MILLIMAN CLIENT REPORT

State Fiscal Year 2022 Medicaid Managed Care Capitation Rate Certification

July 1, 2021 through June 30, 2022

South Carolina Department of Health and Human Services

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Introduction & Executive Summary

BACKGROUND

Milliman, Inc. (Milliman) has been retained by the State of South Carolina, Department of Health and Human Services (SCDHHS) to provide actuarial and consulting services related to the development of capitation rates for its Medicaid Managed Care Program effective July 1, 2021.

This letter provides documentation for the development of the actuarially sound capitation rates. It also includes the required actuarial certification in Appendix 1.

At the time of this report, we acknowledge there is uncertainty regarding the impact of the COVID-19 pandemic on future projections, including whether the pandemic will increase or decrease costs in SFY 2022. The capitation rates include adjustments related to morbidity and COVID-19 policy changes as documented in the report. It is possible that the COVID-19 pandemic, as well as future legislative changes to address the pandemic, could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this report.

To facilitate review, this document has been organized in the same manner as the 2020-2021 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in July 2020(CMS guide). Sections II and III of the CMS guide are not applicable to this certification as the covered populations and services do not include long-term services and supports (Section II), nor the new adult group under 1902(a)(10)(A)(i)(VIII) of the Social Security Act (Section III).

FISCAL IMPACT ESTIMATE

The composite per member per month (PMPM) capitation rates for the Medicaid managed care program are illustrated in Figure 1. These rates are effective for state fiscal year (SFY) 2022 (July 1, 2021 through June 30, 2022). Figure 1 provides a comparison of the SFY 2022 rates relative to the rates effective in SFY 2021. The composite rates illustrated for both SFY 2022 and SFY 2021 are calculated based on projected SFY 2022 enrollment by rate cell. Projected enrollment estimates reflect observed program enrollment through February 2021 with adjustments to reflect anticipated increases in membership due to the Families First Coronavirus Response Act (FFCRA). To account for the observed lag in eligibility completion, the TANF: 0-2 months old projected member months and projected KICK payments reflect annualized November 2020 membership and deliveries, respectively.

FIGURE 1: COMPARISON WITH SFY 2021 RATES (PMPM RATES)

COMPOSITE	SFY 2021 PMPM	SFY 2022 PMPM	INCREASE/ (DECREASE)
Including Add-Ons	$ 307.41	$ 310.62	1.0%
Excluding Add-Ons	$ 291.19	$ 295.49	1.5%

Notes:
1. SFY 2021 and SFY 2022 composite rates reflect projected SFY 2022 enrollment by rate cell.
2. Add-Ons include Hospital Quality Payment Initiative and Supplemental Teaching Payments.

Figure 2 presents a comparison of the certified SFY 2022 capitation rates to the SFY 2021 capitation rates by rate cell, both excluding and including the 438.6 Hospital Quality Payment Initiative and the Supplemental Teaching Payment referred to collectively as add-ons.

FIGURE 2: COMPARISON WITH SFY 2021 RATES BY RATE CELL (PMPM RATES)

		INCLUDING ADD-ONS			EXCLUDING ADD-ONS		
RATE CELL	PROJECTED MONTHS	SFY 2021 RATE	SFY 2022 RATE	INCREASE/ (DECREASE)	SFY 2021 RATE	SFY 2022 RATE	INCREASE/ (DECREASE)
TANF: 0-2 months old (AH3)	81,947	$ 2,284.03	$ 2,423.36	6.1%	$ 2,140.61	$ 2,225.74	4.0%
TANF: 3-12 months old (AI3)	341,296	252.81	263.20	4.1%	229.28	236.81	3.3%
TANF: Age 1-6 (AB3)	2,588,224	140.14	146.98	4.9%	132.69	138.76	4.6%
TANF: Age 7-13 (AC3)	3,000,413	143.51	143.95	0.3%	137.59	137.77	0.1%
TANF: Age 14-18, Male (AD1)	967,378	158.43	158.00	(0.3%)	151.41	150.71	(0.5%)
TANF: Age 14-18, Female (AD2)	975,765	200.88	199.98	(0.4%)	190.70	190.41	(0.2%)
TANF: Age 19-44, Male (AE1)	557,554	218.59	201.32	(7.9%)	208.9	192.68	(7.8%)
TANF: Age 19-44, Female (AE2)	1,927,511	327.36	324.93	(0.7%)	307.81	308.50	0.2%
TANF: Age 45+ (AF3)	334,833	575.19	578.18	0.5%	547.56	552.85	1.0%
SSI - Children (SO3)	135,650	654.16	680.11	4.0%	625.45	649.90	3.9%
SSI - Adults (SP3)	635,155	1,387.67	1,452.45	4.7%	1,330.77	1,396.61	4.9%
OCWI (WG2)	390,533	370.69	285.90	(22.9%)	306.29	255.17	(16.7%)
DUAL	-	170.72	176.49	3.4%	170.72	176.49	3.4%
Foster Care - Children (FG3)	57,622	928.54	940.02	1.2%	904.05	916.21	1.3%
KICK (MG2/NG2)	22,944	6,849.83	7,150.95	4.4%	6,760.78	7,055.39	4.4%
Composite	**11,993,881**	**$ 307.41**	**$ 310.62**	**1.0%**	**$ 291.19**	**$ 295.49**	**1.5%**

Notes:
1. TANF: 0-2 months old projected member months and KICK projected payments reflect annualized November 2020 membership.
2. Add-Ons include Hospital Quality Payment Initiative and Supplemental Teaching Payments

Figure 3 presents the estimated aggregate annual expenditures under the managed care program, based on SFY 2022 projected membership. Further detail by rate cell is illustrated on an annual basis in Appendix 3.

