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: 12

Vendor: MCNA INSURANCE COMPANY

Description: MCNA Insurance Co

Approved By: PAMELA RICE

Approval Date: 06/03/2024 16:10:32

AMENDMENT TO
AGREEMENT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

MVA
(Regional/ Program/ Facility)

Medical Vendor Administration

Bureau of Health Services Financing

AND

MCNA Insurance Company, d/b/a MCNA Dental
Contractor Name

Amendment #: 12
LAGOV#: 2000506243
LDH #:
Original Contract Amount
Original Contract Begin Date 01-01-2021
Original Contract End Date 12-31-2023
RFP Number: 3000013043

AMENDMENT PROVISIONS

Change Contract From: Current Maximum Amount: Current Contract Term: 1/1/2021 - 12/31/2025

Attachment B - Statement of Work
Attachment D8 - Rate Certification Effective 7.1.2023 - 6.30.2024

Change Contract To: If Changed, Maximum Amount: If Changed, Contract Term: N/A

Amd 12 Attachment B12 – Changes to Attachment B, Statement of Work
Attachment D12 - Rate Certification Effective 7.1.2023 - 6.30.2024

Justifications For Amendment:

Revisions contained in this amendment are within scope and comply with the terms and conditions as set forth in the RFP.

This amendment provides the standard mid-year update to the SFY24 rate certification, revises the Statement of Work to establish a process for the unauthorized use of PHI, and clarifies the definitions of "rural" and "urban."

This Amendment Becomes Effective: 07-01-2023

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

MCNA Insurance Company, d/b/a MCNA Dental

DocuSigned by: [signature]

CONTRACTOR SIGNATURE — DATE: 5/5/2024

PRINT NAME: Tom Wiffler

CONTRACTOR TITLE: CEO

STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Secretary, Louisiana Department of Health or Designee

SIGNATURE: DocuSigned by: Kimberly Sullivan 6F18D2F97367420... — DATE: 5/9/2024

NAME: Kimberly Sullivan

TITLE: Medicaid Executive Director

OFFICE: Louisiana Department of Health

PROGRAM SIGNATURE — DATE

NAME

LOUISIANA DEPARTMENT OF HEALTH

DBPM Amendment 12
Attachment B12 – Changes to Attachment B, Statement of Work

Item	Change From	Change To	Justification
1	**[new provisions]**	2.1.5 HIPAA Disclosure Process 2.1.5.1 The Contractor and its subcontractors shall protect confidential information and documents in accordance with the terms of the contract between LDH and Contractor, including the Business Associate Agreement, and in compliance with applicable laws. The Contractor shall disclose in writing any use or disclosure of Protected Health Information (PHI) by Contractor or any of its subcontractors other than as permitted by the Contract within forty-eight (48) hours of becoming aware of the use or disclosure. 2.1.5.2 The Contractor is required to make Breach reports as required by the Business Associate Agreement affecting Enrollees receiving services to LDH with a CAP and timelines for implementation of correction for approval by LDH within ten (10) Business Days of the Contractor's discovery of any HIPAA Breaches, as defined at 45 CFR §164.402, that are committed by Contractor or any of its subcontractors. The Breach report shall include, at a minimum: 2.1.5.2.1 Date of Discovery (as such term is defined under HIPAA). 2.1.5.2.2 Date or date range of violation/potential violation. 2.1.5.2.3 Cause of the incident including sequence and mechanisms. 2.1.5.2.4 Number of unauthorized individuals who viewed PHI. 2.1.5.2.5 Number of affected individuals whose PHI was compromised. 2.1.5.2.6 Steps taken to correct this incident to date, and planned steps to correct incident. 2.1.5.2.7 Steps taken to prevent reoccurrence from happening in the future.	This revision establishes a process for the unauthorized use or disclosure of PHI.

		2.1.5.2.8 Steps taken to mitigate any harmful effects caused by the unauthorized disclosure. 2.1.5.2.9 Any training or other corrective action implemented by the Contractor. 2.1.5.2.10 Plans for notification of CMS/HHS, if required by law. 2.1.5.2.11 Notification plan to individuals. 2.1.5.2.12 A risk assessment which includes the following: 2.1.5.2.12.1 The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification. 2.1.5.2.12.2 The unauthorized person who used the PHI or to whom the disclosure was made, if known. 2.1.5.2.12.3 Whether the PHI was actually acquired or viewed. 2.1.5.2.12.4 The extent to which the risk to the PHI has been mitigated. **[subsequent provisions renumbered]**	
2	**[new provision]**	2.13.8.11 The Contractor's personnel shall comply with all security regulations in effect at the State's premises, the Information Security Policy at https://www.doa.la.gov/doa/ots/policies-and-forms/ and externally for materials and property belonging to the State or to the project. Where special security precautions are warranted, the State shall provide such procedures to the Contractor, accordingly. The Contractor is responsible for reporting to the State any known Data Breach or Security Event, as defined in the OTS Information Security Policy, no later than forty-eight (48) hours after confirmation of the event. The Contractor shall notify the Information Security Team ("IST") by calling the Information Security Hotline at 1-844-692-8019 and emailing the security team at infosecteam@la.gov.	This language is required by the Office of Technology Services (OTS) Information Security Team.
3	**7.1 Glossary** **…**	**7.1 Glossary** **…**	This revision defines urban vs. rural areas to align with the Medicare program definition (42 CFR §412.62).

	Rural Area	Any parish that meets the federal Office of Management and Budget definition of rural.	Rural Area	Any area outside an urban area. ~~parish that meets the federal Office of Management and Budget definition of rural.~~	
	…		…		
	Urban Area	Any parish that meets the federal Office of Planning and Budget definition of urban.	Urban Area	~~Any parish that meets the federal Office of Planning and Budget definition of urban.~~ A Metropolitan Statistical Area (MSA), as defined by the Executive Office of Management and Budget and applied to Census Bureau data. The most recent delineation files and maps are located at https://www.census.gov.	

