National
MLTSS
Health Plan Association

September 2026

Dear Center for Medicaid and CHIP Services (CMCS) staff,

The National MLTSS Health Plan Association (MLTSS Association) greatly appreciated the opportunity to participate in CMS' Listening Session on Medicaid Rate Setting, held on August 26, 2026. During this call, our member plan representatives, as well as representatives from other Medicaid trade associations, had the opportunity to respond to specific CMS questions about the current Medicaid rate-setting process.

As the leading organization representing health plans that contract with states to provide managed long-term services and supports (MLTSS) through the Medicaid program, we are uniquely positioned to provide feedback on the nuances of MLTSS rate setting. MLTSS rates are nuanced and differ in important respects from typical Medicaid managed care rate setting. Below, we outline specific recommendations to strengthen the rate-setting process. We welcome further engagement with CMS on this important topic as CMS considers the future of Medicaid rate development.

Responses to CMS Topics of Interest and Recommendations for CMS Engagement:

1) Use of the Medicaid Managed Care Rate Development Guide, and recommended changes:

MLTSS health plans review and rely on the Medicaid Managed Care Rate Development Guide, and our members value it as a reference point in their engagement with states and state actuaries. However, the rate guide does not resolve the variation plans encounter across states in how rates are developed, documented, and communicated, and it does not address several rate-setting issues that are specific to MLTSS and integrated programs. Members also noted the practical value of a predictable annual release schedule for the guide and a meaningful opportunity to comment on the draft version.

There are areas of rate setting where national standards would meaningfully improve the process, and we describe those in detail in our response to CMS' question on best practice guidance below.

2) What type of guidance would be most helpful to improve consistency and transparency issues across states and plans?

CMS should release (sub-regulatory) guidance setting a minimum standard for the level of detail required in rate development documentation shared with plans. The information currently shared by state actuaries with plans during the rate setting process is insufficient to support meaningful plan analysis of rate development. This information is also shared inconsistently across states, even when the same actuarial firms support multiple states' rate development, highlighting a need for consistent national standards. Documentation should, at a minimum, include:

- Underlying data sources and time periods used to develop rates
- Trend assumptions and the basis for each
- How each adjustment was calculated

- Statistical methodology (including risk adjustment approaches)
- For risk adjustment: number of records dropped when assessments were merged with claims data, the impact of those drops on sensitivity analyses, and variable definitions used in statistical regression models.

Today, plans frequently describe rate development as a black box. Often, state actuaries present a rate range to the state, and the state selects a point within that range, but the materials shared with plans do not explain the basis for that selection. Because assumptions about the program are built into the rates, a lack of visibility into those assumptions directly affects how plans administer the program. These issues are compounded in MLTSS and programs serving dually eligible individuals. This guidance would also serve as an additional layer of protection against rates that are not actuarily sound.

CMS could require states to provide plans with full copies of rate certifications. Some states already do this while others do not. Standardizing this practice would meaningfully improve transparency at low cost.

CMS should issue guidance limiting the use of undocumented managed care efficiency factors, especially in new carve-in situations where no empirical basis exists for the assumed savings. This guidance should require that states provide documentation and justification for efficiency assumptions rather than prescribing specific values. Aggressive efficiency assumptions were common when states first transitioned from fee-for-service (FFS), and some of those assumptions may be reappearing as new populations and geographies are carved in.

3) Transparency in the rate setting process: What information should be shared publicly versus remain proprietary? What are recommended processes or practices that CMS and states should consider?

Meaningful transparency in the rate setting process would enable all parties to see and understand the data, assumptions, and judgments that produced the rates they are asked to operate under.

CMS should release guidance on risk adjustment that includes minimum data validation requirements. Risk adjustment methodology is a specific transparency concern in MLTSS, particularly where risk scoring relies on assessments conducted by plans themselves. data feeding into risk adjustment models should be formally validated, plans should use consistent assessment definitions, and any methodology should pass a basic fairness test.

CMS should encourage states to share their FWA identification approaches with plans, enabling MCOs to collectively identify patterns and assist the state in achieving savings. FWA is an underexplored dimension of rate-setting transparency. States' FWA identification methodologies are opaque, and MCOs lack visibility into how FWA findings inform the data used to set rates.

4) Major challenges during the rate setting process, and recommendations for CMS to facilitate learning across states and plans to address some of these challenges.