FIGURE 3: ESTIMATED ANNUAL FISCAL IMPACT (MILLIONS)

		ANNUAL PROJECTED EXPENDITURES		DOLLAR	PERCENTAGE
	PROJECTED MEMBERSHIP	SFY 2021	SFY 2022	INCREASE/ (DECREASE)	INCREASE/ (DECREASE)
Composite	11,993,881	$ 3,687.0	$ 3,725.5	$ 38.5	1.0%
Total Federal Only		$ 2,722.9	$ 2,751.3	$ 28.4	1.0%
Total State		$ 964.2	$ 974.2	$ 10.1	1.0%

Notes:
1. SFY 2021 and SFY 2022 aggregate annual expenditures were developed based on SFY 2022 projected enrollment and estimated SFY 2022 deliveries.
2. State expenditures based on Federal Fiscal Year 2022 FMAP of 70.75% + 6.2% public health emergency enhancement for July through December 2021 and 70.75% for January through June 2022, resulting in an effective FMAP of 73.85% for the full year.
3. Values have been rounded.

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 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 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and 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) for the provisions effective for the SFY 2022 managed care program rating period.
- 2020-2021 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in July 2020.
- 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]

A. RATE DEVELOPMENT STANDARDS

i. Annual basis

The actuarial certification contained in this report is effective for the capitation rates for the one year rate period from July 1, 2021 through June 30, 2022.

ii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Jeremy D. Palmer, FSA, is in Appendix 1. Mr. Palmer meets the qualification standards established by the American Academy of Actuaries, follows the practice standards established by the

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

Actuarial Standards Board, and certifies that the final rates meet the applicable standards in 42 CFR 438 that are effective for the SFY 2022 managed care program rating period.

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Figure 2. Projected enrollment estimates reflect observed program enrollment through February 2021 with adjustments to reflect anticipated increases in membership due to the Families First Coronavirus Response Act (FFCRA). To account for the observed lag in eligibility completion, the TANF: 0-2 months old projected member months and projected KICK payments reflect annualized November 2020 membership and deliveries, respectively. These rates represent the contracted capitation rates prior to risk adjustment.

(c) Program information

Managed Care program

This certification was developed for the State of South Carolina's Medicaid managed care program.

Medicaid managed care organizations (MCOs) have been operating in South Carolina since 1996. In August 2007, SCDHHS implemented the South Carolina Healthy Connections Choices program to more effectively enroll members in MCOs. This program provides comprehensive services through five MCOs on a statewide basis.

Benefits covered under the Medicaid managed care program are comprehensive in nature. Certain services such as waiver services, non-emergency transportation, dental, and long-term nursing home stays are covered on a fee-for-service basis.

The following table outlines the core benefits covered under the managed care capitation rate.

FIGURE 4: LIST OF CORE BENEFITS

Ambulance Transportation	Hearing Aids and Hearing Aid Accessories	Outpatient Services
Ancillary Medical Services	Home Health Services	Physician Services
Audiological Services	Hysterectomies, Sterilizations and Abortions (as covered in policy guidelines)	Podiatry Services
Autism Spectrum Disorder Services	Independent Laboratory and X-Ray Services	Prescription Drugs
Communicable Disease Services	Inpatient Hospital Services	Psychiatric, Rehabilitative Behavioral Health, and associated outpatient mental health services
Disease Management	Institutional Long-Term Care Facilities/Nursing Homes for short-term stays	Rehabilitative Therapies for Children - Non-Hospital Based
Durable Medical Equipment	Maternity Services	Substance Abuse
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) / Well Child	Medication Assisted Therapy	Tobacco Cessation Coverage
Family Planning Services	Newborn Hearing Screenings	Transplant and Transplant-Related Services
Free-Standing Inpatient Psychiatric Facilities for Under 21	Outpatient Pediatric AIDS Clinic Services (OPAC)	Vision Care Services

Notes:

1. The managed care policies & procedures (P&P) manual indicates that MCOs are responsible for covering corneal transplants. With respect to other types of transplants as outlined in the P&P manual, MCOs are responsible for pre- and post-transplant services as documented in the manual.
2. Free-standing inpatient psychiatric facility coverage applies to individuals under age 21.
3. Medication assisted therapy includes treatment in Opioid Treatment Programs (OTPs).
4. Detailed benefit coverage information for all Core Benefits in this table can be found within the Managed Care Policy and Procedure Manual.
5. Source: https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20PP%20April%202021%20Final.pdf

Rating period

This actuarial certification is effective for the one-year rating period July 1, 2021 through June 30, 2022.

Covered populations

Specific eligibility for the managed care program is defined by the individual's Medicaid eligibility category as assigned by SCDHHS.

The following table outlines these specific SCDHHS Medicaid eligibility categories (also referenced as "payment categories" or "PCATs") that are eligible for inclusion in the risk-based managed care program.

FIGURE 5: MANAGED CARE ELIGIBILITY PAYMENT CATEGORIES

PCAT CODE	PAYMENT CATEGORY	PCAT CODE	PAYMENT CATEGORY
11	MAO (Extended/Transitional)	57	Katie Beckett/TEFRA
12	OCWI (Infants)	59	Low Income Families
13	MAO (Fostercare/Adoption)	60	Regular Foster Care
16	Pass Along Eligibles	61	Foster Care Adults
17	Early Widows/Widowers	71	Breast and Cervical Cancer
18	Disabled Widows/Widowers	80	SSI
19	Disabled Adult Children	81	SSI With Essential Spouse
20	Pass Along Children	85	Optional Supplement
31	Title IV-E Foster Care	86	Optional Supplement & SSI
32	Aged, Blind, Disabled (ABD)	87	OCWI Pregnant Women/Infants
40	Working Disabled	88	OCWI Partners For Healthy Children
51	Title IV-E Adoption Assistance	91	Ribicoff Children

Dual eligible individuals (eligible for coverage by both Medicaid and Medicare) and individuals aged 65 or over are not eligible for enrollment into the managed care program. Any individual identified as dual eligible while enrolled in an MCO is retroactively adjusted to the dual capitation rate cell (discussed further following Figure 7) for any such MCO-enrolled month and are prospectively disenrolled from the managed care program.

