2015 (final version)	2016 (final version, change from 2015)	2017 (newest version)	Type of Change
Introduction - Describes why we are releasing the guidance and overall goals of the guide	Introduction - Adds reference to regulatory requirement for capitation rates to be actuarially sound, to be certified by an actuary that meets standards set forth in 42 CFR §438.6, appropriate for the covered population and services for the period that the rates are effective, and have been developed in accordance with generally accepted actuarial practices and principles.	Introduction - updated the definition of actuarial soundness to be in line with the Managed care final rule and update the citations. Adds language about how the elements in the guide can improve processing times. Clarifies that the actuarial certification needs to be a stand alone document, separate from the contract.	Rev
Section I - Describes the expectations of all Medicaid managed care actuarial certifications	Section I - Clarifies rate certification and supporting documentation to be submitted with attestation, including the actuarial report, other reports, letters, memorandums, and communications, and other workbooks or data.	Section I - updated to reference the new regulatory citations	Rev
	Section I - Added references to Actuarial Standards of Practices for which actuaries developing rates must follow.		
	Section I.1: General Information - Provided more detailed description around documentation expectations of states to provide throughout the certification process.	Section I.1: General Information - Clarify that the rating period must be 12 months to be consisitent with the final rule	Rev
		Section I.3 Projected Benefit Costs and Trends - Added clarifications to be consistent with the final rule including: based only on allowable Medicaid services, no assumptions based on FMAP, if additional MHPAEA services are included, how in-lieu of services are captured, and clarifications on IMD	Rev

Type of Change: Rev = Revision, Del = Deletion, Add = Addition, and Red = Redesgnation.

	Section I.4: Pass Through Payments - Provides descriptions of pass-through payments, certification requirements, and supplemental payment requirements.	Section I.4: Pass through payments - Aligned the description of pass through payments with the final rule and clarified when they can and can't be included in the rates	Rev
		Section I.5 Non-benefit costs: Clarified that assumptions on this group cannot be based on FMAP, noted the Health Insurers Fee Moratorium	Rev
		Section I.7 Risk mitigation, incentives - updated for the final rule to include an attestation on acuity, risk sharing, reinsurance and incentive mechanisms being actuarially sound	Add
		Section I.8 Other considerations: Added that adjustments based on FMAP are not permissable, the effective date of the change should line up with the certification, and all adjustments must be in the certification	Add
	Section II: Managed Care Rate with Long Term Services and Supports (MLTSS) - Provides additional considerations for states with MLTSS programs or programs that include MLTSS benefits		
Section II - Describes expectations around actuarial certification related to the Medicaid Expansion population	Section III: Provides further clarification to what was described in Section II of the 2015 guide about expectations of the expansion group considering this would be the third year of expansion for some states.	Section III: updated the dates and made clarficiations on what data for risk mitigation strategies would be requested in 2017 for the new adult group as some states may be removing the risk mitigation strategy	Rev

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Reason for Change	Burden Change
Alignment with the final rule	No
Alignment with the final rule	No
Alignment with the final rule	No
Alignment with the final rule	No

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Alignment with the final rule	No
Alignment with the final rule	No
Alignment with the final rule	No
Alignment with the final rule	No
Adjusting given the time since some states have covered the new adult group	No

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