CardinalCare
Virginia's Medicaid Program

External Finance Review Committee (EFRC) Meeting

July 23, 2026

DMAS

Agenda

- Budget & Enrollment Review
- Managed Care Program Update
- Complex Care Services Update
- MCO Claims Expense and Utilization Review

EFRC Meeting Requirements
2026 Appropriation Act

Item 295.C.4. The Department of Medical Assistance Services (DMAS) shall convene a meeting three times each fiscal year with the Secretary of Finance, Secretary of Health and Human Resources, or their designees, and appropriate staff from the Department of Planning and Budget, House Appropriations and Senate Finance and Appropriations Committees, and Joint Legislative Audit and Review Commission, to monitor Medicaid expenditures and enrollment growth to determine the program's financial status. At each meeting, DMAS shall report on expenditures (at the service level of detail) and enrollment in the Medicaid and children's health insurance programs to explain any material differences in expenditures compared to the official Medicaid forecast or children's health insurance programs forecasts, adjusted to reflect budget actions from each General Assembly Session. In addition, DMAS shall report on enrollment trends by eligibility category and indicate differences in actual enrollment as compared to the most recent forecast of enrollment. If expenditures are exceeding the budget for Medicaid or the children's health insurance programs, the department shall provide options to bring expenditures in line with available resources. At each meeting, DMAS shall provide an update on any changes to the managed care programs, or contracts with managed care organizations, that includes detailed information and analysis on any such changes that may have an impact on the capitation rates or overall fiscal impact of the programs, including changes that may result in savings. In addition, DMAS shall provide an analysis at each meeting on spending and utilization trends within the managed care programs with a focus on trends that indicate higher growth than was anticipated in the capitation rates. During each fiscal year, the meetings shall be held in April, July, and October of each year to review the time period since the last meeting.

CardinalCare
Virginia's Medicaid Program

Budget & Enrollment Review

Truman Horwitz, Budget Division Director

DMAS

Overview of FY2026

- Appropriation to Actual Overview
- By Program
- Enrollment
- Summary

FY2026 Spending Overview

Preliminary Title XIX and XXI Appropriation to Actual

Title XIX Appropriation to Actual

Expenditures	Appropriation	Actual	Remaining	% Remaining
Base Medicaid	19,870,724,766	19,190,645,395	680,079,371	3.4%
Medicaid Expansion	9,177,304,018	9,345,450,366	(168,146,348)	-1.8%
Total Title XIX	**29,048,028,784**	**28,536,095,761**	**511,933,023**	**1.8%**

Title XXI Appropriation to Actual

Expenditures	Appropriation	Actual	Remaining	% Remaining
FAMIS	543,457,554	531,355,294	12,102,260	2.2%
MCHIP	337,975,150	326,551,625	11,423,525	3.4%
Total Title XXI	**881,432,704**	**857,906,919**	**23,525,785**	**2.7%**

Fund Type (Title XIX and XXI)	Appropriation	Actual	Remaining	% Remaining
General	7,962,794,538	7,839,558,192	123,236,346	1.5%
Federal	18,764,865,950	18,511,455,794	253,410,156	1.4%
FAMIS Trust Fund	14,065,627	14,065,627	-	0.0%
Coverage Assessment	667,368,069	659,261,802	8,106,267	1.2%
Rate Assessment	2,068,355,917	1,917,649,978	150,705,939	7.3%
Private Health Sys Phys Supp Pymnt	16,080,925	16,080,825	100	0.0%
VHCF	435,930,462	435,930,462	-	0.0%
Fund Total	**29,929,461,488**	**29,394,002,680**	**535,458,808**	**1.8%**

- Under 2% of Title XIX and 3% of Title XXI appropriation remains.
- Overall, 1.5% of appropriated GF remains.
- VHCF fully spent down.

FY2026 Base Medicaid

Preliminary Appropriation to Actual

Base Medicaid	Appropriation	Actual	Remaining	%
General Medical Care: Managed Care	9,959,131,077	9,956,229,514	2,901,563	0.0%
General Medical Care: Fee-For-Service	1,947,481,276	1,855,555,195	91,926,082	4.7%
Behavioral Health & Rehabilitative Services: Fee-For-Service	42,318,153	34,791,123	7,527,030	17.8%
Long-Term Care Services: Fee-For-Service	3,093,289,814	3,021,596,653	71,693,161	2.3%
Supplemental Payments	1,076,248,966	943,345,768	132,903,198	12.6%
Private Acute Care Hospital Enhanced Supp Payments	3,572,491,024	3,239,832,947	332,658,077	12.1%
Total	**19,690,960,311**	**19,051,351,199**	**639,609,112**	**3.4%**
Federal Funds	9,906,868,065	9,513,969,674	392,898,391	4.1%
Rate Assessment	1,755,271,270	1,604,565,333	150,705,937	11.1%
Virginia Health Care Fund	435,930,462	435,930,462	0	0.0%
Private Health System Physician Supplemental Payment	12,825,600	12,846,206	-20,606	0.0%
General Fund	7,580,064,915	7,484,039,524	96,025,391	1.3%
Total	**19,690,960,312**	**19,051,351,199**	**639,609,113**	**3.4%**

In Base Medicaid, **1.3% GF remaining**

Trends we're reviewing

- MCO: While right on target, MLTSS is under forecast (LTC populations under forecast) but less pharmacy rebates made this closer.
- FFS General:
  - Dental is below forecast
- FFS BH:
  - More CSA cases identified and trending up
- Supplemental Payments: lower than expected

FY2026 Medicaid Expansion

Preliminary Appropriation to Actual

Medicaid Expansion	Appropriation	Actual	Remaining	%
General Medical Care: Managed Care	5,280,339,163	5,331,104,570	-50,765,407	-1.0%
General Medical Care: Fee-For-Service	570,305,058	544,770,065	25,534,993	4.5%
Behavioral Health & Rehabilitative Services: Fee-For-Service	20,398,957	22,403,352	-2,004,395	-9.8%
Long-Term Care Services: Fee-For-Service	135,518,112	131,249,975	4,268,137	3.1%
Supplemental Payments	295,763,770	185,075,925	110,687,845	37.4%
Private Acute Care Hospital Enhanced Supp Payments	2,874,978,958	3,130,846,479	-255,867,521	-8.9%
Total	**9,177,304,018**	**9,345,450,366**	**-168,146,348**	-1.8%
Federal Funds	8,193,595,977	8,369,869,300	-176,273,323	-2.2%
Rate Assessment	313,084,647	313,084,645	2	0.0%
Coverage Assessment	667,368,069	659,261,802	8,106,267	1.2%
Private Health System Physician Supplemental Payment	3,255,325	3,234,619	20,706	0.6%
Total	**9,177,304,018**	**9,345,450,366**	**-168,146,348**	-1.8%

Note: Appropriation is managed at the Program; sufficient federal funds exist to cover the noted overage. Refer to the overview slide for where all funds finished.

Trends we're reviewing

- Same as base Medicaid.

In Medicaid Expansion, **1.2%**
Coverage Assessment remaining

FY2026 Title XXI

Preliminary Appropriation to Actual

Title XXI Program	Appropriation	Actual	Remaining	%
FAMIS Expenditures	543,457,554	531,355,294	12,102,260	2.2%
MCHIP Expenditures	337,975,150	326,551,625	11,423,525	3.4%
Total	**881,432,704**	**857,906,919**	**23,525,785**	2.7%
State Funds	287,197,821	274,659,229	12,538,592	4.4%
Special Funds	14,065,627	14,065,627	0	0.0%
Federal Funds	580,169,256	569,182,063	10,987,193	1.9%
Total	**881,432,704**	**857,906,919**	**23,525,785**	2.7%

- Movement of appropriation at the end of the year makes this variance look larger than it is.