Additionally, individuals denoted by any of the following recipient of a special program (RSP) indicators in Figure 6 are not eligible for enrollment into the managed care program.

FIGURE 6: RSP INDICATORS NOT ELIGIBLE FOR MANAGED CARE ENROLLMENT

RSP Code	Payment Category	RSP Code	Payment Category
CLTC	Elderly Disabled Waiver	MCCM	Primary Care Case Management (Medical Care Home)
CSWE	Community Supports Waiver - Established	MCHS	Hospice
CSWN	Community Supports Waiver - New	MCPR	Dual Eligible Prime
DMRE	DMR Waiver - Established	MCSC	PACE
DMRN	DMR Waiver - New	MFPP	Money Follows the Person
HIVA	HIV/AIDS Waiver	VENT	Ventilator Dependent Waiver
HSCE	Head & Spinal Cord Waiver - Established	WMCC	Medically Complex Children's Waiver
HSCN	Head & Spinal Cord Waiver - New	COVD	COVID Limited Benefits

Note:

1. All RSP's provided by SCDHHS on January 28, 2021.

The SFY 2022 capitation rate development covers the following capitation rate cells:

FIGURE 7: MANAGED CARE CAPITATION RATE CELLS

RATE CELL	RATE CELL INDICATOR
TANF: 0 - 2 months old	AH3
TANF: 3 - 12 months old	AI3
TANF: Age 1 - 6	AB3
TANF: Age 7 - 13	AC3
TANF: Age 14 - 18 Male	AD1
TANF: Age 14 - 18 Female	AD2
TANF: Age 19 - 44 Male	AE1
TANF: Age 19 - 44 Female	AE2
TANF: Age 45+	AF3
SSI - Children	SO3
SSI - Adult	SP3
OCWI	WG2
Duals	
Foster Care Children	FG3
KICK	MG2/NG2

Note that the Duals rate cell does not have a corresponding rate cell indicator, because individuals identified in this category are not considered eligible for managed care enrollment. This rate cell only applies to individuals who receive retroactive Medicare eligibility while enrolled in an MCO. The Duals rate cell represents the fee-for-service (FFS) equivalent value estimated for this population, which is then adjusted to reflect the managed care program. The capitation rate includes all estimated Medicare crossover claims payments and expenditures related to services covered by Medicaid and not Medicare that are the responsibility of the MCOs for a dually eligible individual.

Eligibility criteria

Most Medicaid beneficiaries are required to enroll in managed care on a mandatory basis. Medicaid beneficiaries who are on waivers, institutionalized, or dual-eligible are served on a fee-for-service basis or in the Healthy Connections Prime dual demonstration program. Beneficiaries that may enroll in Medicaid managed care on a voluntary basis include SSI children, Katie Beckett/TEFRA individuals, foster care children, express lane eligible children (ELE), and children receiving adoption assistance. Further detail and clarification on managed care eligibility criteria can be found within the MCO Policy and Procedure Guide[2] under section 3.1 Member Eligibility.

Special contract provisions

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

- Incentive arrangements
- Withhold arrangements
- Minimum medical loss ratio requirement
- Hospital quality payment initiative in accordance with 42 CFR §438.6(c)
- Supplemental teaching physician payments
- IMDs as an in lieu of provider service
- Pharmacy high cost no experience program
- COVID-19 vaccine administration non-risk arrangement

Please see Section I, item 4, Special Contract Provisions Related to Payment, for additional detail and documentation.

[2] https://msp.scdhhs.gov/managedcare/sites/default/files/MCO%20PP%20April%202021%20Final.pdf

Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the SFY 2022 capitation rates.

iii. 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 associated with the covered populations.

iv. 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.

v. Effective dates

To the best of our knowledge, the effective dates of changes to the SC Medicaid managed care program are consistent with the assumptions used in the development of the certified SFY 2022 capitation rates.

vi. Minimum medical loss ratio

Capitation rates were developed in such a way that the MCOs would reasonably achieve a medical loss ratio, as calculated under 42 CFR 438.8, of at least 86% for the rate year.

vii. 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, and have 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 2022 capitation rates certified in this report represent the final contracted rates by rate cell prior to risk adjustment.

viii. Rate certification for effective time periods

This actuarial certification is effective for the one-year rating period July 1, 2021 through June 30, 2022.

ix. Procedures for rate certification and amendment

In general, a new rate certification will be submitted when the 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. An 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, changes the rates paid to the MCOs

In cases 1 and 2 listed above, a contract amendment must still be submitted to CMS.

B. APPROPRIATE DOCUMENTATION

i. 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.

ii. 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.

iii. 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.

iv. Different FMAP

All populations receive the regular state FMAP of 70.75% for FFY 2022. The enhanced FMAP percentage for CHIP and family planning expenditures in South Carolina is 79.53% and 90.00%, respectively. In addition, SCDHHS has indicated that they have implemented changes to the Medicaid program to meet the requirements outlined in the FFCRA to receive the additional FMAP funding during the COVID-19 national emergency period. Note that the enhanced amounts for CHIP and family planning expenditures are not reflected in the values provided in Appendix 3.

v. Comparison to final certified rates in the previous rate certification and material changes.

