May 12, 2026

Dan Brillman, Deputy Administrator and Director, CMCS
CC Sara Vitolo, Deputy Director, CMCS
CC John Giles, Director, Division of Managed Care, CMCS
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Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: Follow-up; Q2 2026 MHPA/CMS Meeting on Capitation Rate Setting

Dear Deputy Administrator Brillman,

On behalf of the Medicaid Health Plans of America (MHPA), we thank you for the opportunity to provide written follow-up to our April 30th quarterly meeting with the Managed Care Group at CMCS and the Office of the Actuary at CMS. We appreciate CMS's recognition that an open dialogue on the Medicaid rate setting process is foundational to the long-term financial sustainability of the Medicaid program.

MHPA is the only national trade association with a sole focus on Medicaid, representing more than 160 managed care organizations (MCOs) serving over 47 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.

Since the COVID-19 pandemic and related public health emergency (PHE), Medicaid rates have undergone a period of heightened uncertainty relating to rapid acuity and utilization changes among enrollees. Just as Medicaid enrollment began to stabilize in the aftermath of the PHE, we are now beginning to see additional acuity and utilization shifts as a result of programmatic changes from HR1, also referred to as the "Working Families Tax Cut" (WFTC) legislation. We therefore applaud CMS for amending their draft Medicaid Managed Care Rate Development Guide to include references to programmatic changes in the WFTC legislation as a valid reason for rate adjustments.

While we view the recent amendment to the Medicaid Managed Care Rate Development Guide as an important step, additional improvements to the rate setting process would further strengthen the resiliency of the Medicaid program through periods of heightened uncertainty. Improvements in the transparency of the rate setting process, creating a multi-touch rate engagement calendar, and giving Medicaid MCOs more opportunity to provide thoughtful feedback to both states and CMS during rate negotiations would help to ensure actuarial soundness in the rate setting process, including during periods of significant uncertainty.

We believe that there is an opportunity to make meaningful changes to the Medicaid rate setting process – while we recognize that current regulations do not permit some of our recommendations in this letter, we encourage CMS to pursue new rulemaking in 2027 to enable some of these recommendations. MHPA and its member plans stand ready to collaborate with CMS in making

significant reforms to the rate setting process, including through a robust stakeholder input process similarly to how CMS regularly updates quality measures. We believe that it is important for the stability of the Medicaid program to ensure robust participation from MCOs in the rate setting process and rulemaking to modify it. In this document we will provide additional context surrounding the conversations we recently held with CMCS during our quarterly meeting.

We acknowledge that CMS also raised the topic of program integrity and a recent Managed Care Program Annual Reports (MCPAR) data release including a Public Use File (PUF) at the end of our call. While MHPA and its member plans are continuing to review this data release, we are including some remarks at the end of our letter that speak to this issue, as requested by CMS. We look forward to continuing this discussion in the future.

Discussion of Rate Pressures

When the COVID-19 pandemic began, Congress enacted the Families First Coronavirus Response Act (FFCRA), which required Medicaid programs to keep beneficiaries continuously enrolled through the end of the COVID-19 PHE. When the continuous enrollment provision from the FFCRA wound down as a result of the 2023 Consolidated Appropriations Act (the "unwinding"), the Medicaid program saw a historic rise in acuity as healthier enrollees were more likely to lose coverage due to changes in circumstances than enrollees with more acute health conditions.

Acuity changes related to the unwinding

Table 1 shows a specific health plan experience in one state through member Benefit Care Ratio (BCR), which is a ratio of medical costs to revenue, by stayers, leavers, joiners, and churners for the past four quarters. As you can see, the BCR of those staying increased – as did the BCR of the population that was leaving. As illustrated by Table 1, joiners were coming into plans with higher acuity, receiving services such as hospital stays, and were then leaving plans. Revenue did not adequately cover the services provided for these individuals. MCOs appreciate the budgetary pressures facing our state partners and look forward to continuing to partner in a collaborative manner to meet the needs of Medicaid enrollees. However, despite these challenges, only a few states applied an adjustment for member churn due to the PHE unwinding, and many states did not apply adequate acuity adjustments in recently received capitation rates.

