

June 27, 2025

Caprice Knapp, Acting Deputy Administrator and Director, CMCS  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Submitted electronically to <http://www.regulations.gov>

**Re: (CMS-10398 #37) Medicaid Managed Care Rate Development Guide**

Dear Deputy Administrator Knapp,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to respond to the draft 2025-2026 Medicaid Managed Care Rate Development Guide (the “MMCRDG”).

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 managed care organizations (MCOs) serving over 51 million Medicaid beneficiaries in 40 states, the District of Columbia and Puerto Rico. MHPA’s member plans include both for-profit and non-profit, national, regional, as well as single-state health plans that compete in the Medicaid market. Nearly three-quarters of all Medicaid beneficiaries receive health care through MCOs, and the Association provides research and advocacy services that support policy solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

We thank CMS for revising the 2025-2026 MMCRDG, and express appreciation for changes which improve transparency and ensure adequate, prospectively set capitation rates.

Actuarial soundness ensures adequate funding is provided to Medicaid MCOs to manage risk for health care services and related administrative expenses. An actuarially sound capitation rate setting process is critical for ensuring that Medicaid health plans have reasonable and appropriate payment for managing the delivery of holistic health care solutions that provide desired health care outcomes for vulnerable Americans.

MHPA is concerned that several factors are contributing to a unique environment creating significant rate pressures for states and health plans. Factors include trend predictability, program design changes, prescription drug policies, economic pressures relating to tariffs, and regulatory pressures. This underfunding conflicts with and undermines CMS’ objective of supporting a sustainable program which provides high-quality services for Medicaid enrollees.

In our letter below, we will provide detailed information on ongoing rate pressures as well as recommendations for CMS and states to alleviate the situation. In addition, we will provide specific feedback on the changes in the 2025-2026 MMCRDG. **General recommendations are summarized here, and laid out in [additional detail below](#), and our feedback to specific changes in the 2025-2026 MMCRDG are [accessible here](#).**

- **CMS should release guidance to:**
  - **Reinforce the need for mid-year rate adjustments;**
  - **Encourage use of emerging data in rate setting;**

- **Position the final rates near or at the mid-point of the actuarially sound rate range.**
- **Include tools or instructions in rate-setting guide to support states in accurately accounting for policies and program design changes.**
- **Increase monitoring and transparency of rate setting.**
- **Provide technical and analytical assistance for Medicaid State leadership for monitoring financial performance and program stability.**
- **Recommend a 24-month trend projection, down from a 30-month trend projection.**

## Discussion Key Trends Impacting Rates

Program design changes (Single PDL/PBM) for pharmacy benefit combined with hard to predict drug costs

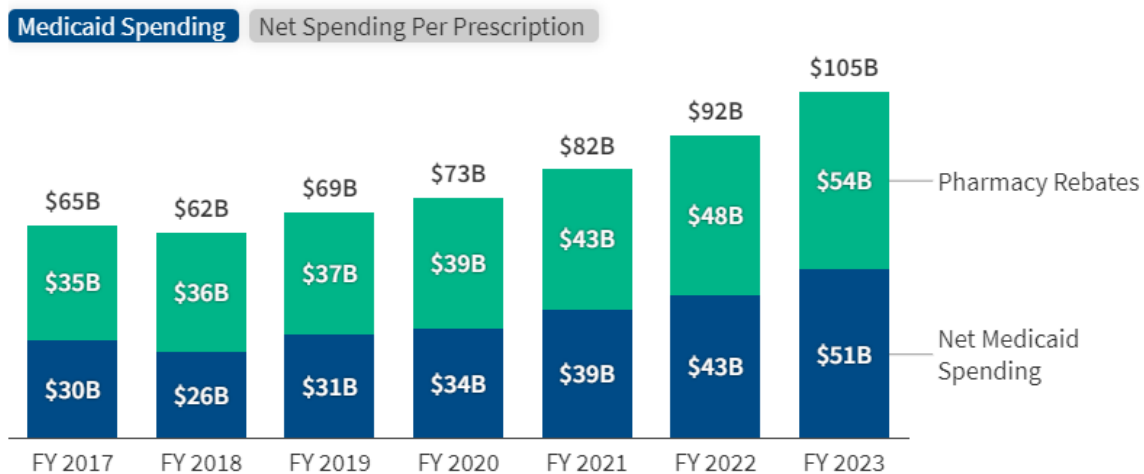
Prescription drug costs have become a major source of spending for state Medicaid programs. In fiscal year (FY) 2021 Medicaid spent \$38.1 billion in net spending on prescription drugs. The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary predicts the introduction of new drugs will push spending growth upward across payers from 2027-32.