There are a number of aspects of the rate-setting process that are especially challenging for MLTSS health plans, including:

1) Predictability, timelines, and communication: There is strong consensus that the current rate setting process lacks predictability and structured timelines. Plans frequently submit written feedback and questions on draft rates and receive no acknowledgment or substantive response, which makes it difficult to understand what was considered and whether the most current available data was used.

   CMS should establish expectations for a structured rate-setting calendar with clearly defined milestones, including: (1) an initial meeting where base data is shared; (2) a plan feedback period; (3) release of draft rates; (4) a formal state response to plan feedback; and (5) final rates - all within a defined, reasonable timeframe.

   CMS should require states to formally respond to plan feedback on draft rates, even if no changes result. Many states currently provide no acknowledgment when plans submit written feedback.

2) Accounting for emerging trends in MLTSS rates: MLTSS rates that are not actuarily sound and do not account for emerging trends directly impede long-term workforce investment.

   CMS should emphasize the expectation that rates be actuarially sound and fully funded at all times — including during periods of state budget pressure. Rates that are not actuarially sound strain program integrity, limit plans' ability to adequately compensate providers, and jeopardize sustainable plan participation.

   CMS should consider mechanisms for plans to document rate increases and receive credit before trend data catches up. Provider rate increases take approximately three years to build into trend data. Plans cannot make sustainable commitments to direct care workforce rates when their own rates may be significantly cut the following year. Direct care workers — the backbone of MLTSS programs — are often most immediately impacted by rate insufficiency.

5) Potential CMS standardization of a specific 12-month rating period.

The MLTSS Association has not adopted a position on standardizing a specific 12-month rating period, and our members raised considerations on both sides during the listening session. From a dually eligible perspective, greater alignment between the Medicaid rating period and the Medicare cycle would be valuable. Where a state's rating period is not aligned with the Medicare timeline, MLTSS and integrated D-SNP plans can face mid-cycle adjustments that affect benefits and carry unintended consequences for members. A standardized rating period would also give CMS a more consistent, apples-to-apples view across state programs.

At the same time, a common rating period would require plans to shift staffing and internal cycles, and clustering rate development dates across states would create administrative pressure on plan resources. Our members indicated that these are challenges plans could adapt to and overcome, provided the

administrative capacity is in place to make the necessary adjustments. We would welcome the opportunity to discuss this question further with CMS as the agency considers it.

6) CMS role in developing best practice guidance, and the topics that would be most beneficial to plans.

There are several areas where national standards and CMS best practice guidance would improve rate-setting outcomes for MLTSS plans and the members they serve. Importantly, guidance in these areas should be MLTSS-specific, as several of these issues have no direct analog in standard Medicaid managed care.

1) Transitions from fee-for-service to MLTSS: FFS-to-MLTSS transitions involve populations and benefit structures with no direct analog in standard Medicaid managed care. The risk of poorly-calibrated transition rates is especially acute given the complex needs of LTSS populations and the limited historical managed care data available at program launch.

   CMS should develop guidance outlining key considerations and best practices for accurate rate setting when states transition populations or benefits from fee-for-service to MLTSS — including partial transitions and carve-ins of specific benefits or populations.

2) Accounting for contractual requirements in MLTSS rates: State actuaries may not consistently review contract requirements when setting rates. Care management ratios and staffing requirements are far more prescriptive in MLTSS contracts than in standard Medicaid managed care, making bottom-up rate development especially critical in the MLTSS context. Other program design decisions (e.g., benefit design changes, single PBM arrangements, care management ratios, pay-for-performance structures, and community reinvestment and spending requirements) are frequently developed separately from the actuarial process, and must be clearly laid out for actuaries and fully reflected in the rates if plans are to operationalize them. This is also an area where CMS can facilitate learning across states, as some states have developed effective practices that others could adopt.

   This is increasingly important as state legislatures place a significant portion of the Medicaid rate at risk and as budget pressure drives program changes and clinical efficiency targets that plans have limited visibility into.

   CMS should recommend that states use a bottom-up approach to develop care management and administrative rate components, grounded in actual contractual requirements rather than generic managed care benchmarks.

   CMS should recommend - and ideally require - that state actuaries document and account for plan-specific contractual obligations when developing administrative and care management rate components. State actuaries should ground administrative and care management rate

assumptions in what plans are actually contractually required to do, not generic managed care administrative percentages.

States should separate care management and general administrative funding in rate documentation. A single combined percentage makes it nearly impossible to assess adequacy.