Table 1

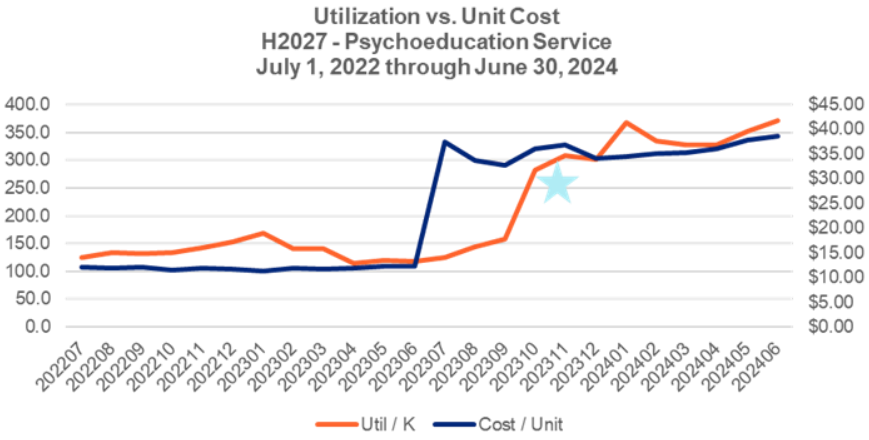
BCR				
Row Labels	2023Q3	2023Q4	2024Q1	2024Q2
Stayer	84%	93%	93%	100%
Joiner	135%	140%	145%	123%
Leaver	80%	79%	75%	106%
Churner	*170%*	*133%*	*108%*	*139%*
Grand Total	**86%**	**94%**	**93%**	**101%**

Increased behavioral health utilization and cost

In a November 2024 letter to CMCS, MHPA highlighted some of the rate pressures that were created by the COVID-19 pandemic and PHE. As states set rates leveraging a baseline period which included the COVID-19 PHE, rapid shifts in acuity resulted in insufficient rates for Medicaid MCOs in many

instances. This rate pressure was exacerbated by additional external factors, including the rise of high-cost specialty drugs and significant increases in behavioral health utilization. The table below illustrates how both cost and utilization for behavioral health services rose rapidly between 2022 and 2024, contributing to rate pressures.

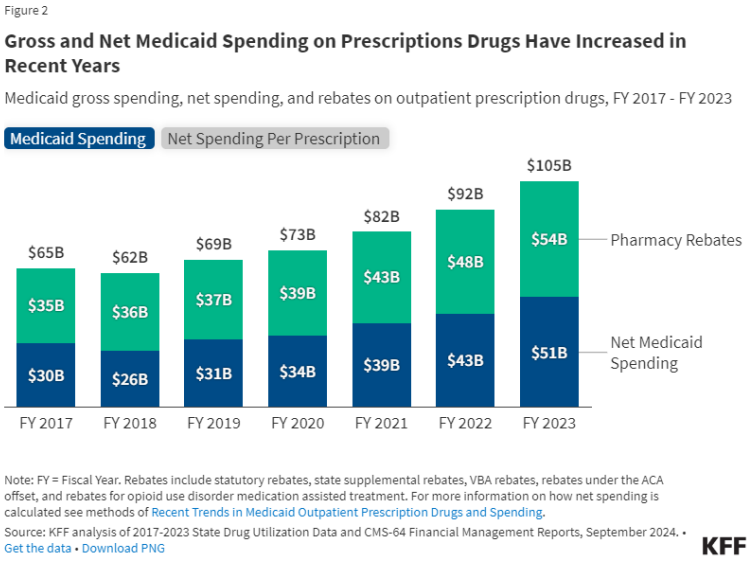
Figure 1: State Example of Fee Schedule Increase and Subsequent Utilization for a Behavioral Health (BH) Code



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.

High-cost specialty drugs and prescription drug program design

Spending on prescription drugs also rose rapidly during the COVID-19 PHE and unwinding period, as evidenced by the table below. Simultaneously, single preferred drug lists (PDLs) and single pharmacy benefit manager (PBM) designs limited and continues to limit the ability of MCOs to effectively manage this benefit.