KFF recently noted **net spending (spending after rebates) on Medicaid prescription drugs is estimated to have increased by 72%**, from \$30 billion in FY 2017 to \$51 billion in FY 2023, likely driven by the emergence of new high-cost specialty drugs.

Figure 2

### Gross and Net Medicaid Spending on Prescriptions Drugs Have Increased in Recent Years

Medicaid gross spending, net spending, and rebates on outpatient prescription drugs, FY 2017 - FY 2023



Note: FY = Fiscal Year. Rebates include statutory rebates, state supplemental rebates, VBA rebates, rebates under the ACA offset, and rebates for opioid use disorder medication assisted treatment. For more information on how net spending is calculated see methods of [Recent Trends in Medicaid Outpatient Prescription Drugs and Spending](#).

Source: KFF analysis of 2017-2023 State Drug Utilization Data and CMS-64 Financial Management Reports, September 2024. • [Get the data](#) • [Download PNG](#)

Simultaneously, single preferred drug lists (PDLs) and single pharmacy benefit manager (PBM) designs limit the MCOs' ability to effectively manage this benefit by restricting mechanisms like promoting generic drugs and other tools to contain costs. Direct-to-consumer advertising increases the likelihood of enrollees using brand name drugs in single-PDL/PBM states, which are significantly more costly. States adopt single PDLs in an effort to maximize federal and supplemental rebate dollars; however, **states are consistently underfunding programs with single PDL and PBMs.**

### Trend Predictability - New population demand not accounted for in rates

As providers and health systems return to "normal" following the public health emergency (PHE), we are seeing an increase in provider capacity and the demand for health care services. This may be in part due to significant focus on workforce recovery and in part due to policy changes that have increased fee schedules, expanded provider types (family members as caregivers) or otherwise made the Medicaid program more attractive to providers. Simultaneously, consumers are utilizing more services – either previously unmet need and/or new health conditions. The increased utilization exceeds the utilization expected by increased acuity of the membership. There is also likely supply/demand interplay between provider access and utilization realized; however, the suite of program changes taken by states and federal governments to increase access has worked and appears to be contributing to increased utilization.

**There has been a general underestimation of these utilization trends in the rates set for 2024, in part due to data lag.**

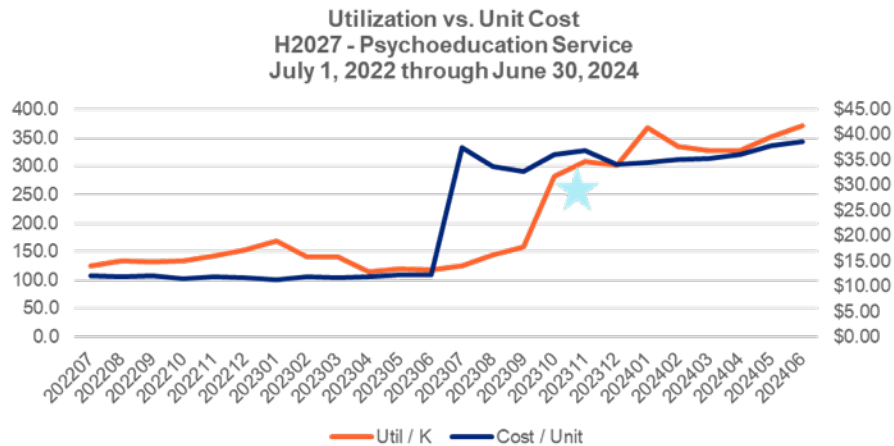
What follows are several examples from different states that underscore the efforts taken to increase access have resulted in more utilization. **To sustain access gains, we respectfully believe that states should accurately reflect the resulting increases in utilization in the MCO capitation rates in a more responsive and consistent manner.** We cannot as an industry sustain 4-5 years of significant program design change that stimulates utilization that is not supported by existing rates.

One plan reviewed core Medicaid members who have been enrolled with the plan since at least 2019. They saw increased access to services due to the expansion of provider capacity over that time. For example: In one market the state increased its fee schedule by 40% for HCBS providers. This drove a corresponding lagged increase in utilization per thousand members of 14%.

In another state a 17% increase in fee schedule rates for Nursing Facilities (NFs)/Skilled Nursing Facilities (SNFs) resulted in a 39% increase in patients per thousand members.

