

December 19, 2025

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

Re: (CMS-10398 #37) Draft - Medicaid Managed Care Rate Development Guide, 2026-2027

Dear Director Brillman:

On behalf of the Medicaid Health Plans of America (MHPA), we appreciate the opportunity to comment on the draft 2026-2027 Medicaid Managed Care Rate Development Guide (the “MMCRDG” or Guide) and to raise several considerations related to the implementation of community engagement requirements of the One Big Beautiful Bill Act (OBBBA).

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 nonprofit, 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 policy and advocacy services that support solutions to enhance the delivery and coordination of comprehensive, cost-effective, and quality health care for Medicaid beneficiaries.

[2026-2027 Medicaid Managed Care Rate Development Guide \(Draft\)](#)

We appreciate that the 2026-2027 MMCRDG follows the same core framework as the prior year’s Guide while adding more clarity, detail, and transparency.

As CMS implements the OBBBA provisions through the MMCRDG, it is important that rate development standards and documentation requirements clearly capture the actuarial and operational impacts of these policy changes. Consistent with the Guide’s emphasis on appropriate documentation and transparency, we encourage CMS to clarify that rate certifications should explicitly describe the data, assumptions, and methodologies used to reflect the varied impacts of OBBBA requirements.

Furthermore, as actual experience from rating periods affected by OBBBA implementation becomes available, we encourage CMS to clarify that states and their actuaries should evaluate rate adequacy and make adjustments, as appropriate, to maintain actuarial soundness. While risk-sharing mechanisms such as risk corridors are useful for addressing uncertainty and experiences that deviate from projections, they should not replace the prospective development of adequate capitation rates. Consistent with the Guide’s emphasis on prospective, actuarially sound rate setting, capitation rates should be developed using reasonable assumptions rather than relying on risk-sharing mechanisms to address potential rate inadequacy.

Our comments on specific sections of the MMCRDG follow:

Risk Mitigation Strategies

CMS is specifically recommending a two-sided risk mitigation strategy when there is significant uncertainty, including for programmatic changes. (p. 12)

OBBBA implementation introduces material uncertainty and potential financial risk for states, the federal government, and MCOs. CMS has previously encouraged the use of two-sided risk mitigation strategies, such as risk corridors, in periods of heightened uncertainty. However, because OBBBA-related impacts may not be evenly distributed across beneficiaries or rate cells, a risk corridor alone may not fully address emerging misalignment between costs and rates. Accordingly, CMS should reiterate that the use of risk-sharing mechanisms does not replace the obligation to maintain actuarially sound capitation rates and does not preclude midyear prospective or retrospective rate adjustments to ensure rates remain aligned with the acuity of the enrolled population.

Given these uncertainties, we encourage CMS to reinforce that states may consider two-sided symmetric risk mitigation strategies in circumstances where actuarial assumptions are subject to significant uncertainty, and to continue such strategies until experience and base data are sufficient to support prospective rate development that meets actuarial soundness standards under 42 CFR § 438.4.

De Minimis Rate Changes

The draft Guide sets forth the requirements for state actions related to limited or de minimis rate changes. (p. 14-15)

The de minimis rate adjustment provision was established in the 2016 Medicaid and CHIP Managed Care Final Rule to simplify administrative processes for small programmatic changes while maintaining actuarial soundness. Federal regulations at 42 CFR § 438.7(c)(3) permit states to make a de minimis capitation rate adjustment of up to $\pm 1.5\%$ for limited programmatic changes without submitting a new rate certification. Any such adjustment must still comply with regulatory requirements including, but not limited to, contract-modification requirements under § 438.3(c) and actuarial soundness standards outlined in § 438.4(b)(1). To further reinforce compliance with regulatory requirements, we recommend CMS require documentation that includes an explicit statement that de minimis rate changes may not be used to circumvent actuarial soundness requirements.

Notably, the Guide also clarifies that each capitation rate cell must be independently certified as actuarially sound, rather than relying on aggregate program funding levels. Additional language noting that states must document their justification for applying a de minimis rate adjustment to each impacted rate cell and a statement that each cell remains actuarially sound net the impact of the proposed de minimis adjustment would reinforce this expectation.

Transparency

Appropriate documentation presents an opportunity to support consistency and transparency in rate development. (p. 15-20)

We believe the principle of transparency should extend to MCOs throughout the documentation and rate approval process. There is significant variability in information shared with MCOs from one state to the other and the reasons why the level of detail varies is unclear. To support consistency and promote transparency, we recommend a minimum universal standard for the level of information shared by the states and their actuaries to CMS and MCOs. For example, excluding any confidential or otherwise sensitive information, CMS could recommend inclusion of a standard package of information to be shared with MCOs that includes, but is not limited to, the rate certification and supporting Excel files. Encouraging states to share with MCOs what rate components are under review, approved, or denied by CMS would also support both efficiency and transparency.

In addition, CMS could add language requiring states to submit all MCO feedback related to the capitation rates being set to CMS as part of the rate review process. This approach would provide CMS insight into any MCO concerns and help support CMS in their rate review and evaluation of actuarial soundness.

Intended User

The certification must identify CMS as an intended user. (p. 15)

The certification is a critical piece of information documenting the development of the capitation rates paid to the MCOs. We recommend that CMS clarify that MCOs are intended users of rate certification, given that certified capitation rates directly inform the financial risk assumed by MCOs and are integral to actuarially and operationally sound decision-making. Explicitly identifying MCOs as intended users would promote consistent interpretation and application of the documentation requirements and support appropriate access to certification materials.

