



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

STEVE FORD
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/343-0634 (TDD)

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MEMORANDUM

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

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

FROM: Steve Ford
Director, Virginia Department of Medical Assistance Services

SUBJECT: Managed Care Spending and Utilization Trends in SFY26

This report is submitted in compliance with Item 291.N.6. of the 2026 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.

SF/wrf

Enclosure

Pc: The Honorable Marvin B. Figueroa, Secretary of Health and Human Resources

Managed Care Spending and Utilization Trends in SFY26

September 1, 2026

Report Mandate:

Item 291.N.6. of the 2026 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 SFY26

This report provides a review of overall medical spend and utilization by Virginia's Medicaid Managed Care Organizations (MCOs) for Fiscal Year (FY) 2026. Full claims data for the second half of FY26 is not yet available as of the deadline for submission of this report. Therefore, the data analyzed in this report covers the partial year period from July 1 through December 31, 2025.

Overall, the total Medicaid per member per month (PMPM) costs increased 9.8% from FY25 (July 1, 2024, through June 30, 2025) to FY26 YTD. The drivers of the increase are a split between cost per claim (+2.6%) and claim volume (+7.0%).

Stratifying by program, Acute (formerly known as Medallion 4) PMPM costs increased 7.7% from FY25 to FY26. For the Managed Long-Term Services and Supports (MLTSS, formerly known as CCC Plus) program, PMPM increased 5.4% from FY25 to FY26. In comparison, the change in PMPM between FY24 and FY25 was +13.6% for Acute and +12.8% for MLTSS.

By reviewing PMPM costs, we can standardize enrollment changes and provide better year-to-year comparisons. This is especially important in the period covered by this report as enrollment has declined after years of sustained growth during and after the COVID-19 public health emergency (beginning in late FY20 and continuing during the period of unwinding from April 2023 through the end of FY24). Accompanying recent enrollment declines, we see increases in PMPM and in the utilization measure of standardized volume of medical claims (Claims per 12K members)—as both have enrollment in their denominators. Medicaid enrollment has declined while member acuity, costs, and utilization (the numerator) have remained high across the program, leading to higher per-member metrics.

The PMPM increase for the Acute program can be attributed to a 3.8% increase in volume of medical claims and a 3.7% increase in cost per claim. The Other Facility category—which

accounts for less than 2% of total medical spend and is mostly comprised of claims for residential treatment facilities for alcohol and substance use—increased the most, at 11.3%, with about two-thirds of the increase attributed to increased utilization, and the remaining third to increased cost per claim. Other categories of spending that increased during this time include pharmacy (+9.2% PMPM, almost entirely attributable to higher cost per script) and physician services (+8.1%, mostly due to higher claim volume per member). Other notable observations for the first half of FY26 include a decline in utilization for hospital inpatient and near flat utilization for ED. Both categories still experienced overall PMPM increases (ER +7.2% and hospital inpatient +3.7%) because of higher per-unit costs.

The MLTSS program’s overall PMPM change can be attributed to an increase in home and community-based services (HCBS). Representing 27% of MLTSS costs and 37% of the total claims per thousand members, HCBS’s PMPM increased 7.7% from FY25 to FY26. This was mostly caused by a 6.2% increase in claim volume and a 1.4% increase in average claim cost. It should be noted that the HCBS category includes personal care, attendant care services, and other similar services. Personal care and attendant care are the top two services by cost each year, and have been the top two for at least the previous three fiscal years. The last three fiscal years have seen agency-directed personal care, consumer-directed personal assistance/attendant care, and outpatient psychiatric services as three of the top four services. Mobile crisis response has risen in each of the last two fiscal years to become the third highest-cost service in FY26 YTD. Other services that make up the top 10 highest-cost services for Medicaid in FY26 include Addiction and Recovery Treatment Services (ARTS) partial hospitalization, agency-directed respite care, applied behavior analysis, mental health skill building, outpatient psychiatric services, and emergency department evaluation and management (E/M) moderate complexity medical decision-making (MDM). All 10 services were also in the top 10 in FY25.

Additionally, PMPM costs increased from FY25 to FY26 in all categories of the Acute and MLTSS programs. This is consistent with the PMPM changes observed in recent fiscal years. For MLTSS, the main contributor is an increase in volume between FY25 and FY26, seen in all categories except pharmacy (which decreased 2.0%). The Acute program’s overall upward change was driven in nearly equal parts by cost per claim and utilization. Overall, 80% of the Acute program’s medical spend is in physician services, pharmacy, and hospital inpatient, while 81% of the MLTSS program’s medical spend is in HCBS, physician services, nursing facility services, and pharmacy.

