Office of State Procurement
Contract Certification of Approval

This certificate serves as a confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000506243

Amendment Number: 15

Vendor: MCNA INSURANCE COMPANY

Description: MCNA Insurance Co

Approved By: PAMELA RICE

Approval Date: 12/23/2025 13:51:11

Rev 2017-01

AMENDMENT TO

AGREEMENT BETWEEN STATE OF LOUISIANA

LOUISIANA DEPARTMENT OF HEALTH

Amendment #: 15

LAGOV#: 2000506243

LDH #:

Agency Name: Bureau of Health Services Financing

(Regional/ Program/ Facility: Medical Vendor Administration

AND

MCNA Insurance Company DBA MCNA Dental

Contractor Name

Original Contract Amount: $355,700,072.00

Original Contract Begin Date: 1/1/2021

Original Contract End Date: 12/31/2023

RFP Number: 300013043

AMENDMENT PROVISIONS

Change Contract From: From Maximum Amount: $620,792,433.00 Current Contract Term: 1/1/2021 - 12/31/2025

Attachment D13 - Rate Certification Effective 1/01/2025

Change Contract To: To Maximum Amount: Changed Contract Term:

Attachment D15 - Rate Certification Effective 7/01/2025

Justifications for amendment:

The purpose of this amendment is to include revisions within the scope and to comply with the terms and conditions as set forth in the RFP. The contract amendment will include rate certification for SFY2026 effective July 1, 2025 (July 1, 2025 - June 30, 2026).

This Amendment Becomes Effective: 7/01/2025

This amendment contains or has attached hereto all revised terms and conditions agreed upon by contracting parties.

IN WITNESS THEREOF, this amendment is signed and entered into on the date indicated below.

CONTRACTOR

DocuSigned by: Shannon LePage
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CONTRACTOR SIGNATURE: Shannon LePage DATE: 12/17/2025

PRINT NAME: Shannon LePage

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE: [signature] DATE: 12/15/25

NAME: Bruce D. Greenstein

TITLE: Secretary

OFFICE: Louisiana Department of Health

Signed by: Seth Gold

PROGRAM SIGNATURE DATE: 12/12/2025

NAME: Seth Gold

MILLIMAN CLIENT REPORT

State Fiscal Year 2026 Louisiana Medicaid Dental Managed Care Capitation Rate Certification

State of Louisiana Department of Health

December 15, 2025

Chris Pettit, FSA, MAAA, Principal and Consulting Actuary
Anders Larson, FSA, MAAA, Principal and Consulting Actuary
Zach Fohl, FSA, MAAA, Consulting Actuary
Brooke DeFries, ASA, MAAA, Associate Actuary

Milliman


Milliman

Table of Contents

Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of Louisiana, Department of Health (LDH) to provide actuarial and consulting services related to the development of capitation rates for the Medicaid dental managed care program. This report documents the development of the actuarially sound capitation rates for the state fiscal year (SFY) 2026 rating period. It also includes the required actuarial certification in Appendix 1.

To facilitate review, this document has been organized in the same manner as the 2024-2025 Medicaid Managed Care Rate Development Guide, finalized by the Centers for Medicare and Medicaid Services in January 2024 (CMS guide). Section II of the CMS guide is not applicable to the dental managed care program in Louisiana because long-term care supports and services (LTSS) are not covered. Section III of the CMS Guide and this certification is only applicable to the Medicaid Expansion populations.

CONTRACTED DBPMS AND PAYMENT METHODOLOGY

The following dental benefit program managers (DBPMs) participate in the Medicaid dental managed care program on a statewide basis during SFY 2026:

- Managed Care of North America (MCNA) Dental
- DentaQuest

Each DBPM will receive a capitation payment that varies for each rate cell. Rate cells are developed on a statewide basis and are described in Section I, subsection 1.A.iii.

FISCAL IMPACT ESTIMATE

The certified capitation rates for the Medicaid dental managed care populations are illustrated in Figure 1. These rates are effective from July 1, 2025 through June 30, 2026 (SFY 2026). The composite rates illustrated for SFY 2025 have been developed based on an estimate of projected enrollment in SFY 2026. The SFY 2025 effective capitation rates are consistent with the report titled:

- *SFY 2025 Louisiana Medicaid Dental Managed Care Rate Certification*, dated June 11, 2024

The rates below do not include funding associated with the Dental Incentive Payment Program (DIPP) state directed payment that was included in the March 7, 2025 certification amendment report. Additional information related to the DIPP is provided in Section I.4.D of this report.

FIGURE 1: COMPARISON WITH SFY 2025 EFFECTIVE CAPITATION PMPM RATES

POPULATION	PROJECTED SFY 2026 AVERAGE MONTHLY ENROLLMENT	SFY 2025	SFY 2026	% CHANGE
LaCHIP Affordable Plan	4,500	$ 25.62	$ 34.43	34.4%
Medicaid Adult	241,400	$ 1.43	$ 1.21	(15.4%)
Medicaid Child/CHIP	716,100	$ 24.87	$ 27.74	11.5%
Medicaid Expansion Adult	486,100	$ 1.12	$ 1.08	(3.6%)
Medicaid Expansion Child	44,600	$ 19.77	$ 25.35	28.2%
Act 450	11,700	$ 3.06	$ 3.68	20.3%
Adult ICF/IID	3,500	$ 1.96	$ 5.23	166.8%
Composite	**1,507,900**	**$ 13.09**	**$ 14.61**	**11.6%**

Notes: 1. SFY 2025 composite rates were developed based on SFY 2026 projected monthly enrollment.
2. Monthly enrollment values are rounded.

Figure 2 compares the estimated federal and state expenditures under the SFY 2026 rates, based on estimated enrollment in SFY 2026.

FIGURE 2: COMPARISON WITH SFY 2025 EFFECTIVE CAPITATION RATES (AGGREGATE EXPENDITURES $ MILLIONS)

POPULATION	SFY 2025 ANNUALIZED EXPENDITURES	PROJECTED SFY 2026 EXPENDITURES	CHANGE
LaCHIP Affordable Plan	$ 1.4	$ 1.9	$ 0.5
Medicaid Adult	$ 4.1	$ 3.5	($ 0.6)
Medicaid Child/CHIP	$ 213.7	$ 238.4	$ 24.7
Medicaid Expansion Adult	$ 6.5	$ 6.3	($ 0.2)
Medicaid Expansion Child	$ 10.6	$ 13.6	$ 3.0
Act 450	$ 0.4	$ 0.5	$ 0.1
Adult ICF/IID	$ 0.1	$ 0.2	$ 0.1
Composite	**$ 236.9**	**$ 264.3**	**$ 27.5**
Federal	164.6	183.8	19.3
State	72.3	80.5	8.2

Notes:
1. SFY 2025 composite rates were developed based on SFY 2026 projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2025 FMAP of 68.06% for 3 months and FFY 2026 FMAP of 67.83% for 9 months for all except the Expansion population. FMAP values do not include CHIP enhanced FMAP.
3. State expenditures based on FMAP of 90% for the Expansion population.

Section I. Medicaid Managed Care Rates

1. General Information

This section provides information listed under the General Information section of CMS guide, Section I.

The capitation rates provided under this certification are “actuarially sound” for purposes of 42 CFR 438.4(a), according to the following criteria:

- The capitation rates provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).

To ensure compliance with generally accepted actuarial practices and regulatory requirements, we referred to published guidance from the American Academy of Actuaries (AAA), the Actuarial Standards Board (ASB), the Centers for Medicare and Medicaid Services (CMS), and federal regulations. Specifically, the following were referenced during the rate development:

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification (for all Practice Areas)); ASOP 23 (Data Quality); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).
- Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F, CMS-2408-F, and CMS 2349-F) for the provisions effective for the SFY 2025 managed care program rating period.
- The most recent *Medicaid Managed Care Rate Development Guide* published by CMS.

Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

- *“Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes.”*[1]

The capitation rates developed may not be appropriate for any specific DBPM. An individual DBPM will need to review the rates in relation to the benefits that it will be obligated to provide. The DBPM should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The DBPM may require rates above, equal to, or below the “actuarially sound” capitation rates that are associated with this certification.

A. RATE DEVELOPMENT STANDARDS

i. All standards and documentation expectations for rate ranges

Unless otherwise stated, all standards and documentation outlined in the CMS guide apply to the development of the rates in this certification. This certification does not include rate ranges.