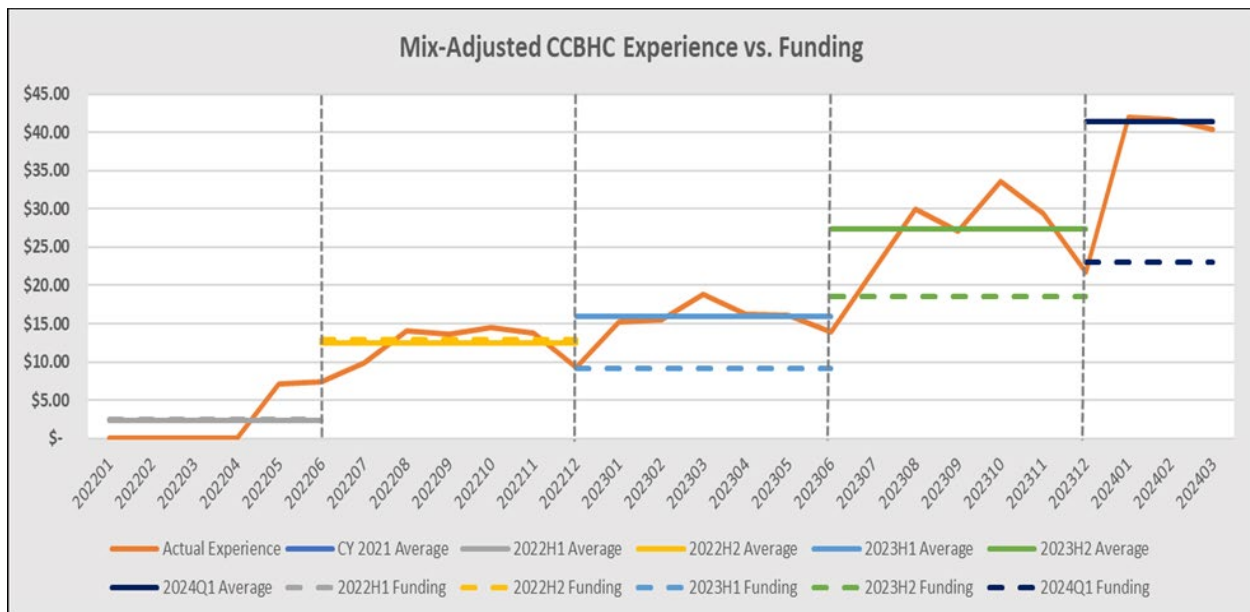
In another state, an actuarial analysis across plans analyzed Applied Behavioral Analysis (ABA) utilization for the period January 2022 – March 2024. The analysis, which was done using MCO data, shows utilization of ABA services increasing at an annualized rate of over 30%; and within child-only rate cells, growth is over 40%. While the fee schedule increase was included in the actuarial rate development, such a dramatic increase in utilization was not included. Figures 1 and 2, below, illustrate these examples.

**Figure 1: State Example of Fee Schedule Increase and Subsequent Utilization for a Behavioral Health (BH) Code**



NOTE: Fee schedule increase pre-dated a utilization per 1000 increase. The rate setting process accounted for the unit increase multiplied by historic utilization. However, the rate setting did **NOT** account for the jump in utilization that was a result of more provider capacity created by the fee schedule increase.

**Figure 2: MCO Financial Impact Over Time of Fee Schedule Increases w/o sufficient corresponding rate increases**



NOTE: Fee schedule increase and program implementation around Certified Community Behavioral Health Clinics (CCBHCs) has brought additional services to states. Unfortunately, the

above graph demonstrates the year-over-year (YOY) worsening of the disparity between actual health plan experience and funding.

**It is also important to note that the increases in provider capacity are not happening equally throughout the states, and we are not seeing corresponding decreases in other areas of spending (e.g. reductions in inpatient, emergency department use, etc.).**

## Economic Pressures

Economic uncertainty in light of new policies, such as a universal 10% tariff on all imports as well as targeted tariffs, have not been captured in the rate setting process and contribute to unpredictability in trends. Because rates are set prospectively using baseline data from previous years, actuarial trending is not adequately addressing the short and long-term impact of such economic policies. We are particularly concerned with the impacts of tariffs on pharmacy costs, which have significant downstream impacts for Medicaid MCOs.

## Costs Associated with Regulatory Enhancements to Access and Quality

MHPA recognizes recent efforts by CMS and Congress to ensure a sustainably funded Medicaid Program that provides high-quality services to Medicaid enrollees. However, additional factors from a high volume of recent policymaking will require states, plans, and providers to make significant investments in areas such as network adequacy and technology to remain compliant with new requirements. Some of the more significant policy changes include:

- Provisions from the Congressional Reconciliation Package which include significant shifts in Medicaid policy, including changes to State Directed Payments, provider-related taxes, mandatory community engagement requirements, cost-sharing for enrollees, and a reduced retroactive coverage lookback period.
- A Notice of Proposed Rulemaking which modifies the ability of states to fund their programs through provider-related taxes.
- The 2024 Medicaid Managed Care Final Rule, including the following provisions:
  - State directed payments (SDPs): Requirement that SDPs to be incorporated into Medicaid managed care capitation rates.
  - Wait-time standards.
  - Establishing a Medicaid and CHIP quality rating website and implementation of a mandatory measure set.