MILLIMAN CLIENT REPORT

State Fiscal Year 2024 Louisiana Medicaid Dental Managed Care Capitation Rate Certification

State of Louisiana Department of Health

December 4, 2023

Chris Pettit, FSA, MAAA, Principal and Consulting Actuary
Anders Larson, FSA, MAAA, Principal and Consulting Actuary
Zach Fohl, FSA, MAAA, Consulting Actuary

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) 2024 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 2023-2024 Medicaid Managed Care Rate Development Guide, finalized by the Centers for Medicare and Medicaid Services in May 2023 (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 DCOS AND PAYMENT METHODOLOGY

The following dental managed care organizations (DCOs) participate in the Medicaid dental managed care program on a statewide basis during SFY 2024:

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

Each DCO 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, 2023 through June 30, 2024 (SFY 2024). The rates for the January to June 2023 time period are inclusive of Full Medicaid Pricing (FMP) amounts. The composite rates illustrated for SFY 2024 have been developed based on an estimate of projected enrollment in SFY 2024. The January 2023 capitation rates are consistent with the following documents:

- *Louisiana Medicaid Dental Benefit Program Capitation Rate Certification*, dated December 21, 2022

FIGURE 1: COMPARISON WITH JANUARY 2023 PMPM RATES

POPULATION	PROJECTED SFY 2024 AVERAGE MONTHLY ENROLLMENT	JANUARY 2023	SFY 2024	% CHANGE
LaCHIP Affordable Plan	1,800	$ 26.82	$ 20.38	(24.0%)
Medicaid Adult	302,500	$ 1.63	$ 1.39	(14.5%)
Medicaid Child/CHIP	815,800	$ 22.08	$ 23.14	4.8%
Medicaid Expansion Adult	660,700	$ 1.04	$ 0.97	(7.1%)
Medicaid Expansion Child	79,900	$ 18.90	$ 11.11	(41.2%)
Act 450	50	$ 23.98	$ 24.83	3.5%
Adult ICF/IID	50	$ 17.72	$ 18.34	3.5%
Composite	**1,860,800**	**$ 11.15**	**$ 11.21**	**0.5%**

Notes: 1. January 2023 and SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment.
2. Monthly enrollment values are rounded.

Figure 2 compares the estimated federal and state expenditures under the SFY 2024 rates, based on estimated enrollment in SFY 2024. Revenue shown in Figure 2 includes FMP amounts for January to June 2023.

FIGURE 2: COMPARISON WITH JANUARY 2023 RATES (AGGREGATE EXPENDITURES $ MILLIONS)

POPULATION	JANUARY 2023	TOTAL DCO EXPECTED PAYMENTS SFY 2024	CHANGE
LaCHIP Affordable Plan	$ 0.6	$ 0.4	($ 0.1)
Medicaid Adult	$ 5.9	$ 5.1	($ 0.9)
Medicaid Child/CHIP	$ 216.2	$ 226.6	$ 10.4
Medicaid Expansion Adult	$ 8.2	$ 7.7	($ 0.6)
Medicaid Expansion Child	$ 18.1	$ 10.7	($ 7.5)
Act 450	$ 0.0	$ 0.0	$ 0.0
Adult ICF/IID	$ 0.0	$ 0.0	$ 0.0
Composite	$ 249.0	$ 250.4	$ 1.4
Federal	174.2	173.3	(0.9)
State	74.8	77.1	2.2

Notes:
1. January 2023 and SFY 2024 composite rates were developed based on SFY 2024 projected monthly enrollment.
2. State expenditures based on Federal Fiscal Year (FFY) 2023 FMAP of 67.28% for 3 months and FFY 2024 FMAP of 67.67% for 9 months for all except the Expansion population. FMAP values do not include CHIP enhanced FMAP or additional FFCRA-related enhanced FMAP during the phase-out period ending December 31, 2023.
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 and CMS-2408-F) for the provisions effective for the SFY 2024 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 dental health plan. An individual dental health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The dental 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 dental health plan 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, 2023, through June 30, 2024.

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 2024 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 DCOs. These rates represent the contracted capitation rates that will be paid to the DCOs. Projected member months illustrated in Appendix 2 represent estimated values for SFY 2024.

(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 managed care organizations participating in the Louisiana dental program on a statewide basis:

- MCNA
- DentaQuest

Each DCO 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, 2023, through June 30, 2024.

(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. No credible historical experience was available from the CY 2022 time period based on submitted encounter data.

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 2024 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 2024 contracted capitation rates.

vii. Minimum medical loss ratio

The capitation rates were developed such that the DCOs 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 population 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 2024 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, 2023, through June 30, 2024.

xii. COVID-19 public health emergency

Please see Section 1, subsection 1.B.x for details on rate adjustments related to the COVID-19 public health emergency (PHE).

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 DCOs.

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 DCOs. 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. 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.

iv. Requirements for a certified capitation rate range

This certification does not include rate ranges.

v. 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.

vi. 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.

vii. 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 77.10% during federal fiscal year (FFY) 2023.

Capitated payments made for the Medicaid Expansion population receive an FMAP rate of 90.0% during SFY 2024. All other capitated payments made receive the regular state FMAP of 67.28% for FFY 2023 and 67.67% for FFY 2024. 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. The FMAP enhancement available following the end of the COVID-19 PHE is also not reflected in values provided in this certification.

viii. Comparison to prior rates

(a) Comparison to prior rates

Figures 1 and 2 above provide a summarized comparison of the SFY 2024 capitation rates to the prior rates for January to June 2023. Comparisons at the rate cell level are provided in Appendix 2.

The following are the key drivers of the rate changes:

- New base period benefit expenses
- Minimum fee schedule implementation
- Removal of Full Medicaid Pricing (FMP)

(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).

ix. 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.

x. COVID-19

We considered the impact of COVID-19 on the estimated utilization and service mix for the covered population in SFY 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 based on anticipated disenrollment during SFY 2024. We note that there continues to be uncertainty related to the impact of COVID-19 on capitation rates, but we have not made an explicit adjustment to the benefit expense for purposes of the SFY 2024 rate development.

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

For the base data summaries, calendar year 2022 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 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. Also directly accounted for is changes in utilization patterns as a result of the COVID-19 pandemic by utilizing CY 2022 as the base data period. The CY 2022 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 2024 experience for these rate cells.

The base data was adjusted to reflect estimated changes between the base data period and SFY 2024. Specifically, we estimated that dental service utilization in the first part of CY 2022 was slightly lower than emerging experience in the remaining months of CY 2022. While we have not opted to make a specific utilization adjustment, we did select a higher prospective utilization trend in developing projected utilization for SFY 2024.

We reviewed the potential 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. At this time we have opted not to make an acuity adjustment for the dental managed care program. We estimated the enrollment changes will not have a material impact on the overall acuity of the population for purposes of SFY 2024 capitation rate development, but will monitor emerging experience related to disenrollment and resulting utilization.

(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 2024 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 2024 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 2024 capitation rate development utilized the following data sources:

- Historical eligibility files provided by LDH
- Encounter data submitted by the participating DCOs
- LDH fee schedules applicable to services affected by reimbursement changes
- Financial reporting templates submitted by the DCOs
- Historical rate development for certain populations

The capitation rates for most populations were developed from historical CY 2022 claims and enrollment data from the managed care enrolled populations. We used utilization and expenditures from the encounter data with runout through February 2023. We applied an adjustment to complete and true-up the expenditures to the level reported in the DCO reported information. This adjustment is described in more detail in Section I, subsection 2.B.iii.

(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 2022 (claims runout through February 2023). We used encounter data corresponding to the same time period for the purposes of evaluating the impact of policy and program adjustments.

For the purposes of trend development, we reviewed monthly DCO financial data experience on an incurred basis over the period from January 2021 through December 2022. Judgment was applied when reviewing the data due to disruptions related to the COVID-19 pandemic.

