INCLINE ACTUARIAL GROUP

INCLINE INSIGHTS

2025–2026 Medicaid Managed Care Rate Development

Summary of changes as compared to the previous year's rate guide

AUTHORS

Colby Schaeffer, ASA, MAAA

PUBLISHED

October 2, 2025

OVERVIEW

What Changed in the 2025–2026 Medicaid Managed Care Rate Guide

CMS has published its rate development guide for Medicaid managed care rating periods beginning between July 1, 2025 and June 30, 2026[1]. This summary captures the substantive changes from the prior year's guide so that states, managed care plans, and their actuaries can identify where certification practice must adapt.

The changes cluster in six areas: the certification and review process, capitation rate amendments, risk-sharing and non-risk services, state directed payments, pass-through payments, and in lieu of services. Several are narrow clarifications; a few — the reduced pass-through cap and the broadened latitude on state directed payments — carry direct financial consequence.

SCOPE OF THIS SUMMARY

This resource is provided for information and reference purposes and does not replace guidance from CMS. If you notice an omission or error, please email colby@inclineag.com.

This document format was updated as of July 28, 2026 from the web version originally posted on Incline's website on October 2, 2025.

SUMMARY OF CHANGES

Year-Over-Year Changes by Topic

Rate Certification and Review Process

- CMS requests that states incorporate responses to questions CMS has previously raised in earlier rate certification reviews, where similar circumstances apply in the current rating period.
- CMS encourages early engagement for technical assistance when procuring managed care contracts or implementing new managed care programs.

Capitation Rates and Amendments

- For rate amendments, when program changes take effect partway through a rating period, states must reflect the financial impact of those changes in capitation rates for the entire time the change is effective — not merely for a shorter subset of that period.
- States must submit a revised rate certification whenever capitation rates, payment arrangements (incentives, withholds, state directed payments, pass-through payments), or ILOSs change in ways not already described in the certification, regardless of how small the change is.
- Retroactive capitation rate adjustments are permitted only when tied to new or amended state directed payments under § 438.6(c), or when correcting a material error in the original data, assumptions, or methodologies used to set rates.
- States must use a separate and distinct contract with their managed care plans for state-only funded capitation rates.
- Final capitation rates must be based only on services covered under the state plan, ILOS(s), and additional services the state deems necessary to comply with 42 CFR Part 438, subpart K.

Risk-Sharing and Non-Risk Services

- Risk-sharing mechanisms may not be added or modified after the start of the rating period.
- Arrangements that remove 100 percent of the risk are not considered risk-sharing mechanisms.
- Non-risk services are explicitly defined as those for which the managed care plan does not bear financial responsibility, because the state reimburses the plan based on actual incurred costs.

State Directed Payments

- CMS removes the requirement that state directed payments meet the requirements in 42 CFR § 438.6(c) and receive prior approval before implementation.
- States may use state directed payments to direct a managed care plan's expenditures, consistent with both 42 CFR § 438.6(c) and § 438.2; such payments in managed care contracts must also meet the standards in 42 CFR § 438.6(c)(2).
- States may require managed care plans to pay providers at least the full (100 percent) Medicare total published payment rate for certain services. The Medicare rate used must have been published within the three years preceding the rating period.
- For alternative minimum fee schedules, states may direct plans to use rates other than

Medicaid state plan rates, including one or more Medicare payment rates.

- In the table of information states must provide for each state directed payment, entering “TBD” is not sufficient.

Pass-Through Payments

- The allowable cap on aggregate pass-through payments to hospitals is reduced from 30 percent to 20 percent of the base amount, tightening the limit on such payments.

In Lieu of Services (ILOS)

- CMS removes all references to the State Medicaid Director Letter published January 4, 2023 (SMD 23-001) and the guidelines it specifies, referencing 42 CFR § 438.16(c) instead.

WORK WITH INCLINE

Incline supports states, managed care plans, and risk-bearing providers on Medicaid capitation rate development, rate filing review, and state directed payment strategy.

Colby Schaeffer, ASA, MAAA — colby@inclineag.com

SOURCES & NOTES

1. Centers for Medicare & Medicaid Services. *2025–2026 Medicaid Managed Care Rate Development Guide: For Rating Periods Starting between July 1, 2025 and June 30, 2026*. CMS, Aug. 2025, https://www.medicaid.gov/medicaid/managed-care/downloads/2025-2026-medicaid-rate-guide-082025.pdf.