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
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.	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.
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.		
	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.	(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.

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
			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.			
		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.	(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, PIHP or PAHP to efficiently deliver covered services to Medicaid-eligible individuals in a manner compliant with contractual requirements. (4) Reminder that the costs of an IMD as an in lieu of service must not be used in rate development.

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
	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.	(1) Reminder the certification must document that total payments under the incentive arrangement will not exceed 105 percent of the approved rates. (2) Clarify the time period for an incentive or a withhold arrangement should be documented. (3) Require documentation on the enrollees, services and providers covered by the withhold arrangement. (4) Require a description of the effect each withhold arrangement has on rate development. (5) Use of standard terminology for initial rate certification, rate amendment and revised certification. (6) Clarify documentation expectations for directed payments, including (a) documentation needed for each directed payment; (b) impact on each rate cell; (c) a descripton of any adjustment applied to account for base period changes; (d) an indication that the payment is consistent with the approved preprint and associated correspondence; (e) if a preprint has not yet been submitted, the certification should indicate timeline for submission; (f) documentation expectations specific to a maximum fee schedule; (g) an explicit actuarial statement that the amount of the separate payment term is certified; and (h) confirmation that there are no additional directed payments or reimbursement requirements (not otherwise authorized) in the program that are not addressed in the certification. (7) Clarify CMS's standards and documentation expectations for pass-through payments, including (a) when a trend adjustment and/or reasonable estimates are utilized; (b) state requirements if the payment is a PMPM tied to enrollment; (c) documentation needed for each payment; (d) identification of provider type of payment; (e) identification of any directed payment that targets the same providers receiving pass-through payment; and (f) documentation to verify historical amount and allowable transition period
		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.	(1) Update regulatory citations for mental health parity standards. (2) Update to guide to reflect fee requirements and repeal for health insurance providers. (3) Documentation of non-benefit costs associated with operational costs associated wtih the provision of services to populations covered under the contract. (4) Outline expectation that actuaries should disclose historical non-benefit cost data in the certification to the extent this information was provided by the plans, and explain how the historical non-benefit cost data was considered in the non-benefit cost assumptions used in rate development
			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.			

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
		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 III - 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.	(1) Utilize the term of "new adult group" throughout the section for consistency. (2) Reorganized this section to clarify CMS documentation expectations for states that have already expanded versus those that are expanding to the new adult group for the first time.
						Creation of Appendix A that outlines the CMS Medicaid Managed Care Rate Development Summary for Accelerated Rate Reviews. The appendix includes a summary of the accelerated rate review process that is optional for states, the criteria for participation, the required submission process and materials, and the rate development summary elements.

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Introduction - (1) Remove reference to pending rulemaking. (2) Indicate this guidance is released in accordance with 42 CFR 438.7(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. Indicate 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) Include footnote #1 indicating that the contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. It additionally states that this document is intended only to provide clarity to the public regarding existing requirements under the law. (6) Revise footnote #2 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.
Section I - 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.
Section I-1: General Information (1) Indicate all standards and documentation expectationsmoutlined 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. Thsi will be handled on a case by case basis with states for unique circumstances. (3) Remove footnote indicating it is not acceptable to certify rate ranges. The removed footnote also references the 1.5% de minimis changes to the rates is repetitive of a previous footnote and was also removed. (4) Clarify that benefits provided on a non-risk basis must be summarized in the rate certification. (5) Include footnote #9 providing a cross reference to Section I, Item 4 which describes additional requirements for the various types of special contract provisions in 42 CFR 438.6. (6) 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. (7) 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). 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, PIHPs, 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. (8) 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. (9) Include footnote #11 to indicate that in accordance with 42 CFR 438.4(c)(2)(ii), states that use rate ranges are not permitted to modify the capitation rates under 438.7(c)(3). (10) Include footnote #12 to indicate that in accordance with 42 CFR 438.4(b)(1) and 438.7(d), 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. (11) Indicate the conditions that must be met for an actuary to develop and certify a range of capitation rates per rate cell as actuarially sound and provide the documentation requirements for rate ranges in accordance with 438.4(c). (12) Revise footnote #13 to include reference to CMS review and approval process for state directed payment arrangements under 42 CFR 438.6(c). (13) 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 emergence. This aligns with the CMCS 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)(1), 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. (14) 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 I, Item 1.A.ix.c of the rate guide. (15) 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). (16) Clarify language around when states may use risk adjustment. (17) 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). (18) 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. (19) 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(e), 438.4(b)(1), and 438.7(c)(3). (20) 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. (21) 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. (22) Include language in the documentation section indicating the certification must clearly indicate whether the actuary is either certifying capitation rates or capitation rate ranges. (23) 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's can use for paying managed care plans at different points within the rate range. (24) Include documentation expectations for when a state develops rate ranges per rate cell in accordance with 42 CFR 438.4(c). (25) 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 deleted from all other sections. Also indicate that the documentation underlying this assurance must be available if requested by CMS. (26) 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). (27) Direct states and actuaries to document in the rate certification the approach to addressing the impact of the COVID-19 public health emergency.