(iii) Data sources

Capitation payment and eligibility information

In a series of transmissions during January through March 2023, we received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2019 through February 2023. After this initial data transfer, we established a process to receive updated MMIS data on a monthly basis.

DCO encounter data

We received DCO 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 2023.

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 DCO was requested to complete a financial reporting template. The recent submission includes data paid through December 2022. Utilization and expenditures were reported by each DCO 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 2024 rate development.

Historical rate development for Act 450 and adult ICF/IID

We utilized the currently contracted rates for the Act 450 and Adult ICF/IID rate cells due to the lack of historical experience for these populations. The current rates were previously developed and certified based on a review of experience for adults in other states' programs. Although the rate cell for the Act 450 population became effective on July 1, 2022, there were no exposure units identified in the encounter data and no reported member months in the financial reports submitted by the DCOs. The rate cell for the Adult ICF/IID population became effective May 1, 2023.

(iv) Sub-capitation

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

(b) Availability and quality of the data

(i) Steps taken to validate the data

In a series of transmissions during January through March 2023, we received eligibility and enrollment extracts from the State's Medicaid Management Information System (MMIS) for encounters, fee-for-service claims, and eligibility data from January 2019 through February 2023. The actuary, the DCOs, 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 DCOs play the initial role, collecting and summarizing data sent to the State. In addition, LDH focuses on encounter data quality and DCO 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

We first validated that we had received complete transmissions by comparing summarized values to control totals provided by the state's fiscal agent contractor (FAC). After processing the data, we compared aggregate encounter claims dollars for each DCO to values in the Encounter Data Reconciliation Reports[2] produced by Myers and Stauffer, on behalf of LDH.

Accuracy

DCO encounter data was reviewed relative to utilization and expenditures reported in the financial reports provided by the DCOs. 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.

[2] https://ldh.la.gov/page/4371

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. Through the data validation process, we identified minor inconsistencies in reported data across sources. We addressed these deviations through the data completion factors.

(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 DCOs. The values presented in this report are dependent upon this reliance.

We find the data used to develop the SFY 2024 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 2024 certified rates is reasonably consistent with the reported financial experience of DCOs.

(iii) Data concerns

Minor data adjustments were made to the data submitted by the DCOs to account for various issues identified during the review process.

Additionally, we utilized historical rate development for the Act 450 and Adult ICF/IID populations due to the absence of credible experience in the encounter data due to timing of coverage for these populations.

(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 2022 was used as base experience in the rate development for most populations.

(d) Reliance on a data book

We did not rely on a data book for the SFY 2024 capitation rate development, but we did utilize historical rates for the Act 450 and Adult ICF/IID populations to establish rates for these rate cells in SFY 2024.

iii. Data adjustments

The capitation rates were developed from CY 2022 experience reported in managed care encounter data for most rate cells. Adjustments made to the base experience are noted below.

(a) Credibility adjustment

The Act 450 and Adult ICF/IID rate cells had no enrollment or experience that could be utilized to serve as the base experience in developing capitation rates for SFY 2024. We determined we did not have sufficient historical data for these populations to use for establishing capitation rates. Instead, we utilized the previously certified rates and applied prospective trend.

(b) Completion adjustment

The capitation rates are based on CY 2022 DCO experience. In the DCO financial reports, DCOs were requested to provide monthly incurred but not paid (IBNP) estimates by population.

We analyzed reported DCO claims completion for reasonableness. We adjusted the IBNP estimates to reflect a 4.0% composite completion adjustment.

The impact of applying the claim completion factors can be found in Appendix 2 of this report. Please note that completion was applied subsequent to the fee schedule re-pricing exercise.

(c) Errors found in the data

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

(d) Program change adjustments

Dental fee schedule

For the SFY 2024 rates, an adjustment was added to reflect the impact of the recently implemented minimum dental fee schedule directed payment. The dental plans are required to pay for covered services at an amount no less than the rates on the published Medicaid dental fee schedule at the time of service. This fee schedule, listed by dental procedure code in Appendix 4, is set to be effective July 1, 2023. To model this reimbursement change, we developed multiplicative adjustment factors by repricing all applicable claims in our base experience under the new fee schedule.

Multiplicative adjustment factors were developed by measuring the change in repriced amounts between the historical encounter data and the new fees. The impact of the fee schedule adjustment by rate cell is listed in Appendix 3. Figure 3 provides a more detailed breakdown of the fee schedule adjustment by class of service

FIGURE 3: FEE SCHEDULE ADJUSTMENT

POPULATION	CLASS I	CLASS II	CLASS III	COMPOSITE
LaCHIP Affordable Plan	1.3437	1.3622	1.7037	1.3617
Medicaid Adult	1.4731	1.3977	1.6974	1.6748
Medicaid Child/CHIP	1.3410	1.3322	1.6936	1.3779
Medicaid Expansion Adult	1.5961	1.9753	1.7000	1.7038
Medicaid Expansion Child	1.3338	1.2852	1.5377	1.3090
Composite	1.3424	1.3306	1.6938	1.3879

Note that a fee schedule adjustment was not applied to the Act 450 and Adult ICF/IID rate cells due to the absence of historical claims experience utilized in the rate development process.

Removal of Full Medicaid Pricing

Historical capitation rates for the Louisiana Medicaid dental program incorporated a program change to increase payments for dental services through the use of a full Medicaid pricing (FMP) adjustment. The adjustment factors represented increases to the base claims experience based on the difference between historical experience and dental community rates. The payments to providers were made on a retrospective basis. The application of these adjustments have been removed with the implementation of the fee schedule adjustment described above. The January 2023 rates for the Act 450 and Adult ICF/IID populations reflect an assumed relativity for FMP. It was determined that maintaining the value of the FMP adjustment for these populations was appropriate based on a review of the fee schedule adjustments in relation to the prior FMP adjustments for the populations with access to comprehensive dental coverage. The FMP adjustments utilized in the prior rating period were approximately a 35-40% increase to the base claims experience, which is consistent with the fee schedule adjustments in the SFY 2024 rate development.

(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 DCOs 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

For most populations, the capitation rates were developed from historical CY 2022 claims and enrollment data.

We used utilization and expenditures from the encounter data with runout through February 2023. 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. We reviewed the allocation of costs by rate cell relative to encounter data for each DCO and their submitted financial reports.

Claims experience was summarized on a rate cell basis, with rate cell assignment based on SFY 2024 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 2024

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 2024 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 2024

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, 2022) to the midpoint of the rate period (January 1, 2024). The trends applied to the Act 450 and Adult ICF/IID populations were only for 9 months based on the current rates being effective from January to June 2023 (midpoint of April 1, 2023).

An additional adjustment of 1.0% was applied when adjusting CY 2022 experience to the SFY 2024 rating period. This adjustment represents an estimate for induced utilization due to the implementation of the dental fee schedule. Although the increase to reimbursement under the fee schedule is projected to be relatively similar with historical FMP contractual payments, the fee schedule is more transparent and is anticipated to lead to higher utilization.