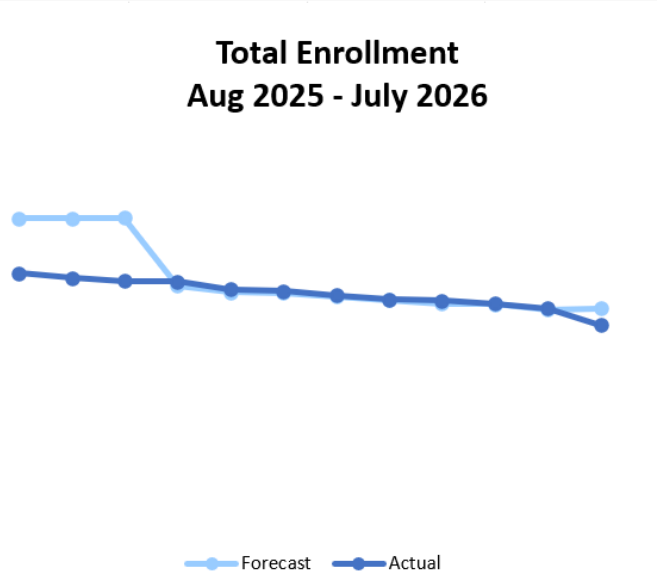
- Against the forecast:
  - FAMIS was within 0.3% and MCHIP within 3.0% of projected spending.
  - GF within 1.1% of forecast

- Trends we're looking into:
  - Decline in expected pharmacy rebates.
  - Declines in children's populations (both CHIP and Base)

Enrollment as of July 1, 2026

Enrollment as of 7/1/2026

Selected Categories	Forecast	Latest	Variance
Non-Long Term Care (LTC)	149,491	147,182	-2,309
LTC Nursing Facilities	17,816	17,478	-338
LTC HCBS + DD	66,288	65,319	-969
Caretaker Adults	116,073	107,837	-8,236
Pregnant Women	28,066	28,886	820
Children	510,249	501,547	-8,702
Expansion - Caretaker	103,581	102,453	-1,128
Expansion - Non-Caretaker	358,739	355,568	-3,171
Title XIX Total	**1,582,023**	**1,555,709**	**-26,314**
MCHIP	87,592	86,259	-1,333
FAMIS Kids	95,731	87,681	-8,050
FAMIS MOMS	5,101	4,789	-312
Title XXI Total	**192,967**	**183,243**	**-9,724**
Total Enrollment	**1,774,990**	**1,738,952**	**-36,038**



Enrollment as of 7/1/2026

Categories	Forecast	Latest	Variance	% Variance	Since June	% Change	Since Last Year	% Change
Aged, Blind, Disabled Total	235,838	232,150	-3,688	-1.56%	1,405	0.60%	3,165	1.38%
Low-income Families and Children Total	703,305	688,048	-15,257	-2.17%	16,508	2.33%	-70,081	-9.14%
Medicaid Expansion Total	576,049	570,582	-5,467	-0.95%	14,593	2.48%	-42,803	-6.90%
CHIP and MCHIP Total	192,967	183,243	-9,724	-5.04%	3,217	1.71%	-12,430	-6.32%
Total Enrollment	**1,774,990**	**1,738,952**	**-36,038**	**-2.03%**	**36,363**	**2.04%**	**-124,336**	**-6.61%**

Summary and Looking Ahead

- Medical Expenditures in FY 2026 were within 1.8% of appropriation; 1.5% of appropriated GF.

- Budget is reviewing the trends to inform the development of the November Forecast

CardinalCare
Virginia's Medicaid Program

Managed Care Program Update

Cheryl Gallon, Deputy for Programs and Operations

DMAS

FY27 Managed Care Contract Updates

- **Federal regulatory changes/updates**
  - Requirements for members subject to Community Engagement Activities, including identification of exempt members and required community engagement activities.
  - MCO requirements to assist members in understanding and accessing Community Engagement activities along with outreach activities and prohibited Managed Care Organization (MCO) activities.
- **General Assembly changes**
  - MCO collaboration with DMAS to implement the single Pharmacy Benefit Manager
  - Provider incentive arrangement requirements.
- **Clarification of program requirements and contract language**
  - Requirement for MCOs to outreach to Medicaid Expansion members enrolled in aid categories 100, 101, 102, and 103 due to Medicaid eligibility redetermination process requirements every six months.
  - Allows MCOs to submit new or updated member physical and mailing addresses reported by members directly to the MCO to DMAS.
  - Requirements for staffing, facilities, and technology necessary to meet the Call Center Performance Standards.
  - Notice requirements for provider payment recoveries conducted by MCOs.

CMS Revalidation

- CMS is requiring states to increase oversight of high-risk Medicaid providers.
- Submitted the CMS High-Risk Provider Revalidation Strategy for CMS review.
- Accelerating revalidation for **808 high-risk providers**
  - Transitioning from a **5-year to a 3-year** revalidation cycle.
- Operational Readiness
  - ➢ Coordinating MES system configuration, provider enrollment vendor activities, and implementation planning.
  - ➢ Developing phased provider communications and operational workflows to support implementation.
- Financial and Program Impact
  - ➢ Supports CMS compliance, reduces federal risk, and balances operational workload and resources.

Unbundling Maternity Codes

- For more than 30 years, providers have billed prenatal, labor and delivery, and postpartum services using global billing codes.
- In January 2026, the American Medical Association's Relative Value Scale Update Committee (RUC) recommended a change to the coding structure to begin in January 2027.
- Services will be billed separately for:
  - Antepartum care,
  - Labor management,
  - Delivery care, and
  - Postpartum care.
- The AMA estimates these changes will be cost neutral.

Program Integrity- Key Activity and Financial Impact

Oversight & Audit Activity

- Monitoring MCO program integrity activities.
- Reviewing audit findings and tracking corrective actions.
- Coordinating with MCOs to address compliance and operational issues.

Financial Impact

- $**37.5M**+ in overpayment findings identified
- Issued **882** final letters and completed **1,246** audits.
- Referred **271** cases to the Medicaid Fraud Control Unit (MFCU)
- Ongoing oversight strengthens program integrity and safeguards Medicaid funds.

Program Integrity- Key Activity and Financial Impact

MCO statistics for SFY26:

	SFY26 TOTAL
Audits Initiated	1,246
Final Letters Mailed	882
Overpayment Findings Identified	$37,500,199.34
MFCU Referrals	271

**Most figures are updated to PID quarterly – all figures will not change weekly.

- PI MCO Analysts are finalizing the review and reconciliation of all 14 Q3 performance metrics for SFY 2026 metric points:
  - Reconciling MCO deliverables with quarterly reports,
  - Updating cases in FADS
- Bi-weekly meetings with MCOs focus on:
  - Review findings,
  - Areas demonstrating improvement and areas requiring further improvement,
  - MCO questions, concerns, and operational issues.

Program Integrity Update- General Audit Procurement

- DMAS is engaged in actively procuring a general provider and behavioral health auditing services provider.
- The resulting contract, once awarded, will:
  - Audit all DMAS Medicaid providers,
  - Develop a process to identify providers engaged in improper billing practices,
  - Conduct random desk and on-site field audits,
  - Perform data analytics as needed,
  - Support Managed Care Organization Program Integrity oversight, and
  - Enhances DMAS' Fraud, Waste, and Abuse (FWA) detection capabilities
- Any interested parties are encouraged to view information related to this procurement directly through eVA, Virginia's Public Procurement Portal