Addressing Undesirable Trends: Initiatives and Outcomes

Throughout FY26, the Department of Medical Assistance Services (DMAS) and Virginia's Medicaid MCOs monitored spending and utilization trends and addressed undesirable trends. MCOs reported that their initiatives focused on lowering inpatient readmissions, improving

member transitions from the emergency department (ED) to other care locations, improving quality and appropriate utilization of behavioral health services, and advancing innovative cost-saving payment models.

Transitions of Care

One MCO began a new partnership in September 2022 with a health system in Northern Virginia to improve the member experience and quality of care during care transitions, with a special focus on transitions for behavioral health (BH) services. Members are identified by the hospital and MCO staff, and the team works to identify social determinants of health (SDOH) barriers and transition needs of the member. Goals of the initiative are to identify opportunities to support a greater safety net for members in the community and reduce avoidable hospital discharge delays, readmissions, and unnecessary ED utilization due to transition gaps. The MCO's weekly multidisciplinary rounds have expanded to include behavioral health. Since inception, 531 members have been supported in transition rounds, resulting in a 22% reduction in ED visits and 47% reduction in inpatient admissions for these members. The MCO sees progress with transitions of care, a reduction in extended length of stay (LOS), and lower overall acute care utilization.

Another MCO expanded its On-Site Transition of Care Program by embedding navigators within hospitals to provide utilization management, case management services, and assist discharge planners in identifying the appropriate transition or outpatient BH services. The positive impact of this program began in January 2024 and continued through FY26.

Beginning July 2025, one managed care organization's Pharmacy Clinical Care team established a standardized Transitions of Care (TOC) model using a national framework to reduce 30-day readmissions. Pharmacy plays a key role in identifying and resolving medication-related risks at discharge, including prior authorization needs, safety concerns, access barriers, and delays in starting therapy. This model aligns pharmacy interventions with broader care management efforts during the transition period, strengthening medication safety, access, and adherence. From July 1 through December 31, 2025, the team performed 218 interventions, and from January 1 through May 31, 2026, the team performed another 239 member interventions. By addressing member needs and gaps early, the program helped prevent avoidable hospital readmissions and supported improved member outcomes.

Another MCO initiated a value-based program in November 2022 to better serve members by decreasing transitions to nursing facilities and reducing ED utilization. The program partner is measured quarterly on established performance measures and can earn bonuses for achieving those measures. Focused efforts and collaboration resulted in the program partner reducing

inpatient admissions by 24% and reducing nursing facility admissions by 25%, compared to other HCBS providers.

Extending into virtual telehealth, one MCO partnered with a telehealth provider to offer a 24/7 home access program to improve member access to care and intervention. This partnership began in November 2022 to identify member gaps in care and reduce unnecessary ED utilization. The program has had over 100,000 member visits since program launch, with 4,772 member visits and an average of 37.9 visits per member in 2025. The provider has supported interventions for members that are focused on social determinants of health (SDOH) with 40% of the SDOH interventions for food insecurity and 44% related to financial needs.

One MCO took a data-focused approach to identify potential readmissions through predictive risk modeling and provide member support and intervention through structured transitions of care programs and multidisciplinary case management. This MCO added targeted behavioral health initiatives and continuous performance monitoring to continue to reduce avoidable utilization and improve care outcomes. The impacts of this program were first recognized in the second half of FY2025.

That same MCO also leveraged a new Nursing Facility Diversion analytical tool in April 2026 and multidisciplinary teams to identify members experiencing functional decline based on diagnoses, frailty, medications, provider, or acute utilization patterns. The clinical team reviews the member cases during complex case rounds to discuss barriers and interventions in support of member's care, recommending more than 30 members for increased complex case management.

Quality and Appropriate Utilization of Behavioral Health Services

The MCOs have also taken steps to monitor and review Behavioral Health utilization. In late FY24 and throughout FY25, one MCO began reviewing utilization of the Mental Health Skill-Building service in cases where the member had been receiving services for more than one year and performing ARTS continued stay review (CSR) to determine whether services should continue. Interventions include reviewing whether continuing the Mental Health Skill-Building service is right for the member and, when necessary, redirecting members to more appropriate services to meet their needs. The ARTS CSRs significantly strengthened the MCO's evidence-based framework to guide the frequency, intensity, and duration of highly utilized services such as partial hospitalization programs (PHP) and intensive outpatient programs (IOP). This enhanced framework promotes consistency in clinical decision-making and proactive engagement with outpatient providers through regular clinical reviews. These reviews help identify opportunities for partnership with high-quality providers and ensure members receive care that is both appropriate and cost-effective. This MCO also hired a Board-Certified Behavioral Analyst (BCBA)

and enhanced their utilization management processes to improve medical necessity review of ABA services. The impacts have been recognized since early FY26.