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

Material changes to the data and methodologies for this rate development in comparison to the prior rate development include:

- Use of base experience period that is closer to the rating period. This change was made due to having experience that is expected to be void of material disruptions to utilization patterns caused by COVID-19.

All material assumptions are documented in this rate certification report.

(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. Note, trend rates do not reflect any specific considerations in population acuity due to the PHE unwinding, but we have considered a higher prospective trend rate based on emerging experience from the first quarter of CY 2022 compared to the most recent experience.

(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 the base experience data period (CY 2022).

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 2024 capitation rates. Based on a review of the historical experience we selected a composite 3.31% annualized utilization trend for all services, reflected as a 5% trend over 18 months.

We have not applied a cost per service trend for the SFY 2024 dental capitation rates based on the implementation of the new fee schedule effective July 1, 2023.

(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 all recent or planned changes in benefits and 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 Healthy Louisiana program.

(b) Required elements

As noted above, a 3.31% annual utilization trend was applied to historical experience with no cost per service trend component.

(c) Variation

We evaluated historical trend patterns by population and major class of service. It was determined that the patterns reflected in the Medicaid Child/CHIP population represented the most credible source for development of prospective trend assumptions. We observed significant variation across other rate cells due to the limited set of services and smaller enrollment. The trend rate assumptions outlined in the previous section were applied to all populations consistently.

(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 Healthy Kids 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) DCO responsibility

During the base period, DCOs were responsible for periods of retroactive eligibility of up to 12 months. DCO 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 DCO base data.

(c) Enrollment treatment

Enrollment is treated consistently with claims.

(d) Adjustments

It was not necessary to make any adjustments to the DCO 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 to June 2023 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.

ii. Appropriate documentation

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

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 explicit 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 DCOs 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, 2023.

Financial consequences

If an DCO 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 DCOs 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 2024 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.

(b) Approval by CMS and consistency with preprints

The directed payment program is a minimum fee schedule using State plan approved rates and therefore does not require a preprint..

(c) Contract arrangements with MCOs

The contract which direct DCO'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 as adjustments in the rate development for reimbursement changes effective July 1, 2023 as described in the Section 1, Subsection 2.B.iii.d.

The minimum fee schedule does not represent a separate payment term.

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 4 below.

FIGURE 4: 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

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 these directed payments.

DCOs are required to contract at or above the state plan fee schedule for the dental services as noted in Appendix 4 of this certification report.

(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 5 below, with more description following the table.

FIGURE 5: 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	Approximately $55 million	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 incorporated through a program change adjustment, described in Section 1, subsection 2.B.iii.d.

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

There are no payment arrangements incorporated as a separate payment term.

(b) Additional directed payments not addressed in the certification

There are not any additional directed payments in the dental managed care program that are not addressed in this certification.

(c) Other requirements regarding reimbursement rates

There are not any additional requirements regarding the reimbursement rates the dental plans must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law, regulation, or waiver.

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 2024.

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 DCO 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 DCOs for historical time periods included reported administrative costs by DCO and served as the primary data source used in the development of the SFY 2024 non-benefit costs. Non-benefit costs were established for each population as a percentage of the of the DCO 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 DCO administrative and healthcare quality improvement (HCQI) expenses for the Medicaid dental managed care program along with national Medicaid health plan administrative expenses. We considered the size of participating dental health plans and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the managed care populations.

Risk margin. Risk margin assumptions have been maintained from the January to June 2023 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 2024, which is 85% and applied separately for the expansion and non-expansion populations to each DCO's reported experience. Under CFR 438.8, adjustments are made to each DCO's medical loss ratio calculation for quality improvement expenses (numerator) and taxes and regulatory fees (denominator).

Premium tax. The final rate is grossed up for a 2.25% premium tax.

(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 2024 non-benefit cost allowance was developed as a percentage of the DCO effective rate for each rate cell on a statewide basis. The administrative load component of the non-benefit expense adjustment is 9.0% with a 2.0% for risk margin. The 2.25% adjustment for premium tax represents a multiplicative adjustment to the fully loaded rate.

iii. Historical non-benefit cost data

We maintained the historical non-benefit cost allowance assumptions utilized in the January to June 2023 rate development following a review of the historical assumptions and DCO reported experience.

6. Risk adjustment and acuity adjustments

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 or acuity. The DCOs assume risk for the cost of services covered under the contract and incur losses if the cost of furnishing the services exceeds the payments under the contract. The capitation rates are developed based on the assumption that the risk is spread evenly across the participating DCOs given the capitation rate structure.

ii. Risk adjustment model

Not applicable.

iii. Acuity adjustments

Not applicable.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data

Not applicable.

(b) Risk adjustment model

Not applicable.

(c) Risk adjustment methodology

Not applicable.

(d) Magnitude of the adjustment

Not applicable.

(e) Assessment of predictive value

Not applicable.

(f) Any concerns the actuary has with the risk adjustment process

Not applicable.

ii. Retrospective risk adjustment

Not applicable.

iii. Risk adjustment documentation

Not applicable.

iv. Acuity adjustments

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 2024 capitation rates for the Medicaid Expansion population.

B. 2022 EXPERIENCE VS. ASSUMPTIONS

CY 2022 actual member months for the Medicaid Expansion populations were materially higher than the CY 2019 member months that were reflected in the rate certification reports for CY 2022 and utilized as base experience. As these reports were performed by a prior actuary, we do not have projected member months for CY 2022 to perform an appropriate comparison.

On an aggregate basis, using the CY 2022 managed care enrollment distribution, actual CY 2022 benefit expenses was approximately 38% below the estimated benefit expenses as documented in the respective CY 2022 rate certification reports for the Medicaid Expansion rate cells.

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 2024.

2. Projected Benefit Costs

C. DESCRIPTION OF PROJECTED BENEFIT COSTS

i. Description of projected benefit costs

(a) Experience specific to newly eligible adults

CY 2022 DCO experience for the Medicaid Expansion population comprised the underlying data used in the development of the SFY 2024 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 2022 DCO experience was used as the underlying data source in the development of the SFY 2024 capitation rates. CY 2019 DCO experience was used as the underlying data source for previous capitation rates. Other assumptions are generally consistent with the historical rate certifications.

C. DESCRIPTION OF KEY ASSUMPTIONS

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 2024 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.

D. 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.

E. 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

DCO non-benefit costs were available for CY 2022. We reviewed this information as we developed non-benefit cost assumptions as outlined in Section 1, subsection 5 of this report..

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, subsection 7 of this report. No additional risk mitigation strategies are in effect for the SFY 2024 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 2024 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 2024 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 DCOs 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 2024 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, DCO-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 DCO. 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 2024 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, 2023. 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 2024.