(a) Comparison to final certified rates in the previous rate certification

The previous rate certification applied to SFY 2021 capitation rates. A comparison to SFY 2021 certified rates by rate cell is provided in Figure 2.

(b) Description of material changes to the rate development process not addressed in other sections of this rate certification

The risk corridor arrangement included in the SFY 2021 Medicaid managed care program has been removed for SFY 2022.

vi. Known amendments

As of the date of this report, there are no known future amendments to the SFY 2022 capitation rates.

2. Data

This section provides information on the data used to develop the capitation rates. The March 2019 through February 2020 base experience data (base data) described in this section was provided in the SFY 2022 Capitation Rate Methodology and Data Book, dated March 22, 2021. Additionally, the base data is illustrated in Appendix 6.

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 I, item 2 provides documentation of the data types, sources, validation process, material adjustments and other information relevant to the documentation standards required by CMS.

B. APPROPRIATE DOCUMENTATION

i. Requested data

As the actuary contracted by the SCDHHS to provide consulting services and associated financial analyses for many aspects of the South Carolina Medicaid program (and not just limited to capitation rate development), Milliman intakes and summarizes eligibility and expenditure data on a monthly basis from Clemson, SCDHHS's data administrator. As such, there is no separate data request from Milliman to the state specifically related to the base data for the capitation rate development. The remainder of this section details the base data and validation processes utilized in the SFY 2022 capitation rate development. Additionally, Appendix 6 summarizes the unadjusted base data.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of data

The primary data sources used or referenced in the development of the capitation rates are the following:

- Encounter data submitted by the MCOs and accepted through the monthly encounter data warehousing process through January 2021;
- FFS claims for dual eligible individuals incurred March 2019 through February 2020, and paid through January 2021;
- FFS claims for Hepatitis C pharmacy expenditures for managed care enrollees;
- FFS claims incurred by managed care enrollees for managed care-covered services;
- SFY 2022 managed care in-rate criteria;
- FFS claims for institution for mental disease (IMD) services for managed care enrollees under age 21;
- FFS claims for analysis of newborn enrollment delays;
- SFY 2022 MCO Rate-Setting Survey completed by each MCO;
- Statutory financial statement data;
- Monthly disenrollment files for January through March 2020;
- March 2019 through February 2020 Bridges invoice data for managed care enrollees;
- Therapeutic Foster Care placements during SFY 2019 and October through December 2019; and,
- January 2019 through June 2020 financial summary reports provided by the MCOs (EQI reports) for base data validation analysis.

Age of the data

The data serving as the base experience in the capitation rate development process was incurred March 2019 through February 2020. The encounter data for the base period reflected encounters adjudicated and submitted through the monthly encounter data warehousing process through January 2021. The base data time period for the SFY 2022 capitation rate development has been selected to reflect program experience prior to the declaration of the

COVID-19 State of Emergency in South Carolina in March 2020[3]. The FFS data used in the analysis and review of the IMD under 21 carve-in and the Hepatitis C pharmacy carve-in was incurred July 2018 through June 2020, with paid run-out through January 2021.

For the purposes of trend development, we reviewed encounter experience from SFY 2017 through November 2020 and paid and submitted through the data warehousing process through January 2021.

We also summarized statutory financial statement data from calendar years 2018, 2019, and 2020, collected using SNL Financial.

Data sources

The historical claims and enrollment experience for the encounter data obtained through the encounter data warehousing process was provided to Milliman by Clemson, the data administrator for SCDHHS. The sources of other data are noted in i and ii above.

Sub-capitation

The encounter data summaries have been adjusted to include estimated expenditures for sub-capitated claims. Sub-capitated expenditures were estimated by repricing each sub-capitated encounter to the Medicaid FFS fee schedules and using total submitted sub-capitated units. For claims where a Medicaid FFS rate did not exist (less than 1% of sub-capitated encounters), the expenditures were estimated by assuming the average cost per unit for the non-repriced sub-capitated claims would be equal to the average cost per unit for other sub-capitated claims in the specified category of service.

(b) Availability and quality of the data

(i) Steps taken to validate the data

The base experience used in the capitation rates primarily relies on encounter data submitted to SCDHHS by participating MCOs. The actuary, the MCOs, and SCDHHS all play a role in validating the quality of encounter data used in the development of the capitation rates.

The fee-for-service (FFS) data is provided by SCDHHS. Milliman has many years of experience working with SCDHHS's FFS data. We perform routine reconciliation of SCDHHS's financial data as part of the monthly data validation process and provide budgeting and forecasting assistance to the State, which involves aggregate claim reconciliation to SCDHHS's financial statements.

The remainder of the validation section relates to encounter data used in the rate development.

Completeness

Encounter data is summarized quarterly through the encounter quality initiative (EQI) process. Separate sets of summaries, by rate group, are prepared for each MCO. Each summary illustrates utilization, cost per service, and per member per month cost for the population, stratified by category of service. The format of each quarterly exhibit is similar to the base data exhibits that were provided as part of SFY 2022 Capitation Rate Methodology and Data Book, dated March 22, 2021, allowing most data issues to be discovered before the annual capitation rate development process.

The quarterly EQI reconciliation process allows for three months of run-out from the end of the reported calendar quarter. For example, the first report of the calendar year would include the following claims:

- Services incurred January 1 through March 31
- Paid on or before June 30

The actuary compares the EQI summaries to summary totals submitted by the MCOs. Where the difference between the MCO's encounter data and financial data is more than 3%, the MCO is subject to a financial penalty per their contract with the state. MCOs are rarely penalized, and the discrepancy is more commonly under 1%.

