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February 21, 2014

**Subject:** Rite Smiles Dental capitation rate certification letter

Dear Ms. Florio:

HealthCare Analytics, in a collaborative work effort with the staff at the Executive Offices of the Rhode Island Health and Human Services (OHHS) and the actuarial firm of Donlon & Associates, Inc., has developed an actuarially sound capitation rate for Rite Smiles, the State of Rhode Island's (State) Medicaid managed dental care program for children, for the rate period July 1, 2014, through June 30, 2015 (SFY '15).

This certification memo presents the rate development methodology and the certification of its actuarial soundness, for the purpose of seeking rate approval from the Centers for Medicare and Medicaid Services (CMS) under 42 CFR 438.6(c).

### **Actuarially Sound Dental Capitation Rate**

Table 1 presents the proposed actuarially sound rate for Rite Smiles - the State's Medicaid managed dental care program for children.

**Table 1: Actuarially sound dental capitation rate  
July 1, 2014 – June 30, 2015**

	<b>Monthly capitation rate</b>
<b>Per eligible child</b>	<b>\$18.54</b>

With respect to the rates currently in force, the rate effective 7/1/2014 represents a 9.9% increase. Key factors behind this rate increase are:

- The use of higher utilization trends, based on the experience, for the major expense type of service categories, including Diagnostic, Preventive and in particular Orthodontics – which continues to become a greater portion of the total expenses for the older children as they approach ages which typically require higher level of care

- Noticeably higher anticipated costs for older children, than their younger counterparts – e.g. 11-14 year-olds' claims costs are anticipated to be approximately 90% higher, on average, than 0-10 year-olds' claims

Please refer to the exhibit on the last page of this document, page 8, for details on the rate development and resulting final capitation rate.

## Capitation Rate Development Methodology

### Overview

In 2006, the State introduced Rlte Smiles, a managed dental care program for children with eligibility limited to those born on or after May 1, 2000. This program is expected to improve children's oral health through increased access to dentists and greater attention to preventive dental care than has been achievable in the State's fee-for-service (FFS) provision of dental services to Medicaid recipients. We examined the possibility of maintaining 2 rate cells, one for children aged 0-9 and another for children aged 10-14, as orthodontia services account for an increased portion of the total expenses in this latter age group. We concluded that it would be administratively simpler to maintain a single capitation rate since there is currently only one carrier participating in the program.

The proposed capitation rate was developed consistent with guidance provided in the CMS Rate Checklist. Dental claims data for several periods from the State's Dental Benefit Manager's (DBM) encounter data and Rhode Island's Fee-For-Service (RI-FFS) data were analyzed, completed, smoothed and trended. Adjustments were made, as applicable, to reflect programmatic changes to the State Plan that affect either the base period data (historical program changes) or future experience during the rating period (prospective program changes). Finally, we appropriately adjusted the costs using managed care and administrative load assumptions. We discuss each step of our methodology in greater detail below.

### Base Period Data

For the 7/1/2014 – 6/30/2015 (SFY '15) rates, we used a combination of encounter data and RI-FFS data, for the covered services in the Rlte Smiles program. For children ages birth to 11, we used encounter data supplied by the State for dates of service between July 2011 and June 2013. For children aged 12, we relied on encounter data for dates of service between July 2011 and June 2012, and supplemented that with RI-FFS dental claims experience for dates of service between July 2012 and June 2013. For children ages 13 and 14, we relied on RI-FFS dental claims experience for dates of service between July 2010 and June 2013.

To smooth out year-to-year variations, particularly in low volume services, we trended the data for the most recent 2 and 3 year periods of the encounter and RI-FFS data, respectively, to the July 2012 – June 2013 period and blended them at various credibility weights to establish a

blended base period. The data for children aged birth to 11 were blended by placing 70% credibility on the most recent year and 30% on the previous year. The data for children age 12 were blended by placing 60% credibility on the encounter data for the most recent period and 40% on the FFS data from the previous period. The data for children ages 13 and 14 were blended by placing 75% credibility on the most recent period, 20% credibility on the next most recent period and 5% on the oldest period.