[1] http://www.actuarialstandardsboard.org/asops/medicaid-managed-care-capitation-rate-development-and-certification/

ii. 12-month rating period

The actuarial certification contained in this report is effective for the capitation rates for the one-year rating period from July 1, 2025, through June 30, 2026.

iii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Chris Pettit, FSA, is in Appendix 1. Mr. Pettit meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the Actuarial Standards Board, and certifies that the rates meet the applicable standards in 42 CFR 438 that are effective for the SFY 2026 managed care program rating period.

(b) Certified capitation rates for each rate cell

The certified rates by rate cell are contained in Appendix 2. Capitation rates are the same for all DBPMs. These rates represent the contracted capitation rates that will be paid to the DBPMs. Projected member months illustrated in Appendix 2 represent estimated values for SFY 2026.

(c) Program information

(i) Managed care program

This certification was developed for the Louisiana Medicaid dental managed care program operated by the State of Louisiana.

LDH has operated a managed care dental benefit program for Medicaid children and adults since July 1, 2014. LDH contracts with the following dental benefit program managers participating in the Louisiana dental program on a statewide basis:

- MCNA
- DentaQuest

Each DBPM receives a capitation payment for each rate cell. Coverage for comprehensive dental care is funded through the dental capitation rates for all children (including Medicaid expansion child), adults residing in an intermediate care facility with development or intellectual disabilities and for adults enrolled in certain Home and Community Based waivers. Dental capitation rates for remaining adult populations are limited to the coverage of dentures (complete, relines, repairs) and certain services associated with denture construction.

(ii) Rating period

This actuarial certification is effective for the one-year rating period of July 1, 2025, through June 30, 2026.

(iii) Covered populations

The dental managed care program is divided into seven different rate cells for the following specific populations:

Louisiana Children's Health Insurance Program (LaCHIP) Affordable Plan

The LaCHIP Affordable plan population includes uninsured children in moderate income families whose income is too much to qualify for regular LaCHIP. A monthly premium per household applies for families that have at least one child enrolled in LaCHIP Affordable plan.

Medicaid Child/CHIP

The Medicaid Child/CHIP rate cells covers all children aged 0-20 years covered through the traditional Medicaid program and those qualifying for coverage under LaCHIP.

Medicaid Adult

The Medicaid adult population includes non-disabled adults who are not eligible for Medicare and do not qualify for one of the other populations noted below.

Medicaid Expansion Child

The Affordable Care Act Expansion (ACA) child population is comprised of Louisiana residents between 19 and 20 years of age, who are U.S. citizens or who have legal status and are eligible for Medicaid and have a monthly income less than 138% of the federal poverty level (FPL).

Medicaid Expansion Adult

The Affordable Care Act Expansion (ACA) adult population is comprised of Louisiana residents between 21 and 64 years of age, who are U.S. citizens or who have legal status and are eligible for Medicaid and have a monthly income less than 138% of the federal poverty level (FPL).

Act 450

LDH expanded the dental managed care program to cover adults ages 21 and up with intellectual or developmental disabilities who are enrolled in the New Opportunities Waiver, Residential Options Waiver or the Supports Waiver. This rate cell became effective on July 1, 2022.

Adult ICF/IID

LDH expanded the dental managed care program to cover adults ages 21 and up residing in an intermediate care facility (ICF) for individuals with intellectual disabilities. This rate cell became effective on May 1, 2023.

(iv) Eligibility criteria

Eligibility criteria for the covered populations is described above.

(v) Special contract provisions

This rate certification report contains documentation of the following special contract provisions related to payment included within rate development.

- Minimum medical loss ratio requirement

Please see Section I, subsection 4 for additional detail and documentation.

(vi) Retroactive adjustment to capitation rates

This rate certification report is for prospective SFY 2026 capitation rates.

iv. Differences among capitation rates

Any proposed differences among capitation rates according to covered populations are based on valid rate development standards and are not based on the rate of federal financial participation (FFP) associated with the covered populations.

v. Cross-subsidization of rate cell payment

The capitation rates were developed at the rate cell level and neither cross-subsidize nor are cross-subsidized by payments from any other rate cell.

vi. Effective dates

To the best of our knowledge, the effective dates of changes to the Medicaid dental managed care program are consistent with the assumptions used in the development of the certified SFY 2026 contracted capitation rates.

vii. Minimum medical loss ratio

The capitation rates were developed such that the DBPMs are reasonably expected to achieve a medical loss ratio (MLR), as calculated under 42 CFR 438.8, greater than 85 percent for the rate year. The capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

The Louisiana dental contract has remittance provisions with a minimum MLR of 85 percent separately for the Medicaid Expansion populations and all other populations combined. The terms and conditions are outlined in Section I, subsection 4.C.ii.(b).

viii. Conditions for actuarially sound rate ranges

This certification does not include rate ranges.

ix. Documentation for actuarially sound rate ranges

This certification does not include rate ranges.

x. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs. To our knowledge, there are no reasonable, appropriate, and attainable costs that have not been included in the certification.

(b) Outside the rate setting process

There are no adjustments to the rates performed outside the rate setting process.

(c) Final contracted rates

The SFY 2026 capitation rates certified in this report represent the final contracted rates by rate cell.

xi. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period of July 1, 2025, through June 30, 2026.

xii. COVID-19 public health emergency

Please see Section 1, subsection 1.B.xi. for details on rate adjustments related to the COVID-19 public health emergency (PHE) along with Section 7 related to acuity adjustments due to the PHE unwinding.

xiii. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the capitation rates change. The following exceptions are allowed per §438.7 of CMS 2390-F:

1. A contract amendment that does not affect the rates.
2. A de minimis increase or decrease of up to 1.5% in the capitation rate per rate cell.
3. Risk adjustment, under a methodology described in the initial certification, that changes the rates paid to the DBPMs.

In cases 1 and 2, a contract amendment must still be submitted to CMS. In the event program provisions are invalidated by courts of law or by changes in statutes, regulations, or approvals, an amendment will be submitted.

B. APPROPRIATE DOCUMENTATION

i. Actuarial certification

The actuary is certifying capitation rates for the DBPMs. This certification does not include rate ranges.

ii. Documentation of required elements

This report contains appropriate documentation of all elements described in the rate certification, including data used, assumptions made, and methods for analyzing data and developing assumptions and adjustments.

iii. Medical loss ratio documentation

Using the values illustrated in Appendix 2, the simplified medical loss ratio (defined as the base benefit expense divided by the effective capitation rate for purposes of this report) is 88%. This value is above the minimum standard of 85% and is prior to adjustment for healthcare quality improvement expenses as required in the medical loss ratio definition outlined in 42 CFR § 438.8, which would further increase the pricing medical loss ratio. The dental plan can reasonably achieve a medical loss ratio of at least 85% as required per 42 CFR § 438.4(b)(9).

We considered the historical medical loss ratios, capitation rate changes, and emerging benefit expense trends when developing the SFY 2026 dental capitation rates as required per 452 CFR § 438.5(b)(5).

iv. Ranges of assumptions

The specific assumptions underlying the capitation rates have been disclosed in this certification. We have not developed ranges around assumptions used in the capitation rate development.

v. Requirements for a certified capitation rate range

This certification does not include rate ranges.

vi. Index

The index to this rate certification is the table of contents, found immediately after the title page. The index includes section numbers and related page numbers. Sections not relevant to this certification continue to be provided, with an explanation of why they are not applicable.

vii. Consistency with rate of FFP

The capitation rates for all populations were developed in a manner consistent with 42 CFR 438.4(b)(1), including that any differences in the assumptions, methodologies, or factors used to develop capitation rates for covered populations are based on valid rate development standards that represent actual cost differences in providing covered services to the covered populations, and that these differences do not vary with the rate of FFP associated with the covered populations in a manner that increases federal costs.

viii. Different FMAP

Capitated payments made for children enrolled in the CHIP population who are eligible for Title XXI benefits receive an enhanced FMAP rate of 77.48% during federal fiscal year (FFY) 2026 (77.64% in FFY 2025).

Capitated payments made for the Medicaid Expansion population receive an FMAP rate of 90.0% during SFY 2026. All other capitated payments made receive the regular state FMAP of 68.06% for FFY 2025 and 67.83% for FFY 2026. The enhanced FMAP percentages (with the exception of the 90.0% rate for the Medicaid Expansion population) are not reflected in values provided in this certification.

ix. Comparison to prior rates

(a) Comparison to prior rates

Figures 1 and 2 above provide a summarized comparison of the SFY 2026 capitation rates to the prior MCO effective rates for SFY 2025. Comparisons at the rate cell level are provided in Appendix 2.

(b) Description of other material changes

There are no material changes to the capitation rates or the rate development process that are not otherwise addressed in this report.