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Section I-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 I, 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) Included footnote #22 with a reference to 42 CFR 438.4(b)(1) and cross-reference to Section I, Item 1 in this guide that discusses how variations in costs by FMAP need to be evaluated and justified/explained.

July 2021 to June 2022
Section I-4: Special Contract Provisions Related to Payment (1) Include new footnote #24 to indicate that this rate guidance does not address all requirements for these special contract provisions. States, plans and actuaries are encouraged to review 42 C.F.R. § 438.6 and additional guidance issued by CMS (posted on Medicaid.gov and in the HHS Guidance Portal) for more information and guidance. (2) Include requirement that all risk sharing arrangements must be described in the contracts and rate certification documents for the rating period prior to the start of the rating period and may not be added or modified after the start of the rating period in accordance with 42 CFR 438.6(b)(1). Also include a new footnote (#25) providing guidance on this provision. (3) Changed title and related langauge in Section 4.D from "Delivery System and Provider Payment Initiatives" to "State Directed Payments" for consistency. (4) Clarify the types of state directed payments to conform to recent regulatory changes for state directed payments that are minimum fee schedules using Medicaid State Plan approved rates and those using rates not based on the Medicaid State Plan. (5) Indicate that all state directed payments, except for minimum fee schedules using Medicaid State Plan approved rates, must receive written prior approval from CMS per 42 CFR 438.6(c)(2). (6) Indicate that the state directed payment(s) included in the rate certification must be consistent with the information in the approved preprint and related preprint review documents in order for CMS to review and evaluate the state-directed payment and the associated capitation rates and rate certification for approval under 42 CFR 438.4 through 438.7. (7) Include requirement that all contract arrangements that direct expenditures of MCOs, PIHPs or PAHPs must be developed in accordance with 42 CFR 438.5. (8) Include new footnote #27 clarifying that while some state directed payments do not require written approval prior to implementation, all state directed payments must meet the standards in 42 CFR 438.6(c)(2)(ii)(A) through (F) and be documented in the rate certifications and states' contracts with its managed care plans. (9) Clarify that state must address how each state directed payment is reflected in the rates in accordance with 42 CFR 438.7(b)(6) in order to comply with the requirement that the rate certification include a description of any special contract provision related to payment described in 438.6; in addition, CMS requires the information specified here in order to evaluate compliance of the state-directed payment under 42 CFR 438.6(c) and the rates as a whole under 42 CFR 438.4 through 438.7. Also indicate that the documentation requirements are required to comply with 42 CFR 438.7(b)(6) and 438.7(d), and that the method by which a state incorporates a state directed payment into a related rate certification(s) will be identified and documented as part of the preprint review process. (10) Clarify that states "should" rather than "must" submit documentation to CMS that incorporates the total amount of the payment into the rate certification's rate cells consistent with the distribution methodology described in the approved state directed payment preprint, as if the payment information (e.g., providers receiving the payment, amount of the payment, utilization that occurred, enrollees seen, etc.) had been known when the rates were initially developed (only applicable to those state directed payments utilizing separate payment terms) per OGC guidance. (11) Clarify that states should use a table format when providing the documentation requested by CMS for the state directed payments utilized by the state within the applicable Medicaid managed care program to comply with 42 CFR 438.7(b)(6), 438.6(c) and 438.6(d). (12) Clarify that the description of each state directed payment must be consistent with the approved preprint and related preprint review documentation. (13) Clarify that each state directed payment rate adjustment must be separately identified and state cannot combine the impacts of state directed payments. (14) Clarify documentation expectations for state directed payments utilizing separate payment terms. (15) Indicate that pass-through payments to network providers that are hospitals, nursing facilities or physicians are allowable for the transition period identified in 42 CFR 438.6(d)(6) for states transitioning services and populations from a FFS delivery system to a managed care delivery system when the sate meets the requirements in 42 CFR 438.6(d)(d) and the documentation requirements for these payments (per recent regulatory changes). Include new footnote #33 indicating this as well. (16) Include new footnote #35 indicating that the new pass-through payment provision is effective for rating periods beginning on or after July 1, 2021 in accordance 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). (17) Update citations throughout to ensure correct. (18) Included language in the Pass-Through Payment section clarifying that states must document how the pass-through payment will be paid for clarity and consistency. (19) Clarify documentation expectations for what states must submit regarding how the non-federal share of pass-through payments are financed. (20) Include new footnote #36 indicating that States must use permissible funding sources that comply with federal statute and regulations, including section 1903(w) of the Act and 42 CFR Part 433 subpart B, to fund the non-federal share of pass-through payments, per OGC and FMG guidance. (21) Include language requesting states provide an explanation of any changes to the methodology utilized for the base amount calculation from the previous years' calculations including a rationale and the fiscal impact of the proposed methodology changes. This detail aids our review of compliance with 42 CFR 438.6(d) to evaluate any changes to the base amount calculation to ensure reasonableness of state' base amount calulations, including any reasonable estimates they utilize in accordance with 438.6(d)(2)(iv).
Section I-5: Projected Non-Benefit Costs (1) Remove all references to the Health Insurance Providers Fee (HIPF) as this has been repealed as of January 1, 2020. (2) 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).
Section I-6: Risk Adjustment and Acuity Adjustments (1) Remove language indicating CMS may consider acuity adjustments as a risk mitigation strategy.