[3] https://governor.sc.gov/sites/default/files/Documents/Executive-Orders/2020-04-06%20eFILED%20Executive%20Order%20No.%202020-21%20-%20Stay%20at%20Home%20or%20Work%20Order.pdf

We provide all the individual encounter claims back to the MCOs for analysis. This allows the MCOs to identify any claims that need to be resubmitted or research any discrepancies that may exist in the final summary.

Finally, we submitted encounter data validation letters to each of the MCOs to confirm that their summarized data including March 2019 through February 2020 incurred claims is appropriate for use in the development of the capitation rate.

The annual rate setting process for SFY 2022 uses one year of experience data, with eleven months of run-out.

The base encounter data used in the development of the rates was adjudicated through January 31, 2021. The eleven months of claims run-out after the end of the fiscal year results in incurred but not paid (IBNP) claim liability estimates having a limited effect on the estimated incurred expenditures for March 2019 through February 2020. However, as noted in this report, claims completion is applied to the encounter data for estimated March 2019 through February 2020 claims adjudicated after January 31, 2021.

Accuracy

Checks for accuracy of the data begin with the MCOs' internal auditing and review processes.

When the data is submitted to SCDHHS, it is subjected to most of the validation checks SCDHHS applies to FFS claims. For example, the data must contain a valid Medicaid recipient ID for an individual who was enrolled at the time the service was provided, and assigned to the MCO.

The actuary also reviews the encounter data to ensure each claim is related to a covered individual and a covered service. A quarterly review of the EQI summaries is performed to ensure that the data for each service is consistent across the MCOs and when compared to prior historical period as applicable. Stratification by rate group facilitates this analysis, as it mitigates the impact of changes in population mix.

The actuary also compares the encounter data with financial information submitted by each MCO. To provide greater transparency to the MCOs in the data validation process for the SFY 2022 capitation rates, a summary was provided to each MCO that starts with total submitted encounter claims and identifies claims that have been removed from the base data summaries, such as voided claims, expenditures for non-state plan services, expenditures for services not covered in the capitation rate, expenditures related to members over age 21 who were in an IMD for at least 15 days in a calendar month, expenditures related to high cost no experience pharmaceutical treatments, and claims that have been removed because of unmatched eligibility records.

Actuary's assessment

As required by Actuarial Standard of Practice (ASOP) No. 23, Data Quality, we disclose that Milliman has relied upon certain data and information provided by SCDHHS and their vendors, primarily the MCOs. The values presented in this letter are dependent upon this reliance.

We found the encounter and FFS data to be of appropriate quality for purposes of developing actuarially sound capitation rates. However, due to the potential under-reporting of encounter data expenditures as reported in the MCOs response to the SFY 2022 MCO Rate-Setting Survey, an adjustment has been made to increase the base data for valid encounters missing from the data submission process.

Encounter data validation letters were submitted to each of the MCOs to confirm that their summarized March 2019 through February 2020 data is appropriate for use in the development of the capitation rates. For MCOs that reported valid encounters missing from the encounter data submissions in their response to the SFY 2022 MCO Rate-Setting Survey, an adjustment has been made to increase the base data. The impact of this adjustment resulted in a net increase of 0.1% to the base data.

Data concerns

We have not identified any material concerns with the quality or availability of the data, other than the under-reporting of encounter data as discussed in the previous section and adjusted for in the development of the actuarially sound capitation rates.

(c) Appropriate data

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

All populations enrolled in managed care during the rate period were included in the risk-based managed care delivery system in the March 2019 through February 2020 base experience period. As such, expenditure data for populations enrolled in FFS during March 2019 through February 2020 is not reflected in the base experience cost models used to develop the capitation rates, with the exception of the dual rate cell. FFS claims experience for managed care enrollees related to managed care covered benefits was utilized to estimate the financial impact of transitioning these expenditures to the MCOs responsibility in SFY 2022.

Use of managed care encounter data

Managed care encounter data was the primary data source used in the development of the capitation rates.

(d) Reliance on a data book

Development of the capitation rates did not rely on a data book or other summarized data source. We were provided with detailed claims data for all covered services and populations. We created data books summarizing March 2019 through February 2020 encounter data, which were shared with SCDHHS and participating MCOs and also included in the Base Experience section of Appendix 6.

iii. Data adjustments

Capitation rates were developed primarily from March 2019 through February 2020 encounter data. Adjustments were made to the base experience for completion, reimbursement changes, managed care efficiencies, and other program adjustments.

(a) Credibility adjustment

The SCDHHS managed care program populations, as represented in the base experience, were fully credible. No adjustments were made for credibility.

(b) Completion adjustment

The encounter data submitted by the MCOs and the FFS data used in developing the capitation rates were analyzed separately to estimate claim completion factors. The base period encounter and FFS data reflect claims incurred March 2019 through February 2020 and paid through January 2021. Separate sets of completion factors for the two data sources were developed by summarizing the claims data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability.

Completion factors were developed by summarizing the data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, using Milliman's Robust Time-Series Analysis System (RTS)[4]. First, we stratified the data by category of service, in the population groupings illustrated in Figure 8. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. The monthly completion factors were applied to base data experience to estimate the remaining claims liability for the fiscal year. Results were aggregated into annual completion factors for the fiscal year.

The claim completion factors applied to the base data are illustrated by population and major service category in Figure 8.