MLR and Rate Development Documentation

The draft Guide directs state actuaries to describe how the rate development ensures that each plan would reasonably achieve an MLR standard of at least 85 percent. (p. 16)

The draft Guide states “(t)he certification must document how the rate development ensures each managed care plan in each managed care program would reasonably achieve a MLR standard of at least 85 percent as required per 42 CFR § 438.4(b)(9). Additionally, per 42 CFR § 438.5(b)(5), in setting actuarially sound capitation rates states must also take into account each plan’s past MLR.” To support transparency, it could be helpful for CMS to direct state actuaries to describe how rate development ensures that each plan would reasonably achieve the administrative load standards.

Rate Cells & Actuarial Soundness

The draft Guide clarifies that each capitation rate cell must be independently certified as actuarially sound, rather than relying on aggregate program funding levels. (p. 16)

We believe this clarification is important in reinforcing that actuarial soundness applies at the rate-cell level, consistent with 42 CFR § 438.4, and that underfunding in one rate cell may not be offset by overfunding in another. By explicitly addressing this issue, the draft Guide provides helpful direction that prevents states from citing overall program adequacy to justify rates that may be insufficient for specific populations or services.

High-Cost Drugs

The draft Guide includes a new requirement related to how emerging high-cost drugs are reflected in projected benefit costs, including any related adjustments and underlying assumptions. (p. 26)

We appreciate the inclusion of “high-cost drugs” in projected benefit costs and would also recommend CMS consider adding the same provision to account for the impact of Single Preferred Drug Lists (PDLs), including the use of single, state-contracted PBMs.

Projected Non-Benefit Costs

The draft Guide discusses how projected non-benefit costs are accounted for in rate development and their required documentation. (p. 52-54)

We request that CMS clarify that the assumptions and methodologies used to develop projected administrative expenses should explicitly address the impact of OBBBA, including, for example: (1) the effect of fixed administrative costs being spread across a reduced enrollment base, and (2) potential increases in administrative expenses related to new compliance requirements, technology integrations or system configurations, and enhanced state reporting obligations.

Risk Adjustment

The draft Guide discusses standards and appropriate documentation for rate certifications describing prospective and retrospective risk adjustment methodologies. (p 54-55)

We support the incorporation of risk adjustment methodologies in the actuarial rate certification. Capitation rates are ultimately materially impacted by any risk adjustment methodologies applied to the certified rates. Given the importance of risk adjustment in the development of actuarial sound rates and the continued financial sustainability of Medicaid MCO participation in the Medicaid program, we encourage CMS to consider the following:

- Add language to the MMCRDG stating that any change in risk adjustment would be considered a change in the actuarially sound rate requiring CMS notification.
- Require identification of risk adjustment methodologies, including risk mitigation mechanisms, prior to the start of the rating period.
- Disallow retroactive changes to a risk adjustment methodology implemented prior to the start of the rating period with limited exceptions. Some examples of exceptions may include addressing material member mix changes due to in-year MCO entry/exit and state auto-assignment algorithm errors.

Also, to align the requirements for the prospective and retrospective risk adjustment methodologies, we recommend CMS add “the party calculating the risk adjustment” to the section 6.B.i. of the MMCRDG for prospective risk adjustment methodologies to mirror the requirement in 6.B.ii. for retrospective risk adjustment methodologies. We also recommend adding that that risk adjustment should be performed by or under the supervision of a credentialed actuary for rate certification descriptions for both the prospective and retrospective risk adjustment methodologies and that the signing actuary cannot rely on risk adjustment results produced by a non-credentialed third-party that they did not directly supervise or support.

Acuity Adjustment Example

The draft Guide removes the PHE unwinding as an example of circumstances warranting retroactive acuity adjustments. (p. 55-56)

We suggest CMS include illustrative examples of the varied impacts related to OBBBA implementation, including community engagement requirements, to clarify circumstances when retrospective acuity adjustments are permissible.

OBBBA & Community Engagement

As you know, OBBBA requires certain adults eligible through the Medicaid expansion to participate in community engagement (CE) activities, such as employment, job training, education, or volunteering, as a condition of continued Medicaid eligibility, unless they qualify for an exemption. With implementation moving forward, we believe it is important to raise a potential operational and rate-setting implication associated with these requirements.

Specifically, the implementation of CE requirements is expected to produce mid-year changes in enrollment composition, as individuals are potentially disenrolled due to employment transitions or failure to meet reporting or administrative requirements. Because individuals who achieve greater employment stability or alternative coverage



options under CE requirements are more likely to disenroll, the remaining Medicaid population is expected to include a higher proportion of enrollees with chronic conditions, functional limitations, and higher health care needs¹. These shifts may occur outside of the regular rate-setting cycle and could materially alter the acuity profile of the remaining enrolled population, similar to the impacts of the PHE unwind.

Without explicit guidance for handling these dynamics, managed care capitation rates may no longer accurately reflect expected costs, raising concerns related to actuarial soundness, access to care, and network stability under 42 CFR § 438.4. We respectfully request CMS consider providing guidance on how states and health plans should account for these enrollment dynamics to ensure continued rate adequacy, actuarial soundness, and access to care for Medicaid beneficiaries. For example, acuity shifts under the OBBBA could be listed as an additional example of a circumstance warranting retroactive acuity adjustments on page 55 of the 2026-2027 guide.

Once again, thank you for the opportunity to respond to the draft 2026-2027 MMCRDG. We appreciate the opportunity to share our perspective 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 with any questions or should you need any additional information.

Sincerely,

/s/

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

¹ <https://www.kff.org/medicaid/understanding-the-intersection-of-medicaid-and-work-an-update/>