July 2021 to June 2022
Section II: Medicaid Managed Care Rates with Long-Term Services and Supports (1) Clarify language indicating all general rate development standards outlined in Section I of this guide apply to rate development for all covered populations and services, but this section provides additional guidance that is specific to rate development guidance for LTSS.
Section III: New Adult Group Capitation Rates (1) Clarify language indicating all general rate development standards outlined in Section I of this guide apply to rate development for all covered populations and services, but this section provides additional guidance that is specific to rate development guidance for the new adult group. (2) Include language under Risk Mitigation Strategies to indicate that in accordance with 42 CFR 438.6(b), if the state utilizes risk-sharing mechanisms with its managed care plan(s) these arrangements must be documented in the contract(s) and rate certification documents for the rating period prior to the start of the rating period, and must be developed in accordance with 438.4, the rate development standards in 438.5, and generally accepted actuarial principles and practices. Also indicate that risk-sharing mechanisms may not be added or modified after the start of the rating period. (3) Include new footnote #41 to clarify risk sharing mechanisms as per 42 CFR 438.6(b)(1).
Appendix A (1) Incorporate the potential use of rate ranges by states (given regulatory changes). (2) Ask states to indicate that the actuary is certifying rates or rate ranges consistent with the certification covered by the previous full review. (3) Include documentation expectations for non-benefit costs changing from the previous rating period. (4) General editing of language for flow and streamlining purposes.