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 DCOs. 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 4, 2023
Date

APPENDIX 2: RATE DEVELOPMENT

Louisiana Department of Health
Managed Care Dental SFY 2024 Capitation Rate Development
July 1, 2023 to June 30, 2024

	LaCHIP Affordable Plan	Medicaid Adult	Medicaid Child/CHIP	Medicaid Expansion Adult	Medicaid Expansion Child	Act 450	Adult ICF/IID	Composite
Projected Member Months (SFY 2024)	21,800	3,629,800	9,790,100	7,928,500	959,100	50	50	22,329,300
Base Claims PMPM	$ 11.81	$ 0.66	$ 13.25	$ 0.45	$ 6.70	$ 20.80	$ 15.37	$ 6.38
Fee Adjusted PMPM	$ 16.08	$ 1.10	$ 18.26	$ 0.76	$ 8.77	$ 20.80	$ 15.37	$ 8.85
IBNR Completion Adjustment	1.0400	1.0400	1.0400	1.0400	1.0400	1.0000	1.0000	
Adjusted Base Claims PMPM	$ 16.72	$ 1.14	$ 18.99	$ 0.79	$ 9.12	$ 20.80	$ 15.37	$ 9.20
Utilization Trend	1.0500	1.0500	1.0500	1.0500	1.0500	1.0250	1.0250	
Induced Utilization Adjustment	1.0100	1.0100	1.0100	1.0100	1.0100	1.0100	1.0100	
Projected SFY 2024 PMPM Benefit Expense	$ 17.74	$ 1.21	$ 20.14	$ 0.84	$ 9.67	$ 21.54	$ 15.91	$ 9.76
Administrative Expense PMPM	$ 1.79	$ 0.12	$ 2.04	$ 0.09	$ 0.98	$ 2.23	$ 1.65	$ 0.99
Profit/Surplus PMPM	0.40	0.03	0.45	0.02	0.22	0.50	0.37	$ 0.22
Premium Tax PMPM	0.45	0.03	0.51	0.02	0.24	0.55	0.40	$ 0.25
Proposed SFY 2024 PMPM Capitation Rate	**$ 20.38**	**$ 1.39**	**$ 23.14**	**$ 0.97**	**$ 11.11**	**$ 24.83**	**$ 18.34**	**$ 11.21**
1H 2023 PMPM Capitation Rate	$ 26.82	$ 1.63	$ 22.08	$ 1.04	$ 18.90	$ 23.98	$ 17.72	$ 11.15
Rate Change	(24.0%)	(14.5%)	4.8%	(7.1%)	(41.2%)	3.5%	3.5%	0.5%

APPENDIX 3: ACTUARIAL COST MODELS

Louisiana Department of Health
Manahed Care Dental SFY 2024 Capitation Rate Development
CY 2022 Base Experience

Rate Cell: Composite

Member Months: 22,097,249

		Claims Experience		Repriced Claims	
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**	**Cost per Service**	**PMPM**
Class I					
Flouride	229.1	$ 20.67	$ 0.39	$ 27.90	$ 0.53
Lab and Other Tests	0.0	46.24	0.00	62.57	0.00
Oral Evaluations	305.9	31.34	0.80	42.34	1.08
Fluoride	264.1	39.54	0.87	53.94	1.19
Prophylaxis	72.3	28.15	0.17	34.54	0.21
X-Rays	284.9	26.37	0.63	36.54	0.87
Other Preventive	8.0	160.60	0.11	160.60	0.11
Class I Subtotal	*1,164.4*	*$ 30.57*	*$ 2.97*	*$ 41.04*	*$ 3.98*
Class II					
Anesthesia	66.4	$ 51.88	$ 0.29	$ 68.27	$ 0.38
Emergency (Palliative)	0.1	57.02	0.00	79.43	0.00
Endodontics	24.0	150.63	0.30	205.99	0.41
Oral Surgery	0.4	215.92	0.01	296.57	0.01
Periodontics	0.2	106.54	0.00	139.38	0.00
Restorations	158.4	98.96	1.31	129.04	1.70
Simple Extractions	35.2	74.75	0.22	103.46	0.30
Space Maintainers	0.0	151.52	0.00	205.13	0.00
Surgical Extractions	16.9	197.24	0.28	271.39	0.38
Other Restorative	4.0	130.38	0.04	183.49	0.06
Class II Subtotal	*305.6*	*$ 96.01*	*$ 2.45*	*$ 127.75*	*$ 3.25*
Class III					
Bridges	0.0	$ 431.29	$ 0.00	$ 731.88	$ 0.00
Dentures	5.4	489.40	0.22	831.02	0.37
Inlays/Onlays/Crowns	58.5	136.47	0.67	230.89	1.13
Repair (Simple)	0.5	70.57	0.00	125.15	0.01
Other Prosthetics	0.7	240.02	0.01	408.88	0.02
Class III Subtotal	*65.1*	*$ 166.33*	*$ 0.90*	*$ 281.72*	*$ 1.53*
Miscellaneous Services	8.3	$ 112.37	$ 0.08	$ 153.71	$ 0.11
Total	**1,543.4**	**$ 49.70**	**$ 6.39**	**$ 68.97**	**$ 8.87**

Louisiana Department of Health
Manahed Care Dental SFY 2024 Capitation Rate Development
CY 2022 Base Experience

Rate Cell: LaCHIP Affordable Plan

Member Months: 21,468

	Claims Experience			Repriced Claims	
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**	**Cost per Service**	**PMPM**
Class I					
Flouride	505.9	$ 20.34	$ 0.86	$ 27.50	$ 1.16
Lab and Other Tests	1.1	47.44	0.00	64.22	0.01
Oral Evaluations	686.4	29.69	1.70	40.40	2.31
Fluoride	612.1	40.39	2.06	55.23	2.82
Prophylaxis	150.4	28.92	0.36	34.54	0.43
X-Rays	623.3	25.55	1.33	35.20	1.83
Other Preventive	17.3	152.82	0.22	152.82	0.22
Class I Subtotal	*2,596.4*	*$ 30.18*	*$ 6.53*	*$ 40.56*	*$ 8.78*
Class II					
Anesthesia	119.1	$ 55.72	$ 0.55	$ 74.14	$ 0.74
Emergency (Palliative)	0.6	58.67	0.00	79.43	0.00
Endodontics	25.2	161.20	0.34	220.70	0.46
Oral Surgery	4.5	219.94	0.08	297.76	0.11
Periodontics	-	-	-	-	-
Restorations	265.5	92.39	2.04	125.41	2.77
Simple Extractions	66.5	74.47	0.41	102.17	0.57
Space Maintainers	-	-	-	-	-
Surgical Extractions	43.6	217.87	0.79	300.79	1.09
Other Restorative	6.1	117.88	0.06	174.04	0.09
Class II Subtotal	*531.0*	*$ 96.82*	*$ 4.28*	*$ 131.88*	*$ 5.84*
Class III					
Bridges	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Dentures	-	-	-	-	-
Inlays/Onlays/Crowns	60.9	131.88	0.67	224.69	1.14
Repair (Simple)	1.7	50.00	0.01	84.61	0.01
Other Prosthetics	-	-	-	-	-
Class III Subtotal	*62.6*	*$ 129.68*	*$ 0.68*	*$ 220.94*	*$ 1.15*
Miscellaneous Services	27.4	$ 139.17	$ 0.32	$ 138.98	$ 0.32
Total	**3,217.4**	**$ 44.05**	**$ 11.81**	**$ 59.98**	**$ 16.08**