(c) De minimis adjustment in prior rating period

LDH did not adjust the actuarially sound capitation rates in the previous rating period by a *de minimis* amount using the authority in 42 C.F.R 438.7(c)(3).

x. Known amendments

There are currently no known amendments that are not accounted for in this rate certification. If a known amendment exists, the state will submit the expected amendment and its anticipated changes to the rates to CMS along with an explanation as to why the amendment is not currently reflected in the rate certification.

xi. COVID-19

We considered the impact of COVID-19 on the estimated utilization and service mix for the covered population in CY 2024. As part of the Consolidated Appropriations Act, 2023, continuous enrollment requirements were decoupled from the public health emergency (PHE), allowing eligibility reviews to begin prior to the expiration of the PHE. The resumption of Medicaid eligibility redeterminations in Louisiana began May 1, 2023, with the disenrollment of ineligible members starting July 1, 2023. We have reflected adjustments to the projected enrollment and utilization trend based on emerging disenrollment data.

(a) State specific, and other applicable national or regional data

For the base data summaries, calendar year 2024 experience was utilized and summarized in Appendix 3. We compared state specific data given the variance observed in experience for other states during the PHE along with assuming decreases in enrollment to the Medicaid Adult, Medicaid Expansion, and Medicaid Child/CHIP populations.

(b) Direct and indirect impacts reflected in capitation rates

The capitation rates account for changes in the projected enrollment due to the public health emergency. Changes in utilization patterns as a result of the COVID-19 pandemic is also directly accounted for by utilizing CY 2024 as the base data period. The CY 2024 period was observed to represent materially stable expenditures in the managed care dental program and was estimated to be the most appropriate representation of estimated SFY 2026 experience for these rate cells.

We reviewed the emerging impact of enrollment changes in the dental managed care program on the acuity of the covered population based on the expectation that members terminated during the redetermination process will be lower acuity than the population average. As the redetermination has ended, we reviewed actual utilization during and after the PHE unwind when selecting utilization trend. Based on results of our analysis, we have not incorporated an adjustment for acuity in the development of the SFY 2026 capitation rates.

(c) COVID-19 costs covered on non-risk basis

Treatment, testing, and vaccines for COVID-19 are outside the scope of the dental managed care program.

(d) Risk mitigation strategies

As documented in Section 1, subsection 4.C.ii.(b), LDH has elected to maintain its minimum medical loss ratio (MLR) requirement at 85% for the SFY 2026 contract year.

2. Data

This section provides information on the base data used to develop the capitation rates. The base experience data described in this section is illustrated in Appendix 3.

A. RATE DEVELOPMENT STANDARDS

In accordance with 42 CFR §438.5(c), we have followed the rate development standards related to base data. The remainder of Section 1, subsection 2 provides documentation of the data types, sources, validation process, material adjustments, and other information related to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

We requested and received data specifically for the capitation rate development. In addition, we intake and summarize monthly eligibility and expenditure data using information provided by LDH. The remainder of this section details the base data and validation processes utilized in the SFY 2026 capitation rate development. In addition, Appendix 3 summarizes the adjusted base data.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The SFY 2026 capitation rate development utilized the following data sources:

- Historical eligibility files provided by LDH
- Encounter data submitted by the participating DBPMs
- LDH fee schedules applicable to services affected by reimbursement changes
- Financial reporting templates submitted by the DBPMs

The capitation rates for most populations were developed from historical CY 2024 claims and enrollment data from the managed care enrolled populations. We used utilization and expenditures from the encounter data with runout through February 2025.

(ii) Age of the data

The data utilized as the base experience in the rate development for this report represents benefit expenses incurred during CY 2024 (with claims runout through February 2025). We used encounter data corresponding to the same time periods for the purposes of evaluating the impact of policy and program adjustments.

For the purposes of trend development, we reviewed monthly DBPM financial data experience on an incurred basis over the period from January 2021 through January 2025. Judgment was applied when reviewing the data due to the PHE unwinding during the base claims period.

(iii) Data sources

Capitation payment and eligibility information

We received updated MMIS data on a monthly basis.

DBPM encounter data

We received DBPM encounter data extracts from the State's MMIS concurrently with the eligibility and enrollment extracts noted above. Our analysis was based on data submitted to the MMIS through February 2025.

LDH fee schedules

We received LDH fee schedules for services affected by reimbursement changes during or after the base experience period.

Financial reports

On a quarterly basis, each DBPM was requested to complete a financial reporting template. The recent submission includes data paid through December 2024. Utilization and expenditures were reported by each DBPM by rate cell, and service. The financial reporting template also captured information related to sub-capitated arrangements, affiliated party contracts, non-benefit costs, and other information pertinent to the SFY 2026 rate development.

(iv) Sub-capitation

There were no sub-capitated claims identified in the historical encounter data or within the information reported by the DBPMs.

(b) Availability and quality of the data

(i) Steps taken to validate the data

We received monthly eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data. The actuary, the DBPMs, and LDH all play a role in validating the quality of encounter and financial reporting information used in the development of the capitation rates. The DBPMs play the initial role, collecting and summarizing data sent to the State. In addition, LDH focuses on encounter data quality and DBPM performance measurement, with measures focused on completeness, accuracy, and comparison between data sources. We perform independent analysis of encounter data and financial reporting information to evaluate the quality of the data being used in the rate development process. Below is a summary of measures specific to each quality area that are applied by either Milliman or LDH.

Completeness

As the actuary, we summarize the encounter data to assess month to month completeness of the encounter data. We evaluate any months where encounter data volume is unusually large or small, indicating a potential issue with the submitted encounter data.

The CY 2024 encounter data used in the development of the rates was adjudicated through February 2025. The two months of claims run-out after year-end was determined to be nearly sufficient for claim submission and payment for the base experience period, and a completion factor was applied to base data in CY 2024.

Accuracy

DBPM encounter data was reviewed relative to utilization and expenditures reported in the financial reports provided by the DBPMs. As the state actuary we also review the encounter data to ensure each claim is related to a covered individual and a covered service. Claims utilized in the rate development process are those that have matching beneficiary IDs that are eligible for the noted service date.

We summarize the encounter data into an actuarial cost model format. Base period data summaries are created to ensure that the data for each service is consistent with prior historical periods. Stratification by rate cell facilitates this review, as it minimizes the impact of changes in population mix. This process helps to identify any potential issues with the submitted data.

Consistency of data across data sources

We compared data across all sources during our base data review and analysis. We utilized the DBPM reported data to validate the encounter data being utilized for rate development was appropriate. Through the data validation process, we identified minor inconsistencies in reported data across sources. We addressed these deviations through the true-up factors noted in Appendix 2.

(ii) Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that we have relied upon certain data and information provided by LDH and its vendors, primarily the DBPMs. The values presented in this report are dependent upon this reliance.

We find the data used to develop the SFY 2026 capitation rates to be suitable for the purpose of developing actuarially sound rates, with certain adjustments as outlined in the following sections. The data has been reviewed by multiple parties for completeness, accuracy, and consistency. The managed care experience base data used in the development of the SFY 2026 certified rates is reasonably consistent with the reported financial experience of DBPMs.

(iii) Data concerns

(c) Appropriate data

(i) Use of encounter and fee-for-service data

Fee-for-service data was not used during the rate development process.

(ii) Use of managed care encounter data

Managed care encounter data in CY 2024 was used as base experience in the rate development.

(d) Reliance on a data book

We did not rely on a data book for the SFY 2026 capitation rate development.

iii. Data adjustments

The capitation rates were developed from CY 2024 experience reported in managed care encounter data for most rate cells. Adjustments made to the base experience are noted below.

(a) Credibility adjustment

No specific credibility adjustment was applied to the data based on our review of the information.

(b) Completion adjustment

The capitation rates were developed from the CY 2024 experience for all rate cells. Adjustments were made to the base experience through a true-up adjustment to gross-up expenditures to the level reported in the DBPM financial templates.

Additionally, encounter data was paid through February 2025 and reflected two months of claims run-out. A separate set of completion factors were developed for each class of service with resulting composite factors applied to each rate cell.

The impact of applying the true-up and claim completion factors can be found in Appendix 2 of this report.

(c) Errors found in the data

On an overall basis, we believe that the encounter data was reasonably consistent with the DBPM reported experience such that we determined it was appropriate for use as the base experience.

(d) Program change adjustments

Expanded sealant coverage

Effective May 1, 2024, EPDST age related restrictions were removed for sealants and coverage was added for the Adult waiver and ICF populations. An additional limit on sealant application was to lengthen the period from one per tooth per 24 months to one per tooth per 36 months. For the SFY 2026 rates, we applied a sealant adjustment to account for observed increase in sealant utilization. This adjustment covers months prior to the coverage change as an adjustments for the observed ramp up period.

