

Medicaid Rate Setting Process Considerations

Recommendations to States for Accurate, Transparent, and Collaborative Rate Setting

Written By

Andrew Schwarze, ASA, MAAA

Josh Rekula, ASA, MAAA



Table of Contents

Executive Summary.....	3
Introduction and Background	4
Process Features Supporting More Transparent Rate Setting	5
The Value of Transparency in Methods and Assumptions.....	5
Transparent Rate Setting Documentation	6
Transparency through MCO Engagement	7
Process Considerations for using Historical Data	9
Reliance on Historical Experience	9
Responsiveness to Emerging Experience.....	9
Timely Rate Setting Data	10
Actuarial Ranges and Uncertainty for Certified Rates.....	10
Actuarial Range Development	10
Asymmetry of Financial Risk	11
Managing Risk within the Rate Range	11
Conclusion	12
Disclosures	12

EXECUTIVE SUMMARY

Most states' Medicaid programs rely on managed care organizations (MCOs) to deliver high quality care, maintain provider networks, support care coordination, and improve health outcomes for vulnerable populations. To achieve these goals, states must develop capitation rates that are actuarially sound.¹ Under this standard, states go through an annual rate setting process, which may include mid-year rate updates, to ensure capitation rates are:

- Projected to cover all reasonable, appropriate, and attainable costs required under the contract;
- Developed using generally accepted actuarial principles and practices;
- Appropriate for the populations and services covered; and
- Reviewed and approved by CMS as actuarially sound.

This report draws on Wakely's experience across multiple state Medicaid programs to identify recurring concerns with how Medicaid capitation rates in a number of states are developed, certified, and implemented. These concerns, which have increased as states have contended in recent years with more rapid shifts in member acuity and utilization, can be addressed by states through robust rate setting processes and practices. Specifically:

Transparency and MCO engagement:

- *Concern:* Limited rate setting transparency and a lack of engagement with MCOs by states during the rate setting process limits the ability of MCOs to evaluate whether rating assumptions, data, and methodologies appropriately reflect emerging issues.
- *Recommendation:* Clear documentation and structured communication by states enable MCOs to review rates and evaluate changes in experience, while ongoing monitoring provides visibility into developing trends. Establishing formal engagement processes and feedback loops can improve data quality, strengthen actuarial support, and enable more timely and targeted adjustments when needed.

Timeliness of data:

- *Concern:* Reliance by states on historical data without appropriate adjustments can lead to delayed responses to changing circumstances, particularly when older historical data is used.
- *Recommendation:* Use of timely data and structured incorporation of emerging experience can help reduce delayed rate responses and improve rate accuracy. In practice, this means prioritizing processes that shorten the gap between base data and

¹ See 42 U.S.C. § 1396b(m)(2) (i.e., §1903(m)(2) of the Social Security Act and 42 C.F.R. § 438.4–438.7.

rate period or supplement base data with credible, emerging indicators of utilization and acuity shifts.

Actuarial range and rate selection:

- *Concern:* Wide actuarial rate ranges can lead to programmatic underfunding when the lower end of the range is selected by states. Additionally, the consistent use of multiple individually reasonable, lower bound estimates when developing rates, may result in inadequate rates in aggregate, which can be a concern with or without the use of rate ranges.
- *Recommendation:* The asymmetric nature of financial risk where MCOs are more exposed to underestimation than overestimation makes careful consideration of the actuarial rate range and selection point critical, and we recommend rate setting actuaries consider and document how the selection point differs from the best estimate. Providing a clearly defined best estimate and assessing the plausibility of combined assumptions can help ensure rate selections support stable program outcomes.

While no single approach is appropriate in all circumstances, state practices such as clear communication of uncertainty, structured monitoring of experience, and mechanisms to respond to emerging results can help reduce the risk of material misalignment between expected and actual program outcomes and support more accurate, adaptable, and transparent outcomes under uncertain conditions.