July 2022-June 2023	Type of Change	Reason for Change	Burden Change
Introduction (1) Remove introductory reference to 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) as this was introduced in the Rate Guide last year. (2) Edit footnote to remove reference that all regulations related to rate setting at 42 C.F.R. §§ 438.4, 438.5, 438.6 and 438.7 are applicable to rating periods beginning on or after July 1, 2021 as that rating period has passed and CMS wishes to update the footnote to be standard and reference applicability to all rating periods going forward. (3) Include new footnote to indicate that states must comply with all applicable federal statutory and regulatory requirements as well as guidance that impacts Medicaid managed care rate development. Also added language noting that CMS will evaluate if addendums to this rate guide are necessary if any new federal requirements are implemented.	Revise	Streamline document. Improve and clarify expectations for states and their actuaries.	No
Section I-1: General Information (1) Include language indicating a letter from the certifying actuary could be certifying final capitation rates or rate ranges in accordance with 42 C.F.R. § 438.4(c). (2) Include new footnote specifying that for the regulatory requirement that states document any risk-sharing arrangement(s) prior to the start of the rating period, CMS will accept states' submissions of draft managed care contract actions that are not officially executed and documentation from a state's actuary that may not reflect final full rate development or is limited to a description of the risk-sharing arrangement(s). Language is consistent with the updated State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval. (3) Clarify documentation expectations for any applicable assumptions included or not included in rate development related to the COVID-19 public health emergency (PHE) within the rate certification to help mitigate common questions. (4) Included footnote referencing previous footnote about documentation expectations for risk-sharing arrangement(s). (5) Aligned language around rate ranges to reference upper bounds and lower bounds for consistency and clarify the documentation expectations for each rate cell. (6) Included specific documentation expecations addressing the COVID-19 PHE such as information related to utilization, enrollment, deferred caseload, vaccinations or treatments and a description of any related costs covered on a non-risk basis outside of the capitation rates. This helps mitigate the need for common questions to states.	Revise	Improve and clarify expectations for states and their actuaries.	No

July 2022-June 2023	Type of Change	Reason for Change	Burden Change
Section I-2: Data (1) Included a new footnote providing additional clarification around standards for selection of appropriate base data including that the data must be from the 3 most recent years that have been completed prior to the rating period for which rates are being developed. Provides additional guidance regarding appropriate base data (ie, 42 C.F.R. § 438.5(c)(2)) given recent state questions. This guidance is consistent with preamble in 81 FR 27573.	Revise	Improve and clarify expectations for states and their actuaries consistent with 81 FR 27573.	No
Section 1-3: Projected Benefit Cost and Trends (3) Clarified that documentation must be provided to support the chosen trend rate and explanation of outlier and/or negative trends.		Improve and clarify expectations for states and their actuaries.	

July 2022-June 2023	Type of Change	Reason for Change	Burden Change
Section I-4: Special Contract Provisions Related to Payment (1) Included a new footnote referencing a previous new footnote about documentation expectations for risk-sharing arrangement(s). (2) Expanded documentation requirements for risk-sharing arrangements to include documentation demonstrating that the arrangement is consistent with pricing assumptions used in rate development and that it does not result in a remittance if calculated based on pricing assumptions used in capitation rate development. Mitigates the need for common questions to states. (3) Clarified the documentation needed when a remittance is required to mitigate the need for common questions to states. (4) Clarified that the rate certification and supporting documentation must include a description of each state directed payment, including those that do not require prior approval in accordance with 42 C.F.R. § 438.6(c). This includes minimum fee schedules using Medicaid State plan approved rates as defined in 42 C.F.R. § 438.6(a). (5) Included language and a new footnote indicating that in accordance with 42 C.F.R. § 438.6(d)(5), for rating periods beginning on or after July 1, 2022, states cannot require pass-through payments for physicians or nursing facilities. Pass-through payments for physicians and nursing facilities are no longer allowed as the transition period has ended. The only exception relates to states initially transitioning services or populations from a FFS delivery system to a managed care delivery system, per 42 C.F.R. § 438.6(d)(6). (6) Updated the allowable amount of hospital pass-through payments to be the "lesser of" historical amount or 50 percent of the base amount in accordance with 42 C.F.R. § 438.6(d)(3). (7) Clarified that the base amount, when discussed in reference to hospital pass-through payments, is used when determining the allowable amount of pass-through payments for hospitals as defined in 42 C.F.R. § 438.6(d)(2). (8) Corrected citations throughout the pass-through payment section related to 42 C.F.R. §§ 438.6(d)(2)(i)(A), (i)(B), (ii)(A) and (ii)(B) and 42 C.F.R. § 438.6(d)(6).	Revise	Streamline document. Update actuarial and documentation expectations.	No

July 2022-June 2023	Type of Change	Reason for Change	Burden Change
Section III - New Adult Group Capitation Rates (1) Included a new footnote referencing footnote about documentation expectations for risk-sharing arrangement(s).	Revise	Improve and clarify expectations for states and their actuaries. Streamline documentation expectations.	No