

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	July 2020 to June 2021	July 2021 to June 2022 (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 requirements for rate certification 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.	Introduction - Include acknowledgements for (1) pending rulemaking, and (2) implementation of a new accelerated rate review process. Additionally, acknowledges that: (1) following CMS guidance included within this guide is more likely to result in a faster CMS review and reduce the number of questions; and (2) while CMS does not prescribe a specific format for supplying the information in the rate certification, each of the relevant sections in the guide must be discussed in sufficient detail.	Introduction - Reference to pending rulemaking. (2) Include this guidance as released in accordance with 42 CFR 438.4(e) and now incorporates 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754). (3) Update language to reference that all standards and documentation expectations in the guide also apply to rate ranges in accordance with 42 CFR 438.4(c). (4) Include language noting that this rate development guide does not replace or revise the guidance in place for prior rating periods. Include that adherence by states and their actuaries to the rate development standards and documentation expectations outlined in this guide, will aid in ensuring compliance with the regulations and in CMS's review and approval of actuarially sound capitation rates and associated federal financial participation. (5) Does not prescribe a specific format for supplying the information in the rate certification, each of the relevant sections in the guide must be discussed in sufficient detail. (6) Revise footnote #1 to reference the federal standards for rate development are located in 42 CFR 438.4 through 438.7. (7) Include reference to Appendix A which outlines the accelerated rate review process and procedures that was incorporated in the 2020-2021 rate guide. (8) General updates to citations.	Revise	Streamline document and align with the 2020 Final Medicaid and Children's Health Insurance Program (CHIP) Managed Care Rule published in the Federal Register on November 13, 2020 (CMS-2408-F) (85 FR 72754).	No
Section 1 - Describes the expectations of all Medicaid managed care actuarial certifications	Section 1 - 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 1 - updated to reference the new regulatory citations	Section 1: Medicaid Managed Care Rates (changes made to intro to Section 1 and formatting changes throughout all sub-sections of Section 1) - 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.	Section 1 - Update to reference rate ranges in accordance with 42 CFR 438.4(c). Also include language indicating that actuaries are obligated to follow Actuarial Standards of Practice in order to develop rates that are actuarially sound and tie this to 42 CFR 438.4 through 438.7.	Revise	Alignment with the Final Rule; Improve and clarify expectations for states and their actuaries	No	
Section 1.1: General Information - Provided more detailed description around documentation expectations of states to provide throughout the certification process.	Section 1.1: 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), indicate 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 actuarial 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 1.6, 1.8 and 1.9 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.	Section 1.1: General Information - Clarify that the rating period must be 12 months to be consistent with the final rule	Section 1.1: 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), indicate 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 actuarial 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 1.6, 1.8 and 1.9 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 certify 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, PHIP or PAHP would reasonably achieve a medical loss ratio of at least 85 percent, and outline documentation expectations if the state chooses 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 a referenced plural certification). Removal of the requirement to provide a comparison of the final rate ranges in the previous rating period 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.	(1) Revise a footnote (#6) to remove a reference to July 1, 2018 as this guide is applicable to rating periods beginning July 1, 2019 through June 30, 2020. (2) Use of standard terminology for initial rate certification, rate amendment and revised rate certification. (3) Clarify that effective date of program changes must be consistent with rate development assumptions. (4) Clarify that the terms and conditions of any state remittance must be outlined in the rate certification. (5) Remind states of timely filing requirements in 45 CFR 95, and timely submission of rate certifications. (6) Remind states that a rate amendment is needed when loss of program authority occurs. (7) Clarify CMS's documentation expectations related to certification of specific rates for each rate cell in accordance with 42 CFR 438.4(b)(4) and 438.7(c). (8) Clarify the certification must include an index that identifies the location for each item described within this guide and that the certification include not only an index, but also follow the structure of the rate guide. (9) Clarify that if there are services, populations or programs that receive a higher FMAP, the costs subject to this different FMAP must be separated in the rate certification to the extent possible. (10) Clarify that the state's actuary must describe what is leading to large or negative changes in rates from the previous year, and include a description of any other material changes compared to the prior rating period. (11) Clarify that the rate certification include a list of known amendments that will be provided to CMS in the future with estimated timeline(s) for submission and why the current certification cannot account for changes that will be made to the rates.	