MCOs' financial experience in CY2024 and anticipated impacts of WFTC Legislation on acuity

These factors converged in CY2024, where a Milliman Research Report which analyzed the financial results of Medicaid MCOs that year, found that the MCOs analyzed experienced composite underwriting losses of 0.6% in CY2024.

We have significant concerns that the implementation of community engagement requirements and more frequent redeterminations from the WFTC legislation, combined with existing rate pressures related to high-cost drugs and behavioral health treatment, are likely to create a similar financial strain for both states and Medicaid MCOs. Notably, the WFTC legislation includes two provisions which will take effect on January 1, 2027, one to increase the frequency of redeterminations to twice a year for the Medicaid expansion population (up from once a year) and another to impose community engagement requirements on the same group with exceptions. Both the applicability of these requirements to the Medicaid expansion population as well as exemptions being available for enrollees who are medically frail are likely to result in a significant increase in acuity in the Medicaid population overall for expansion states.

Making the Medicaid program more resilient to periods of uncertainty

While it is reasonable in periods of stability for the Medicaid program to leverage three-year baseline periods in creating rates, periods of uncertainty require a nimbler approach. The recommendations we discuss below, including leveraging emerging data in rate development and utilizing risk mitigation mechanisms, can help to ensure that the program remains actuarially sound and adequately funded as we navigate this period of heightened uncertainty. This in turn will ensure that Medicaid enrollees are able to continue accessing high quality care via a robust provider network. In the long term, we also discuss recommendations below relating to transparency and process improvements, with the objective of making the Medicaid program more resilient and responsive to future periods of uncertainty and risk.

Recommendations Related to Transparency

We recommend a **tri-directional exchange of information with a minimum universal standard between states, MCOs, and CMS**, to ensure that all stakeholders are able to provide input and weigh in on rate setting considerations.

- Specifically, we recommend that states be required to share rate certifications and supporting materials with MCOs at time of submission to CMS. This exchange of information should include the rate certifications and supporting materials, including methodologies, key assumptions, and exhibits. We recognize that given the competitive nature of the Medicaid managed care industry, CMS must strike a balance between protecting proprietary information and ensuring relevant stakeholders have meaningful visibility into the rate development process.
- We recommend that states be required to provide explicit quantifications of adjustments and assumptions when submitting rate certifications and supporting materials to CMS and MCOs. Notably, policy and program changes should include clear and expected per member per month (PMPM) impacts by zone (region) and rate cell, as well as the analysis and models, justifications and methodologies used to develop adjustments.

- States should be required to identify trend sources and benchmarks used when sharing this information, providing historical support (i.e., trend modeling and analyses) and rationale for trend selections.
- We ask that CMS provide increased transparency into their decision framework for reviewing state rate certifications. It would be beneficial for all stakeholders involved to have line of sight into the CMS review checklist so that MCOs have a better understanding of how the Office of the Actuary is reviewing rate setting submissions. This approach could mirror the process CMS currently uses for Section 1115 waivers.
- We ask that as states consider making low acuity non-emergent (LANE) inefficiency adjustments, that MCO levers be considered thoughtfully. MCOs should have the opportunity to intervene and influence outcomes before receiving an inefficiency adjustment.
- We recommend that these requirements be included in iterative guidance and then incorporated into the Medicaid Managed Care Rate Development Guide.

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. Increased transparency would facilitate auditing rate certifications by MCOs and CMS and would also help to ensure that rates remain actuarially sound, particularly in this environment of heightened uncertainty.

Recommendations to Improve the Rate Setting Process

Parallels to the COVID-19 PHE and the Involving MCOs in the Rate Certification Process

We recommend that CMS take steps to proactively mitigate the uncertainty we discussed in our section on rate pressures, including programmatic changes from the WFTC legislation, high-cost specialty drugs, and increased cost and utilization related to behavioral health treatments. We are concerned to hear that in early discussions, some states plan to account for these programmatic changes in mid-year adjustments rather than anticipating the impact of these changes. The unwinding of the COVID-19 PHE provides a parallel historical experience that states can and should leverage to prospectively set rates in anticipation of a period of heightened acuity beginning in 2027.