INTRODUCTION AND BACKGROUND

States using Medicaid managed care typically pay MCOs a per-member-per-month (PMPM) capitation rate intended to cover the cost of providing covered services to an enrolled population. These rates are developed by actuaries using historical claims and encounter data adjusted for known or expected program changes and certified as actuarially sound in accordance with federal laws and guidance² as well as applicable Actuarial Standards of Practice (ASOPs).³

Medicaid capitation rates are typically developed using historical programmatic data adjusted with prospective assumptions. Wakely's work with state Medicaid associations and MCOs has highlighted that this structure can introduce challenges during periods of heightened

² Including 42 CFR § 438 (<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438>) and the CMS 2026-2027 Medicaid Managed Care Rate Development Guide, February 2026 (<https://www.medicaid.gov/medicaid/managed-care/downloads/2026-2027-medicaid-rate-guide-022026.pdf>)

³ This report is not intended to replace or supersede those standards or guidelines.

uncertainty, such as those associated with changes in member eligibility parameters, benefit changes, legislative changes, and broader market disruptions.

These considerations are particularly relevant in the current policy environment. The enrollment decline after the end of the federal Public Health Emergency (PHE) has materially altered population acuity in many states. Anticipated Federal policy changes now underway, including more frequent eligibility redetermination and new community engagement requirements for expansion populations, are expected to introduce further uncertainty into rate development. The process features described in this report can help states and their actuaries navigate these conditions more effectively.

This report focuses on key process considerations that we see as facilitating effective and timely rate setting by states.

PROCESS FEATURES SUPPORTING MORE TRANSPARENT RATE SETTING

The Value of Transparency in Methods and Assumptions

Transparency in Medicaid rate setting is important to allow MCOs to evaluate whether the resulting rates reasonably reflect expected cost levels for the covered populations and services, consistent with federal actuarial soundness standards in 42 CFR § 438.4. Transparent documentation also improves the ability to distinguish between (1) experience that emerges differently than projected due to genuine shifts in morbidity, utilization, provider reimbursement, or benefit mix, and (2) differences attributable to methodological choices such as data credibility, completion factors, service category mappings, or the treatment of programmatic changes.

The CMS Medicaid Managed Care Rate Development Guide emphasizes appropriate documentation of methods, assumptions, and data as part of the actuarial rate certification process. Sufficient levels of disclosure strengthen rate adequacy discussions by making uncertainty visible and quantifiable. This transparency allows MCOs to focus on the assumptions that drive the largest portions of cost and test how sensitive projected rates are to reasonable changes in those assumptions.

For example, an acuity adjustment that includes the assumed volume and relative costs (either as a ratio or a PMPM) of members staying, joining and/or leaving the program along with descriptions of how those values were developed will allow for additional review and validation for MCOs. If instead, the acuity adjustment is not sufficiently documented or only included as a component of other adjustments such as trend, the appropriateness of rating assumptions will be more difficult to evaluate.

When the rate setting actuary's assumptions are clear, plans are also better positioned to review the emerging data and understand how it aligns to what was assumed in the rates. In periods of

elevated uncertainty, transparency also supports more targeted mitigation tools (for example, defining triggers for rate amendments, risk corridors, or other contract adjustments) because assumptions are documented up front and can be more readily evaluated based on emerging experience.

Transparent Rate Setting Documentation

Medicaid rate setting assumptions are documented in the actuarial rate certification developed by the state's actuary. Rate certifications are required for Medicaid managed care capitation rates and must meet the specifications of the CMS Medicaid Managed Care Rate Development Guide. This guide gives certifying actuaries flexibility in the level of detail used to describe assumptions. MCOs rely on the actuarial rate certification to understand reasonability of assumptions and the state's expectations for the program.

We are aware of some instances where MCOs are not provided with the actuarial rate certification. To increase transparency, we believe that MCOs should be considered an intended user⁴ of the rate certification, given the significant financial risk undertaken, and their reliance on capitation rates that appropriately account for all reasonable, appropriate, and attainable costs.

We have also seen limited documentation supporting mid-year de minimis rate adjustments. While these changes are not subject to CMS recertification, the revised rates are still required to be actuarially sound. In some cases, the support provided for de minimis rate changes has not sufficiently demonstrated actuarial soundness. We recommend that states similarly document the basis for any de minimis changes and share relevant information with MCOs to confirm that the resulting rates remain actuarially sound.

