January to December 2015	January to December 2016	Jan to June 2017 version	July 2017 to June 2018	July 2018 to June 2019	July 2019 to June 2020 (new version)	Type of Change	Reason for Change	Burden 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.	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.	Introduction - Update to reference new regulatory requirements that take effect with rating periods effective on or after July 1, 2018.	Introduction - Include acknowledgement that CMS is conducting a comprehensive review of the managed care regulations. Update to reference new regulatory requirements that take effect with rating periods effective on or after July 1, 2019.	Revise	Acknowledgement of policy work; Alignment with the final rule.	No
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: 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.	Update to reference new regulatory requirements that take effect with rating periods effective on or after July 1, 2018.	Update to reference new regulatory requirements that take effect with rating periods effective on or after July 1, 2019.	Revise	Alignment with the final rule.	No
	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 consistent with the final rule	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 categories 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.	Add new regulatory requirements that take effect with rating periods effective on or after July 1, 2018, including (1) the requirement that actuaries must certified rates and can no longer certify rate ranges; and (2) the ability to increase or decrease the capitation rate per rate cell up to 1.5 percent without submitting a revised rate certification. Also clarify that states provide a comparison of the final certified rates to those in the previous rating period and a description of any other material changes to the rates that are not otherwise addressed in other sections of the guide.	Add new regulatory requirement, that takes effect with rating periods effective on or after July 1, 2019, that capitation rates must be developed in such a way that the MCO, PIHP or PAHP would reasonably achieve a medical loss ratio of at least 85 percent, and outline documentation expectations if the state chooses as its option to include a remittance. Additionally, include two minor revisions to (1) acknowledge that a certification may cover one or more programs; and (2) that the appropriate documentation requirements applies to the rate certification (when previously it referenced plural certifications). Removal of the requirement to provide a comparison of the final rate ranges in the previous rate certification as rate ranges were no longer allowed for the previous rating period beginning between July 1, 2017 through June 30, 2018. A request that if there are large, or negative changes in rates from the previous year, that the actuary describe in the rate certification what is leading to these differences (this last item is included in the documentation expectations as CMS has routinely asked about this detail during the review period and inclusion of this detail in the initial rate certification documentation would reduce administrative burden.	Revise	Alignment with the final rule; Request actuaries provide documentation in the initial rate certification that is frequently asked as part of CMS questions to reduce burden within the review/comment period.	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.					

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		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.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).	Clarify data request related to section 120002 of the 21st Century Cures Action (P.L. 114-255).	Clarify that when IMDs are used to provide in-lieu-of services, states may make a monthly capitation payment to a MCO or PIHP for en enrollee age 21 to 64 receiving inpatient treatment in an Institution for Mental Disease (IMD) for a short-stime stay of no more than 15 days during the period of the monthly capitation capitation in accordance with 42 CFR 438.6(e) (note: This change was made to acknowledge this Federal requirements applies when IMD is used to provide in-lieu-of services as some states have other approved Medicaid authority for IMD). Remove the data collection related to section 12002 of the 21st Centure Cures Act as CMS is working on a state survey to gather this detail through another avenue. Include a statement that states need to document the amount of overpayments that MCOs collect from providers and describe how those overpayments were considered in the rate development process (included in response to GAO study 18-528 recommendation 3). A request that the actuary describe in the rate certification the chosen trend rates and explain any outlier and negative trends (this item is included in the documentation expectations as CMS has routinely asked about this detail during the review period and inclusion of this detail in the initial rate certification documentation would reduce administrative burden.	Revise	Improve clarity for states (given inquiries over last year) on IMD policy; Remove administrative effort for data collection from section 12002 of the 21st Century Cures Action given other collection method; Documation rate development impact Federal requirement on overpayments and in response to GAO study 18-528 recommendation 3; Request actuaries provide documentation in the initial rate certification that is frequently asked as part of CMS questions to reduce burden within the review/comment period.	No
	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.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.	Clarify rate development standards for risk-sharing mechanisms given the new requirement that actuaries must certified rates and can no longer certify rate ranges. Request a description of how the payments are included in the capitation rates consistent with the 438.6(c) preprint submitted to CMS. Clarify the rate development standards for pass-through payments given the publication of the final regulation for use of new or increased pass-through payments in Medicaid managed care delivery systems (CMS-2402-F published on January 18, 2017).	Correction of minor language to reflect language consistency in the guide. Clarification that CMS expects the rate certification to document that incentive payments will not exceed 105 percent of the capitation rates (this is already expressly outlined in the rate development standards). Clarification that the rate certification must certify capitation payments minus any portion of the withhold that is not reasonable achievable as actuarially sound this is already expressly outlined in the rate development standards). Clarify the directed payment requirements for delivery system and provider payment initiatives, describe that these payment(s) can be incorporated into rate development either in the base capitation rates as a rate adjustment or through a separate payment term and outline the documentation requirements. Clarify the pass-through payment requirements, including the necessary historical documentation that allows a transition period for pass-through to hospitals, physicians and nursing facilities, and outline the related documentation requirements.	Revise	Alignment with the final rule; Request actuaries provide documentation in the initial rate certification that is frequently asked as part of CMS questions to reduce burden within the review/comment period.	No
		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.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.	Clarify two issues related to Health Insurance Providers Fee: (1) add the years (2018 or 2019) for which the documentation should address how the fee is incorporated into capitation rates; and (2) clarify that state's actuary should provide documentation as to whether or not the Health Insurance Providers Fee has been included in the capitation rates for 2014, 2015 and 2016.	Update to reference the Health Insurance Providers Fee (HIPF) moratorium for the fee paid for calendar year 2019 as well as the documentation needed for the HIPF paid for calendar year 2020. Clarify that the state's actuary sound provide documentation as to whether or not the HIPF has been included in the capitation rates for 2014, 2015, 2016, and/or 2018.	Revise	Continuing resolution language, H.R. 195, Division D - Suspension of Certain Health-Related Taxes; Oversight of rate development	No

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			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.					
		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	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.					
		Section I.8 Other considerations: Added that adjustments based on FMAP are not permissible, the effective date of the change should line up with the certification, and all adjustments must be in the certification.	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.					
			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.					
	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: 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.	Clarifies the rate development standards for New Adult Group capitation rates given the new regulatory requirement that actuaries must certified rates and can no longer certify rate ranges.				
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 clarifications 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.	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.		For states that required a risk mitigation strategy specific to the Medicaid Expansion population for the initial rating period that included this population, document that CMS believes this strategy should not be removed until the following three criteria are met: (1) the state uses data only from this population to develop capitation rates; (2) the state has settled/reconciled the previous risk mitigation; and (3) the state can demonstrate that capitation rates are stable or that rates have been adjusted consistent with differences in early experience.	Revise	To address uncertainty regarding this new population	No