Louisiana Department of Health
Manahed Care Dental SFY 2024 Capitation Rate Development
CY 2022 Base Experience

Rate Cell: Medicaid Adult

Member Months: 3,602,708

	Claims Experience			Repriced Claims	
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**	**Cost per Service**	**PMPM**
Class I					
Flouride	0.2	$ 19.50	$ 0.00	$ 26.40	$ 0.00
Lab and Other Tests	-	-	-	-	-
Oral Evaluations	8.5	33.33	0.02	63.18	0.04
Fluoride	0.3	46.95	0.00	65.00	0.00
Prophylaxis	-	-	-	-	-
X-Rays	2.7	54.86	0.01	74.68	0.02
Other Preventive	1.3	159.18	0.02	159.18	0.02
Class I Subtotal	*13.0*	*$ 51.00*	*$ 0.06*	*$ 75.13*	*$ 0.08*
Class II					
Anesthesia	0.0	$ 94.16	$ 0.00	$ 127.46	$ 0.00
Emergency (Palliative)	-	-	-	-	-
Endodontics	0.0	421.73	0.00	570.94	0.00
Oral Surgery	0.0	140.19	0.00	189.92	0.00
Periodontics	0.0	107.14	0.00	145.04	0.00
Restorations	0.3	124.16	0.00	164.92	0.00
Simple Extractions	0.2	62.37	0.00	107.04	0.00
Space Maintainers	-	-	-	-	-
Surgical Extractions	0.2	137.35	0.00	187.84	0.00
Other Restorative	0.0	139.27	0.00	206.67	0.00
Class II Subtotal	*0.8*	*$ 114.95*	*$ 0.01*	*$ 160.68*	*$ 0.01*
Class III					
Bridges	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Dentures	13.5	490.37	0.55	831.61	0.93
Inlays/Onlays/Crowns	0.0	202.03	0.00	299.58	0.00
Repair (Simple)	0.9	88.86	0.01	156.39	0.01
Other Prosthetics	1.9	226.66	0.04	387.88	0.06
Class III Subtotal	*16.3*	*$ 437.00*	*$ 0.59*	*$ 741.75*	*$ 1.01*
Miscellaneous Services	0.1	$ 54.73	$ 0.00	$ 54.73	$ 0.00
Total	**30.2**	**$ 261.29**	**$ 0.66**	**$ 437.61**	**$ 1.10**

Louisiana Department of Health
Manahed Care Dental SFY 2024 Capitation Rate Development
CY 2022 Base Experience

Rate Cell: Medicaid Child/CHIP

Member Months: 9,717,083

	Claims Experience			Repriced Claims	
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**	**Cost per Service**	**PMPM**
Class I					
Flouride	518.2	$ 20.67	$ 0.89	$ 27.91	$ 1.21
Lab and Other Tests	0.0	47.44	0.00	64.22	0.00
Oral Evaluations	666.6	31.34	1.74	42.21	2.34
Fluoride	583.3	39.31	1.91	53.63	2.61
Prophylaxis	164.2	28.15	0.39	34.54	0.47
X-Rays	617.4	25.99	1.34	35.91	1.85
Other Preventive	16.0	160.97	0.21	160.97	0.21
Class I Subtotal	*2,565.8*	*$ 30.32*	*$ 6.48*	*$ 40.65*	*$ 8.69*
Class II					
Anesthesia	143.4	$ 50.81	$ 0.61	$ 67.14	$ 0.80
Emergency (Palliative)	0.2	56.88	0.00	79.43	0.00
Endodontics	53.0	144.07	0.64	197.02	0.87
Oral Surgery	0.9	216.64	0.02	297.93	0.02
Periodontics	0.4	106.23	0.00	139.53	0.00
Restorations	339.5	98.16	2.78	128.65	3.64
Simple Extractions	76.4	75.32	0.48	103.31	0.66
Space Maintainers	0.1	151.52	0.00	205.13	0.00
Surgical Extractions	29.0	201.65	0.49	276.27	0.67
Other Restorative	7.8	130.50	0.08	183.43	0.12
Class II Subtotal	*650.6*	*$ 93.95*	*$ 5.09*	*$ 125.16*	*$ 6.79*
Class III					
Bridges	0.0	$ 431.29	$ 0.00	$ 731.88	$ 0.00
Dentures	0.1	484.33	0.00	845.60	0.00
Inlays/Onlays/Crowns	132.1	136.08	1.50	230.44	2.54
Repair (Simple)	0.5	49.75	0.00	85.64	0.00
Other Prosthetics	0.1	368.69	0.00	627.52	0.01
Class III Subtotal	*132.8*	*$ 136.14*	*$ 1.51*	*$ 230.57*	*$ 2.55*
Miscellaneous Services	18.5	$ 112.16	$ 0.17	$ 152.47	$ 0.23
Total	**3,367.6**	**$ 47.23**	**$ 13.25**	**$ 65.08**	**$ 18.26**

Louisiana Department of Health
Manahed Care Dental SFY 2024 Capitation Rate Development
CY 2022 Base Experience

Rate Cell: Medicaid Expansion Adult

Member Months: 7,811,075

	Claims Experience			Repriced Claims	
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**	**Cost per Service**	**PMPM**
Class I					
Flouride	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Lab and Other Tests	0.0	3.00	0.00	3.00	0.00
Oral Evaluations	4.2	36.67	0.01	63.96	0.02
Fluoride	0.0	48.01	0.00	65.00	0.00
Prophylaxis	-	-	-	-	-
X-Rays	5.9	47.97	0.02	78.07	0.04
Other Preventive	0.3	166.78	0.00	166.78	0.00
Class I Subtotal	*10.4*	*$ 47.03*	*$ 0.04*	*$ 75.06*	*$ 0.06*
Class II					
Anesthesia	0.0	$ 91.58	$ 0.00	$ 123.97	$ 0.00
Emergency (Palliative)	-	-	-	-	-
Endodontics	0.0	256.36	0.00	347.06	0.00
Oral Surgery	-	-	-	-	-
Periodontics	-	-	-	-	-
Restorations	0.0	97.21	0.00	123.26	0.00
Simple Extractions	3.3	57.89	0.02	107.04	0.03
Space Maintainers	-	-	-	-	-
Surgical Extractions	0.9	73.52	0.01	176.12	0.01
Other Restorative	0.0	128.56	0.00	174.04	0.00
Class II Subtotal	*4.2*	*$ 61.61*	*$ 0.02*	*$ 121.70*	*$ 0.04*
Class III					
Bridges	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Dentures	8.9	488.77	0.36	830.50	0.62
Inlays/Onlays/Crowns	-	-	-	-	-
Repair (Simple)	0.4	85.71	0.00	157.96	0.00
Other Prosthetics	1.0	228.12	0.02	387.14	0.03
Class III Subtotal	*10.3*	*$ 450.30*	*$ 0.39*	*$ 765.52*	*$ 0.65*
Miscellaneous Services	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Total	**24.8**	**$ 216.30**	**$ 0.45**	**$ 368.53**	**$ 0.76**