Other MCO Initiatives and Program Innovations

Other MCO initiatives and program innovations include:

- **Initiating a virtual medical practice focused on improving maternal and newborn health through personalized, 24/7 support** – This program offers comprehensive care from preconception through an infant’s first year, supplementing traditional OB-GYN visits with a dedicated team that includes doulas, therapists, dietitians, and lactation consultants. Initially the program was deployed in three full regions (Southwest, Roanoke/Allegheny, and Tidewater). To address a large, contiguous maternal care desert, in May 2026, the following localities were added: Lunenburg, Greenville, and Southampton counties, and the city of Emporia.
- **Pre-admission services three days before inpatient admission** – Created a new payment policy to bundle all preadmission services within three days prior to inpatient stay (including day of admission). Evaluation of program impact began in the second half of FY25.
- **Coordination of Benefits (COB) process updates** – MCOs aim to achieve savings through COB recovery process improvements.
- **Capitated Lab Services** – After the MCO re-contracted lab services from fee-for-service to a capitated model, savings began in the second half of FY25.

Table 1 – MCO Cost and Utilization Metrics by Fiscal Year - Acute Program

Notes about the data and their interpretation as previously described in the report:

- PMPM (“Per member per month”)
 - Standardized way of looking at cost based on enrollment trends which is critical during time periods with significant or atypical fluctuations in membership
 - Calculated as Total Cost divided by Enrollment
- Cost per Claim
 - Average cost of a paid claim
 - Calculated as Total Cost divided by Total Count of Claims
- Utilization
 - Annualized metric for assessing volume of claims and services received by membership
 - Calculated as Total Count of Claims divided by Enrollment (which is divided by 1,000)

Medical Expense Category	Measure	SFY2024	SFY2025	SFY2026
Grand Total	PMPM	\$342	\$389	\$419
	Cost Per Claim	\$186	\$195	\$202
	Claims Per 1,000 Members	22,114	23,951	24,863
ER	PMPM	\$22	\$22	\$24
	Cost Per Claim	\$164	\$163	\$173
	Claims Per 1,000 Members	1,589	1,652	1,661
Inpatient	PMPM	\$63	\$73	\$75
	Cost Per Claim	\$7,910	\$8,944	\$9,453
	Claims Per 1,000 Members	95	97	95
Other Facility	PMPM	\$6	\$7	\$8
	Cost Per Claim	\$1,261	\$1,239	\$1,282
	Claims Per 1,000 Members	53	69	74
Outpatient	PMPM	\$47	\$48	\$52
	Cost Per Claim	\$551	\$539	\$556
	Claims Per 1,000 Members	1,035	1,058	1,122
Pharmacy	PMPM	\$85	\$97	\$106
	Cost Per Claim	\$118	\$129	\$140
	Claims Per 1,000 Members	8,630	9,040	9,140
Physician Services	PMPM	\$120	\$142	\$153
	Cost Per Claim	\$134	\$141	\$144
	Claims Per 1,000 Members	10,712	12,035	12,770

Table 2 – MCO Cost and Utilization Metrics by Fiscal Year - MLTSS Program

Medical Expense Category	Measure	SFY2024	SFY2025	SFY2026
Grand Total	PMPM	\$2,011	\$2,269	\$2,391
	Cost Per Claim	\$217	\$228	\$231
	Claims Per 1,000 Members	111,017	119,203	124,202
ER	PMPM	\$31	\$32	\$34
	Cost Per Claim	\$112	\$109	\$109
	Claims Per 1,000 Members	3,284	3,527	3,714
Home & Community Based Services	PMPM	\$495	\$593	\$639
	Cost Per Claim	\$146	\$165	\$167
	Claims Per 1,000 Members	40,534	43,173	45,843
Inpatient	PMPM	\$209	\$233	\$233
	Cost Per Claim	\$6,737	\$7,628	\$7,412
	Claims Per 1,000 Members	372	366	377
Nursing Facility	PMPM	\$434	\$454	\$469
	Cost Per Claim	\$5,773	\$5,883	\$5,950
	Claims Per 1,000 Members	902	927	946
Other Facility	PMPM	\$31	\$35	\$40
	Cost Per Claim	\$618	\$603	\$607
	Claims Per 1,000 Members	599	690	783
Outpatient	PMPM	\$121	\$123	\$131
	Cost Per Claim	\$492	\$481	\$496
	Claims Per 1,000 Members	2,951	3,076	3,167
Pharmacy	PMPM	\$291	\$328	\$349
	Cost Per Claim	\$138	\$149	\$162
	Claims Per 1,000 Members	25,358	26,376	25,855
Physician Services	PMPM	\$400	\$471	\$497
	Cost Per Claim	\$130	\$138	\$137
	Claims Per 1,000 Members	37,015	41,068	43,517

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.