Risk adjustment methodology documentation is another area where transparent rate setting documentation is important and sometimes lacking. Although rate certifications may describe the risk adjustment approach at a high level, there are a number of items that are generally not included, such as technical details like the weights that will be used, the number of diagnoses used, the dates related to when data will be pulled from state systems, and the paid-through date of the data used for risk adjustment. We have seen instances where changes to these parameters have not been communicated to MCOs prior to implementation. Without this information MCOs may be limited in their ability to confirm that complete and accurate data is being used for risk adjustment.

⁴ ASOP No. 41, *Actuarial Communications*, defines an intended user as "any person who the actuary identifies as able to rely on the actuarial findings." MCOs are commonly understood to receive rate certifications and use the information provided to support business decisions.

We recommend that risk adjustment specifications be finalized and communicated to MCOs before the rating period begins, as is expected for risk corridors and other financial terms. Where a mid-year change is unavoidable, we recommend that the state and its actuary document the reason for the change and its expected effect on plan payments. The University of California, San Diego, which developed and maintains the most common Medicaid risk adjustment model, the Chronic Illness and Disability Payment System (CDPS, or CDPS+Rx when pharmacy data is included), also recommends documentation that should be provided to MCOs when using their risk adjustment model.⁵ This guidance recommends providing MCOs member-level and/or disease category-level data to support the MCOs' ability to validate the risk adjustment data.

Transparency in rate setting is further supported by a robust process which engages MCOs in the rate setting process.

Transparency through MCO Engagement

MCOs use the funding provided through capitation payments to pay for care and services provided to the enrolled Medicaid populations that they cover. As users of the capitation rate funding, the MCOs should be engaged in the development and certification of the capitation payments.

Engaging MCOs throughout the rate setting and monitoring process is important to help the state and its actuary improve data quality and proactively identify potential emerging issues. This reduces the risk that differences between projected and emerging experience are driven by avoidable data issues or known emerging changes and supports more accurate capitation rates. Some states collect information from MCOs through a rate setting survey that allows plans to provide data and identify any potential rate setting concerns.

One approach to improving engagement that Wakely has observed is for states and their actuaries to hold a dedicated rate setting methodology meeting with MCOs before draft rates are shared. The purpose is not to negotiate rates, but to align on the technical framework and ensure there are no "surprises" in how key rate setting components will be treated. A practical agenda includes:

⁵ University of California, San Diego. Guidelines for Using Chronic Illness and Disability Payment System Models for Risk Score Development. UC San Diego, accessed August 4, 2026. https://hwsph.ucsd.edu/_files/research/cdps/Guidelines%20for%20Using%20CDPS%20Models%20for%20Risk%20Score%20Development.pdf.

- Confirmation of the base data period and encounter/claim data including any data quality checks and known limitations;
- If the trend assumptions are not available, the approach to trend development and major drivers;
- Outline of any service category definitions and/or rate cell changes and supporting detail;
- List of benefit and policy change adjustments expected to be included in the rates;
- If enrollment and/or acuity shift adjustments are expected, the methodology that will be used to estimate the impact;
- Changes to any contract provisions that interact with rates (for example, risk mitigation mechanisms, risk adjustment, withholds).

This early alignment improves the actuarial defensibility of assumptions and reduces late-cycle rework that can compress the CMS certification timeline.

In our experience it is beneficial when states and their actuaries implement a meaningful feedback loop once draft rates (or draft assumptions) are released. As a best practice, the process should include a defined comment window, and a response to the feedback supplied. Where feedback is not incorporated, the response should explicitly state the rationale for not incorporating the feedback. Ideally the feedback would be aggregated (to avoid sharing MCO specific sensitive information), and responses provided in a written format and shared with all MCOs and CMS so that CMS has insight into areas of potential MCO concern. This structure helps ensure plans have the opportunity to provide feedback which can lead to more appropriate assumptions when MCO input helps clarify emerging experience or programmatic challenges and it creates a documentation trail that supports the rate certification of how assumptions and methods were developed.

