2015 (final version)	2016 (final version, change from 2015)	Jan to June 2017 version
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.
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
	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

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

		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
	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

		Section I.5 Non-benefit costs: Clarified that assumptions on this group cannot be based on FMAP, noted the Health Insurers Fee Moratorium
		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
		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

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

	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. No assumptions based on FMAP.

July 2017 to June 2018 (new version)	Type of Change	Reason for Change	Burden Change
Introduction - Update to reference new regulatory requirements that take effect with rating periods effective on or after July 1, 2017. Revises throughout the document to consistently reference a rate certification (previously used terminology of both rate certification and actuarial certification). Clarify that states submit contract actions, actuarial certification(s) and associated supporting documentation as distinct documents within one submission and if multiple rate certifications are associated with the same contract action(s), that states describe the supporting documentation that relates to each certification.	Revise	Alignment with the final rule	No
Section I: Medicaid Managed Care Rates (changes made to intro to Section I and formatting changes throughout all sub-sections of Section I) - Update to reference new regulatory requirements that take effect with rating periods effective on or after July 1, 2017. Restructure to have two components of each sub-section that clarify the rate development standards and requirements for appropriate documentation.	Revise	Alignment with the final rule; Improve clarity for states on what are rate development standards versus documentation expectations	No

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

Section I.1: General Information - Add clarifications to be consistent with the final rule including: what standards the letter from the certifying actuary must include (given requirements that take effective with rating periods effective on or after July 1, 2017), indication that the contract must specify the final capitation rates, reminder, effective 7/1/2018, actuaries must certify specific rates for each rate cell and will no longer be permitted to certify rate ranges, clarification that certification provides a summary of special contract provisions related to payment, expectations for retroactive adjustments to capitation rates, no assumptions based on FMAP, and procedures for when rate certifications are necessary. Move detail from Sections I.6, I.8 and I.9 of the January-June 2017 guide into this section to streamline the document into clear categores for states (i.e. Rate Range Development, Other Rate Development Considerations, Procedures For Rate Certifications for Rate and Contract Amendments). Clarify that the rate certification assures that rates at any point within the rate range would be actuarially sound. Clarify that effective dates of programmatic changes should be consistent with the rate development assumptions. Clarify that the certification must document any assumptions for which values are varied in order to develop rate ranges. Clarify that rates must be certified for all time periods in which they are effective, a rate certification must be provided for rates for all time periods, and rates from a previous rating period cannot be used for a future time period without a certification of the rates for this new rating period.	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations	No
Section I.2 Data - Add clarifications to be consistent with the final rule including: data the state should provide to the actuary and the related exception process, rate development standards, and documentation expectations.	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations	No

Section I.3: Projected Benefit Costs and Trends - Add clarifications to be consistent with the final rule including: no assumptions based on FMAP, further clarifies that cost of an IMD as an in lieu of service must not be used in rate development, rate development standards and documentation expectations for trend, documentation expectations for material and non-material adjustments, and documentation of any recoveries of overpayments made to providers by health plans. Also adds a data request related to section 12002 of the 21st Century Cures Act (P.L. 114-255).	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations; Data request for section 12002 of the 21st Century Cures Act	No
Section I.4: Special Contract Provisions Related to Payment - Create one sub-section to include all rate development components pertaining to special contract provisions (incentives, withholds, risk-sharing, delivery system and provider payment initiatives, and pass-through payments) to streamline the document into clear categories for states, including moving some detail from Sections I.4 and I.7 of the January-June 2017 guide into this section (i.e. Pass-Through Payments and Risk Mitigation, Incentives and Related Contractual Provisions). Add clarifications to be consistent with the final rule including: definitions of incentive payment and withhold and the documentation expectations, capitation payments minus any portion of the withhold that is not reasonably achievable must be actuarially sound, standards and documentation related to risk-sharing strategies and reinsurance, delivery system and provider payment initiatives, definition a pass-through payment and clarification that capitation rates may only include pass-through payments to hospitals, physicians and nursing facilities.	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations	No

Section I.5: Projected Non-Benefit Costs - Add clarifications to be consistent with the final rule including: rate development standards and documentation expectations for non-benefit costs and acuity adjustments as well as documentation expectations for material adjustments. Clarify what the health insurance providers fee is and reference CMS FAQs to direct states and actuaries to this guidance.	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations	No
Section I.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section I.I above. Given restructuring, this section now focuses on risk adjustment and acuity adjustment to streamline the document into clear categories for the state, including moving some detail from Sections I.7 of the January-June 2017 guide into this section (i.e. Risk Mitigation, Incentives and Related Contractual Provisions). Add clarifications to be consistent with the final rule including: what is an acuity adjustment and rate development standards and documentation expectations for risk adjustment and acuity adjustments.	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations	No
Note that Section I.7 of January-June 2016 guide (Risk Mitigation, Incentives and Related Contractual Provisions) is eliminated and items were restructured and consolidated into Sections I.4 and I.6 above as described.	Remove	Removed given restructuring to improve clarity for states on rate development standards and documentation expectations	No
Note that Section I.8 of January-June 2016 guide (Other Rate Development Considerations) is eliminated and items were restructured and consolidated into Section I.1 above as described.	Remove	Removed given restructuring to improve clarity for states on rate development standards and documentation expectations	No
Note that Section I.9 of January-June 2016 guide (Procedures For Rate Certifications for Rate and Contract Amendments) is eliminated and items were restructured and consolidated into Section I.1 above as described.	Remove	Removed given restructuring to improve clarity for states on rate development standards and documentation expectations	

Section II: Medicaid Managed Care Rates with Long-Term Services and Supports - Restructure to have two components of each sub-section that clarify the rate development standards and requirements for appropriate documentation. Remove indicate that blended rate structure is preferred in acknowledgment that states operate different rate development designs to achieve similar goals and clarify that other payment structures, incentives or disincentives by states.	Revise	Alignment with the final rule; Improve clarity for states on rate development standards and documentation expectations	No
Section III: New Adult Group Capitation Rates - Update the dates for previous rating periods that states covered the new adult group in Medicaid managed care plans.	Revise	Adjusting given the time since some states have covered the new adult group	No