Section 1.1: General Information (1) Indicate all standards and documentation expectations outlined in rate guide, unless otherwise specified, also apply for rate ranges developed in accordance with 42 CFR 438.4(c). (2) Remove language indicating CMS will consider a rating period other than 12 months for rate certifications to address highly unusual circumstances, such as when a state is aligning program rating periods to ensure that it is aligned with 42 CFR 438.2. The rate certification must be consistent with the rate ranges in the previous footnote and was also removed. (3) Clarify that benefits provided on a non-risk basis must be summarized in the rate certification. (4) Update footnote #9 providing a cross reference to Section 1, Item 4 which describes additional requirements for the various types of special contract provisions in 42 CFR 438.6. (5) Clarify CMS's documentation expectations related to rate amendments such that all differences from the most recently certified rates must be addressed including when rates have been impacted by a de minimis amount in accordance with 42 CFR 438.7(c)(3) and also address and account for differences from the most recently certified rates. Indicate this only applies to certified rates and not rate ranges. (6) Include the documentation requirement that the actuary must confirm that any proposed differences among capitation rates according to covered populations are based on valid rate development and are not based on the rate of FFP associated with the covered populations in a manner that increases Federal costs in accordance with 42 CFR 438.4(b)(1) and 438.7(c). Deleted this language from all other sections as it provides more assurance to include here. The determination that differences in the assumptions, methodologies, or factors used to develop capitation rates for MCOs, PHIPs, and PAHPs increase Federal costs and vary with the rate of FFP associated with the covered populations must be evaluated for the entire managed care program and include all managed care contracts for all covered populations. (7) Include footnote #10 to indicate that the rate guide utilizes the term "rate amendment" throughout this guide to reference an amendment to the initial rate certification. (8) Include footnote #11 to indicate that in accordance with 42 CFR 438.4(c)(2)(i), states that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3). (9) Include footnote #12 to indicate that in accordance with 42 CFR 438.4(b)(1) and 438.7(c), CMS may require a state to provide written documentation and justification that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations or contracts represent actual cost differences based on the characteristics and mix of the covered services or the covered populations. (10) Revise footnote #13 to include reference to CMS review and approval process for state developed payment arrangements under 42 CFR 438.6(c). (11) Clarify CMS's documentation expectations related to accounting for the impacts of the COVID-19 public health emergency by using applicable national or regional data. CMS also recommends states implement a 2-sided risk mitigation strategy for rating periods impacted by the public health emergency. This aligns with the CMS Informational Bulletin published on May 14, 2020 and COVID Frequently Asked Questions for State Medicaid and CHIP Agencies. Also include language that the state must ensure that it complies with the requirements in 42 CFR 438.6(b)(3) including that the risk mitigation strategy must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period. (12) Include language indicating that in accordance with 438.4(c)(2)(ii), States that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3). Also include reference stating that CMS standards for a revised rate certification if the state and its actuary determine that changes are needed within the rate range during the rate year are outlined in Section 1, Item 1.A.3.c of the rate guide. (13) Indicate that if the actuary certified rate ranges for the rate cell(s), the state may increase or decrease the capitation rates per rate cell within the certified rate range up to 1 percent during the rating period, in accordance with 42 CFR 438.4(c)(2). (14) Clarify language around when states may use risk adjustment. (15) Include a new footnote #15 indicating that states that implement capitation rate adjustments that result in an increase or decrease of more than 1.5% will need to submit a rate amendment and contract amendment per 42 CFR 438.7(c)(3). (16) Include a new footnote #16 explaining that states are permitted to either use the rate range option under 42 CFR 438.4(c)(1) or use the de minimis rate adjustment under 438.7(c)(3), but state are not permitted to use both mechanisms in combination. (17) Include a new footnote #17 explaining the documentation expectations for contract amendments that are required for all de minimis rate changes in accordance with 42 CFR 438.3(c), 438.4(b)(1), and 438.7(c)(3). (18) Include a new footnote #18 indicating the requirements for when a state adjusts the capitation rates within the permissible 1% range in accordance with 42 CFR 438.4(c) when rate ranges are utilized. (19) Clarify that states must submit a contract amendment in addition to a rate amendment when there is a loss of program authority due to courts of law, or changes in federal statutes, regulations or approval, and indicate that CMS can provide technical assistance as needed. (20) Include language in the documentation section indicating the certification must clearly indicate whether the actuary is either certifying capitation rates or capitation rate ranges. (21) Include new footnotes (#19 and #20), with a reference to the preamble of the 2020 Managed Care Rule (85 FR 72764) and the documentation requirements for the criteria state can use for paying managed care plans at different points within the rate range. (22) Include documentation expectations for when a state develops rate ranges per rate cell in accordance with 42 CFR 438.4(c). (23) Include documentation requirements that the actuary must assure that any proposed differences among capitation rates according to covered populations are based on valid rate development and are not based on the rate of FFP associated with the covered populations in a manner that increases Federal costs in accordance with 42 CFR 438.4(b)(1) and 438.7(c). Also indicate that the documentation underlying this assurance must be available if requested by CMS. (24) Clarify documentation expectations around whether the state adjusted the actuarially sound capitation rates in the previous rating period by a de minimis amount in accordance with 42 CFR 438.7(c)(3).	Revise	Alignment with the Final Rule; Improve and clarify expectations for states and their actuaries; Request actuaries provide documentation in the rate certification that is frequently asked as part of CMS questions to reduce burden within CMS's review process.	No
Section 1.2 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.			Section 1.2 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.							