## What is on the horizon to create future pressure in 2025 and beyond?

PHE/Redetermination impacted base data is the source for prospective rate setting. All three completed years necessary for 2025 rate setting were substantially impacted by COVID and PHE continuous eligibility. Due to the significant environmental and marketplace changes during the past 4 years, simply trending forward pre-pandemic or mid-pandemic utilization patterns does not accurately account for the current design of the program, provider rates or behavior patterns or the Medicaid population health needs. ***In addition to leveraging 2023 data to establish rates, we***

**encourage the consideration of emerging utilization data for future rates given the significant shift in acuity and utilization.**

Significant program design changes have already been implemented, and more policies are planned for 2025- 2030. **We must accurately, consistently, and expeditiously account for changes that will impact utilization patterns in prospective rate setting.** As recent and future rulemaking by CMS is implemented, having stability in the program and adequate rates is more important than ever as states and MCOs need to make investments to be prepared for new requirements. If we do not account for the behavior change induced by these changing policies, the industry will be perpetually underfunded. (Figure 2 demonstrates how lagged rating drives perpetual underfunding and instability).

Actuarial soundness requires capitation rates to provide for all reasonable, appropriate, and attainable costs, **including administrative expenses.** Our analysis of 2024 and draft 2025 administrative funding reveals that overall, 2025 administrative funding is projected to be significantly lower. This decrease is attributed to significant losses in member volume that were not adequately offset by an appropriate economies of scale adjustment (i.e., fixed cost leveraging). Additionally, there are several enhanced requirements at the state and federal level that require additional administrative resources for successful implementation.

## Actions CMS and States can take to stabilize the Medicaid program and rate setting

- **Release of guidance for reinforcing the need for mid-year rate adjustments.**
  - We encourage CMS to provide states with guidance laying out the various options available to them for adjusting rates based on trends, acuity, and the other factors laid out above.
- **Provide guidance to encourage use of emerging data in rate setting**
  - We encourage CMS to include in the above guidance best practices and tools for leveraging current emerging data in rate setting.
- **Provide guidance to position the final rates near or at the mid-point of the actuarially sound rate range.**
  - Due to all the considerations discussed above, there has been a material mismatch between key pricing assumptions and emerging actual experience. On top of this, the wide range of key assumptions has caused additional pricing pressures due to the fact that in many states the final rates are positioned near or at the bottom of the rate range. MHPA highly recommends that CMS issue policy guidance to require/encourage positioning the final rates at or near the mid-point of a rate range until experience stabilizes.
- **Include tools or instructions in rate-setting guide to support states in accurately accounting for policies and program design changes** intended to increase access (e.g. provider fee schedule increases, single PDL/PBM design, prior authorization/gold card, payment policy, network design requirements) that will likely cause changes in utilization.

- ***Increase monitoring and transparency of rate setting.***
  - Ensuring transparency in the rate-setting process, including contract and rate renewals, promotes active stakeholder engagement that supports greater clarity, the identification of issues, and better feedback. Proactive communication and ongoing dialogue throughout the rate-setting process can also support efficiencies. MHPA has consistently advocated for transparency between States and MCOs in the rate setting process, going back to comments on the 2020-2021 Medicaid Managed Care Rate Development Guide. MHPA encourages adoption of the following safeguards to support consistency and transparency throughout the rate-setting process:
    - Proactive communication with MCOs early in capitation rate development.
    - Allow greater opportunity for MCO engagement and active participation throughout the rate development process.
    - Increased documentation of the rate setting decision-making process.
    - Furthermore, it is critical that CMS monitor trends and acuity on an ongoing basis to ensure that rates continue to be actuarially sound, so that adjustments can be made when utilization is not reflecting the assumptions made during rate development. Health plans have made significant efforts to work with states to address these concerns through mid-year adjustments, with little success.
  
- ***Provide technical and analytical assistance for Medicaid state leadership for monitoring financial performance and program stability.***
  - It is critical that states monitor trends and acuity on an ongoing basis so that adjustments can be made when utilization materially deviates from assumptions made during rate development. Many Medicaid Agencies have lost staff capacity, historic knowledge and programmatic expertise following the PHE. High turnover has created shifts in the roles, processes and procedures state agencies have in place to monitor rates, health plan sustainability and anticipate program shifts. While contracted actuarial firms support rate development, it is expected that Medicaid agencies have consistent reviews and monitoring in place to identify early deviations from actuarial assumptions. CMS could enhance the technical assistance provided to states and reinforce the need to have processes, procedures and tools in place to consistently monitor program efficiency and stability.
  