### **Completion Factors**

The encounter data for the birth to 12-year old populations were for claims incurred during July 2010 through June 2013, and paid through November 2013, estimated to be 100% complete by the OHHS staff analysis.

The FFS data for the 12 to 14-year olds were for claims incurred July 2010 through June 2013, and paid through October 2013, estimated at 100% complete by the OHHS staff analysis.

### **Trend adjustments**

We evaluated the trends in both the RI-FFS and encounter data to develop utilization, unit cost and PMPM cost levels for the rate period. In reviewing the utilization patterns between the different data sources and different ages, we observed that there was a great deal of volatility in the RI-FFS data between SFY '11, SFY '12 and SFY '13. We observed that some services, in particular Orthodontia, had a greater influence on the overall expense of the older ages. As well, we observed an acceleration in Orthodontia utilization in younger age groups including 8, 9 and 10 year-olds. Thus we developed composite trends that were primarily based on total DBM experience, to be applied to all types of service except for the big cost drivers such as Diagnostic, Preventive, Restorative and Orthodontia. For Diagnostic, Preventive and Restorative services we applied the observed 2-year average trends for those specific types of services. For Orthodontia, we recognized the accelerated and high utilization trends observed in the older children for year 1 of the trending period, and assumed greater care and utilization management efforts by the DBM for year 2 of the trend period.

A summary of the average annual PMPM trend assumptions used in the rate development is shown in Table 2.

**Table 2: Average annual PMPM trend assumptions  
Base year (7/1/2012 – 6/30/2013) to Contract Year**

<b>Service Category</b>	<b>Year 1 of Trend Period</b>	<b>Year 2 of Trend Period</b>
Adjunctive	5.51%	5.51%
Dentures	5.51%	5.51%
Diagnostic	3.53%	3.53%
Endodontic	5.51%	5.51%
Oral Surgery	5.51%	5.51%
Orthodontics	22.83%	9.52%
Periodontics	5.51%	5.51%
Preventive	7.94%	7.94%
Prosthodontics	5.51%	5.51%
Restorative	1.05%	1.05%

### Relational modeling (smoothing)

We reviewed the results of the data blending for the base period as discussed above, and concluded that the aforementioned steps provided sufficient smoothing of the base period and that no additional smoothing would be necessary.

### Inclusion of copayments

Item AA.3.7 of the CMS Rate Checklist requires that an amount equal to the value of any copayments collected from the Medicaid enrollee through the FFS program should be included in the FFS base data for development of capitation rates. This adjustment was not necessary for this analysis because copayments do not apply for the target population of the Rlte Smiles program.

### Historical program changes

The State's DBM supplied us with their updated fee schedules, the impact of which we took into consideration for the capitation rate development.

### Prospective program changes

The Rlte Smiles program manager indicated that there are no prospective program changes that would require adjustments to the capitation rates for the 7/1/2014 – 6/30/2015 rate period.

### Managed care adjustments

Since we use RI-FFS data to inform us of the potential utilization mix patterns for the kids "aging-in" into the older age groups (partially for age 12 and fully for ages 13 and 14), we made adjustments to the RI-FFS data to better reflect the impact of the managed care program on the utilization of certain services – i.e. greater emphasis on preventive and diagnostic services, and to account for a different level of provider reimbursement under the DBM compared to the traditional FFS Medicaid. Thus, we "re-priced" the RI-FFS data using the DBM's fee schedules and we adjusted the utilization of certain service categories based on a blend of the observed

differences between FFS and managed care inherent in the historical data at our disposal, and the prior consultant's observations.