States with mature MLTSS programs should consider annual rate surveys of plans capturing actual reported costs for mandatory functions. Florida has used such a survey for four to five years with strong results.

3) Tying MLTSS rates to fee schedules and mid-year capitation updates: MLTSS rates are not tied to a fee schedule and are more likely to change frequently. Mid-year adjustments are especially relevant in MLTSS given structural data lag issues and the complexity of LTSS utilization patterns, which can shift rapidly in ways that encounter data does not capture until years later. Mid-year adjustments vary by state. Some states have enrollment platform limitations that make using more current data operationally impossible. CMS guidance should acknowledge these real barriers.

   CMS should provide guidance in the Medicaid Managed Care Rate Development Guide on:
   - The benefits of tying MLTSS rates more directly to fee schedules, reducing disconnects between managed care and fee-for-service provider reimbursement.
   - Effectively utilizing mid-year capitation rate updates to incorporate emerging utilization and cost data, with acknowledgment of the federal requirement that changes exceeding +/−1.5% of existing rates trigger new contract amendments.

4) Rate cell population division for HCBS/LTSS populations: Current macro-level rate cells are a particular problem in MLTSS because LTSS populations are clinically heterogeneous. Rate cells built for a general Medicaid managed care population do not capture the cost drivers specific to HCBS enrollment, directly affecting the accuracy of actuarial assumptions and rate adequacy.

   CMS should outline actuarial approaches to more granular rate cell design in MLTSS, moving away from broad macro-level rate cells that do not adequately support accurate cost prediction. This could include creating new rate cells within the HCBS population based on specific clinical indicators, enabling more accurate analyses by both actuaries and plans. This approach would also ensure that individuals receiving LTSS are captured within LTSS-specific rate cells, or that a risk-adjustment indicator is included to account for their acuity.

5) Maximizing use of emerging data: Lags in data used for rate setting is especially problematic in MLTSS: encounter and claims data typically lag two to three years, and risk score modeling adds another year of lag. For a population whose care needs can change rapidly, this structural lag

creates systematic mismatch between rate assumptions and actual plan experience. A mid-year reconciliation approach — analogous to CMS's HCC reconciliation in Medicare Advantage — has been proposed as one potential solution.

CMS should issue guidance highlighting the value of maximizing the use of emerging data to support rate setting, including pathways for states to achieve this through investments in data sharing, TMSIS reforms, use of HIEs, and other means.

6) Rate setting for integrated care plans / D-SNPs: Rate setting for integrated D-SNP/MLTSS plans is an area where CMS has unique leverage given its joint authority over Medicare and Medicaid. This is an MLTSS-specific issue with no analog in standard managed care. Key issues include:
    - Splitting care management and care coordination costs between Medicaid and Medicare in integrated programs is genuinely difficult, and few actuaries specialize in both domains.
    - States sometimes cite a plan's D-SNP model of care to avoid funding care management in MLTSS rates — even when the state itself mandated those staffing ratios in the Medicaid contract.
    - Crossover claim assumptions are often not disclosed to plans, and state actuaries sometimes make these assumptions without fully understanding the Medicare benefit structure.
    - In lieu of services (ILOS) that generate Medicare savings may require Medicaid-funded LTSS resources, but there is no mechanism for states to account for Medicare-Medicaid interactions in MLTSS rate development.

    CMS could develop best practice guidance for states, their actuaries, and health plans in developing actuarily sound rates for integrated programs. This guidance would address the challenges in allocating care management and care coordination costs across Medicare and Medicaid, accounting for care management costs in MLTSS rates, crossover claim assumptions, and cost-savings generated from ILOS and other Medicaid-funded services.

7) Specific Federal regulatory barriers that plans would recommend for revision to improve the rate-setting process.

The MLTSS Association did not identify federal regulatory provisions requiring wholesale revision. Members did highlight the practical impact of certain federal requirements and processes on the rate-setting cycle. For example, members noted that in some markets plans do not see final rates until they have been approved by CMS, which creates operational pressure; greater speed to an answer, including conditional approval, would help plans understand what is coming. Overall, it would be helpful for plans to understand what information CMS reviews when rate certifications are submitted, and to have a feedback loop with CMS on final rates.

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The MLTSS Association greatly appreciates the opportunity to provide these recommendations to strengthen the Medicaid rate-setting process and welcome the opportunity to continue to collaborate with CMS on this critical issue.

If you have any questions, please feel free to contact me at mkaschak@mltss.org.

Sincerely,



Mary Kaschak

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