Louisiana Department of Health
Manahed Care Dental SFY 2024 Capitation Rate Development
CY 2022 Base Experience

Rate Cell: Medicaid Expansion Child

Member Months: 944,915

	Claims Experience			Repriced Claims	
Dental Service Category	**Units/1,000**	**Cost per Service**	**PMPM**	**Cost per Service**	**PMPM**
Class I					
Flouride	16.6	$ 19.62	$ 0.03	$ 26.40	$ 0.04
Lab and Other Tests	-	-	-	-	-
Oral Evaluations	216.2	30.13	0.54	40.11	0.72
Fluoride	161.7	47.67	0.64	65.00	0.88
Prophylaxis	-	-	-	-	-
X-Rays	241.6	30.91	0.62	43.28	0.87
Other Preventive	13.7	155.71	0.18	155.71	0.18
Class I Subtotal	*649.8*	*$ 37.17*	*$ 2.01*	*$ 49.58*	*$ 2.68*
Class II					
Anesthesia	74.9	$ 72.67	$ 0.45	$ 90.14	$ 0.56
Emergency (Palliative)	0.2	58.67	0.00	79.43	0.00
Endodontics	14.9	389.89	0.48	533.46	0.66
Oral Surgery	0.4	204.57	0.01	274.21	0.01
Periodontics	1.3	107.48	0.01	138.75	0.01
Restorations	205.5	112.59	1.93	135.53	2.32
Simple Extractions	7.6	77.48	0.05	106.78	0.07
Space Maintainers	-	-	-	-	-
Surgical Extractions	88.7	192.75	1.42	263.12	1.94
Other Restorative	12.8	129.77	0.14	183.97	0.20
Class II Subtotal	*406.2*	*$ 132.81*	*$ 4.50*	*$ 170.69*	*$ 5.78*
Class III					
Bridges	-	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Dentures	0.2	489.88	0.01	828.99	0.01
Inlays/Onlays/Crowns	9.0	195.96	0.15	298.65	0.23
Repair (Simple)	0.1	57.50	0.00	97.30	0.00
Other Prosthetics	0.1	359.82	0.00	608.90	0.01
Class III Subtotal	*9.5*	*$ 202.80*	*$ 0.16*	*$ 311.84*	*$ 0.25*
Miscellaneous Services	2.9	$ 125.30	$ 0.03	$ 248.29	$ 0.06
Total	**1,068.4**	**$ 75.25**	**$ 6.70**	**$ 98.49**	**$ 8.77**

APPENDIX 4: FEE SCHEDULE

Louisiana Department of Health
Medicaid Dental Managed Care Program
Dental Fee Schedule

Code	Description	Fee Effective 7/1/2023
D0120	Periodic oral evaluation - established patient	36.88
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	65.65
D0150	Comprehensive oral evaluation - new or established patient	64.13
D0210	Intraoral - complete series of radiographic images	81.46
D0220	Intraoral - periapical first radiographic image	19.89
D0230	Intraoral - periapical each additional radiographic image	16.81
D0240	Intraoral - occlusal radiographic image	27.63
D0272	Bitewings - two radiographic images	29.01
D0330	Panoramic radiographic image	77.23
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	37.12
D0470	Diagnostic casts	64.22
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	74.49
D0474	Accession of tissue, gross and microscopic examination; including assessment of surgical margins for presence of disease, preparation and transmission of written report	77.03
D1110	Prophylaxis - adult	65.00
D1120	Prophylaxis - child	47.41
D1206	Topical application of fluoride varnish	32.88
D1208	Topical application of fluoride - excluding varnish	26.40
D1351	Sealant - per tooth	34.54
D1354	Interim caries arresting medicament application - per tooth	14.63
D1510	Space maintainer - fixed, unilateral - per quadrant	205.13
D1516	Space maintainer - fixed - bilateral, maxillary	279.71
D1517	Space maintainer - fixed - bilateral, mandibular	279.71
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	52.49
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	52.49
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	52.49
D1556	Removal of fixed unilateral space maintainer - per quadrant	51.80
D1557	Removal of fixed bilateral space maintainer - maxillary	51.80
D1558	Removal of fixed bilateral space maintainer - mandibular	51.80
D1575	Distal shoe space maintainer - fixed - unilateral - per quadrant	205.13
D2140	Amalgam, one surface, primary This procedure is reimbursable for tooth letters A through T. However, this procedure is reimbursable for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	87.71
D2140	Amalgam-one surface posterior - permanent teeth only This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32	101.25
D2150	Amalgam- two surfaces posterior - permanent teeth only This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	158.58
D2150	Amalgam, two surfaces, primary This procedure is reimbursable for tooth letters A through T. However, this procedure is reimbursable for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	111.20
D2150	Amalgam-two surfaces posterior - permanent teeth only This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	124.74
D2160	Amalgam- three surfaces posterior - permanent teeth only This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	148.21
D2160	Amalgam, three surfaces, primary This procedure is reimbursable for and tooth letters A through T. However, this procedure is reimbursable for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	134.68
D2160	Amalgam-three surfaces posterior - permanent teeth only This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	178.00
D2161	Amalgam - four or more surfaces, primary or permanent	178.00
D2330	Resin-based composite, one surface, anterior This procedure is reimbursable for tooth letter C, H, M and R for recipients under 21 years of age; and tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	102.90
D2330	Resin-based composite, one surface, anterior This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	129.98
D2331	Resin-based composite, two surfaces, anterior This procedure is reimbursable for tooth letters C, H, M and R for recipients under 21 years of age; and tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	127.77
D2331	Resin-based composite, two surfaces, anterior This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces, combo except MI or DI.	168.39
D2331	Resin-based composite, two surfaces, anterior This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with two surfaces, combo of MI or DI.	171.09
D2332	Resin-based composite, three surfaces, anterior This procedure is reimbursable for tooth letters C, H, M and R for recipients under 21 years of age; and tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	155.40
D2332	Resin-based composite, three surfaces, anterior This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	205.49
D2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior This procedure is reimbursable for tooth letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	194.77
D2335	Resin-based composite, four or more surfaces or involving incisal angle, anterior This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27 with four surfaces, including the surface I.	269.23
D2390	Resin-based composite crown, anterior This procedure is reimbursable for tooth letters C, H, M, and R for recipients under 21 years of age. This procedure is also reimbursable for tooth Letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age.	285.25
D2390	Resin-based composite crown, anterior This procedure reimbursable for Tooth Number 6, 7, 8, 9, 10, 11, 22, 23, 24, 25, 26, 27.	413.86
D2391	Resin-based composite - one surface, posterior This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	101.25

