalizations or ED visits (such as Physician Services and Pharmacy) experienced similar results in utilization from FY24 to FY25. Acute Physician Services utilization increased by 15.7% and scripts per member also increased 5.2%; MLTSS, as previously stated, experienced a 3.3% increase in Physician Services claims volume and a 5.3% increase in standardized Pharmacy script counts.

Addressing undesirable trends: Initiatives and Outcomes

Throughout FY25, the Department of Medical Assistance Services (DMAS) and Virginia's MCOs monitored spending and utilization trends and addressed undesirable trends.

One health plan began a polypharmacy program in Petersburg, Virginia to focus on residents taking 10+ unique medications monthly or 6+ medications prescribed by 10+ prescribers. The health plan's clinical pharmacists contacted members to provide education and reconcile medications, leading to a 13.8% reduction in acute admissions and an 11.7% reduction in ED visits. The program resulted in $170,000 in cost avoidance and has since been expanded to all members on 10+ maintenance medications.

Another initiative to improve health and reduce duplicate prescriptions was the Drug Savings Review (DSR) Program which identifies evidence-based clinical opportunities to reduce inappropriate utilization by sending timely and actionable interventions to prescribers within 72 hours of claim adjudication. In 2024, over 44,000 interventions were carried out, saving almost

$2,340,000 by addressing therapeutic duplications, inappropriate treatment durations, and clinically meaningful drug-to-drug or drug-to-disease interactions.

An initiative created to address high utilizers for behavioral and physical health care involved health navigators supporting members in accessing long-term and specialty care and addressing Social Determinants of Health (SDOH) needs. The program served 468 members and resulted in a 31% reduction in ED utilization, 48% reduction in admissions, and a drastic 50% improvement in the following HEDIS measures: Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Substance Use (FUA), and Follow-Up After Emergency Department Visit for Mental Illness (FUM) for enrolled members.

Other initiatives and program innovations by MCOs

Behavioral Health- One health plan began a Value-Based Payment partnership with an integrated Behavioral Health Home to focus on member engagement, whole health collaboration across providers, and decrease unnecessary utilization of higher levels of care. As a result, this health plan observed a decrease in ED utilization from 374.6 per thousand members to 222.3 per thousand members. Additionally, inpatient medical utilization decreased to 26.7 per thousand members from 58.9 per thousand members and behavioral health admissions decreased to 40.4 per thousand members from 76.9 per thousand members.

Another partnership to provide wrap around care focused on family education and support, medication management, psychotherapy, and Social Determinants of Health (SDOH) needs for members aged 12-26. Over 95% of program participants did not need higher levels of care while in treatment or post-discharge and inpatient readmissions were significantly reduced.

Maternal Health- One health plan initiated a new Behavioral Health Collaborative Care Model, which integrated mental health services into primary care by placing a BH Care Manager (BHCM) in primary care practices. The BHCM serves as a conduit to direct patient's care to the primary care Provider.

Big 3 By Cost Category

Program: MEDALLION4 (Acute)

Healthplan*: All

Eligibility Category: All

		SFY2023	SFY2024	SFY2025	% Difference SFY24- 25
Grand Total	PMPM	$312	$339	$376	10.7%▲
	Cost Per Claim	$171	$187	$193	3.4%▲
	Claims Per 12K Members	21,843	21,826	23,376	7.1%▲
ER	PMPM	$19	$21	$23	5.4%▲
	Cost Per Claim	$143	$164	$164	0.1%▲
	Claims Per 12K Members	1,585	1,576	1,658	5.2%▲
In-Patient	PMPM	$57	$62	$66	7.3%▲
	Cost Per Claim	$8,173	$8,400	$8,947	6.5%▲
	Claims Per 12K Members	83	88	89	0.8%▲
Nursing Facility	PMPM	$0	$0	$0	-27.5%▼
	Cost Per Claim	$3,798	$4,326	$4,559	5.4%▲
	Claims Per 12K Members	0	0	0	-31.2%▼
Other Facility	PMPM	$5	$5	$7	21.5%▲
	Cost Per Claim	$1,221	$1,286	$1,285	-0.1%▼
	Claims Per 12K Members	52	51	62	21.6%▲
Out-Patient	PMPM	$40	$47	$46	-1.6%▼
	Cost Per Claim	$494	$551	$523	-5.1%▼
	Claims Per 12K Members	971	1,026	1,063	3.6%▲
Pharmacy	PMPM	$80	$84	$96	13.7%▲
	Cost Per Claim	$111	$118	$127	8.1%▲
	Claims Per 12K Members	8,670	8,552	8,999	5.2%▲
Physician Services	PMPM	$111	$119	$138	15.7%▲
	Cost Per Claim	$127	$136	$144	5.9%▲
	Claims Per 12K Members	10,483	10,533	11,505	9.2%▲

**Beginning SFY2024, Virginia Premier has become part of Sentara.*

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Big 3 By Cost Category

Program: CCCPLUS (MLTSS)

Healthplan*: All

Eligibility Category: All

		SFY2023	SFY2024	SFY2025	% Difference SFY24- 25
Grand Total	PMPM	$1,808	$1,997	$2,181	9.2%▲
	Cost Per Claim	$210	$218	$230	5.5%▲
	Claims Per 12K Members	103,408	109,970	113,845	3.5%▲
ER	PMPM	$26	$31	$32	3.2%▲
	Cost Per Claim	$100	$112	$114	1.9%▲
	Claims Per 12K Members	3,155	3,265	3,306	1.2%▲
In-Patient	PMPM	$181	$206	$222	8.0%▲
	Cost Per Claim	$6,872	$7,320	$8,507	16.2%▲
	Claims Per 12K Members	317	338	314	-7.1%▼
Nursing Facility	PMPM	$396	$431	$445	3.2%▲
	Cost Per Claim	$5,303	$5,780	$5,965	3.2%▲
	Claims Per 12K Members	895	895	895	0.0%▲
Other Facility	PMPM	$32	$30	$32	5.6%▲
	Cost Per Claim	$586	$627	$674	7.5%▲
	Claims Per 12K Members	658	583	572	-1.8%▼
Out-Patient	PMPM	$105	$121	$118	-2.4%▼
	Cost Per Claim	$454	$494	$485	-1.8%▼
	Claims Per 12K Members	2,772	2,933	2,917	-0.5%▼
Pharmacy	PMPM	$270	$289	$324	12.0%▲
	Cost Per Claim	$129	$138	$146	6.3%▲
	Claims Per 12K Members	25,069	25,214	26,545	5.3%▲
Physician Services	PMPM	$797	$889	$1,008	13.5%▲
	Cost Per Claim	$136	$139	$153	9.8%▲
	Claims Per 12K Members	70,542	76,743	79,296	3.3%▲

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About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for approximately two million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.