CardinalCare
Virginia's Medicaid Program

Complex Care Services Update

Tammy Whitlock, Deputy for Complex Care

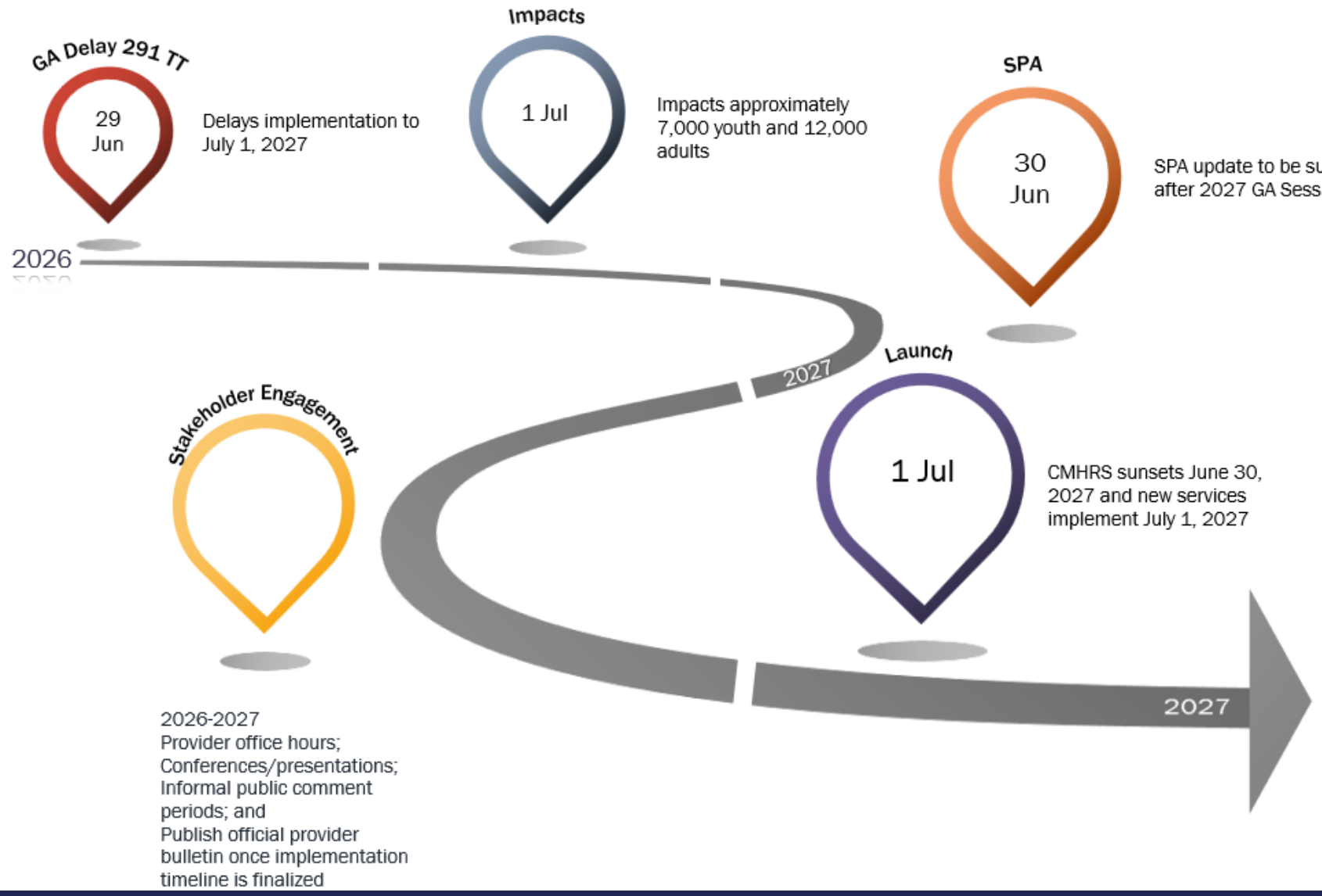
DMAS

2026 General Assembly Mandates: Behavioral Health

- Behavioral Health Redesign: ***291.TT***
- ABA Provisional Diagnosis: ***291.WW.2***
- 4-hour Mobile Crisis Limit: ***291.KKKKK***
- Eliminate Community Stabilization: ***291.LLLLL***

Behavioral Health Redesign Update/Timeline

Authorized in 2024 to replace legacy mental health rehabilitative service with a new array of trauma informed, evidence based rehabilitative services with an initial “Go Live” of July 2026



Mobile Crisis and Community Stabilization: Update/Timeline

- **291.KKKKK** Mobile Crisis Service
  - Limit to 4 hours per incident
  - Reimbursements made only to providers with DBHDS license and contract with CSBs

- **291.LLLLL**
- Community Stabilization
  - Seek federal authority to eliminate the Community Stabilization Service effective July 1, 2026.

Mobile Crisis and Community Stabilization: Update/Timeline- Continued

Initial Member Outreach *(CMS Requirement) by July 15, 2026*

Will include Provider Outreach (also serves as Managed Care 60-notice)

Policy Manual Changes, pending CMS Feedback by October 1, 2026

Policy manuals require 30-day public comment period

SPA Changes Submitted to CMS by August 1, 2026

Cannot implement until CMS approves the SPA

Approvals are not back-dated

ABA Provisional Diagnosis: Update/Timeline

291 WW.2

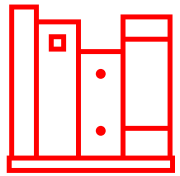
- Impose a 20 hour per week cumulative limit per recipient on services provided under ABA, effective July 1, 2026
  - Can be exceeded based upon documented medical necessity under early and periodic screening, diagnostic and treatment (EPSDT).
- Require a diagnosis of autism spectrum disorder prior to authorizing ABA services; however, children age 5 and younger may receive a provisional diagnosis for one-year utilizing a protocol designated by DMAS.

ABA Provisional Diagnosis: Update/Timeline- Continued

- SPA Changes
  - DMAS is confirming whether SPA updates are required as any restrictions to this service are overridden by EPSDT policy
  - SPA update may be needed for restriction to who can provide a provisional Autism diagnosis

July 27, 2026: Initial Member outreach about service reduction

CMS Requirement, Outreach also serves as Managed Care 60-notice



By September 1, 2026: Policy Manual & Communicate date for implementation

Policy manual will go up for a 30- day formal public comment

September 1, 2026: Launch ABA Workgroup (291 WW.3)

2026 General Assembly Mandates: HCBS Waiver Amendments

- Standardize Hourly HCBS Waiver Limits: ***291.MMMMM***
- Removed Caregiver Exemption: ***291.NNNNN***
- Incorporating SF into service broker: ***295.PP***
- LTSS Screening for Children- ***295.OO***

HCBS Waiver: Implementation Dependencies

Steps to implement Waiver items following budget approval:

- **Public Comment Period**:
  - Publish the draft waiver amendments to the Virginia Regulatory Town Hall for a mandatory 30-day public comment window.

- **CMS Submission and Review:**
  - Final Waiver Amendments submitted to the Centers for Medicare & Medicaid Services (CMS). Following the public comment period, CMS has up 90-days to review. If CMS requests more information, this extends time for approval.

- **Operational Readiness and Go-Live**:
  - Upon receiving CMS approval, DMAS will issue official provider communications, update policy manuals/bulletins, execute necessary system modifications, and finalize contract revisions with Fiscal/Employer Agents (F/EAs). Policy changes will formally take effect once system testing is complete.

HCBS Waiver - Implementation Targets

Removed Caregiver Exemption

Mandate EVV for all caregivers by **October 2026**

- Eliminate the live-in caregiver exemption requiring Electronic Visit Verification (EVV) for all personal care providers to strengthen program oversight.

Standardize Hourly HCBS Waiver Limits

Integrate soft caps by **January 2027**

- Align the Community Living and Family and Individual Support waivers with the Commonwealth Coordinated Care Plus waiver by implementing a 56-hour soft limit on personal care and assistance services.

LTSS Screening for Children

Launch child assessment tool by **January 2027**

- DMAS & VDH to debut a children's assessment tool. Limits to screening frequency, unless there is a documented change in medical condition or needs, was effective July 1, 2026.

Incorporating SF into service broker

Consolidate service facilitation by **March 2027**

- Transition standalone service facilitation into the statewide service broker model, requiring Support Brokers to contract with the Fiscal/Employer Agent to manage planning, care plans, authorizations, and employer support.

*Implementation dates are tentative and subject to public comment, CMS review and approval of waiver applications

CardinalCare
Virginia's Medicaid Program

Virginia Medicaid Analytic Insights

Rich Rosendahl, Deputy of Healthcare Analytics and Transformation

Updated with Claims data through December 31, 2025

DMAS

Key Takeaways

1. Compared to FY25, FY26 YTD (July-December 2025) PMPM up 10% due mostly to increases in claim volume
   - Utilization up (+7%), Cost per claim up (+3%)

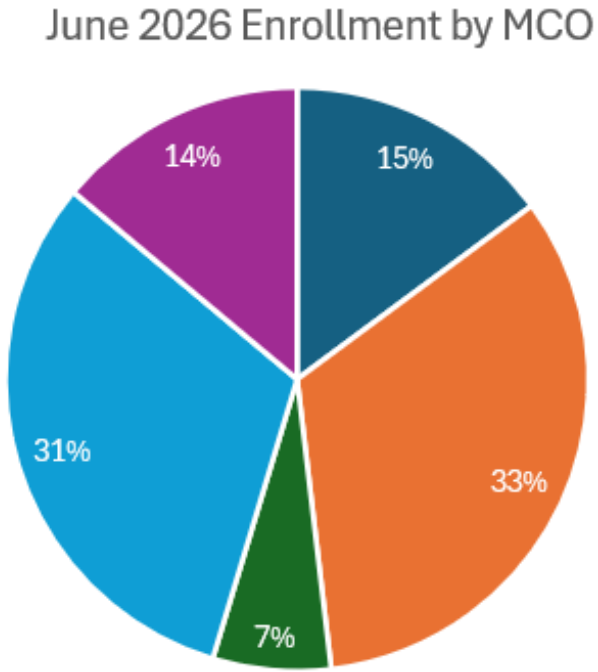
2. Agency Directed Personal Care services, $631M through first six months, continues to be the number one service by cost and is up 11.8% from FY25 (annualized)

3. Managed Care Organizations (MCOs) reporting a combined $347M loss through three quarters of FY26 with two MCOs reporting gains

MCO Enrollment (June 2026)

Within United's population, they have a higher percentage of Aged Adults (12%), representing 29% of all Aged Adults in Managed Care

Sentara, the second largest MCO, has a higher percentage of children (48%) compared to the other MCOs (33-44%). Sentara covers 36% of all Children enrolled in Managed Care.