Therefore, we recommend that states document their assumptions in detail in their rate certification and share that certification with MCOs. We also recommend that states conduct a pre-draft rate setting methodology meeting with plans before draft rates are shared, implement a structured feedback loop with written responses to MCO comments, and share those responses – in an aggregated fashion – with all MCOs and CMS. These practices improve actuarial defensibility and give CMS early visibility into areas of MCO concern.

PROCESS CONSIDERATIONS FOR USING HISTORICAL DATA

Reliance on Historical Experience

Capitation rate setting generally relies on historical experience as the starting point for developing expected future costs.⁶ This historical data is typically referred to as “base data” and is completed, adjusted, and projected to the applicable rate period. Base data is generally from a period 24 to 36 months prior to the rating period. For example, calendar year (CY) 2027 rates may use CY 2025 data as the base period (a 24-month difference midpoint to midpoint). As a result, there is an inherent difference that must be reflected through the application of adjustments for the impact of trend, program, benefit, population, or other changes that represent differences between the base period and rating period.

During periods of relative stability, the difference between base data and rating period may not pose significant challenges to accurate rate setting. However, when key drivers of costs such as acuity, utilization intensity, or service settings are changing rapidly, even very recent historical experience may no longer be representative of future conditions. Under these types of highly dynamic or uncertain conditions, it may be difficult to develop accurate prospective rating assumptions. This can lead to misalignment between projected costs embedded in rates and actual program experience.

Emerging changes in Medicaid managed care programs can be challenging to accurately assess prospectively. The use of emerging experience and consideration of mid-year rate updates can help mitigate this issue. Otherwise, the timing difference associated with base data means capitation rates may not reflect the new information for several years.

Responsiveness to Emerging Experience

Capitation rate setting generally requires various adjustments to ensure the data is fit for use, such as incurred but not reported (IBNR) completion and other adjustments. Base data for more recent periods requires more material completion adjustment than for periods with more runout. However, recent encounter or financial data that is not used directly in rate setting can still be useful in informing emerging trends, enrollment changes, etc. While care must be taken to ensure that this data is used appropriately, it can reveal meaningful information about emerging trends and program changes that would be otherwise unavailable.

As program conditions evolve more rapidly, Wakely has observed increased MCO interest in processes that allow states to monitor emerging experience and assess deviations from

⁶ There are scenarios where historical experience may not be available or appropriate to use. These situations are outside the scope of this report.

expectations. While certified rates are typically fixed for a rating period, structured monitoring can inform state thinking around future rates or, in some cases, mid-year adjustments.

The goal of monitoring is to ensure that rate setting actuaries and MCOs have shared visibility into how experience is developing relative to rating assumptions, and to allow states to make adjustments where necessary, sooner rather than later.

Timely Rate Setting Data

The use of older base data places a greater reliance on projection adjustments, as a larger share of the rate may be driven by assumptions rather than observed data. This results in increased uncertainty.

In general, the use of more recent base data by states – as close to a 24-month midpoint-to-midpoint difference as possible – may result in more accurate capitation rates, as the base data will more closely resemble anticipated rating period experience and require fewer actuarial adjustments. Using more recent data increases the reliance on IBNR completion adjustments, but given sufficient historical data, IBNR completion is often more reliable with fewer months of runout than the increased uncertainty introduced through the need for other more material rating adjustments.

A combination of timely rate setting data and use of emerging experience helps support a robust rate setting process. To the extent that older rate setting data must be used, additional reliance on emerging experience can help close the gap.

We recommend that states use the most recent base data feasible, supplement it with credible emerging experience indicators, and establish structured monitoring processes to identify and respond to deviations from rating assumptions during the rating period. Where older base data must be used, emerging experience should play a more prominent role in rate development and monitoring.

ACTUARIAL RANGES AND UNCERTAINTY FOR CERTIFIED RATES

Actuarial Range Development

Actuarial analyses rarely yield a single “correct” result. Instead, actuaries often arrive at a range of reasonable estimates, reflecting uncertainty in data, assumptions, and future conditions. The existence of a reasonable range implies that different outcomes are plausible, and all the rates within the range are actuarially sound. Even when a rate range is not certified, a rate range may be used by actuaries in the rate development process to allow states to select a rate within a range of reasonable results.