[4] The Robust Time Series Reserve Analysis System (RTS) is a model designed to assist an actuary in performing an Incurred But Not Paid (IBNP) reserving analysis. The RTS is unique because it contains functionality that: provides reasonable best estimates despite contaminated data, provides reasonable margins for the total reserve, independently models shock claims, and provides forecasts of future cash flows. This methodology forecasts future claim runout using time series forecasting which employs the interrelationship between claim payments during the first three months of claim payments for each incurred month.

FIGURE 8: COMPLETION FACTORS APPLIED TO BASE EXPERIENCE DATA

CATEGORY OF SERVICE	TANF/FOSTER	SSI	OCWI	DUAL	KICK
Hospital					
Inpatient	1.0089	1.0133	1.0043	1.0098	1.0052
Outpatient	1.0027	1.0030	1.0043	1.0087	1.0087
Pharmacy	1.0001	1.0002	1.0000	1.0007	N/A
Ancillaries	1.0023	1.0020	1.0017	1.0032	N/A
Professional	1.0026	1.0045	1.0017	1.0051	1.0016

Note:
1. Completion factors for the Dual population were developed from FFS source data. All other populations were developed from encounter data.

(c) Errors found in the data

Encounter data validation letters were submitted to each of the MCOs to confirm that their summarized base data is appropriate for use in the development of the capitation rates. For MCOs that reported valid encounters missing from the encounter data submissions in their response to the SFY 2022 MCO Rate-Setting Survey, an adjustment has been made to increase the base data.

Based on a review of March 2019 through February 2020 FFS claims payments, expenditures for managed care enrolled members related to managed care covered benefits were identified through the FFS claims payment transactions. An adjustment has been made to the base data to reflect the additional expenditures anticipated to be processed by the MCOs in SFY 2022. The base data has been increased by approximately $5.9 million for the FFS claims related to managed care covered services.

(d) Program change adjustments

All program and reimbursement changes that have occurred in the Medicaid managed care program on or after March 1, 2019, the beginning of the base experience period used in the capitation rates, are described below.

Changes in Provider Reimbursement

Changes in provider reimbursement were evaluated by performing repricing analyses on the individual encounter data for physician services. We reviewed the distribution of the MCO paid amount relative to the repriced value using Medicaid fee-for-service reimbursement. We established an upper and lower bound from this distribution to ensure we captured a representative sample of claims that encompassed the multimodal distribution of the repriced values relative to the MCO paid amounts. Additionally, we reviewed the upper and lower bounds to ensure we captured a representative volume of the encounter claims reflected in the March 2019 – February 2020 base data for the repricing and reimbursement adjustment analyses.

Federally Qualified Health Centers (FQHC) Physician Reimbursement Changes

To develop the adjustment factor for FQHC physician reimbursement, we performed a repricing analysis to evaluate individual encounter data claims using Medicaid FQHC reimbursement methodology at the current Prospective Payment System (PPS) rates. This includes application of the July 1, 2020 PPS fee schedule update. We reviewed all FQHC physician claims in the base data and applied the FQHC reimbursement methodology, state plan copayments for eligible populations, and current PPS rates. The repricing analysis captured approximately 98% of total FQHC claims. For claims that were unable to be repriced due to unknown provider IDs, the repricing adjustment factor was assumed to be 1.0.

Effective July 1, 2021, SCDHHS anticipates a change to the PPS rates paid to FQHC providers to reflect scope of service changes. The FQHC provider-specific PPS rates reflect the full payment to the FQHC, including the wrap-around payment. The estimated impact of this rate change is less than $0.1 million.

Physician (non-FQHC) Reimbursement Changes

To develop the adjustment factor for physician reimbursement, we performed a repricing analysis to evaluate individual encounter data claims using Medicaid FFS reimbursement methodology at the current Medicaid fee schedule. This includes application of the enhanced fee schedule for qualifying physicians providing evaluation & management services. Although the enhanced fee schedule was effective prior to March 2019, the entirety of the fee schedule change is not reflected in the March 2019 through February 2020 base data as some MCOs do not reflect the increase through the encounter claims. Therefore, the repricing of all qualifying physician claims to the enhanced fee schedule increases the physician expenditures reported in the encounter base data (see 'Base Physician Repricing' in Figure 9).

The review of the distribution of MCO paid amounts relative to the repriced values using Medicaid FFS reimbursement methodology for physician and ancillary services indicated a more consistent reimbursement methodology between the MCOs and Medicaid FFS for physician services than observed for facility services. Similar to SFY 2021, a more prominent mode existed in the distribution with very little unusual activity in the tails of the distribution. As such, we kept the upper and lower bounds consistent with SFY 2021 assumptions.

We began with all non-FQHC physician claims and excluded any claims where the MCO paid amount was either below 50% of the repriced value or above 150% of the repriced value, to focus the analysis within a reasonable repricing bound. The application of exclusion criteria resulted in the repricing of approximately 92.3% of total non-FQHC physician dollars.

Effective July 1, 2019, SCDHHS implemented a change to the physician fee schedule for the following services:

- **Durable Medical Equipment (DME) Adjustment**. The DME reimbursement rates reflect reimbursement consistent with the Medicare January 2019 DMEPOS Non-Rural fee schedule.
- **July 1, 2019 Physician Fee Schedule Adjustment**. Physician fee schedules for family practice, obstetrics and gynecology, pediatric subspecialists, neonatologists, lab and radiology, podiatrists, chiropractors, enhanced qualifying providers, and other medical professionals. The physician reimbursement rates reflect updated rates based on a relativity to the 2019 Medicare Fee Relative Value Unit (RVU) and Clinical Lab Fee schedules.