Aetna has the third highest number of Cardinal Care members, which has remained relatively stable over time

Anthem continues to have the highest number of Cardinal Care members and administers Virginia's Foster Care program

Humana is a new entrant into VA Medicaid as a result of the most recent 2024 CCMC RFP that went into effect July 2025. Humana's membership has a higher percentage of Expansion Adults (45%) compared to the other MCOs (30-39%)

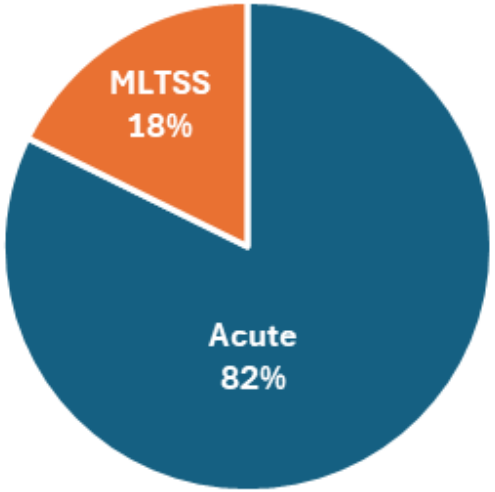
Member Profile Comparison Chart

	Member Count	Average Age	% with at least one Medical Claim	% with at least one Prescription	Number of Claims per Year - SFY25						
					All	HCBS	ER	Physician	Dental	Pharmacy	Behavioral Health
All Medicaid	1,630,366	39	81%	59%	41.71	9.45	1.33	17.94	0.95	10.81	2.79
Children	692,871	12	88%	76%	14.72	0.02	0.89	8.15	1.29	3.68	1.82
Expansion Adults	544,988	42	73%	63%	37.82	1.28	1.47	18.25	0.68	14.95	2.53
Blind and Disabled	133,721	35	93%	67%	160.09	67.83	2.33	57.4	0.79	28.65	9.17
Other Adults	114,726	43	81%	75%	36.71	0.72	1.86	18.1	0.77	14.19	2.62
Aged Adults	90,036	82	90%	39%	107.08	59.16	1.27	31.05	0.51	10.84	1.48
Pregnancy Related	37,185	32	79%	62%	28.38	0.08	2.24	16.63	0.55	7.13	1.22
Foster Care/Adoption Assistance	16,839	13	89%	71%	52.09	4.9	1.32	28.82	1.46	13.61	11.91

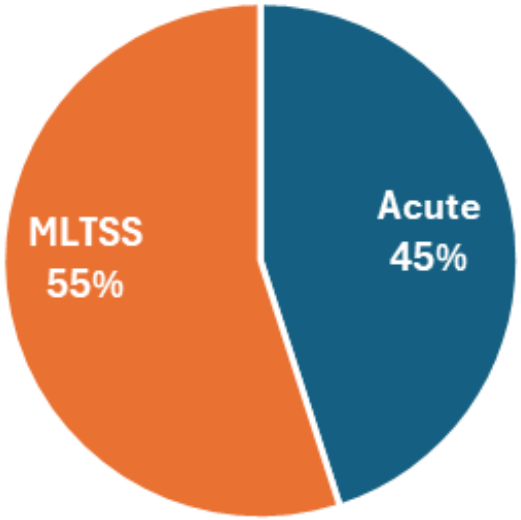
- All Medicaid members have an average age of 39 and 81% of them have at least one Medical claim per year
- Aged, Blind and Disabled have the most claims due to high utilization of Physician (which includes home care and other waiver services) and prescriptions
- Pregnant and postpartum members with the fewest number of dental claims—a potential opportunity for increasing total wellness in that eligibility category

Cardinal Care Member Months and Cost by Program (Managed Care)

FY26 MCO Member Months by Program



FY26 Total MCO Spend by Program



The MLTSS population represents 18% of Managed Care Enrollees, however, it accounts for more than 55% of the cost of the Managed Care Program

*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025
Pharmacy data does not include rebates

Summary – All Programs

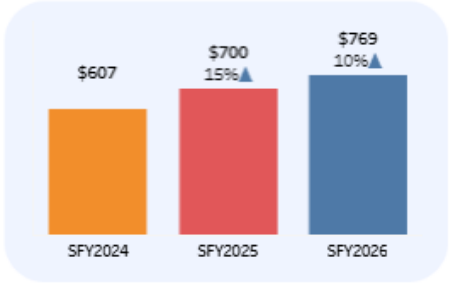
*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025

Per Member Per Month Cost

SFY 2026

$769

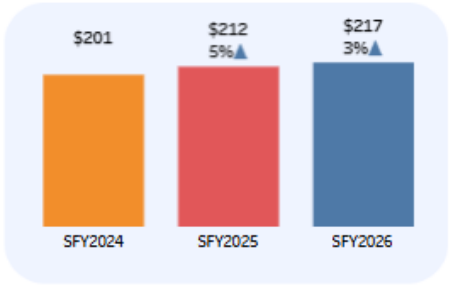
10% YOY▲



Cost Per Claim

$217

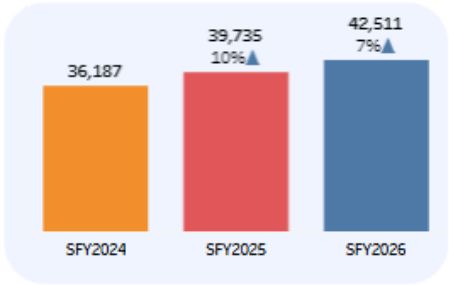
3% YOY▲



Claims Per 1000 Members

42,511

7% YOY▲



- PMPM for FY26 YTD up 10% compared to FY25
- Increase in PMPM driven by 7% increase in Utilization (standardized claim volume) and 3% increase in average cost counters
- FY25 was 15% higher PMPM compared to FY24 due to a 10% increase in Utilization and 5% increase in CPC

Stoplight – PMPM Changes by Program (FY26 vs. FY25)

Red: percent change greater than 10%

Yellow: percent change between 4% and 9%

Green: percent change less than 3%

Dark Green: percent change 0% or negative

ACUTE

Other Facility (+11%)

Outpatient (9%)
Pharmacy (+9%)
Grand Total (+8%)
Physician Svcs (+8%)
ER (+7%)
Inpatient (+4%)

MLTSS

Other Facility (+14%)

Home & Community Based Svcs (+8%)
ER (+6%)
Outpatient (+6%)
Pharmacy (+6%)
Physician Svcs (+6%)
Grand Total (+5%)

Nursing Facility (+3%)
Inpatient (0%)

*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025
Pharmacy data does not include rebates

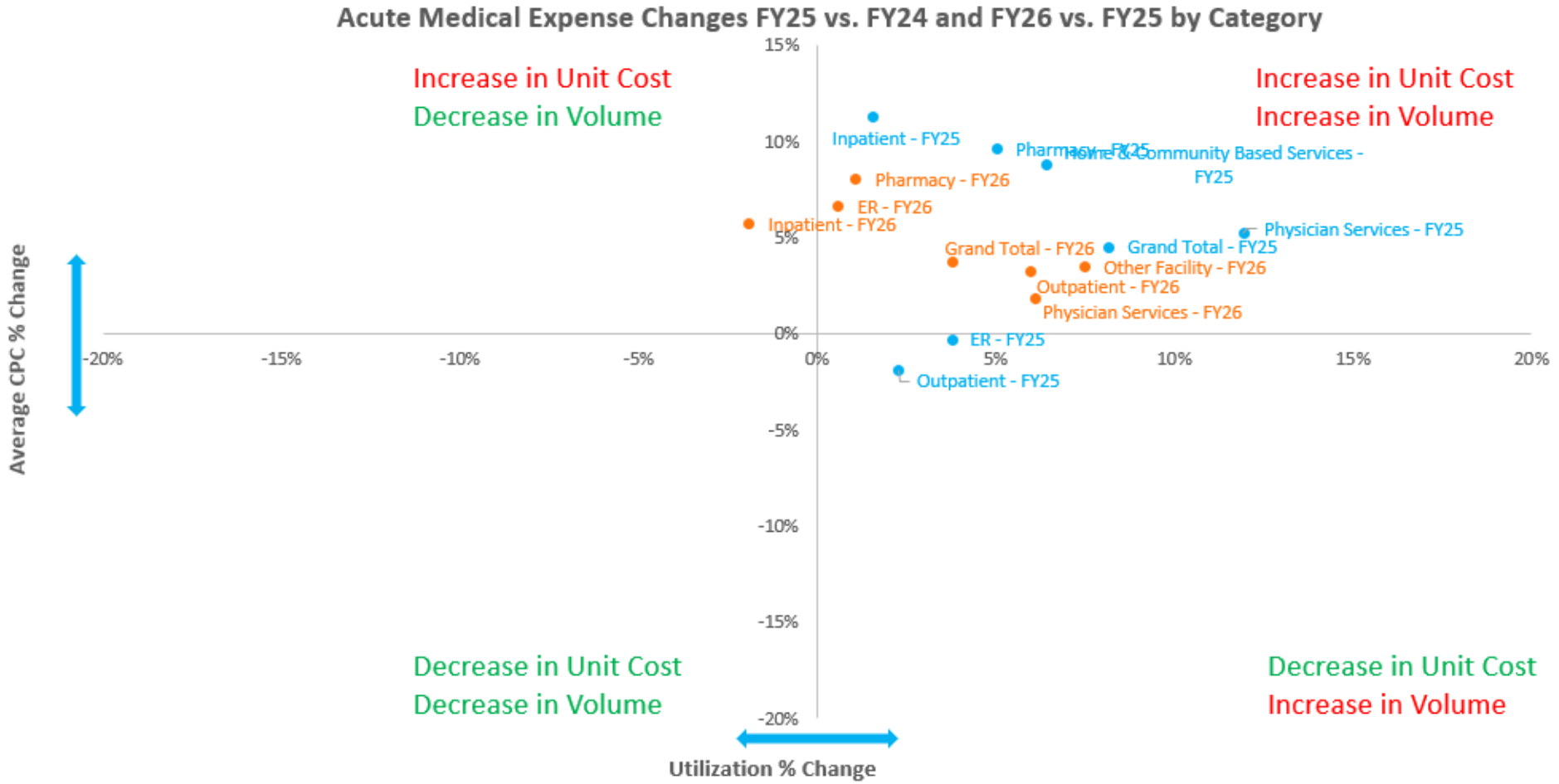
Cardinal Care Acute Overview (Managed Care)