(e) Exclusion of payments or services from benefit expense data

Encounters without a corresponding eligibility record were excluded from the data provided by LDH. No other specific payments or services were excluded from the data.

3. Projected Benefit Cost and Trends

This section provides information on the development of projected benefit costs in the capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Final capitation rate compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-covered services provided by the DBPMs as value-added are not included in the capitation rate development.

ii. Benefit cost trend assumptions

Projected benefit cost trend assumptions are developed in accordance with generally accepted actuarial principles and practices. The primary data used to develop benefit cost trends is historical claims and enrollment from the covered populations. In addition, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iii. In lieu of services

There are no use of ILOS for the Louisiana dental managed care program.

iv. ILOS Cost Percentages

There are no use of ILOS for the Louisiana dental managed care program.

v. Benefit expenses associated with members residing in an IMD

There are no members covered over the age of 21 in the Louisiana dental program with program costs associated with an Institution for Mental Diseases (IMD) stay of more than 15 days in a month and thus is not applicable to this certification.

B. APPROPRIATE DOCUMENTATION

i. Projected benefit costs

This section provides documentation of the methodology utilized to develop the benefit cost component of the capitation rates at the rate cell level.

ii. Development of projected benefit costs

(a) Description of the data, assumptions, and methodologies

This section of the report outlines the data, assumptions, and methodology used to project the benefit costs to the rating period. The baseline benefit costs were developed using the following steps:

Step 1: Create per member per month (PMPM) cost summaries

The capitation rates were developed from historical CY 2024 claims and enrollment data.

We used utilization and expenditures from the encounter data with runout through February 2025. We applied adjustments to complete the expenditures to represent fully completed experience for the base time period. Utilization and costs are reported by population and detailed service line. As the encounter data served as the base experience, a true-up adjustment was made to gross-up the base expenditures to the level reported by the DBPM financial templates.

We summarized the base expenditures by each rate cell and compared them to the reported expenditures from the DBPM. Initial factors were developed from the expenditures from the DBPM reports divided by the total expenditures from the base data by rate cell. Figure 3 provides a more detailed breakdown of the true-up adjustment by rate cell.

FIGURE 3: TRUE-UP ADJUSTMENT DEVELOPMENT

RATE CELL	TRUE-UP FACTOR
LaCHIP Affordable Plan	1.0469
Medicaid Adult	1.0971
Medicaid Child/CHIP	1.0307
Medicaid Expansion Adult	1.0597
Medicaid Expansion Child	1.0345
Act 450	1.1845
Adult ICF/IID	2.9450

Additional adjustments were applied to complete the expenditures to represent fully completed experience for the base time period. Claims experience was summarized on a rate cell basis, with rate cell assignment based on SFY 2026 criteria.

The base data was described further in section 2.B.ii.

Step 2: Adjust for prospective program and policy changes to state fiscal year 2026

We adjusted the base experience for known policy and program changes that have occurred or are expected to be implemented between the base data experience period and the end of the SFY 2026 rate period. In a previous section, we documented these items and the adjustment factors for each covered population.

Step 3: Trend to state fiscal year 2026

Assumed trend factors were applied for 18 months to the adjusted utilization and unit cost values, or per member per month (PMPM) values, as appropriate, from the midpoint of the base experience period (July 1, 2024) to the midpoint of the rate period (January 1, 2026).

(b) Material changes to the data, assumptions, and methodologies

All rate development data and material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis.

(c) Overpayments to providers

We are not aware of any overpayments to providers reflected in the base experience period.

iii. Projected benefit cost trends

This section discusses the data, assumptions, and methodologies used to develop the benefit cost trends, i.e., the annualized projected change in benefit costs from the historical base period to the rating period of this certification. We evaluated prospective trend rates using base and emerging experience, as well as external data sources.

(a) Required elements

(i) Data

The primary data used to develop benefit cost trends is historical claims and encounters from the covered populations. Data used for trend development included two years of cost and utilization experience, from CY 2021 through February 2025.

We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries, specific to dental services.

(ii) Methodology

For internal LDH data, historical utilization and per member per month cost data was stratified by month, rate cell, and class of service. We evaluated historical trend over recent time periods to identify the range of trends proposed for establishing SFY 2026 capitation rates. Figure 4 provides a summary of the selected annual trends applied to the different classes of dental services.

FIGURE 4: BENEFIT TREND FACTORS

SERVICE CATEGORY	UTILIZATION TREND	CPS TREND
Class I	3.75%	0.25%
Class II	3.50%	0.50%
Class III	3.50%	0.50%
Miscellaneous Services	3.50%	0.50%

(iii) Comparisons

Historical trends should not be used in a simple, formulaic manner to determine future trends; a great deal of actuarial judgment is also needed.

We referred to the sources listed in the prior section as well as considered changing practice patterns and the impact of reimbursement changes on utilization in the managed care populations.

Explicit adjustments were made outside of trend to reflect recent changes in reimbursement from the base experience period to the rating period.

(iv) Documentation of Trends

Documentation supporting the chosen trend selections is provided in Section I, subsection 3.B.iii.(b) below. There were no outlier or negative trends selected for the Louisiana dental program.

(b) Required elements

Figure 4 above indicates the trends that were utilized to establish trended costs for the SFY 2026 rating period. We have illustrated the split between cost per service and utilization in Figure 4.

(c) Variation

Based on the different classes of service covered under the Louisiana dental program and the distribution of services amongst the procedures codes, we developed separate trend assumptions by class of service.

(d) Material adjustments

No material adjustments were noted in the data utilized for calculating trends.

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect impacts related to managed care efficiencies for utilization or unit cost.

(ii) Trend changes other than utilization and cost

We did not adjust the benefit cost trend for changes other than utilization or unit cost.

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

LDH assessed the State's compliance with the parity standards of the Mental Health Parity and Addiction Equity Act (MHPAEA) as required by 42 CFR 438.3(c)(1)(ii). Mental health/substance abuse services are not a covered service for the Louisiana Dental program and does not impact the rates.

v. In Lieu of Services

The projected benefit costs do not include costs for in lieu of services.

vi. Retrospective Eligibility Periods

(a) DBPM responsibility

During the base period, DBPMs were responsible for periods of retroactive eligibility of up to 12 months. DBPM requirements for the rating period are consistent with the base period and continue to be responsible for periods of retroactive eligibility.

(b) Claims treatment

As noted earlier, claims for retrospective eligibility periods are reflected in the DBPM base data.

(c) Enrollment treatment

Enrollment is treated consistently with claims.

(d) Adjustments

It was not necessary to make any adjustments to the DBPM base data for retroactive eligibility.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the January 2025 to June 2025 rating period.

(a) Change to covered benefits

Material changes to covered benefits have been described in program adjustments described in Section I, subsection 2.B.iii Program Change Adjustments.

(b) Recoveries of overpayments

No overpayment issues were indicated to have been reflected in the historical paid encounter data and therefore no adjustment has been made to the base experience for overpayment recoveries.

(c) Change to payment requirements

Material changes to required provider payments have been described in program adjustments in Section I, subsection 2.B.iii Program Change Adjustments.

(d) Change to waiver requirements

There were no material changes related to waiver requirements or conditions.

(e) Change due to litigation

There were no material changes due to litigation.

viii. Documentation of Material Changes

Material changes to covered benefits and provider payments have been described in program adjustments described in Section I, subsection 2.B.iii Program Change Adjustments. This information includes the data, assumptions, and methodology used in developing the adjustment, estimated impact by population, and aggregate impact on the managed care program’s benefit expense.

4. Special Contract Provisions Related to Payment

A. INCENTIVE ARRANGEMENTS

i. Rate development standards

This section provides documentation of the incentive payment structure in the Louisiana Medicaid dental managed care program consistent with the definition of an incentive arrangement in 42 CFR §438.6(a).

We acknowledge that total payments under this incentive arrangement will not exceed 105% of the approved capitation payments under the contract as required in 42 CFR §438.6(b)(2).

ii. Appropriate documentation

(a) Pediatric special needs incentive program

During the rating period, DPBMs will be eligible to earn up to $9.3 million through a pediatric special needs incentive program.

(i) Time period

An incentive arrangement is being implemented during the SFY 2026 rating period, to be effective January 1, 2026 and continue through June 30, 2026.