Section 1.3: 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 1.3: 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 1.3: 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 1.3: Projected Benefit Costs and Trends - Added 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 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 12002 of the 21st Century Cures Act (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 PHIP for an enrollee age 21 to 64 receiving inpatient treatment in an institution for Mental Disease (IMD) for a short-stay of no more than 15 days during the period of the monthly capitation payment in accordance with 42 CFR 438.6(e) (note: This change was made to acknowledge that 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 Century 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 responses 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.	(1) Clarify the documentation expectations for the description of any data used or assumptions made in developing projected benefit cost trends. (2) Update regulatory citations for mental health parity standards. (3) Require an assurance that the payment represents a payment amount that is adequate to allow the MCO, PHIP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with the requirements of the ACA. (4) Reminder that the costs of an IMD as an in-lieu of service must not be used in rate development.	Section 1-3: Projected Benefit Costs and Trends (1) Remove the documentation requirement that the actuary must confirm that any proposed differences among capitation rates according to covered populations are based on valid rate development and are not based on the rate of FFP associated with the covered populations (this is now in the General Information section above). (2) Include footnote #21 indicating the state must ensure that it complies with 42 CFR 438.4(b)(1) and reference that rate development standards and documentation requirements are outlined in Section 1, Item 1 of this guide. (3) Added citation to section 1903(m)(7) of the Social Security Act in description of requirements for when IMDs are used to provide in-lieu-of services. (4) Include footnote #22 with a reference to 42 CFR 438.4(b)(1) and cross-reference to Section 1, Item 1 in this guide that discusses how variations in costs by FMAP need to be evaluated and justified/explained.	Revise	Alignment with the Final Rule; Streamline documentation expectations.	No

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	Section 1.4. Pass Through Payments - Provides descriptions of pass-through payments, certification requirements, and supplemental payment requirements.	Section 1.4. 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 1.4. Special Contract Provisions Related to Payment - Create one sub-section to include all rate development components pertaining to special contract provisions (incentives, withhold, risk-sharing, delivery system and provider payment initiatives, and pass-through payments) to streamline the document into clear categories for states. (i.e. Pass-Through Payments and Risk Mitigation, through payments in Medicaid managed care delivery systems (CMS-2402-F published on January 18, 2017).	Section 1.4. Special Contract Provisions Related to Payment - Create one sub-section to include all rate development components pertaining to special contract provisions (incentives, withhold, risk-sharing, delivery system and provider payment initiatives, and pass-through payments) to streamline the document into clear categories for states. (i.e. Pass-Through Payments and Risk Mitigation, through payments in Medicaid managed care delivery systems (CMS-2402-F published on January 18, 2017).	Section 1.4. Special Contract Provisions Related to Payment - Create one sub-section to include all rate development components pertaining to special contract provisions (incentives, withhold, risk-sharing, delivery system and provider payment initiatives, and pass-through payments) to streamline the document into clear categories for states. (i.e. Pass-Through Payments and Risk Mitigation, through payments in Medicaid managed care delivery systems (CMS-2402-F published on January 18, 2017).	Section 1.4. Special Contract Provisions Related to Payment - Create one sub-section to include all rate development components pertaining to special contract provisions (incentives, withhold, risk-sharing, delivery system and provider payment initiatives, and pass-through payments) to streamline the document into clear categories for states. (i.e. Pass-Through Payments and Risk Mitigation, through payments in Medicaid managed care delivery systems (CMS-2402-F published on January 18, 2017).	Section 1.4. Special Contract Provisions Related to Payment - Create one sub-section to include all rate development components pertaining to special contract provisions (incentives, withhold, risk-sharing, delivery system and provider payment initiatives, and pass-through payments) to streamline the document into clear categories for states. (i.e. Pass-Through Payments and Risk Mitigation, through payments in Medicaid managed care delivery systems (CMS-2402-F published on January 18, 2017).	Revision	Alignment with the Final Rule, Consistency across CMS documents, Improve and clarify expectations for states and their actuaries; Request actuaries provide documentation in the rate certification that is frequently asked as part of CMS's review process.	No