		SFY2024	SFY2025	SFY2026	% Difference SFY24-25	% Difference SFY25-26
Grand Total	PMPM	$342	$389	$419	13.6%	7.7%
	Cost Per Claim	$186	$195	$202	4.9%	3.7%
	Claims Per 12K Members	22,114	23,951	24,863	8.3%	3.8%
ER	PMPM	$22	$22	$24	3.4%	7.2%
	Cost Per Claim	$164	$163	$173	-0.5%	6.6%
	Claims Per 12K Members	1,589	1,652	1,661	4.0%	0.6%
Inpatient	PMPM	$63	$73	$75	15.3%	3.7%
	Cost Per Claim	$7,910	$8,944	$9,453	13.1%	5.7%
	Claims Per 12K Members	95	97	95	2.0%	-1.9%
Other Facility	PMPM	$6	$7	$8	27.4%	11.3%
	Cost Per Claim	$1,261	$1,239	$1,282	-1.8%	3.5%
	Claims Per 12K Members	53	69	74	29.7%	7.5%
Outpatient	PMPM	$47	$48	$52	0.2%	9.4%
	Cost Per Claim	$551	$539	$556	-2.0%	3.2%
	Claims Per 12K Members	1,035	1,058	1,122	2.3%	6.0%
Pharmacy	PMPM	$85	$97	$106	14.8%	9.2%
	Cost Per Claim	$118	$129	$140	9.6%	8.0%
	Claims Per 12K Members	8,630	9,040	9,140	4.8%	1.1%
Physician Services	PMPM	$120	$142	$153	18.3%	8.1%
	Cost Per Claim	$134	$141	$144	5.3%	1.8%
	Claims Per 12K Members	10,712	12,035	12,770	12.3%	6.1%

- Acute program PMPM increased 7.7% from FY25 due to a near even split between average cost and volume
- Pharmacy PMPM increased 9.2% with essentially all of that due to an increase in cost per script
- Physician Services PMPM increased due to more claims per 1,000 indicating members are seeing more doctors and specialists in office settings
- Reminder the majority of Other Facility (approximately 1.9% of total Acute spend) claims are residential treatment facilities for Alcohol and Substance abuse, dialysis and hemodialysis, Hospice/Home Health and Ambulatory Service Centers
  - The current 11.3% increase in PMPM is driven by Alcohol and Drug treatment

***SFY2026 reflects claims paid July 1, 2025 – December 31, 2025**
Pharmacy data does not include rebates

Cardinal Care Acute PMPM Drivers (Managed Care)



- Overall, nearly all Acute medical expense categories' PMPM experienced increases in unit cost and volume
  - Increases at a smaller magnitude compared to FY25 vs. FY24

- **FY25 vs. FY24 Percent changes**
- **FY26 vs. FY25 Percent changes**

*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025
Pharmacy data does not include rebates

Cardinal Care Complex Overview (Managed Care)

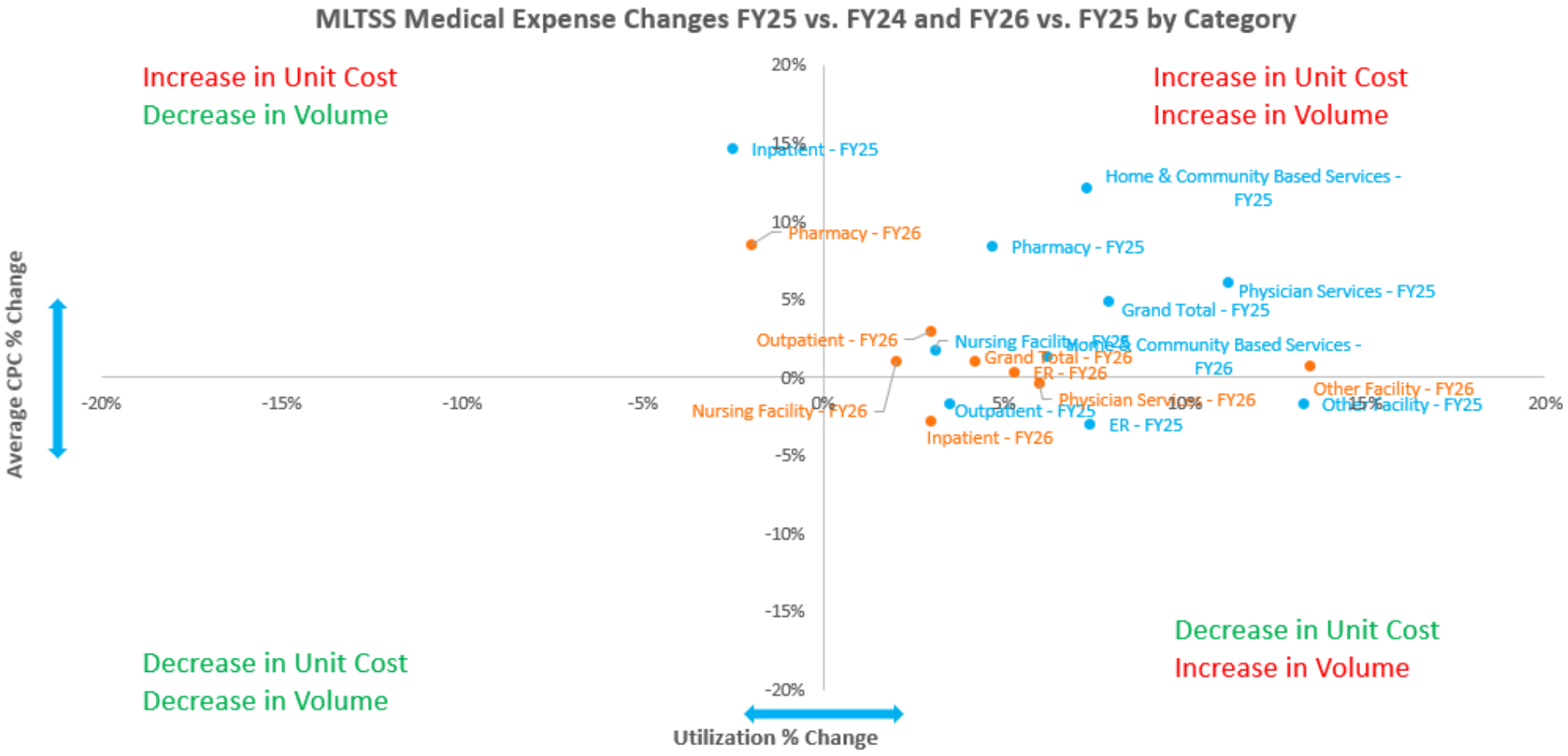
		SFY2024	SFY2025	SFY2026	% Difference SFY24- 25	% Difference SFY25- 26
Grand Total	PMPM	$2,011	$2,269	$2,391	12.8%	5.4%
	Cost Per Claim	$217	$228	$231	5.1%	1.1%
	Claims Per 12K Members	111,017	119,203	124,202	7.4%	4.2%
ER	PMPM	$31	$32	$34	3.9%	5.6%
	Cost Per Claim	$112	$109	$109	-3.3%	0.3%
	Claims Per 12K Members	3,284	3,527	3,714	7.4%	5.3%
Home & Community Based Services	PMPM	$495	$593	$639	19.9%	7.7%
	Cost Per Claim	$146	$165	$167	12.6%	1.4%
	Claims Per 12K Members	40,534	43,173	45,843	6.5%	6.2%
Inpatient	PMPM	$209	$233	$233	11.5%	0.1%
	Cost Per Claim	$6,737	$7,628	$7,412	13.2%	-2.8%
	Claims Per 12K Members	372	366	377	-1.5%	3.0%
Nursing Facility	PMPM	$434	$454	$469	4.7%	3.2%
	Cost Per Claim	$5,773	$5,883	$5,950	1.9%	1.1%
	Claims Per 12K Members	902	927	946	2.7%	2.0%
Other Facility	PMPM	$31	$35	$40	12.4%	14.3%
	Cost Per Claim	$618	$603	$607	-2.5%	0.7%
	Claims Per 12K Members	599	690	783	15.2%	13.5%
Outpatient	PMPM	$121	$123	$131	1.9%	6.1%
	Cost Per Claim	$492	$481	$496	-2.2%	3.0%
	Claims Per 12K Members	2,951	3,076	3,167	4.2%	3.0%
Pharmacy	PMPM	$291	$328	$349	12.8%	6.4%
	Cost Per Claim	$138	$149	$162	8.4%	8.5%
	Claims Per 12K Members	25,358	26,376	25,855	4.0%	-2.0%
Physician Services	PMPM	$400	$471	$497	17.6%	5.5%
	Cost Per Claim	$130	$138	$137	6.0%	-0.4%
	Claims Per 12K Members	37,015	41,068	43,517	10.9%	6.0%