(ii) Covered enrollees, services, and providers

This incentive arrangement is applicable to all participating DBPMs and provides additional funding that may support providers who deliver dental services to special needs pediatric patients. These include children who are blind; disabled; have intellectual or developmental disabilities; or, members identified as a Chisholm Class member.

(iii) Purpose

The purpose of the incentive arrangement is to provide enhanced funding based on the additional time and care that accompanies the treatment of a special needs pediatric patient.

(iv) Payments will not exceed 105 percent

The annualized amount associated with this incentive arrangement is $9.3 million and will not exceed 105% of the total capitation payments, or for any one DBPM.

(v) Effect on capitation rates

This incentive arrangement does not have any direct impact on the development of the capitation rates.

B. WITHHOLD ARRANGEMENTS

i. Rate development standards

This section provides documentation of the withhold arrangements in the Louisiana Medicaid dental managed care program.

ii. Appropriate documentation

There are currently no withhold arrangements in the Louisiana Medicaid dental managed care program.

C. RISK SHARING MECHANISMS

i. Rate development standards

This section provides documentation of the risk-sharing mechanisms in the Louisiana Medicaid dental managed care program.

ii. Appropriate documentation

(a) Description of the risk-sharing mechanism

There are currently no risk-sharing mechanisms in the Louisiana Medicaid dental managed care program outside of the minimum Medical Loss Ratio described in Section I, subsection 4.C.ii.(b).

(b) Medical loss ratio

Description

LDH requires all DBPMs participating in the Healthy Louisiana dental managed care program to maintain a minimum medical loss ratio (MLR) of 85%, separately for the Medicaid Expansion and all other populations combined. For each of the two MLR calculations, the MLR is defined as the ratio of the numerator, as defined in accordance with 42 CFR 438.8(e), to the denominator, as defined in accordance with 42 CFR 438.8(f), plus a credibility adjustment, as defined in accordance with 42 CFR 438.8(h). These items will be accrued on an incurred year basis for the MLR calculation. MLR will be measured on a SFY basis starting on July 1, 2025.

Financial consequences

If a DBPM does not meet the minimum MLR threshold, then LDH will recoup the capitation revenue that represents the difference between the total capitation revenue for the applicable population multiplied by the minimum medical loss ratio, less actual benefit expenses incurred.

(c) Reinsurance requirements and effect on capitation rates

LDH does not require that DBPMs participating in the Medicaid managed care program maintain a specific stop-loss reinsurance policy. Reinsurance premiums and recoveries have not been reflected in the rate development.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate development standards

This section provides information on directed payments for certain providers which are pertinent to the SFY 2026 dental capitation rates.

(a) Description of Managed Care Plan Requirement

Effective July 1, 2023, LDH implemented a minimum fee schedule covering dental services. Although there is not a required preprint, the minimum fee schedule is documented as a directed payment in the associated managed care plan contract

Effective January 1, 2025, LDH will implement a value-based state directed payment for general and pediatric dentists practicing in dental clinics, Federally Qualified Health Centers, and Rural Health Clinics and who are participating in the Louisiana Medicaid dental program. Clinics will earn incentive payments based on their performance on quality measures.

All directed payments described in this amendment are consistent with LDH descriptions of the 438.6(c) pre-prints which have been submitted to CMS, if required.

(b) Approval by CMS and consistency with preprints

All directed payments described in this rate certification have been submitted to CMS. The descriptions in this rate certification are consistent with the 438.6(c) pre-prints that have been submitted to CMS.

(c) Contract arrangements with MCOs

The contract which direct DBPM’s expenditures were developed in accordance with 42 CFR §438.4 and 42 CFR §438.5.

(d) Inclusion of Provider Payment Initiatives in Capitation Rates

The required fee schedule amounts are reflected in the base data as implementation of the minimum fee schedule was prior to the beginning date of the base period experience.

The minimum fee schedule does not represent a separate payment term

DIPP Directed Payments

The payments for the DIPP directed payment are made on a retrospective basis to the DBPMs.

ii. Appropriate documentation

(a) Description of Delivery System and Provider Payment Initiatives

(i) Description of delivery system and provider payment initiatives included in the capitation rates

State directed payments incorporated in the capitation rates are listed in Figure 5 below.

FIGURE 5: SUMMARY OF DIRECTED PAYMENTS INCLUDED IN CERTIFICATION

CONTROL NAME OF THE STATE DIRECTED PAYMENT	TYPE OF PAYMENT	BRIEF DESCRIPTION	IS THE PAYMENT INCLUDED AS A RATE ADJUSTMENT OR SEPARATE PAYMENT TERM?
Dental minimum fee schedule[1]	Minimum fee schedule	Minimum fee schedule for dental providers	Rate adjustment
TBD	Add-on based on utilization	Add-on paid to general and pediatric dentists based on utilization of dental services	Separate payment term

Note: LDH is not required to submit pre-prints for minimum fee schedules on an annual basis and therefore we do not have a current control name for the minimum fee schedule.

- **Dental minimum fee schedule -** DBPMs are required to contract at or above the state plan fee schedule for the dental services.

- **DIPP**

  DIPP is a value-based state directed payment for general and pediatric dentists practicing in dental clinics, Federally Qualified Health Centers, and Rural Health Clinics and who are participating in the Louisiana Medicaid dental program.

  Clinics will earn incentive payments based on their performance on quality measures. Clinic performance will be tracked by the dental plans and reported to LDH twice a year. The program will include the three measures that are referenced in the submitted preprint.

  Each measure will have a benchmark. The benchmark for each reporting round is equal to the state Medicaid median for all dental clinics during the same six-month period of the prior year.

Each participating clinic will have a performance target for each measure. During SFY 2025, the performance target will be equal to the clinic's performance on a given measure in the prior year.

(ii) Description of payment arrangements incorporated as a rate adjustment

State directed payments incorporated in the capitation rates as a rate adjustment are listed in Figure 6 below, with more description following the table.

FIGURE 6: DIRECTED PAYMENTS INCORPORATED AS RATE ADJUSTMENTS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	RATE CELLS AFFECTED	IMPACT	DESCRIPTION OF THE ADJUSTMENT	CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT	ADDITIONAL INFORMATION OR MAXIMUM FEE SCHEDULES
Dental minimum fee schedule	All	Included in the base data	Reflects adjusted experience in rate development	N/A	N/A

The minimum fee schedule directed payment is incorporated into the base capitation rates, with the respective change in fee schedule reflected in the base experience and thus no additional adjustment is necessary.

(iii) Description of payment arrangements incorporated as a separate payment term

State directed payments incorporated in the capitation rates as a rate adjustment are listed in Figure 7 below, with more description following the table.

FIGURE 7: DIRECTED PAYMENTS INCORPORATED AS SEPARATE PAYMENT TERMS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	AGGREGATE AMOUNT INCLUDED IN THE CERTIFICATION	STATEMENT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM	MAGNITUDE ON A PMPM BASIS	CONFIRMATION THE RATES ARE CONSISTENT WITH PREPRINT	CONFIRMATION THE ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT END OF RATING PERIOD
TBD	$ 12,200,000	Yes	$0.67	Yes	Yes

Actuarial certification of separate payment terms.

The actuary certifies the amounts of the separate payment terms provided in this document.

Provider types receiving the payment

Providers who are part of the DIPP directed payment include general and pediatric dentists practicing in dental clinics, Federally Qualified Health Centers, and Rural Health Clinics and who are participating in the Louisiana Medicaid dental program.

Distribution methodology

DBPM encounter data will be used to directly link payments to utilization of dental services for DBPM enrollees.

Once a clinic's performance is reported, each participating clinic will receive a weight for a measure based on the clinic's performance during the measurement period. A participating clinic's payment for a given period will be determined by the clinic's performance relative to the benchmark and the clinic's performance target.

- 100% weight applied for clinics with performance during the measurement period that is equal to or greater than the benchmark and equal to or greater than the clinic-specific performance target
- 80% weight applied for clinics with performance during the measurement period that is below the benchmark and equal to or greater than the clinic-specific performance target
- 60% weight applied for clinics with performance during the measurement period that is greater than or equal to the benchmark but below the performance target
- 0% weight applied for clinics with performance during the measurement period that is below the benchmark and below the performance target

The value of the incentive earned by each clinic will be determined based on the clinic's proportion of total number of numerator cases (subsequent dental exams, fluoride services, or restorative services) across all participating providers during the measurement period, weighted based on the clinic's quality incentive weight.

Estimated PMPM payout

The estimated PMPM payout is provided in Appendix 2.

Consistency with 438.6(c) preprint

The directed payments, as described in this rate certification, are consistent with 438.6(c) preprints submitted to CMS.