**Table 3: Managed Care adjustments applied to FFS data  
Base year (7/1/20121 – 6/30/2013) to Contract Year**

<b>Service Category</b>	<b>Utilization Adjustment</b>
Adjunctive	0.0%
Dentures	0.0%
Diagnostic	28.0%
Endodontic	0.0%
Oral Surgery	66.0%
Orthodontics	25.0%
Periodontics	-22.0%
Preventive	48.0%
Prosthodontics	0.0%
Restorative	53.0%

### **Administrative Load**

Based on OHHS staff's evaluation of the DBM's historical performance, and in light of the increasing capitation rates driven primarily by the ageing-in of the children into older and more expense ages, and administrative load of 8% was included in the capitation rate for administrative expenses, profit and contingency. This load is \$1.46 PMPM for the rate period 7/1/2014 – 6/30/2015.

### **Provider Tax**

The capitation rate also includes the State-mandated provider tax of 2.0% of premium to which the contracted DBM will be subject, as the tax is a cost of doing business in Rhode Island. This provider tax amounts to \$0.36 PMPM for the rate period 7/1/2014 – 6/30/2015.

### **Issuer Tax**

As well, the capitation rate includes the Issuer Tax as imposed by The Affordable Care Act (ACA) at an estimated rate of 2%, based on United Healthcare's (parent company of the current DBM) preliminary estimate of the Issuer tax on the medical lines of business. It is anticipated that should the actual tax be determined to be less than that allocated, a refund will be issued to the State.

### **Risk Corridor**

The financial arrangement between the State and the Rlte Smiles DBM utilizes a risk-share arrangement with a baseline dental expenditure of \$16.35 PMPM. If dental expenditures fall between 101% and 104% of the baseline, the State will assume 60% of the excess and the plan will assume the risk of 40% of the excess. If the dental expense exceeds 104% of the baseline, the State will assume 90% of the excess and the plan will assume 10% of the excess. When dental expenses are between 96% and 99% of the baseline, the gains will be shared 60% to the

State ad 40% to the plan. If the dental expense is below 96% of the baseline, the gains will be shared 90% to the State and 10% to the plan.

## Actuarial Certification

In preparing the capitation rate for the July 1, 2014, through June 30, 2015, Rlte Smiles program, HealthCare Analytics used and relied upon enrollment, eligibility, encounter, FFS and benefit design information supplied by the State and its vendors. The State and its vendors are responsible for the validity and completeness of this supplied data and information. HealthCare Analytics reviewed the data and information for internal consistency and reasonableness, but did not audit it. If the data and information is incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

HealthCare Analytics worked with the actuarial firm of Donlon & Associates, Inc. to review, test for reasonableness and certify that the rate was developed in accordance with generally accepted actuarial practices and principles, and is appropriate for the Medicaid-covered populations and services under the managed care contract.

Donlon & Associates, Inc. certifies that the rate in this memo was developed in accordance with generally accepted actuarial practices and principles, and is appropriate for the Medicaid-covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

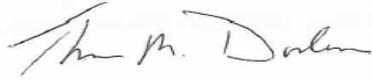
The capitation rate developed by HealthCare Analytics is an actuarial projection of future contingent events. Actual Rlte Smiles costs will differ from these projections. HealthCare Analytics has developed this rate on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438(c) and in accordance with applicable law and regulations. Use of this rate for any purpose beyond that stated may not be appropriate.

DBMs are advised that the use of this rate may not be appropriate for their particular circumstance and HealthCare Analytics disclaims any responsibility for the use of this rate by DBMs for any purpose. HealthCare Analytics recommends that any DBM considering contracting with the State should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to this rate before deciding whether to contract with the State.

This certification letter assumes the reader is familiar with the Rhode Island Rlte Smiles program, Medicaid eligibility rules and actuarial rating techniques. It is intended for the State and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections

to understand the technical nature of these results. This document should only be reviewed in its entirety. To the best of our knowledge, there are no subsequent events that would impact our work or the conclusions presented in this report.

If you have any questions or comments on the assumptions or methodology, please contact Tom Donlon of Donlon & Associates, Inc. at (630) 505-0830.



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