Attachment A2.1 – Data Book Supplemental Information

1: DMS will not provide experience at a D-code level. This experience has been summarized into rating categories as presented in the data book. The impact of claims lag on the rates can also be seen in the data book as the IBNR adjustment. As discussed at the Bidder's Conference, FY15 has 9 months of runout and the IBNR adjustment is immaterial.

2: Member access is not anticipated to change drastically under the managed care delivery system. Minor increases to sealants (1%-2%) have been incorporated to reflect more preventive work. Decreases to imaging (4%-10%) and restorative (1.5% - 5%) are based medical best practices. DMS does not currently have membership projections for 2018. FY15 membership has been provided in the presentation, and more detailed membership information is available in the accompanying document titled "Rating Region Membership".

3: Managed care savings were determined by reviewing service utilization patterns in the data and comparing those patterns to managed dental programs. Additionally, The State's Medicaid Actuary has access to the dental data for a program that recently transitioned from fee-for-service to managed care. Using this data, The State's Medicaid Actuary is able to see reasonable service delivery changes for year 1 of a managed program. On top of these two sources, The State's Medicaid Actuary discussed changes in service delivery under a dental managed care program with our independent clinician and incorporated his expertise in the final savings rates.

4: Managed care savings were only applied to children because that is where the largest differences in service patterns from a managed program were observed. Adult utilization was fairly consistent with reference points, and a significant increase in service penetration did not appear likely. The adult rate is very small to begin with, and The State's Medicaid Actuary did not think it was reasonable to expect additional savings in year one of a managed care program. The unit cost for children increases because in general the preventable services are the less expensive services in a given category, and so as those cheaper services are removed, the remaining services are more expensive.

5: Historical trends are based on observed changes in Arkansas' dental data from FY14 to FY15. Changes were smoothed across service category.

6: Prospective trends are based on changes in Arkansas' dental data, detailed reference dental data from other states, and standard inflation measures such as the Producer Price Index and Consumer Price Index. The State's Medicaid Actuary also reviewed published trend rates from other Medicaid programs.

7: The underlying unit cost is 100% of the Medicaid fee-for-service reimbursement. There are no fee differences between CHIP and Medicaid, but there are patient cost share differences.

8: The only program change is the Orthodontia change for ARKids B. This program change impacts benefit access and overall cost of care, but not the cost of specific services.

9: The Expansion QHP population did not have sufficient data upon which to base an actuarially sound rate. Based on The State's Medicaid Actuary' experience with Arkansas medical data and dental data from reference states, the Medicaid TANF and Disabled populations are close estimates for the non-frail expansion population. Additionally, dental spend typically varies primarily by age, rather than Medicaid eligibility category. Due to these reasons The State's Medicaid Actuary set the Expansion QHP rate as equal to the standard Medicaid rate for each age band. It is anticipated that there will be some service category level differences, but the aggregate rates are expected to be comparable between the Medicaid adults and the Expansion QHP adults.

10: The values observed are based on Arkansas' dental data. No adjustments were made by The State's Medicaid Actuary to the data. The FY14 data is comparable to FY15 for each service and population, indicating a potential difference in treatment patterns between the CHIP and Medicaid 0-1 populations.

11: Rate development has incorporated utilization increases to allow for more preventative services. Additionally, administrative funding has been added to the rate development at a level commensurate with typical dental managed care programs to fund quality measures and utilization management practices.