As noted above, we applaud CMS in including language on the WFTC legislation in their most recent Medicaid Managed Care Rate Development Guide. We appreciate CMS acknowledging the importance of programmatic changes in the rate setting process and encourage CMS to consider these factors in their thorough review of rate submissions by states. A strong rate review process between CMS and states, involving a robust back and forth on the reasonableness of assumptions helps to pressure test rate submissions to ensure accurate, actuarially sound rates.

We suggest that beyond the rate review process, rate certifications could also be periodically audited by a second CMS actuary or a third-party actuary to create a peer-review process, promoting accountability. A thorough review by CMS, incorporating MCO input, would ensure a collaborative rate review process with all relevant stakeholders involved – critical in an environment of complexity. MCOs have in-house actuarial expertise and access to robust data on their enrollees – it would be beneficial to all stakeholders for them to have a seat at the table and to be involved in this process from start to finish.

Mid-year Retroactive Rate Adjustments

In the absence of prospective rate setting which anticipates shifts in utilization, acuity, and costs, we recommend that CMS provide guidance (via the Medicaid Managed Care Rate Development Guide) and technical assistance to states on the importance of leveraging mid-year, retroactive rate adjustments to ensure actuarial soundness. However, CMS should emphasize **that mid-year adjustments must be based on a concrete programmatic change or incorrect material assumption(s) impacting rate adequacy**. We are concerned that particularly with significant changes to Medicaid financing mechanisms as a result of the WFTC legislation, some states may be incentivized to leverage mid-year adjustments to true-up to state budgets rather than stabilize the program – indeed, we have already seen at least one state exploring this option. This is why we believe it is critical that risk mitigation **methodologies** be defined prospectively, as required by the Medicaid Managed Care Rate Development Guide. In the aftermath of the COVID-19 PHE, adjustments were needed for unforeseen and hard to measure events, not to remedy budget shortfalls. In periods of uncertainty, transparency in assumptions will allow for auditing of these adjustments.

Leveraging current and emerging data

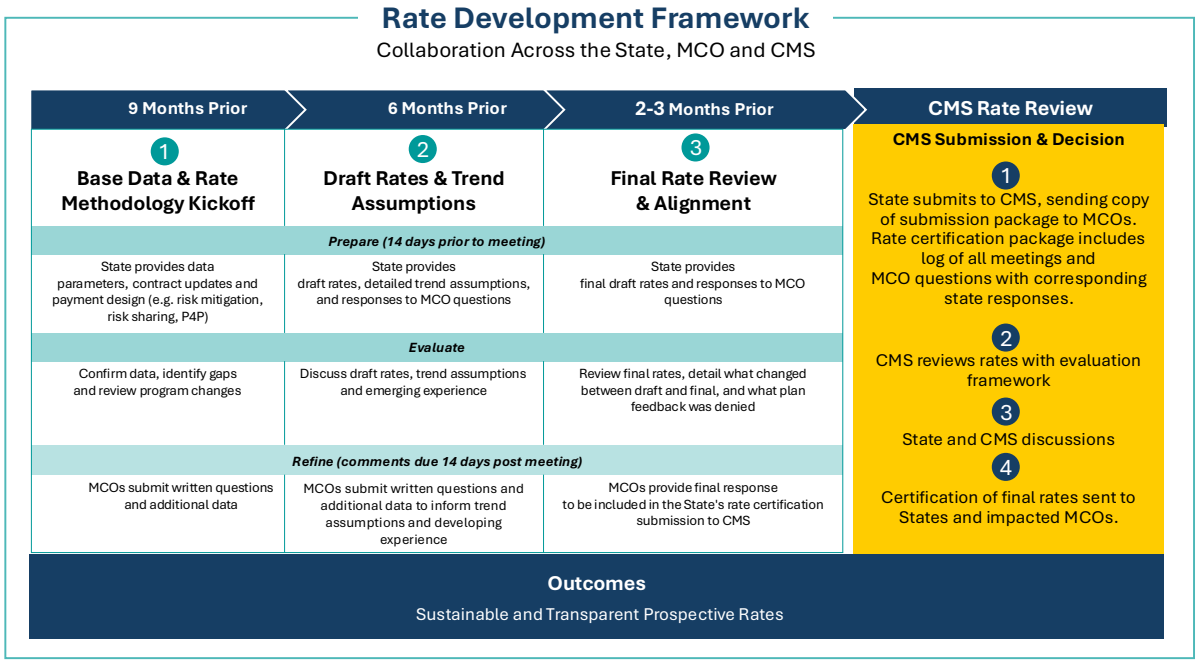
CMS can also mitigate this period of uncertainty by providing guidance (via the Medicaid Managed Care Rate Development Guide) and technical assistance to states on using more current and emerging data in rate development. While we recognize that the Medicaid program will have to eventually revert to leveraging a stable baseline period to establish rates, this period of heightened risk justifies the temporary use of more current and emerging data to ensure that rates reflect the real-world experience being lived by enrollees, states, and MCOs. Using real-time pharmacy data and avoiding over-reliance on dated experience years can help to ensure that rates are adequate and actuarially sound. We would like to emphasize our awareness that some historic data is needed for risk-based rate setting and continue to support a prospective rate setting process. However, the current environmental factors we have discussed justify a more dynamic approach until acuity, utilization, and cost stabilizes.