The 'Base Physician Repricing' column in Figure 9 represents the combined impact of repricing to the fee schedule effective July 1, 2019, including the enhanced fee schedule discussed above. Additionally, per guidance from SCDHHS, the STP methodology was updated to transition claims provided by teaching physicians and billed by a non-teaching facility, out of the STP program and into standard physician billing. As such, these claims qualify for the enhanced fee scheduled, where appropriate. The estimated impact of the repricing adjustment based on SFY 2022 projected enrollment is approximately $36.9 million.

Effective July 1, 2020, SCDHHS implemented a change to the physician fee schedules for the following services:

- **Vision Adjustment**. The vision reimbursement rates reflect updated rates based on a relativity to the 2019 Medicare RVU fee schedule. For vision procedure codes not included on the Medicare RVU fee schedule, reimbursement rates reflect a 5% increase from the current fee schedule. The estimated impact of this rate change is approximately $1.2 million.
- **Anesthesia Adjustment**. The anesthesia reimbursement rates reflect updated rates based on a relativity to the 2019 Medicare RVU fee schedule. Epidural codes are not included in this update; therefore, reimbursement rates for epidural codes will remain at the current fee schedule. The estimated impact of this rate change is approximately $0.6 million

Figure 9 presents the combined results of the FQHC and non-FQHC repricing analyses.

FIGURE 9: COMPOSITE PHYSICIAN AND ANCILLARIES PMPM ADJUSTMENTS BY RATE CELL

RATE CELL	FQHC FEE SCHEDULE	BASE PHYSICIAN REPRICING	JULY 2020 VISION	JULY 2020 ANESTHESIA	COMPOSITE ADJUSTMENT
TANF: 0-2 months old (AH3)	$ 0.53	$ 1.84	$ 0.03	$ 0.06	**$ 2.46**
TANF: 3-12 months old (AI3)	0.29	4.16	0.03	0.05	**4.53**
TANF: Age 1-6 (AB3)	0.17	2.70	0.08	0.04	**2.99**
TANF: Age 7-13 (AC3)	0.18	2.10	0.18	0.02	**2.48**
TANF: Age 14-18, Male (AD1)	0.18	2.03	0.14	0.02	**2.37**
TANF: Age 14-18, Female (AD2)	0.24	3.02	0.20	0.02	**3.48**
TANF: Age 19-44, Male (AE1)	0.13	1.64	0.03	0.03	**1.83**
TANF: Age 19-44, Female (AE2)	0.32	3.58	0.02	0.06	**3.98**
TANF: Age 45+ (AF3)	0.41	3.81	0.02	0.10	**4.34**
SSI - Children (SO3)	0.33	6.58	0.21	0.06	**7.18**
SSI - Adults (SP3)	0.41	7.19	0.03	0.15	**7.78**
OCWI (WG2)	0.34	3.64	0.04	0.05	**4.07**
DUAL	-	-	0.01	0.01	**0.02**
Foster Care - Children (FG3)	0.95	9.97	0.26	0.04	**11.22**
KICK (MG2/NG2)	6.35	26.59	-	1.78	**34.72**

For each rate cell, more detailed PMPM adjustments are applied at the category of service level and can be found in the “reimbursement adjustment” section of Appendix 7.

Inpatient Hospital Reimbursement Changes

Effective July 1, 2020 and October 1, 2020, SCDHHS implemented updates to the inpatient hospital Medicaid FFS reimbursement rates for Conway Hospital and Medical University of South Carolina (MUSC), respectively. The base rate for Conway Hospital was reduced by approximately 2.7%, while the base rate for MUSC was increased by approximately 22.7%. Based on guidance from SCDHHS, the inpatient hospital reimbursement updates are anticipated to be effective for the managed care program as of July 1, 2021. To reflect the increased reimbursement level in Medicaid FFS, we performed a repricing analysis on inpatient claims in the March 2019 through February 2020 base data.

The repricing analysis was performed by comparing reimbursement at the Medicaid FFS fee schedule effective during the March 2019 through February 2020 base data period, and the Medicaid FFS fee schedule anticipated to be effective during SFY 2022 for Conway Hospital and MUSC. The estimated impact of this adjustment based on SFY 2022 projected membership is an increase to inpatient hospital expenditures of approximately 2.2%, or $15.9 million.

Historical Program Change Review

Autism Spectrum Disorder (ASD) Services

Effective July 1, 2019, SCDHHS implemented a rate of $34.56 per hour for therapy services provided by Registered Behavioral Technicians (RBTs) and a rate of $62.96 per hour for therapy services provided by BCBAs and BCaBAs. An adjustment was applied to the March 2019 through June 2019 base data period to reflect the July 1, 2019 fee schedule update, resulting in an increase to base data ASD expenditures of approximately $0.2 million.

Breast Cancer (BRCA) Genetic Testing

Effective July 1, 2019, SCDHHS implemented a policy change to provide coverage of BRCA genetic testing to identify harmful mutations in either one of the two breast cancer genes (BRCA1 and BRCA2) as a state plan covered benefit, and added it to the managed care program covered services. Using emerging data through December 2020, an adjustment was applied to the base data period to reflect a full year of estimated BRCA genetic testing expenditures in the base period. The estimated impact of this adjustment is approximately $0.1 million.

Same Day Sick and Well Visit Policy

Effective July 1, 2019, SCDHHS implemented a policy change to permit coverage of well and sick visits on the same day for beneficiaries up to age 21 as a method to increase EPSDT participation. Using observed emerging utilization of well visits on the same data as sick visits following implementation of the policy change on July 1, 2019, an adjustment was applied to the base data period to reflect a full year of the same day sick and well visit policy change in the base period. The estimated impact of this adjustment is approximately $0.6 million,

Free-Standing Inpatient Psychiatric Facility carve-in for individuals up to age 21

Prior to July 1, 2019, all free-standing inpatient psychiatric facility services in IMDs for individuals up to age 21 were paid on a fee-for-service basis. Beginning on July 1, 2019, these services provided to managed care beneficiaries up to age 21 are included in the managed care capitation rate.