Last Update: 6/18/2026 10:30:21 AM

- Overall program PMPM is up 5.4% due to mostly an increase in utilization
- HCBS experienced a 7.7% increase in PMPM due mostly to an increase in volume
- Like Acute, Pharmacy PMPM increased due to cost despite a decrease in volume
- Physician Services PMPM increase is due entirely to an increase in utilization

*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025
Pharmacy data does not include rebates

Cardinal Care MLTSS PMPM Drivers (Managed Care)

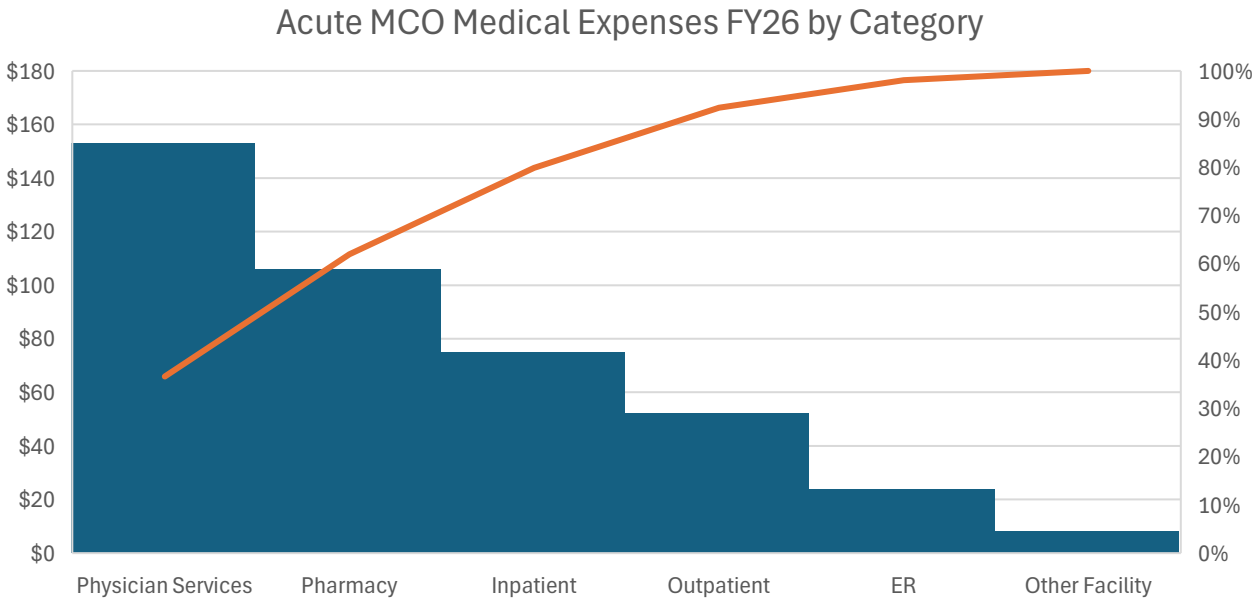


- Similar to the Acute program, MLTSS FY26 vs. FY25 (orange dots) skewing more towards lower CPC and Utilization increases
  - While most categories experienced increases, they are at a lower magnitude than previous comparisons

- **FY25 vs. FY24 Percent changes**
- **FY26 vs. FY25 Percent changes**

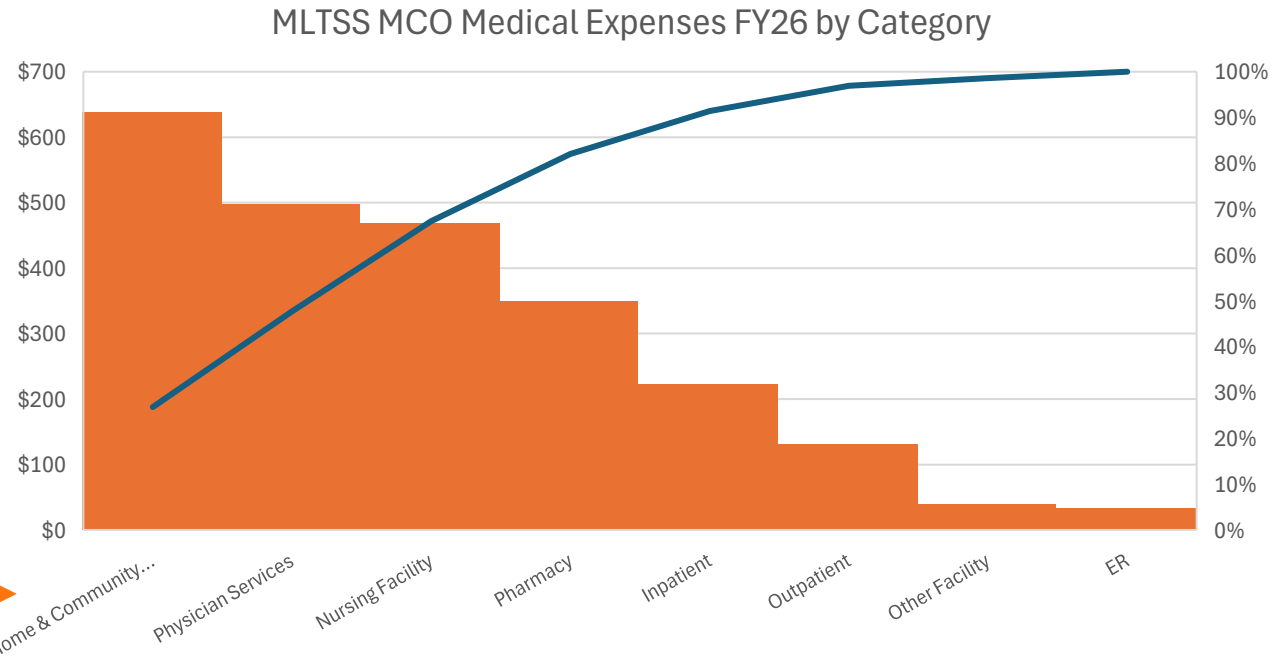
*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025
Pharmacy data does not include rebates

Cost Category Comparison by Program



- **80% of Acute MCO spend in FY25 in Physician Services, Pharmacy, and Inpatient**
- **ER accounts for 6% of Acute FY25 medical expense**

- **81% of MLTSS MCO spend in FY25 in Home & Community Based Services, Physician Services, Nursing Facility, and Pharmacy**



*SFY2026 reflects claims paid July 1, 2025 – December 31, 2025
Pharmacy data does not include rebates

Summary: What Services and Prescriptions do Members Use?

Top 5 Services FY2026	Percent Change: FY25 Total vs. annualized FY26
1 Agency Directed Personal Care (T1019)	11.77%
2 Consumer Directed Personal Assistance/Attendant Care (S5126)	-1.96%
3 Mobile Crisis Response (H2011)	57.07%
4 Outpatient Psychiatric Services (99214)	-2.32%
5 ARTS Partial Hospitalization (S0201)	21.07%
Top 5 Prescriptions FY2026	
1 Biktarvy 50-200-25 Tablet	2.05%
2 Humira (CF) PEN 40mg/0.4MLPEN	-8.53%
3 Dupixent PEN 300 mg/2MLPEN Inj	17.91%
4 Suboxone 8 mg-2mg Film	0.00%
5 Eliquis 5mg Tablet	5.72%

- Mobile Crisis Response (H2011) continues to increase year over year (#2 highest spend service code in Acute)
- ARTS Partial Hospitalization (S0201) also continues a rapid, upward trajectory over the past three years (#14 in FY24, #7 FY25 and #5 FY26)
- Dollar amounts displayed on following slides
- In January 2026, DMAS began preferring biosimilars within the *Cytokine and CAM Antagonists* class. We expect to see Humira to decrease as members are switched to biosimilar versions.