- ***Recommend a 24-month trend projection, down from a 30-month trend projection.***
  - In order to ensure that capitation rates are reflective of recent trends, including increased enrollee utilization and acuity, we recommend reducing the trend projection for rates from 30 months to 24 months. A 24-month trend projection would allow for states to account for emerging data and would result in more accurate, sustainable rates.

## Feedback on Changes in the Draft 2025-2026 Medicaid Managed Care Rate Development Guide

### CMS Suggests that States Incorporate Feedback from Previous Reviews of Rate Certifications in the Certification for Documentation for the Current Rating Period:

CMS is placing renewed emphasis on leveraging previous feedback in current rate submissions. Addressing prior review issues proactively can improve the efficiency of the review process.

Added on pg. 4 of 2025-2026 Guide: “To the extent that CMS has asked questions in CMS’s review of a prior rate certification(s) on a particular topic, and similar circumstances or issues are applicable in the program for the current rating period, CMS suggests that the state address the information requested during prior reviews in the certification documentation for the current rating period. This practice may reduce the need for similar questions asked in prior reviews, and improve the efficiency of the review process.”

*MHPA expresses support for this clarification, which will streamline future rate certifications and help to ensure that states are incorporating learnings from previous rate certification reviews in future rate submissions.*

### Limitations on Timing for Rate Adjustments Effective Part-way through the Rating Period

The Guide now explicitly states that for rate adjustments that are effective part-way through the rating period, those adjustments cannot be applied to rates for a shorter period of time than the change is effective.

Added on pg. 8 of the 2025-2026 Guide: The assumptions used for development of the capitation rates must be consistent with the effective dates of changes to the Medicaid managed care program (including but not limited to eligibility, benefits, payment rate requirements, incentive programs, and program initiatives). **More specifically, for rate amendments, the impact of program changes that are effective part-way through the rating period, may not be applied to the capitation rates for a shorter period of time than the change is effective.**

*MHPA seeks clarity on the purpose of this modification in the MMCRDG, and requests that CMS provide an example to illustrate a situation where this modification could have an impact. For example, is this change intended to address situations where a type of programmatic change is effective on July 1, but the rating exercise isn’t completed until October 1<sup>st</sup>, leading state actuaries in some instances to double the impact to rates from October 1<sup>st</sup> onward, stacking six months of impact into three months of rates? Would this change require state actuaries to instead make retroactive adjustments to rates going back to the July 1<sup>st</sup> effective date?*

### Clarifies the definition of non-risk

Newly added footnote on page 7 of the 2025-2026 Guide: “**Non-risk means that the managed care plan is not at financial risk for changes in utilization or for the costs incurred, and may be reimbursed by the state on the basis of incurred costs. These services must not be included in the capitation rates and rate certification submitted to CMS for review.**”

*MHPA expresses support for this clarification – a definition of non-risk is helpful to include in the MMCRDG and will help to allay confusion on this issue in the future.*

## Clarification that an Arrangement that Removes 100% of the Risk is not a Risk-Sharing Mechanism

In the context of the section on risk-sharing mechanisms, adds a footnote to clarify what a risk-sharing mechanism is.

Footnote 28 added on page 30 of the Guide: **Note that CMS does not consider an arrangement that removes 100 percent of the risk to be a risk-sharing mechanism.**

*MHPA seeks clarity from CMS on the purpose of this change, and requests that CMS provide an example to illustrate a situation where this change could have an impact. For example, would this clarification impact situations where a state delegates coverage of a high-cost gene therapy to a health plan through a non-risk model, but the health plan is unable to obtain the same rate as the state agency, resulting in the health plan funding the excess cost?*

Once again, thank you for the opportunity to respond to the draft 2025-2026 MMCRDG. We believe that adequate, current, and actuarially sound rates in Medicaid support access to care and services for Medicaid beneficiaries. We appreciate the opportunity to share our perspective on addressing these challenges and look forward to continuing to work with CMS and our state partners to make a meaningful difference in the lives of Medicaid beneficiaries.

Please feel free to reach out to me directly at [sattanasio@mhpa.org](mailto:sattanasio@mhpa.org) with any questions or should you need any additional information.

Sincerely,

/s/

Shannon Attanasio  
Senior Vice President, Government Relations, Policy & Advocacy