Louisiana Department of Health
Medicaid Dental Managed Care Program
Dental Fee Schedule

Code	Description	Fee Effective 7/1/2023
D2391	Resin-based composite, one surface, posterior This procedure is reimbursable for tooth letters A, B, I, J, K, L, S and T.	87.71
D2392	Resin-based composite - two surfaces, posterior This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo of MO or DO.	158.58
D2392	Resin-based composite, two surfaces, posterior This procedure is reimbursable for permanent teeth, Tooth Numbers 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with two surfaces combo except MO or DO.	124.74
D2392	Resin-based composite, two surfaces, posterior This procedure is reimbursable for tooth number 1 through 5, 12 through 16, 17 through 21, and 28 through 32 and tooth letters A, B, I, J, K, L, S and T.	111.20
D2393	Resin-based composite - three surfaces, posterior This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo except OBL.	178.00
D2393	Resin-based composite - three surfaces, posterior This procedure reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32 with three surfaces combo of OBL.	148.21
D2393	Resin-based composite, three surfaces, posterior This procedure is reimbursable for tooth letters A, B, I, J, K, L, S and T.	134.68
D2394	Resin-based composite - four surfaces, posterior - permanent teeth only This procedure is reimbursable for Tooth Number 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 28, 29, 30, 31, 32.	178.00
D2394	Resin-based composite, four or more surfaces, posterior This procedure is reimbursable for tooth letters A, B, I, J, K, L, S and T.	158.85
D2920	Re-cement or re-bond crown	84.61
D2929	Prefabricated porcelain/ceramic crown, primary teeth only anterior teeth only	218.86
D2930	Prefabricated stainless steel crown - primary tooth	215.83
D2931	Prefabricated stainless steel crown - permanent teeth only This procedure is reimbursable for Tooth Number 1 through 32.	341.88
D2931	Prefabricated stainless steel crown, permanent tooth This procedure is reimbursable for tooth number 1 through 32.	257.27
D2932	Prefabricated resin crown	280.57
D2933	Prefabricated stainless steel crown with resin window	285.75
D2934	Prefabricated esthetic coated stainless steel crown primary teeth only anterior teeth only This procedure is reimbursable for Tooth Letter C, D, E, F, G, H, M, N, O, P, Q, R.	370.37
D2934	Prefabricated esthetic coated stainless steel crown- primary tooth This procedure is reimbursable for tooth letters C, H, M, and R for recipients under 21 years of age and for tooth letters D, E, F, G, N, O, P and Q only if the recipient is under 5 years of age	370.37
D2950	Core buildup, including any pins when required	174.04
D2951	Pin retention - per tooth, in addition to restoration	47.65
D2954	Prefabricated post and core in addition to crown	271.94
D3110	Pulp cap - direct (excluding final restoration)	51.80
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	127.77
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	127.77
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	205.82
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	455.84
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	535.25
D3330	Endodontic therapy, molar tooth (excluding final restoration)	642.31
D3346	Retreatment of previous root canal therapy - anterior	529.73
D3352	Apexification/recalcification - interim medication replacement	164.38
D3410	Apicoectomy - anterior	437.87
D3430	Retrograde filling - per root	174.04
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	399.88
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	158.85
D4355	Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit	117.41
D5110	Complete denture - maxillary	837.66
D5120	Complete denture - mandibular	837.66
D5130	Immediate denture - maxillary	837.66
D5140	Immediate denture - mandibular	837.66
D5211	Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	795.36
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	795.36
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1,164.27
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	1,164.27
D5511	Repair broken complete denture base, mandibular	211.53
D5512	Repair broken complete denture base, maxillary	211.53
D5520	Replace missing or broken teeth - complete denture (each tooth)	110.00
D5611	Repair resin partial denture base, mandibular	211.53
D5612	Repair resin partial denture base, maxillary	211.53
D5630	Repair or replace broken retentive/clasping materials - per tooth	201.38
D5640	Replace broken teeth - per tooth	110.00
D5650	Add tooth to existing partial denture	110.00
D5660	Add clasp to existing partial denture – per tooth	119.00
D5750	Reline complete maxillary denture (indirect)	402.75
D5751	Reline complete mandibular denture (indirect)	402.75
D5760	Reline maxillary partial denture (indirect)	351.99
D5761	Reline mandibular partial denture (indirect)	351.99
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary	634.59
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular	634.59

Louisiana Department of Health Medicaid Dental Managed Care Program Dental Fee Schedule		
Code	**Description**	**Fee Effective 7/1/2023**
D6241	Pontic - porcelain fused to predominantly base metal	828.68
D6545	Retainer - cast metal for resin bonded fixed prosthesis	667.34
D7111	Extraction, coronal remnants - primary tooth	87.71
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	107.04
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	176.12
D7220	Removal of impacted tooth - soft tissue	203.75
D7230	Removal of impacted tooth - partially bony	271.11
D7240	Removal of impacted tooth - completely bony	332.52
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	376.41
D7250	Removal of residual tooth roots (cutting procedure)	195.46
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	345.29
D7280	Exposure of an unerupted tooth	310.79
D7283	Placement of device to facilitate eruption of impacted tooth	332.90
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	263.83
D7286	Incisional biopsy of oral tissue - soft	206.51
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	152.03
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	189.92
D7510	Incision and drainage of abscess - intraoral soft tissue	148.48
D7880	Occlusal orthotic device, by report	461.69
D7910	Suture of recent small wounds up to 5 cm	190.61
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	211.21
D7961	Buccal / Labial Frenectomy (Frenulectomy)	211.21
D7962	Lingual Frenectomy (Frenulectomy)	211.21
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	324.91
D8050	Interceptive orthodontic treatment of the primary dentition	438.00
D8060	Interceptive orthodontic treatment of the transitional dentition	438.00
D8070	Comprehensive orthodontic treatment of the transitional dentition	4,182.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	4,281.00
D8090	Comprehensive orthodontic treatment of the adult dentition	4,515.00
D8220	Fixed appliance therapy	534.71
D9110	Palliative (emergency) treatment of dental pain - minor procedure	79.43
D9222	Deep sedation/general anesthesia – first 15 minutes	147.79
D9223	Deep sedation/general anesthesia – each additional 15 minute increment	100.15
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	49.72
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	147.79
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	100.15
D9248	Inon-intravenous conscious sedation	169.83
D9420	Hospital or ambulatory surgical center call	106.18
D9440	Office visit - after regularly scheduled hours	79.59
D9920	Behavior management, by report	68.87
D9944	Occlusal guard - hard appliance, full arch	473.96
D9945	Occlusal guard - soft appliance, full arch	473.96
D9946	Occlusal guard - hard appliance, partial arch	473.96
D9951	Occlusal adjustment - limited	145.04
D9997	Dental case management - patients with special health care needs	29.00

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