Leveraging a structured, multi-touch rate engagement calendar and process

To create a more thoughtful, collaborative, and transparent rate setting process, we recommend that CMS require a **structured, multi-touch rate engagement calendar** and process. This requirement could be incorporated into the Medicaid Managed Care Rate Development Guide. A calendar would ensure adequate lead time for both the state and the MCO to engage meaningfully in rate negotiations, which is especially important during this period if heightened risk and uncertainty. We note that this recommendation may require notice and comment rulemaking, however, we believe the result would improve the current process. Below is a description of what we would consider an ideal engagement calendar and process that would allow for this thoughtful collaboration:

- **1st round** – Base data and rate methodology kickoff meeting, ideally nine months before rates are effective. This round would allow for "traffic control," allowing for early identification of issues where there is consensus versus issues that merit deeper discussion between the state and the MCO.
- **2nd round** – Draft rate meeting – six months before rates are effective. In this round we begin to see draft rate certifications – MCOs begin to ask questions and provide feedback on those rate certifications.

- **3rd and final round** – Two to three months before rates are effective, the state shares the final rates, what changed between draft and final rates, why it was changed, and what plan feedback was approved and denied. To incorporate the emerging experience into rate negotiations, this step would involve a discussion of recent changes in trends, acuity, and utilization, allowing adjustments to be made before rates are finalized to ensure accuracy. Plans would then have opportunity to provide final feedback on these rates, which would be packaged with the rate certification before it is submitted to CMS for approval.
    - We recommend **a 14-day feedback period** for plans after each round to allow for meaningful analysis and response. We recommend that as with the notice of proposed rulemaking process, states be required to respond to MCO feedback with explanations.
- **CMS review round –** The state would now submit rates to CMS, including final MCO feedback on those rates, as well as a written explanation by the state of what feedback was accepted or declined. As part of OACT review, CMS would be required to read and respond to MCO feedback, providing explanations for why they accepted or did not accept the input (similarly to the 1115 waiver review process). The final CMS approval or denial would be shared with both the state and the MCO, including a log of questions and responses as well as explanations.



Discussion of Recent MCPAR Public Use File and Program Integrity

On April 30th, CMS released a PUF containing data from MCPAR reports. We thank CMS for their commitment to transparency and welcome the opportunity to discuss the performance of Medicaid MCOs. On our quarterly call, CMS staff highlighted concerns surrounding this MCPAR data as it pertains to program integrity and number of referrals to the state and invited MHPA to provide context for this data in this follow-up letter. Program integrity is of the utmost importance to MHPA and its member plans. MHPA has recently submitted two letters to CMS discussing program integrity efforts, including our response to the CRUSH RFI (accessible here) and a letter discussing fraud, waste and

abuse (FWA) in Applied Behavioral Analysis (ABA) (accessible here). MHPA also released an issue brief on how MCOs are taking action against FWA in Medicaid in February 2026, accessible here. Below is a brief discussion of how MCOs are addressing FWA, as well as additional context for the MCPAR data release.