Statement that certification will be amended if rates vary from initial estimate

To the extent the final directed payments by rate cell vary from the initial estimates presented in Appendix 2, the rate certification will be amended to reflect the final payments made to the providers.

E. PASS-THROUGH PAYMENTS

i. Rate development standards

There are no pass-through payments applicable to the Louisiana Medicaid dental managed care program in SFY 2026.

5. Projected Non-Benefit Costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit cost component of the capitation rates includes reasonable, appropriate, and attainable expenses related to DBPM operation of the Medicaid dental managed care program.

The remainder of Section I, item 5 provides documentation of the data, assumptions, and methodology that we utilized to develop the non-benefit cost component of the capitation rates.

ii. PMPM versus percentage

The non-benefit cost was developed as a percentage of the capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

(a) Description of the data, assumptions, and methodologies

Data

The financial reports submitted by the DBPMs for historical time periods included reported administrative costs by DBPM and served as the primary data source used in the development of the SFY 2026 non-benefit costs. Non-benefit costs were established for each population as a percentage of the of the DBPM effective capitation rates.

In addition, we reviewed average costs from other dental plans in the Medicaid market on a national basis.

Assumptions and methodology

In developing the non-benefit costs, we reviewed historical DBPM administrative and healthcare quality improvement (HCQI) expenses for the Medicaid dental managed care program along with national Medicaid dental plan administrative expenses. We considered the size of participating dental plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the managed care populations. A 10.0% administrative load was applied to the base benefit expense.

Underwriting margin. Underwriting margin assumption of 2.0% has been maintained from the SFY 2025 capitation rates and apply to all benefit expenses included in the capitation rate.

In evaluating the reasonableness of the margin assumptions, we have considered the minimum medical loss ratio requirement for SFY 2026, which is 85% and applied separately for the expansion and non-expansion populations to each DBPM's reported experience. Under CFR 438.8, adjustments are made to each DBPM's medical loss ratio calculation for quality improvement expenses (numerator) and taxes and regulatory fees (denominator).

Premium tax. A 2.25% premium tax is applied to the fully loaded capitation rate. This includes premium tax applicable to the DIPP directed payment.

(b) Material changes since last rate certification

There were no material changes since the prior certification.

(c) Other material adjustments

No other material adjustments were made.

ii. Non-benefit costs, by cost category

The SFY 2026 non-benefit cost allowance was developed as a percentage of the DBPM effective rate for each rate cell on a statewide basis. The administrative load component of the non-benefit expense adjustment is 10.0% with a 2.0% for risk margin. The 2.25% adjustment for premium tax represents a multiplicative adjustment to the fully loaded rate, including the DIPP.

iii. Historical non-benefit cost data

The historical non-benefit costs reported by the DBPMs in their financial reports was approximately $1.15 PMPM for administrative and HCQI related expenses. We have made adjustments for the SFY 2026 rating period based on the impact of lower projected enrollment for SFY 2026.

6. Risk adjustment

This section provides information on risk adjustment included in the contract.

A. RATE DEVELOPMENT STANDARDS

i. Overview

The Medicaid dental managed care capitation rates have been developed as full risk rates without an adjustment for risk.

ii. Risk adjustment model

Not applicable.

7. Acuity adjustments

This section provides information related to the acuity adjustment applied to the SFY 2026 capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Permissible acuity adjustments

(a) Prospective or retrospective

No acuity adjustments were applied in the development of the SFY 2026 DBPM capitation rates.

(b) Retrospective acuity adjustments

Not applicable.

B. APPROPRIATE DOCUMENTATION

i. Documentation of acuity adjustments

(a) Description of acuity adjustment

Not applicable.

(b) Acuity adjustment model

Not applicable.

(c) Data sources

Not applicable.

(d) Relationship and potential interactions

Not applicable.

(e) Frequency of acuity score calculations

Not applicable.

(f) Adjustment to capitation rates

Not applicable.

(g) Accordance with generally accepted actuarial principles

Not applicable.

Section II. Medicaid Managed Care Rates with Long Term Services and Supports

Section II of the CMS Guide is not applicable to the Louisiana Medicaid dental managed care program. Managed long-term services and supports (MLTSS) populations are excluded and not covered.

Section III. New Adult Group Capitation Rates

LDH began enrolling beneficiaries into the Medicaid Expansion population beginning July 1, 2016.

1. Data

A. DATA USED IN CERTIFICATION

Section I, subsection 2 of this report thoroughly describes the data used in developing actuarially sound SFY 2026 capitation rates for the Medicaid Expansion population.

B. EXPERIENCE VS. ASSUMPTIONS

We have made no specific adjustments to reflect differences in projected versus actual experience for benefit expense outside of updating the base experience for SFY 2026.

2. Projected Benefit Costs

A. DESCRIPTION OF PROJECTED BENEFIT COSTS

i. Description of projected benefit costs

(a) Experience specific to newly eligible adults

CY 2024 DBPM experience for the Medicaid Expansion population comprised the underlying data used in the development of the SFY 2026 Medicaid Expansion capitation rates as outlined in Section 1 of this report.

(b) Changes in data sources, assumptions, or methodologies since last certification

The data sources, assumptions, and methodologies are consistent with the prior certification with the exceptions outlined in Section 1 of this report.

(c) Assumption changes since last certification

CY 2024 DBPM experience was used as the underlying data source in the development of the SFY 2026 capitation rates. SFY 2023 DBPM experience was used as the underlying data source for previous capitation rates. Other assumptions are generally consistent with the historical rate certifications.

Adjustment for pent-up demand. It was assumed that the baseline experience data did not require these adjustments.

Adjustment for adverse selection. It was assumed that the baseline experience data did not require these adjustments.

Adjustment for demographics of the new adult group. We believe the current rate cell structure of the Expansion population appropriately adjusts capitation payments to the extent the demographic mix of the Expansion population changes significantly during the SFY 2026 rate period.

Differences in provider reimbursement rates or provider networks. We are not aware of any provider network differences between the Medicaid Expansion population and other Medicaid populations. Variations in assumptions by covered population were not based on the rate of federal financial participation associated with the population.

II. CHANGES TO BENEFIT PLAN

No benefit changes have been made to services covered under the state plan for the Expansion population, other than those discussed in Section 1 of this report.

B. OTHER MATERIAL CHANGES OR ADJUSTMENTS TO BENEFIT COSTS

No other material changes or adjustments were made in the rate development process other than those discussed in Section 1 of this report.

3. Projected Non-Benefit Costs

A. CHANGES IN DATA SOURCES, ASSUMPTIONS, OR METHODOLOGIES SINCE LAST CERTIFICATION

We made an increase to the non-benefit expense assumptions from the prior rates to reflect the impact of lower projected enrollment.

B. ASSUMPTION DIFFERENCES RELATIVE TO OTHER MEDICAID POPULATIONS

We did not alter non-benefit expense assumptions across populations or rate cells.

4. Final Certified Rates

A. COMPARISON TO PREVIOUS CERTIFICATION

Figures 1 and 2 in Section I of this report provide a comparison of the Medicaid expansion rate cells to the previously certified capitation rates.

B. DESCRIPTION OF OTHER MATERIAL CHANGES TO THE CAPITATION RATES

All material changes to the Medicaid Expansion rate development methodology are outlined in Section I of this report.

5. Risk Mitigation Strategies

A. DESCRIPTION OF RISK MITIGATION STRATEGY

The risk mitigation strategy for the Medicaid Expansion population is outlined in Section I of this report. No additional risk mitigation strategies are in effect for the SFY 2026 rating period.

B. CHANGES TO RISK MITIGATION STRATEGY RELATIVE TO PRIOR YEARS

Consistent with the other Louisiana Medicaid dental managed care program populations, the minimum medical loss ratio (MLR) requirement will remain at 85% for the SFY 2026 contract year.

Limitations

The information contained in this report has been prepared for the State of Louisiana, Department of Health (LDH) and their consultants and advisors to provide documentation of the development of the state fiscal year 2026 actuarially sound capitation rates for the populations served under the Louisiana Medicaid dental managed care program. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report will be shared with CMS and the DBPMs and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for LDH by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to develop actuarially sound capitation rates for the state fiscal year 2026 rating period. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by LDH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes eligibility and FFS claims and encounter data, DBPM-reported financial experience, as well as information related to LDH's eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.

Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual DBPM. Results will differ if actual experience is different from the assumptions contained in the capitation rate setting documentation. LDH and Milliman provide no guarantee, either written or implied, that the data and information is 100% accurate or error free.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

We acknowledge the unique nature of the COVID-19 Public Health Emergency and the anticipated resumption of redeterminations and terminations of coverage that will occur during the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. We acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX 1: ACTUARIAL CERTIFICATION

State of Louisiana
Department of Health
Louisiana Medicaid Dental Managed Care Program
State Fiscal Year 2026 Capitation Rates
Actuarial Certification

I, Chris Pettit, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the qualification standards established by the American Academy of Actuaries and have followed the standards of practice established by the Actuarial Standards Board. I have been employed by the State of Louisiana, Department of Health to perform an actuarial review and certification regarding the development of capitation rates for the Louisiana Medicaid dental managed care program effective July 1, 2025. I am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.4(a), according to the following criteria:

- *the capitation rates provide for all reasonable, appropriate, and attainable costs that are required under terms of the contract and for the operation of the MCO for the time period and population covered under the terms of the contract, and such capitation rates were developed in accordance with the requirements under 42 CFR 438.4(b).*

For the purposes of this certification and consistent with the requirements under 42 CFR 438.4(a), "actuarial soundness" is defined as in ASOP 49:

"Medicaid capitation rates are "actuarially sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk-adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits; health benefit settlement expenses; administrative expenses; the cost of capital, and government-mandated assessments, fees, and taxes."

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of Louisiana. The "actuarially sound" capitation rates that are associated with this certification are effective for state fiscal year 2026.

The "actuarially sound" capitation rates are based on a projection of future events. Actual experience may be expected to vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State and DBPMs. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

I acknowledge that LDH may elect to amend the capitation rates in accordance with 42 CFR 438.7(c)(3), which indicates that a capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. The capitation rates developed may not be appropriate for any specific dental health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

I acknowledge the unique nature of the COVID-19 Public Health Emergency and the anticipated resumption of redeterminations and terminations of coverage that will occur during the rating period. The assumptions documented in this certification report reflect information known to us at the time of this report. I acknowledge that the resumption of redeterminations and enrollment unwinding period could have a material impact on utilization, acuity, Medicaid enrollment, service delivery, and other factors related to the capitation rates illustrated in this rate certification.

Chris Pettit, FSA
Member, American Academy of Actuaries

December 15, 2025
Date

APPENDIX 2: RATE DEVELOPMENT

Louisiana Department of Health
Managed Care Dental Capitation Rate Development
July 1, 2025 to June 30, 2026

	LaCHIP Affordable Plan	Medicaid Adult	Medicaid Child/CHIP	Medicaid Expansion Adult	Medicaid Expansion Child	Act 450	Adult ICF/IID	Composite
Projected Member Months (SFY 2026)	53,500	2,897,300	8,593,100	5,833,600	535,100	140,000	41,800	18,094,400
Base Claims PMPM	$ 26.06	$ 0.88	$ 21.38	$ 0.81	$ 19.46	$ 2.49	$ 1.42	$ 11.23
True-Up	1.0469	1.0971	1.0307	1.0597	1.0345	1.1845	2.9450	
IBNR Completion Adjustment	1.0103	1.0200	1.0112	1.0188	1.0116	1.0124	1.0102	
Adjusted Base Claims PMPM	$ 27.56	$ 0.98	$ 22.29	$ 0.88	$ 20.37	$ 2.99	$ 4.24	$ 11.74
Sealant Utilization Adjustment	1.0130	1.0000	1.0095	1.0000	1.0093	1.0000	1.0002	
Trend	1.0606	1.0606	1.0606	1.0606	1.0606	1.0606	1.0606	
Projected SFY 2026 PMPM Benefit Expense	$ 29.62	$ 1.04	$ 23.86	$ 0.93	$ 21.80	$ 3.17	$ 4.50	$ 12.57
Administrative Expense PMPM	$ 3.37	$ 0.12	$ 2.71	$ 0.11	$ 2.48	$ 0.36	$ 0.51	$ 1.43
Profit/Surplus PMPM	0.67	0.02	0.54	0.02	0.50	0.07	0.10	$ 0.29
Premium Tax PMPM	0.77	0.03	0.62	0.02	0.57	0.08	0.12	$ 0.33
Proposed SFY 2026 PMPM Capitation Rate	**$ 34.43**	**$ 1.21**	**$ 27.74**	**$ 1.08**	**$ 25.35**	**$ 3.68**	**$ 5.23**	**$ 14.61**
SFY 2025 Capitation Rate	$ 25.62	$ 1.43	$ 24.87	$ 1.12	$ 19.77	$ 3.06	$ 1.96	$ 13.09
Rate Change	34.4%	(15.4%)	11.5%	(3.6%)	28.2%	20.3%	166.8%	11.6%
State Directed Payment	$ 0.22	$ 0.00	$ 1.39	$ 0.00	$ 0.44	$ 0.12	$ 0.01	$ 0.67
Premium Tax PMPM	$ 0.01	$ 0.00	$ 0.03	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.02
Proposed SFY 2026 PMPM Total Expected Payments	**$ 34.66**	**$ 1.21**	**$ 29.16**	**$ 1.08**	**$ 25.80**	**$ 3.80**	**$ 5.24**	**$ 15.30**
January 2025 PMPM Total Expected Payments	$ 26.39	$ 1.43	$ 27.62	$ 1.12	$ 20.67	$ 3.29	$ 1.97	$ 14.42
Rate Change	31.3%	(15.1%)	5.6%	(3.2%)	24.8%	15.4%	166.1%	6.1%

APPENDIX 3: ACTUARIAL COST MODELS

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: LaCHIP Affordable Plan

Member Months: 40,256

	Claims Experience		
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**
Class I			
Fluoride	844.2	$ 28.52	$ 2.01
Lab and Other Tests	-	-	-
Oral Evaluations	1,029.6	39.99	3.43
Prophylaxis	925.3	54.00	4.16
Sealants	419.1	36.21	1.26
X-Rays	979.8	34.84	2.85
Other Preventive	65.3	71.56	0.39
Class I Subtotal	*4,263.3*	*$ 39.69*	*$ 14.10*
Class II			
Anesthesia	212.8	$ 74.23	$ 1.32
Emergency (Palliative)	-	-	-
Endodontics	39.6	225.73	0.75
Oral Surgery	2.1	268.73	0.05
Periodontics	-	-	-
Restorations	446.8	137.78	5.13
Simple Extractions	82.9	102.00	0.70
Space Maintainers	4.2	188.36	0.07
Surgical Extractions	58.1	302.24	1.46
Other Restorative	8.0	181.94	0.12
Class II Subtotal	*854.6*	*$ 134.73*	*$ 9.60*
Class III			
Bridges	-	$ 0.00	$ 0.00
Dentures	-	-	-
Inlays/Onlays/Crowns	112.7	229.78	2.16
Occlusal Adjustments	-	-	-
Occlusal Guards	1.5	473.96	0.06
Repair (Simple)	0.3	79.00	0.00
Other Prosthetics	0.3	375.00	0.01
Class III Subtotal	*114.8*	*$ 232.93*	*$ 2.23*
Miscellaneous Services	17.3	$ 95.29	$ 0.14
Total	**5,250.0**	**$ 59.57**	**$ 26.06**

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: Medicaid Adult

Member Months: 3,103,745

	Claims Experience		
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**
Class I			
Fluoride	0.0	$ 26.98	$ 0.00
Lab and Other Tests	-	-	-
Oral Evaluations	5.2	58.65	0.03
Prophylaxis	0.0	57.72	0.00
Sealants	-	-	-
X-Rays	2.2	59.91	0.01
Other Preventive	1.5	196.93	0.03
Class I Subtotal	*9.0*	*$ 82.40*	*$ 0.06*
Class II			
Anesthesia	0.0	$ 169.83	$ 0.00
Emergency (Palliative)	-	-	-
Endodontics	-	-	-
Oral Surgery	-	-	-
Periodontics	0.0	117.41	0.00
Restorations	0.0	111.30	0.00
Simple Extractions	0.1	95.23	0.00
Space Maintainers	-	-	-
Surgical Extractions	0.0	115.93	0.00
Other Restorative	-	-	-
Class II Subtotal	*0.1*	*$ 108.12*	*$ 0.00*
Class III			
Bridges	-	$ 0.00	$ 0.00
Dentures	11.2	809.82	0.75
Inlays/Onlays/Crowns	-	-	-
Occlusal Adjustments	-	-	-
Occlusal Guards	-	-	-
Repair (Simple)	0.9	143.74	0.01
Other Prosthetics	1.7	355.16	0.05
Class III Subtotal	*13.8*	*$ 709.25*	*$ 0.82*
Miscellaneous Services	0.0	$ 106.18	$ 0.00
Total	**23.0**	**$ 459.06**	**$ 0.88**