Asymmetry of Financial Risk

Often, multiple variables may combine to generate the rate range. For example, a range of trend assumptions, acuity adjustments, and other adjustments could all be included in the development of the rate range. Incorporating a high and low estimate for each of these variables may result in a broad range of reasonable rates. Certifying rates at the lower bound of this rate range would assume that each of the underlying assumptions were at the lower end of their individual ranges. When taken individually these assumptions may be reasonable, but states concurrently using the lowest assumptions for each may represent an unlikely or potentially unreasonable estimate.

Wakely has observed that in many markets, recent experience has shown higher than expected costs due to drivers such as acuity or utilization trend. These drivers can cause outcomes aligned more towards the higher end of the expected reasonable range. If rates were set by the state closer to the lower bound of the expected reasonable range, it can result in systemic underfunding and, in some cases, the rates may be insufficient to cover all reasonable and appropriate costs required under the contract. While lower than expected deviations are also possible, states setting rates towards the lower bound of reasonable estimates is setting an expectation that costs will materialize lower than the best estimate. Therefore, MCO downside risk is typically a greater concern given its implications for access, plan stability, and program continuity, and given that most Medicaid managed care programs have a minimum medical loss ratio (MLR) requirement which can create a hard cap on the MCOs' upside risk.

Managing Risk within the Rate Range

States recognizing and clearly communicating the presence of actuarial uncertainty along with best estimates can help MCOs better understand the range of potential outcomes and avoid overinterpreting the precision of rate ranges. The asymmetry of financial risk means that while states are generally protected from overrating programs through minimum MLR arrangements, MCOs often are not similarly protected from underfunding.

Because all rates within the rate range are deemed to be actuarially sound, state actuaries should consider whether the cost outcomes supporting all the rates within the range produce a reasonable result in relation to the selected rate. Given these uncertainties, we believe that state rate ranges should generally be centered around the best estimate. Rates that deviate from the best estimate due to either multiple assumptions or repeated rate selection at the lower-bound in consecutive rate setting cycles are more likely to result in persistent underrating or underfunding.

The state actuary may also want to consider the width of the rate range relative to the risk margin assumed in the rating. An overly broad rate range, while potentially being actuarially sound, can still result in unfavorable outcomes for the program and this risk generally will fall on MCOs due

to the structure of risk in rate setting. Conversely, narrow rate ranges (and/or setting rates at the midpoint or higher) can help mitigate this risk to MCOs and better ensure accurate rate setting.

We recommend that states document the rationale for their rate selection point within the certified actuarial range and assess whether the combined assumptions represent a plausible best estimate rather than a concurrent alignment of multiple individual lower bound assumptions. States selecting rates at or near the best estimate, rather than the lower bound of the reasonable range, reduces the risk of programmatic underfunding given the asymmetric structure of financial risk in Medicaid managed care.

CONCLUSION

State Medicaid rate setting processes must balance actuarial rigor, regulatory requirements, and administrative feasibility. While historical data will remain a cornerstone of actuarial rate development, periods of heightened uncertainty place greater emphasis on how rate setting is managed as a process.

Acknowledging uncertainty, narrowing actuarial ranges, monitoring emerging experience, and fostering transparent engagement can help states better navigate conditions where traditional rate setting approaches may be slow to respond.

DISCLOSURES

This report was prepared to summarize state rate setting process considerations for Medicaid Managed Care programs. We relied on discussions with AHIP and information from Wakely's support of various Medicaid markets.

Responsible Actuary. We, Andrew Schwarze and Josh Rekula, are the actuaries responsible for this communication. We are Members of the American Academy of Actuaries and Associates of the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, the responsible actuaries are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance. We have relied on others for various information used in the report. If the underlying information is incomplete or inaccurate, our conclusions may be impacted, potentially significantly.

Subsequent Events. There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.



Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

[Wakely.com](https://www.wakely.com)

© 2026 Wakely Consulting Group. All Rights Reserved.