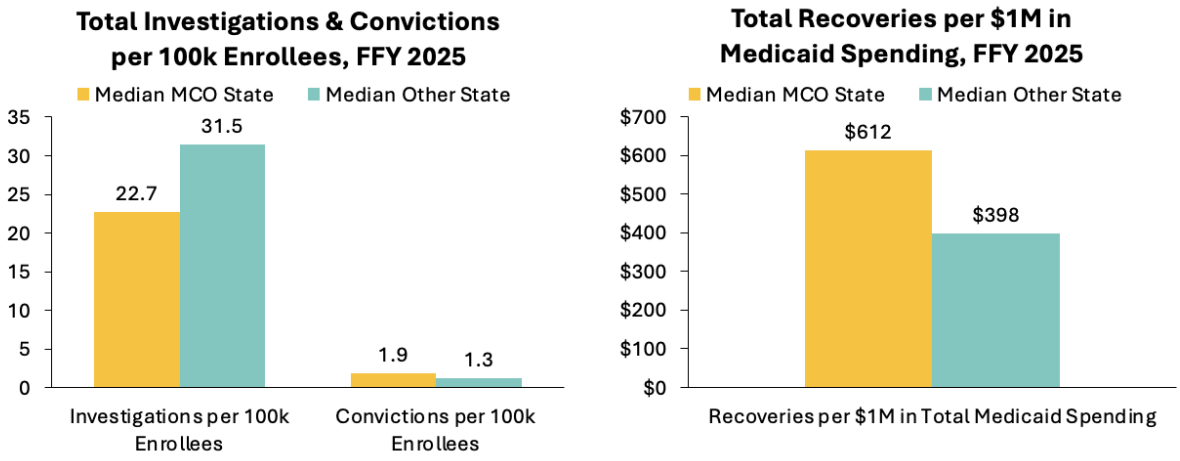
How MCOs are Detecting and Combating FWA

Medicaid MCOs are working closely with state and federal partners to protect the integrity of the Medicaid program supplementing federal and state oversight with a front-line layer of prevention, detection, and enforcement. A critical component of that partnership is the referral of suspected fraud to Medicaid Fraud Control Units (MFCUs), state-level law enforcement agencies that investigate and prosecute Medicaid fraud. Medicaid MCOs have doubled the number of fraud referrals to MFCUs from just under 3,000 in 2021 to nearly 6,000 in 2025.[i]

In states where managed care is the predominant delivery system, the MFCU reporting data reflect the meaningful impact of Medicaid MCO program integrity strategies over other states.[ii] For example, the latest MFCU data for 2025 show that the median MCO state recovered $612 for every $1 million of a state's total Medicaid budget through MCFU investigations, exceeding the median of other states which recovered $398 per $1 million in total Medicaid spending.

Moreover, the median MCO state opened fewer investigations per enrollee compared to other states, yet yielded more convictions and higher recoveries, meaning fraud dollars are recouped more efficiently. See Figure 1 for additional details on the impact of Medicaid MCO program integrity efforts for FFY 2025.

Figure 1. MFCU Investigations, Convictions, and Recoveries in States with Managed Care As the Predominant Delivery System vs. Other States, FFY 2025



Note: MFCU = Medicaid Fraud Control Unit. FFY = Federal Fiscal Year. M = Million. k = Thousands. "Other states" include 13 states where less than half of all enrollees are in MCOs based on 2024 CMS MCO Enrollment Reports (AL, AK, AR, CO, CT, ID, MA, ME, MT, ND, SD, VT, WY).
Source: MHPA analysis of Statistical Chart data from Medicaid Fraud Control Unit Annual Report: Fiscal Year 2025.

We believe ensuing program integrity is essential for promoting accountability, value, and the long-term fiscal sustainability of the Medicaid program. Medicaid MCO approaches for program integrity are wide-ranging and comprehensive with direct ramifications for the rate setting process. For example, robust monitoring and advanced data analytics, including algorithms and data mining,

enable Medicaid MCOs to identify patterns and insights that can prevent payment for extreme quantities of services provided on the same day, medically impossible or unlikely services, and services improperly combined or separated for payment purposes. MCOs also work to ensure payment integrity by reviewing claims to verify billing accuracy. By flagging these trends early, MCOs help ensure that actuarially sound rates reflect legitimate utilization, while preventing fraudulent claims from distorting the data that underpins future rate periods.