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: Medicaid Child/CHIP

Member Months: 8,736,856

Dental Service Category	Claims Experience Units/1,000	Cost per Service	PMPM
Class I			
Fluoride	599.0	$ 28.87	$ 1.44
Lab and Other Tests	0.0	62.48	0.00
Oral Evaluations	737.9	41.49	2.55
Prophylaxis	644.4	53.01	2.85
Sealants	273.5	36.23	0.83
X-Rays	705.5	35.70	2.10
Other Preventive	21.6	213.77	0.39
Class I Subtotal	*2,981.9*	*$ 40.84*	*$ 10.15*
Class II			
Anesthesia	167.0	$ 70.47	$ 0.98
Emergency (Palliative)	0.2	74.07	0.00
Endodontics	58.3	206.65	1.00
Oral Surgery	2.0	263.76	0.04
Periodontics	0.6	143.31	0.01
Restorations	371.8	136.18	4.22
Simple Extractions	84.0	102.55	0.72
Space Maintainers	3.7	216.71	0.07
Surgical Extractions	40.9	281.90	0.96
Other Restorative	10.1	180.79	0.15
Class II Subtotal	*738.7*	*$ 132.49*	*$ 8.16*
Class III			
Bridges	-	$ 0.00	$ 0.00
Dentures	0.1	780.97	0.00
Inlays/Onlays/Crowns	147.4	232.42	2.86
Occlusal Adjustments	0.0	114.82	0.00
Occlusal Guards	0.6	466.64	0.02
Repair (Simple)	0.6	84.10	0.00
Other Prosthetics	0.2	610.63	0.01
Class III Subtotal	*148.9*	*$ 233.54*	*$ 2.90*
Miscellaneous Services	20.8	$ 104.38	$ 0.18
Total	**3,890.4**	**$ 65.96**	**$ 21.38**

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: Medicaid Expansion Adult

Member Months: 6,393,390

	Claims Experience		
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**
Class I			
Fluoride	0.0	$ 29.64	$ 0.00
Lab and Other Tests	-	-	-
Oral Evaluations	4.6	61.16	0.02
Prophylaxis	0.0	47.41	0.00
Sealants	-	-	-
X-Rays	8.3	63.14	0.04
Other Preventive	1.8	194.45	0.03
Class I Subtotal	*14.7*	*$ 78.42*	*$ 0.10*
Class II			
Anesthesia	-	$ 0.00	$ 0.00
Emergency (Palliative)	-	-	-
Endodontics	-	-	-
Oral Surgery	-	-	-
Periodontics	-	-	-
Restorations	0.0	97.99	0.00
Simple Extractions	3.8	87.12	0.03
Space Maintainers	-	-	-
Surgical Extractions	1.8	118.63	0.02
Other Restorative	-	-	-
Class II Subtotal	*5.6*	*$ 97.00*	*$ 0.05*
Class III			
Bridges	-	$ 0.00	$ 0.00
Dentures	9.2	810.95	0.62
Inlays/Onlays/Crowns	-	-	-
Occlusal Adjustments	-	-	-
Occlusal Guards	-	-	-
Repair (Simple)	0.6	145.88	0.01
Other Prosthetics	1.3	358.94	0.04
Class III Subtotal	*11.1*	*$ 723.12*	*$ 0.67*
Miscellaneous Services	-	$ 0.00	$ 0.00
Total	**31.4**	**$ 309.93**	**$ 0.81**

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: Medicaid Expansion Child

Member Months: 537,205

	Claims Experience		
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**
Class I			
Fluoride	117.6	$ 28.89	$ 0.28
Lab and Other Tests	0.1	64.22	0.00
Oral Evaluations	416.4	39.30	1.36
Prophylaxis	313.2	64.32	1.68
Sealants	108.1	34.48	0.31
X-Rays	456.3	42.88	1.63
Other Preventive	31.8	179.92	0.48
Class I Subtotal	*1,443.5*	*$ 47.75*	*$ 5.74*
Class II			
Anesthesia	154.8	$ 99.45	$ 1.28
Emergency (Palliative)	0.3	61.98	0.00
Endodontics	35.9	494.39	1.48
Oral Surgery	1.6	206.38	0.03
Periodontics	2.3	128.37	0.03
Restorations	414.1	155.13	5.35
Simple Extractions	11.6	105.88	0.10
Space Maintainers	0.0	205.13	0.00
Surgical Extractions	188.1	268.81	4.21
Other Restorative	28.9	181.23	0.44
Class II Subtotal	*837.6*	*$ 185.09*	*$ 12.92*
Class III			
Bridges	0.0	$ 828.68	$ 0.00
Dentures	0.4	854.69	0.03
Inlays/Onlays/Crowns	21.7	324.79	0.59
Occlusal Adjustments	0.0	100.00	0.00
Occlusal Guards	3.2	469.32	0.12
Repair (Simple)	0.3	104.14	0.00
Other Prosthetics	0.5	554.75	0.02
Class III Subtotal	*26.1*	*$ 352.05*	*$ 0.77*
Miscellaneous Services	6.9	$ 54.47	$ 0.03
Total	**2,314.1**	**$ 100.92**	**$ 19.46**

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: Act 450

Member Months: 137,784

	Claims Experience		
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**
Class I			
Fluoride	24.7	$ 28.52	$ 0.06
Lab and Other Tests	-	-	-
Oral Evaluations	65.5	40.15	0.22
Prophylaxis	52.4	62.39	0.27
Sealants	0.6	34.54	0.00
X-Rays	51.8	43.26	0.19
Other Preventive	12.4	140.06	0.14
Class I Subtotal	*207.5*	*$ 51.10*	*$ 0.88*
Class II			
Anesthesia	14.1	$ 114.54	$ 0.13
Emergency (Palliative)	0.1	79.43	0.00
Endodontics	1.6	393.84	0.05
Oral Surgery	0.6	260.55	0.01
Periodontics	2.6	151.20	0.03
Restorations	42.4	152.11	0.54
Simple Extractions	22.7	92.62	0.18
Space Maintainers	-	-	-
Surgical Extractions	10.2	187.11	0.16
Other Restorative	1.4	172.08	0.02
Class II Subtotal	*95.7*	*$ 141.02*	*$ 1.12*
Class III			
Bridges	-	$ 0.00	$ 0.00
Dentures	4.3	838.90	0.30
Inlays/Onlays/Crowns	3.4	357.50	0.10
Occlusal Adjustments	-	-	-
Occlusal Guards	0.3	473.96	0.01
Repair (Simple)	0.3	65.15	0.00
Other Prosthetics	0.9	332.30	0.02
Class III Subtotal	*9.2*	*$ 571.02*	*$ 0.44*
Miscellaneous Services	13.1	$ 40.23	$ 0.04
Total	**325.5**	**$ 91.85**	**$ 2.49**

Louisiana Department of Health
SFY 2026 Dental Capitation Rate Setting
CY 2024 Base Experience

Rate Cell: Adult ICF/IID

Member Months: 42,458

	Claims Experience		
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**
Class I			
Fluoride	33.6	$ 26.73	$ 0.07
Lab and Other Tests	-	-	-
Oral Evaluations	0.3	64.13	0.00
Prophylaxis	55.4	64.91	0.30
Sealants	0.3	34.54	0.00
X-Rays	7.1	21.20	0.01
Other Preventive	31.7	164.74	0.43
Class I Subtotal	*128.3*	*$ 77.05*	*$ 0.82*
Class II			
Anesthesia	1.7	$ 109.78	$ 0.02
Emergency (Palliative)	-	-	-
Endodontics	-	-	-
Oral Surgery	-	-	-
Periodontics	0.8	117.41	0.01
Restorations	19.8	168.34	0.28
Simple Extractions	12.2	102.20	0.10
Space Maintainers	-	-	-
Surgical Extractions	2.3	215.22	0.04
Other Restorative	-	-	-
Class II Subtotal	*36.7*	*$ 145.47*	*$ 0.45*
Class III			
Bridges	-	$ 0.00	$ 0.00
Dentures	1.7	823.34	0.12
Inlays/Onlays/Crowns	-	-	-
Occlusal Adjustments	-	-	-
Occlusal Guards	-	-	-
Repair (Simple)	-	-	-
Other Prosthetics	0.8	290.17	0.02
Class III Subtotal	*2.5*	*$ 645.62*	*$ 0.14*
Miscellaneous Services	5.4	$ 41.19	$ 0.02
Total	**173.0**	**$ 98.83**	**$ 1.42**

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