***SFY2026 reflects claims paid July 1, 2025 – December 31, 2025**
Pharmacy data does not include rebates

Top Services – All Programs

SFY 24 Top 15 Services

Rank	Proc Code with Description	SFY2024
1	T1019 (AGENCY DIRECTED PERSONAL CARE)	$907,864,701
2	S5126 (CONSUMER DIRECTED PERSONAL ASSISTANCE/ATTENDANT..	$586,854,491
3	99214 (OUTPATIENT PSYCHIATRIC SERVICES)	$238,485,329
4	H0046 (MENTAL HEALTH SKILL BUILDING)	$200,914,550
5	99213 (OUTPATIENT PSYCHIATRIC SERVICES)	$172,337,619
6	99284 (ED E&M- MODERATE COMPLEXITY MDM)	$150,035,806
7	99283 (ED E&M- LOW COMPLEXITY MDM FOR LOW-SEVERITY PRESENTI..	$136,218,289
8	97153 (APPLIED BEHAVIOR ANALYSIS)	$131,032,786
9	T1005 (AGENCY DIRECTED RESPITE CARE)	$126,754,299
10	H2011 (MOBILE CRISIS RESPONSE)	$118,993,907
11	90837 (OUTPATIENT PSYCHOTHERAPY)	$116,107,841
12	H0023 (MENTAL HEALTH CASE MANAGEMENT)	$108,190,169
13	S9482 (COMMUNITY STABILIZATION)	$107,798,659
14	S0201 (ARTS PARTIAL HOSPITALIZATION)	$107,404,598
15	S5150 (CONSUMER DIRECTED RESPITE CARE)	$105,091,484

SFY 25 Top 15 Services

Rank	Proc Code with Description	SFY2025
1	T1019 (AGENCY DIRECTED PERSONAL CARE)	$1,134,258,287
2	S5126 (CONSUMER DIRECTED PERSONAL ASSISTANCE/ATTEN..	$618,113,502
3	99214 (OUTPATIENT PSYCHIATRIC SERVICES)	$241,873,247
4	H0046 (MENTAL HEALTH SKILL BUILDING)	$198,577,439
5	H2011 (MOBILE CRISIS RESPONSE)	$176,196,070
6	97153 (APPLIED BEHAVIOR ANALYSIS)	$171,384,134
7	S0201 (ARTS PARTIAL HOSPITALIZATION)	$165,520,303
8	99213 (OUTPATIENT PSYCHIATRIC SERVICES)	$159,931,159
9	T1005 (AGENCY DIRECTED RESPITE CARE)	$153,020,698
10	99284 (ED E&M- MODERATE COMPLEXITY MDM)	$150,742,508
11	99283 (ED E&M- LOW COMPLEXITY MDM FOR LOW-SE..	$135,577,290
12	90837 (OUTPATIENT PSYCHOTHERAPY)	$134,312,088
13	S9482 (COMMUNITY STABILIZATION)	$133,726,565
14	H0010 (ARTS RESIDENTIAL TREATMENT ASAM LEVEL 3.3 A..	$109,101,685
15	H0023 (MENTAL HEALTH CASE MANAGEMENT)	$107,384,604

SFY 26 Top 15 Services

Rank	Proc Code with Description	SFY2026
1	T1019 (AGENCY DIRECTED PERSONAL CARE)	$631,149,921
2	S5126 (CONSUMER DIRECTED PERSONAL ASSISTANCE/ATTENDANT CARE)	$303,329,396
3	H2011 (MOBILE CRISIS RESPONSE)	$138,325,751
4	99214 (OUTPATIENT PSYCHIATRIC SERVICES)	$117,965,277
5	S0201 (ARTS PARTIAL HOSPITALIZATION)	$106,610,921
6	T1005 (AGENCY DIRECTED RESPITE CARE)	$99,718,498
7	97153 (APPLIED BEHAVIOR ANALYSIS)	$94,401,176
8	H0046 (MENTAL HEALTH SKILL BUILDING)	$88,523,067
9	99284 (ED E&M- MODERATE COMPLEXITY MDM)	$73,790,812
10	99213 (OUTPATIENT PSYCHIATRIC SERVICES)	$72,883,442
11	90837 (OUTPATIENT PSYCHOTHERAPY)	$72,070,977
12	99283 (ED E&M- LOW COMPLEXITY MDM FOR LOW-SEVERITY PRESENTING PROBL..	$65,733,185
13	H0010 (ARTS RESIDENTIAL TREATMENT ASAM LEVEL 3.3 AND 3.5)	$62,105,151
14	S5150 (CONSUMER DIRECTED RESPITE CARE)	$61,364,768
15	H0023 (MENTAL HEALTH CASE MANAGEMENT)	$52,309,866

- FY26 values represent July – December 2025
  - To accurately compare to previous FY's, multiply dollar amounts by 2.
- Agency Directed Personal Care up 25% from FY24 to FY25 and 11.8% from FY25 to FY26 (annualized)
- Mobile Crisis Response up 48% from FY24 to FY25 and 57% from FY25 to FY26 (annualized)
- ARTS Partial Hospitalization up 53.5% from FY24 to FY25 and 21% from FY25 to FY26 (annualized)

***SFY2026 reflects claims paid July 1, 2025 – December 31, 2025**
Pharmacy data does not include rebates

Top 15 Prescription Drugs by Fiscal Year

SFY24 Top 15 Drugs

Rank	Brand Name	SFY2024
1	HUMIRA(CF) PEN 40MG/0.4MLPEN I	$123,468,187
2	BIKTARVY 50-200-25 TABLET	$98,776,981
3	SUBOXONE 8 MG-2 MG FILM	$58,342,330
4	STELARA 90 MG/ML SYRINGE	$44,316,996
5	DUPIXENT PEN 300 MG/2MLPEN INJ	$43,655,228
6	TRULICITY 0.75MG/0.5PEN INJCTR	$39,623,313
7	ELIQUIS 5 MG TABLET	$33,999,018
8	HUMIRA(CF) PEN 80MG/0.8MLPEN I	$33,651,590
9	TRULICITY 1.5 MG/0.5PEN INJCTR	$30,336,498
10	JARDIANCE 25 MG TABLET	$27,921,084
11	ENBREL SURECLICK 50MG/ML(1)PEN	$26,746,039
12	INVEGA SUSTENNA 234MG/1.5 SYRI	$26,102,660
13	JARDIANCE 10 MG TABLET	$24,954,041
14	TRIKAFTA 100-50-75 TABLET SEQ	$24,212,764
15	TRULICITY 3 MG/0.5MLPEN INJCTR	$22,936,530

SFY25 Top 15 Drugs

Rank	Brand Name	SFY2025
1	HUMIRA(CF) PEN 40MG/0.4MLPEN I	$117,214,150
2	BIKTARVY 50-200-25 TABLET	$107,206,164
3	DUPIXENT PEN 300 MG/2MLPEN INJ	$63,133,376
4	SUBOXONE 8 MG-2 MG FILM	$58,575,479
5	STELARA 90 MG/ML SYRINGE	$42,697,428
6	TRULICITY 0.75MG/0.5PEN INJCTR	$38,860,980
7	TRULICITY 1.5 MG/0.5PEN INJCTR	$36,788,569
8	ELIQUIS 5 MG TABLET	$36,707,862
9	JARDIANCE 25 MG TABLET	$32,392,409
10	HUMIRA(CF) PEN 80MG/0.8MLPEN I	$31,669,730
11	VRAYLAR 1.5 MG CAPSULE	$29,840,196
12	JARDIANCE 10 MG TABLET	$29,196,750
13	ENBREL SURECLICK 50MG/ML(1)PEN	$27,998,315
14	INVEGA SUSTENNA 234MG/1.5 SYRI	$27,471,727
15	TRULICITY 3 MG/0.5MLPEN INJCTR	$25,931,391

SFY26 Top 15 Drugs

Rank	Brand Name	SFY2026
1	BIKTARVY 50-200-25 TABLET	$54,696,083
2	HUMIRA(CF) PEN 40MG/0.4MLPEN I	$53,630,231
3	DUPIXENT PEN 300 MG/2MLPEN INJ	$37,166,528
4	SUBOXONE 8 MG-2 MG FILM	$29,291,905
5	ELIQUIS 5 MG TABLET	$19,425,167
6	STELARA 90 MG/ML SYRINGE	$18,482,018
7	TRULICITY 1.5 MG/0.5PEN INJCTR	$18,180,643
8	TRULICITY 0.75MG/0.5PEN INJCTR	$17,698,361
9	JARDIANCE 25 MG TABLET	$17,017,576
10	HUMIRA(CF) PEN 80MG/0.8MLPEN I	$16,939,712
11	JARDIANCE 10 MG TABLET	$15,651,995
12	VRAYLAR 1.5 MG CAPSULE	$15,171,249
13	ENBREL SURECLICK 50MG/ML(1)PEN	$14,852,758
14	TRULICITY 3 MG/0.5MLPEN INJCTR	$14,305,551
15	FARXIGA 10 MG TABLET	$13,954,860

