

Generic Supporting Statement  
Medicaid Managed Care Rate Development Guide  
(CMS-10398 #37, OMB 0938-1148)

Notes: This December 2025 iteration is being submitted to OMB for approval as a revised generic collection of information request

The contents of this Supporting Statement and the associated attachments have been reviewed to ensure that they are consistent with the Trump administration's policies, goals, and objectives. This includes compliance with Executive Order 14168 and OMB's SPD 15 standards.

## **A. Background**

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of Medicaid and CHIP, including program waivers and demonstrations, and other technical assistance initiatives.

## **B. Description of Information Collection**

Medicaid managed care is the predominant delivery system for Medicaid beneficiaries to access health care services. State Medicaid agencies contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) (collectively known as "managed care plans" or "MCPs") that are contracted to provide services to a defined group of Medicaid beneficiaries and accept a fixed, prospective monthly payment for each enrolled beneficiary (also referred to as risk-based managed care). Capitation rates refer to these fixed per member per month payments that a state makes to an MCP on behalf of each beneficiary enrolled under a contract in a risk-based managed care program. A state's actuary develops capitation rates for its risk-based managed care program consistent with the process and requirements in 42 CFR 438.5(b).

Section 1903(m)(2) of the Social Security Act and § 438.4 require that capitation rates be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCP for the time period and the population covered under the terms of the contract.

In accordance with § 438.7, states must submit to CMS for review and approval all rate certifications for MCPs. The state's actuary is responsible for certifying that the managed care

program's capitation rates are actuarially sound for a specific time period and documents the rate development process and the final certified capitation rates in a rate certification.

The attached Medicaid Managed Care Rate Development Guides (otherwise referred to as the "rate guide" or "rate guides") outlines the rate development standards and CMS's expectations for documentation included in rate certifications such as descriptions of base data used, trend factors to base data, projected benefit and non-benefit costs, and any other considerations or adjustments used when setting capitation rates. The information outlined in the respective rate guide must be included within the rate certification in adequate detail to allow CMS to determine compliance with applicable provisions of part 438, including that the data, assumptions, and methodologies used for rate development are consistent with generally accepted actuarial principles and practices and that the capitation rates are appropriate for the populations and services to be covered. While there is no voluntary or mandatory template that states' actuaries must utilize for the rate certification, the rate guide is intended to serve as a useful resource for states and their actuaries, and outlines federal standards for rate development in §§ 438.4 through 438.7 and describes information required from states and their actuaries as part of actuarial rate certifications required under § 438.7(a). Adherence by states and their actuaries to the rate development standards and documentation expectations outlined in the rate guide, will aid in ensuring compliance with the regulations and support CMS's review and approval of actuarially sound capitation rates and associated federal financial participation.

CMS's review process for managed care rate development is an essential federal oversight function aimed at ensuring that capitation rates for MCPs are compliant with applicable federal laws/regulations and are not: too low such that MCPs are insufficiently funded to provide contractually required services; or too high and a waste of state and federal tax dollars.

The attached rate guides are effective for rating periods indicated below. The 2020 Medicaid and CHIP Managed Care final rule requires that CMS annually publish this guidance per § 438.7(e).

#### 2024-2025 Rate Guide and 2024-2025 Rate Guide Addendum (Discontinued)

The rate guide and addendum are obsolete since we collected this information from July 1, 2024, to June 30, 2025.

#### 2025-2026 Rate Guide (Extension Without Change)

We are collecting this information from July 1, 2025, to June 30, 2026.

#### 2026-2027 Rate Guide (Revised)

We will be collecting this information from July 1, 2026, to June 30, 2027.

### **C. Deviations from Generic Request**

No deviations are requested.

## D. Burden Hour Deduction

### *Wage Estimates*

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' (BLS) May 2024 National Occupational Employment and Wage Estimates for all salary estimates (<https://www.bls.gov/oes/tables.htm>). In this regard, the following table presents BLS' mean hourly wage, our estimated cost of fringe benefits and other indirect costs (calculated at 100 percent of salary), and our adjusted hourly wage.