Contextualizing the MCPAR data release

Transparency and accountability are critical to ensure that the Medicaid program is administered effectively, including through managed care. We believe there are opportunities to improve data collection through the MCPAR to allow CMS to more effectively compare plan performance across states. In addition, there are several factors that MCPAR does not currently account for, but that we believe are critical components of the program integrity ecosystem that plans operate in.

There is significant variation between states in how MCPAR data is collected, including the range of program integrity referrals which are captured by the state. The reporting templates for states vary significantly, with some states asking plans to pass along a wide range of program integrity referrals to the state, while other states ask the plan to filter through program integrity referrals internally before elevating to the state. For example, in some states, a member losing an ID card is required to be referred to the state, whereas in other states only more significant instances of provider fraud are referred to the state. Standardizing the reporting templates that states provide to MCOs would ensure that all data is being collected on a level playing field, facilitating more informative comparisons of plan performance across states.

In addition, the count of program integrity referrals to the state does not capture the efforts that MCOs are engaging in to deter FWA before it occurs. We believe that deterring FWA proactively is one of the differentiators that makes MCOs so effective, while ensuring that high quality providers are continuing to deliver appropriate services to Medicaid enrollees.

Specifically, there are several “gates” that providers must pass in an MCO environment before receiving payment for a claim, some of which do not exist in a FFS environment. These gates, while extremely effective at deterring FWA, are not captured in a statistic that measures how many program integrity referrals are made to a state.

The first gate, network development, allows MCOs to ensure that providers with credentialing issues or program sanction history never receive payments via the Medicaid program. Once providers are in network, these screening and oversight activities continue on a routine basis. In addition, MCOs develop and implement anti-fraud plans that are approved by the respective state Medicaid regulators, outlining risk-based approaches to program integrity. Perhaps most critically, MCOs engage in robust utilization management controls, as well as pre-payment claims editing and other pre- and post-pay data-driven surveillance and auditing, to ensure that any inappropriate claims are detected and addressed and that services being delivered are safe, appropriate, and medically necessary.

MCOs have largely adjusted their program integrity efforts to engage proactively, in advance of problematic claims, as opposed to the pay and chase approach that was more prevalent in the past. This strategy explains why MCOs are opening fewer investigations but making larger recoveries than

in FFS states. The FWA that exists after these proactive measures tends to be more sophisticated and harder to identify. But through rigorous processes, systems, and other tools, MCOs can thoroughly capture dollars attributed to FWA.

Another factor that should be considered as CMS reviews this data is how MCOs support criminal investigations into fraudulent providers. When an MCO refers a fraudulent provider to the state, they are often told to continue paying claims while the investigation unfolds, allowing law enforcement to continue to collect evidence of fraud to ensure a conviction. These investigations can sometimes take years, and result in MCOs being required to continue to pay out claims to providers they know are engaging in FWA.

These factors are important to consider as CMS reviews MCPAR data and continues to reform the program. We welcome further discussion on this topic in an upcoming quarterly call as well as any follow-up questions CMS may have.

Once again, thank you for the opportunity to provide a follow-up after our call on April 30, 2026. We believe that adequate, current, and actuarially sound rates in Medicaid support access to care and services for Medicaid beneficiaries. These recommendations related to transparency and process improvements will help to create a Medicaid program that is more resilient to periods of risk and uncertainty. 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 enrollees.

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

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[i] Medicaid Fraud Control Units Annual Report: Fiscal Year 2025 (March 2026). Available at: https://oig.hhs.gov/documents/evaluation/11553/OEI-09-26-00140.pdf. More information available at: https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/

[ii] *NOTE: "All other states" include states where less than half of all enrollees are in MCOs (AL, AK, AR, CO, CT, ID, MA, ME, MT, ND, SD, VT, WY) and includes AR, CO, ID, MA, and ND, which have some MCO enrollees but less than half of their total population. In 2023, MS also had <50% of enrollees in MCOs and is counted as "All other" for 2023 and "MCO" for 2024 and 2025.*