		Section 1.5 Non-benefit costs: Clarified that assumptions on this group cannot be based on FMAP, noted the Health Insurers Fee Moratorium	Section 1.5: Projected Non-Benefit Costs - Add clarifications to be consistent with the final rule (i.e. FMAP, noted the Health Insurers Fee Moratorium)	Section 1.5: Projected Non-Benefit Costs - Add clarifications to be consistent with the final rule (i.e. FMAP, noted the Health Insurers Fee Moratorium)	Section 1.5: Projected Non-Benefit Costs - Add clarifications to be consistent with the final rule (i.e. FMAP, noted the Health Insurers Fee Moratorium)	Section 1.5: Projected Non-Benefit Costs - Add clarifications to be consistent with the final rule (i.e. FMAP, noted the Health Insurers Fee Moratorium)	Section 1.5: Projected Non-Benefit Costs - Add clarifications to be consistent with the final rule (i.e. FMAP, noted the Health Insurers Fee Moratorium)	Revision	Alignment with The Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502; Streamline document	No
		Section 1.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section 1.1 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 1.7 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 1.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section 1.1 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 1.7 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 1.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section 1.1 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 1.7 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 1.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section 1.1 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 1.7 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 1.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section 1.1 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 1.7 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 1.6: Risk Adjustment and Acuity Adjustments - Note this section previously was focused on Rate Range Development that has been moved and consolidated to Section 1.1 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 1.7 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.	Revision	Improve and clarify expectations for states and their actuaries	No
		Section 1.7 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 1.7 of January-June 2016 guide (Risk Mitigation, Incentives and Related Contractual Provisions) is eliminated and items were restructured and consolidated into Sections 1.4 and 1.6 above as described.	Note that Section 1.7 of January-June 2016 guide (Risk Mitigation, Incentives and Related Contractual Provisions) is eliminated and items were restructured and consolidated into Sections 1.4 and 1.6 above as described.	Note that Section 1.7 of January-June 2016 guide (Risk Mitigation, Incentives and Related Contractual Provisions) is eliminated and items were restructured and consolidated into Sections 1.4 and 1.6 above as described.	Note that Section 1.7 of January-June 2016 guide (Risk Mitigation, Incentives and Related Contractual Provisions) is eliminated and items were restructured and consolidated into Sections 1.4 and 1.6 above as described.	Note that Section 1.7 of January-June 2016 guide (Risk Mitigation, Incentives and Related Contractual Provisions) is eliminated and items were restructured and consolidated into Sections 1.4 and 1.6 above as described.			
		Section 1.8 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 1.8 of January-June 2016 guide (Other Rate Development Considerations) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.8 of January-June 2016 guide (Other Rate Development Considerations) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.8 of January-June 2016 guide (Other Rate Development Considerations) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.8 of January-June 2016 guide (Other Rate Development Considerations) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.8 of January-June 2016 guide (Other Rate Development Considerations) is eliminated and items were restructured and consolidated into Section 1.1 above as described.			
		Section II: Medicaid Managed Care Rates with Long-Term Services and Supports (MLTSS) - Provides additional considerations for states with MLTSS programs or programs that include MLTSS benefits	Note that Section 1.9 of January-June 2016 guide (Procedures For Rate Certifications for Rate and Contract Amendments) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.9 of January-June 2016 guide (Procedures For Rate Certifications for Rate and Contract Amendments) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.9 of January-June 2016 guide (Procedures For Rate Certifications for Rate and Contract Amendments) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.9 of January-June 2016 guide (Procedures For Rate Certifications for Rate and Contract Amendments) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Note that Section 1.9 of January-June 2016 guide (Procedures For Rate Certifications for Rate and Contract Amendments) is eliminated and items were restructured and consolidated into Section 1.1 above as described.	Revision	Improve and clarify expectations for states and their actuaries.	No
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 the new adult group as some states may be removing the risk mitigation strategy. No assumptions based on FMAP.	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.	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.	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.	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.	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.	Revision	Alignment with the Final Rule, Improve and clarify expectations for states and their actuaries.	No
								Revision	Alignment with the Final Rule, Request actuaries provide documentation in the initial rate certification that is frequently asked as part of CMS's review process.	No
								Revision	Alignment with the Final Rule, Request actuaries provide documentation in the initial rate certification that is frequently asked as part of CMS's review process.	No