- In January 2026, DMAS began preferring biosimilars within the *Cytokine and CAM Antagonists* class
  - We expect to see Humira and Stelara drop as members are switched to biosimilar versions
- Biktarvy 5-200-25 tablet rose from second position in FY25 to the first position in SFY26
- Eliquis 5 MG tablet rose from the eighth position in FY25 to the fifth position in FY26 YTD (anti-coagulant primarily used in Adult Population)

***SFY2026 reflects claims paid July 1, 2025 – December 31, 2025**
Pharmacy data does not include rebates

MCO Financial Summary – FY26 (July 2025 – March 2026)

	Aetna		
	FY26 Q1-Q3		
	Acute	MLTSS	Total
Net Gain (Loss)	$ 36,617,133	$ 5,756,330	$ 42,373,463
Operating Margin (%)	3.76%	0.53%	2.10%
Medical Loss Ratio (%)	86.34%	91.10%	88.90%
Total Admin Expense Ratio (%)	10.00%	8.40%	9.20%

	Sentara		
	FY26 Q1-Q3		
	Acute	MLTSS	Total
Net Gain (Loss)	$ (150,773,667)	$ (33,973,500)	$ (184,747,167)
Operating Margin (%)	-8.72%	-1.86%	-5.20%
Medical Loss Ratio (%)	96.00%	94.47%	95.20%
Total Admin Expense Ratio (%)	12.70%	7.40%	10.00%

	Anthem		
	FY26 Q1-Q3		
	Acute	MLTSS	Total
Net Gain (Loss)	$ (92,541,239)	$ (135,252,401)	$ (227,793,641)
Operating Margin (%)	-5.11%	-5.80%	-5.50%
Medical Loss Ratio (%)	96.13%	101.49%	99.10%
Total Admin Expense Ratio (%)	9.00%	4.30%	6.40%

	United		
	FY26 Q1-Q3		
	Acute	MLTSS	Total
Net Gain (Loss)	$ (3,878,732)	$ 41,862,520	$ 37,983,789
Operating Margin (%)	-0.56%	3.31%	1.90%
Medical Loss Ratio (%)	91.61%	92.97%	92.50%
Total Admin Expense Ratio (%)	9.00%	3.70%	5.60%

	Humana		
	FY26 Q1-Q3		
	Acute	MLTSS	Total
Net Gain (Loss)	$ (37,222,940)	$ 21,468,590	$ (15,754,350)
Operating Margin (%)	-11.15%	4.90%	-2.04%
Medical Loss Ratio (%)	94.39%	87.45%	90.40%
Total Admin Expense Ratio (%)	16.80%	7.70%	11.60%

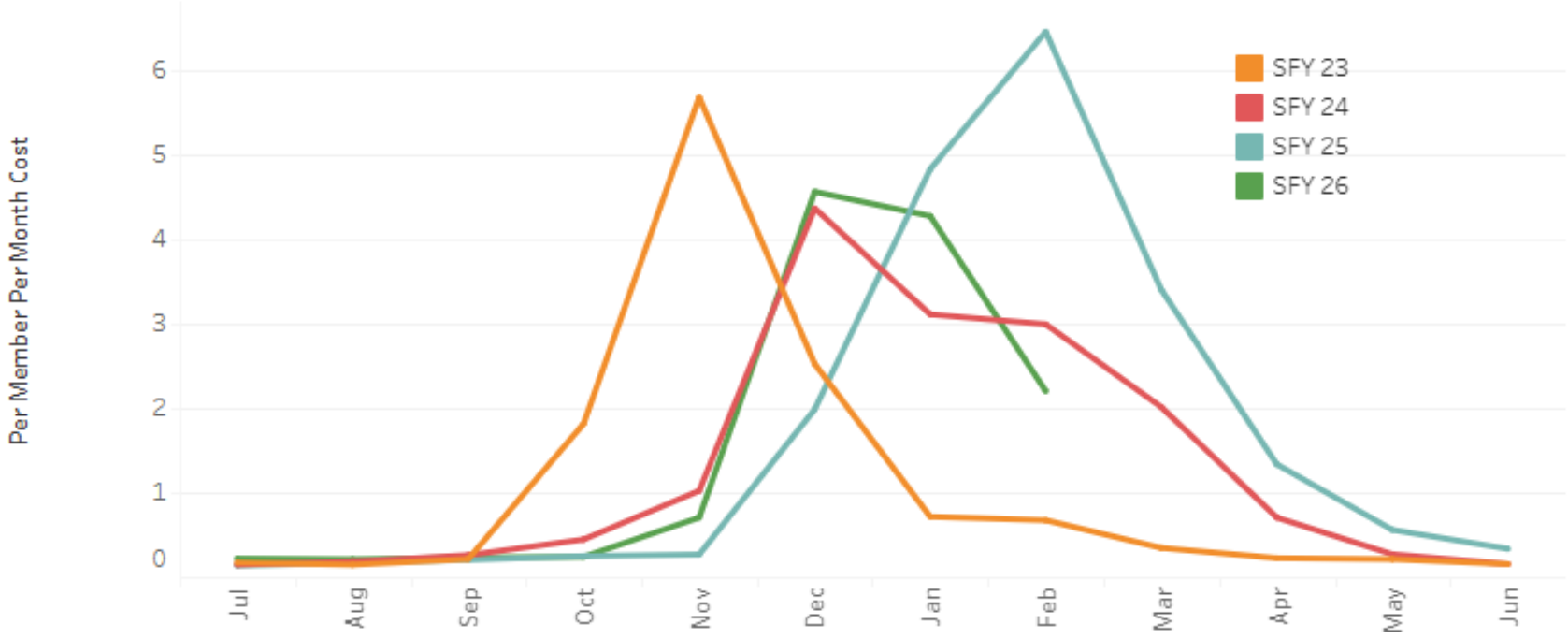
	All MCO Total		
	FY26 Q1-Q3		
	Acute	MLTSS	Total
Net Gain (Loss)	$ (247,799,445)	$ (100,138,460)	$ (347,937,905)
Operating Margin (%)	-4.48%	-1.44%	-2.79%
Medical Loss Ratio (%)	93.70%	95.58%	94.75%
Total Admin Expense Ratio (%)	10.79%	5.87%	8.05%

- Overall CCMC $347.9M loss with a $100M loss in MLTSS and $247.8M loss for Acute
- Two MCOs (Aetna and United) profitable through first three quarters of FY26
  - Aetna only MCO with a net gain in Acute program
  - Aetna, Humana and United with net gains in MLTSS program
- Anthem and Sentara, who account for 65% of CCMC enrollment, carry overall losses of over $412M

***SFY2026 reflects claims paid July 1, 2025 – December 31, 2025. Data is preliminary and should be used with caution. Pharmacy data does not include rebates.**

Flu Details – All Medicaid Programs

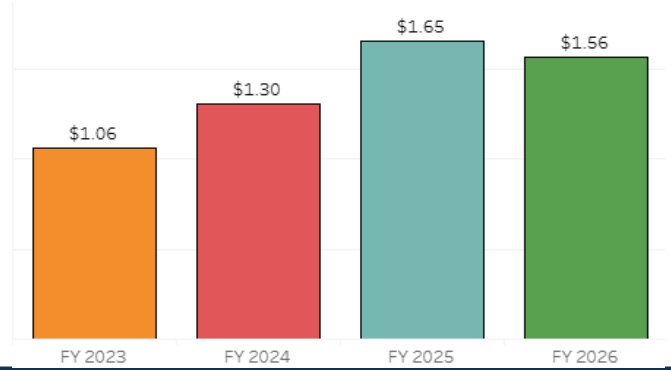
Flu PMPM by Fiscal Year



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY 23	$0.17	$0.14	$0.21	$1.81	$5.67	$2.52	$0.71	$0.67	$0.34	$0.22	$0.21	$0.15
SFY 24	$0.14	$0.18	$0.26	$0.44	$1.02	$4.36	$3.10	$2.99	$2.01	$0.70	$0.27	$0.15
SFY 25	$0.14	$0.17	$0.20	$0.25	$0.26	$1.98	$4.82	$6.45	$3.40	$1.33	$0.56	$0.33
SFY 26	$0.22	$0.21	$0.23	$0.24	$0.70	$4.56	$4.27	$2.20				

- SFY26's flu season peaked in December 2025 and January 2026 but the PMPM cost was lower in SFY26 than SFY25
- FY25 had two of three highest individual months in last three FYs
  - January and February 2025 alone account for over $22M in medical expenses to MCOs
- Flu PMPM increased 27% from SFY24 to SFY25 but decreased 5% from SFY25 to SFY26

Total Flu PMPM



*SFY2025 reflects claims paid July 1, 2025 – December 31, 2026