BLS's wage estimates are updated annually. Current and historic wage figures can be found at the above BLS address and can be used to calculate current cost estimates. May 2024 is current as of the date of this collection of information request.

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefits and Other Indirect Costs (\$/hr)	Adjusted Hourly Wage (\$/hr)
Community and Social Service Occupations	21-0000	30.31	30.31	60.62

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and other indirect costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

### *Burden Estimates*

As of August 2025, there are 46 States and DC (for a total of 47 Medicaid agencies) that operate risk-based managed care programs and must prepare and submit a rate certification to CMS as required under § 438.7(a).

#### *Currently Approved Burden (2024-2025 Rate Guide and Addendum) (Discontinued)*

The 2024-2025 rate guide and addendum are obsolete since we collected this information from July 1, 2024, to June 30, 2025. We propose to discontinue the rate guide, the addendum, and the associated burden since the rating period ended on June 30, 2025. Timewise, OMB approved 754 hours (137 rate certifications x 5.5 hr/submission).

#### *Currently Approved Burden (2025-2026 Rate Guide) (Extension without Change)*

We are collecting this information from July 1, 2025 to June 30, 2026, and are not proposing any changes to the active rate guide. Timewise, OMB has approved 754 hours (137 rate certifications x 5.5 hr/submission). By using the most recent BLS wage figure (from \$56.72/hr to \$60.62/hr, adjusted) we estimate an updated cost of \$45,707 (754 hr x \$60.62/hr) from \$42,767.

### 2026-2027 Rate Guide (Revised)

As noted, CMS is required to publish rate guidance, at least annually. To meet this requirement the attached 2026-2027 rate guide revises the 2025-2026 rate guide. The attached crosswalk and redline versions of the Guide sets out such changes.

In this iteration, we estimate that (on average) it will take a state 7 hours per certification to organize and describe the data in a way that complies with the 2026-2027 rate guide. This is an increase of 1.5 hours from the 2025-2026 rate guide.

The increase is due to a new expectation for states' actuaries to certify the portion of the capitation rates (or rate ranges) that is attributable to all state directed payments. This new documentation expectation will improve transparency and ensure CMS has the documentation necessary to understand the impact of state directed payments on overall capitation rates that receive federal financial participation. CMS believes this new expectation is necessary given the increased spending associated with state directed payments

We continue to estimate that a total of 137 rate certifications will be submitted among the 47 Medicaid agencies. In aggregate we estimate a burden of 959 hours (137 rate certifications x 7 hr/submission) at a cost of \$58,135 (959 hr x \$60.62/hr).

### *Annual Burden Summary*

Rate Guide	Respondents	Total Annual Responses	Burden per Response (hours)	Total Time (hours)	Labor Cost (\$/hr)	Total Annual Cost (\$)
2024-2025 Rate Guide and Addendum (Discontinued)	47	(137)	(5.5)	(754)	60.62	(45,707)
2025-2026 Rate Guide (Extension)	47	137	5.5	754	60.62	45,707
2026-2027 Rate Guide (Revised)	47	137	7	959	60.62	58,135
<b>Total</b>	<b>47</b>	<b>137</b>	<b>Varies</b>	<b>959</b>	<b>60.62</b>	<b>58,135</b>

### *Information Collection Instruments and Instruction/Guidance Documents*

The rate guides outline implementing guidance for state submission of rate certifications for Medicaid managed care capitation rates per §§ 438.4 through 438.7.

- 2025-2026 Managed Care Rate Development Guide (No Change)
- 2026-2027 Managed Care Rate Development Guide (Revised)

## **E. Timeline**

Our 14-day notice published in the Federal Register on December 8, 2025 (90 FR 56765). Comments must be received by December 22, 2025.

CMS aims to publish the 2026-2027 rate guide in January 2026 to allow states and actuaries adequate time to utilize this guide for rate development activities that will begin in January 2026 for rating periods that start July 1, 2026 (which is when this rate guide is effective).

In order for CMS to have the ability to review and analyze the rate certification and allow sufficient time for questions and answers, states start submitting their certifications at least 60 days prior to the contract start date for MCPs and states need sufficient time to review this guidance and incorporate the elements into its rate certification prior to their submission to CMS in accordance with § 438.7.