We estimated the impact of including IMD services in the managed care program effective July 1, 2019 by reviewing IMD encounter expenditures related to MCO-enrolled members up to age 21 by rate cell and repricing all SC DMH long-term psychiatric facility per diem rates to the January 1, 2020 fee schedule. The PMPM, including the impact of the SC DMH fee schedule change, observed for each rate cell during July 2019 through February 2020, when the service was carved-in to managed care, was applied to the March 2019 through June 2019 portion of the encounter base data period prior to the IMD carve-in. The estimated impact of this base data adjustment is approximately $4.5 million.

Figure 10 illustrates the build-up of the adjusted base data expenditures for the IMD children carve-in.

FIGURE 10: IMD CHILDREN CARVE-IN - ADJUSTED BASE DATA

	JUL 2019 - FEB 2020 REPRICED BASE DATA			MAR 2019 - JUN 2019 ADJUSTMENT			ADJUSTED BASE DATA		
	< 21 MEMBER MONTHS	PMPM	EXPENDITURES (MILLIONS)	< 21 MEMBER MONTHS	PMPM	EXPENDITURES (MILLIONS)	< 21 MEMBER MONTHS	PMPM	EXPENDITURES (MILLIONS)
Composite	4,791,075	$ 1.86	$ 8.9	2,378,882	$ 1.86	$ 4.4	7,169,957	$ 1.86	$ 13.3

Notes:

1. July 2019 through February 2020 base data includes all IMD encounter data for July 2019 through February 2020 MCO-enrolled individuals under age 21 repriced to the January 1, 2020 fee schedule.
2. March 2019 through June 2019 adjustment reflects the estimated impact to the base data period prior to the IMD carve-in (effective July 1, 2019).
3. Values are rounded.

IMD as an "In Lieu of" Service

Effective July 1, 2019, SCDHHS expanded the use of IMDs to all MH/SA diagnoses as an "in lieu of" service for the 21 to 64-year old managed care population for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment, we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

In addition, we reviewed utilization in another Medicaid state who recently implemented IMD as an "in lieu of" service, as well as emerging experience through October 2020. Based on our review of emerging utilization, we observed an estimated utilization increase of approximately 25% to the Inpatient MH/SA (non-PRTF) services for the adult population beginning July 1, 2019 as a result of the implementation of IMDs as an in lieu of service. The aggregate impact of these assumptions results in additional estimated expenditures of approximately $2.1 million to the base data.

A review of emerging IP MH/SA experience through October 2020 indicates a material shift between IP psychiatric utilization and IMD utilization. Based on this review, IMD utilization accounts for approximately 40% of total IP MH/SA utilization in the adult population. As such, the March 2019 through February 2020 adjusted base data is stratified between IP psychiatric services and IMD in-lieu-of as $13.7 million and $9.1 million, respectively. Figure 11 provides a summary of the adjusted base data to reflect new utilization for the portion of the base data period prior to the implementation of the July 1, 2019 IMD in lieu of provision and the repriced unit costs for IMD services represented in the base data.

FIGURE 11: IMD IN-LIEU OF PROJECTED UTILIZATION

	BASE DATA			ADJUSTED BASE DATA			
	IP PSYCH	IMD	TOTAL	IP PSYCH	IMD	ESTIMATED IMD NEW UTILIZATION	TOTAL
Utilization (Days)	22,723	9,109	31,832	20,484	9,109	4,547	34,141
Utilization per 1000	103.5	41.5	145.0	93.3	41.5	20.7	155.5
Cost per Day	$ 667.06	$ 604.40	$ 649.13	$ 667.06	$ 667.06	$ 667.06	$ 667.06
Total Expenditures (millions)	$ 15.2	$ 5.5	$ 20.7	$ 13.7	$ 6.1	$ 3.0	$ 22.8

Notes:

1. IP psychiatric and IMD base data includes all March 2019 through February 2020 IP MH/SA expenditures for the 21 to 64 managed care population.
2. Adjusted base data is split approximately 40% IMD and 60% other.
3. New utilization for IMD in-lieu-of services is assumed to reflect the unit cost of existing state plan providers and is therefore modeled after the IP psychiatric hospital cost per day ($667.06) in the base data.

Opioid Treatment Clinic Programs (OTPs) carve-in

Effective July 1, 2019, SCDHHS carved in OTPs for Medication-Assisted Treatment (MAT) for managed care beneficiaries with a confirmed diagnosis of opioid use disorder (OUD) to the managed care capitation rate. An adjustment was applied to the March 2019 through February 2020 base data to account for the following:

- **Effective date of carve-in.** OTP services were carved in to managed care July 1, 2019 and are therefore not represented in the March 2019 through June 2019 portion of the base data experience.
- **Ramp-up period**. We observed a ramp-up of OTP utilization from July 1, 2019 through February 2020. Therefore, an adjustment has been made to reflect a full year of experience in the base data at current utilization levels.

The adjustment was developed by reviewing emerging cost and utilization of OTP services through November 2020. Experience was stratified by rate cell to review emerging trends in methadone treatment prevalence of OUD-diagnosed individuals. Based on this review, we estimated the following methadone treatment prevalence for each population:

- TANF Children/SSI Children/Foster Care Children: 0.0% of OUD-diagnosed individuals
- TANF – Age 19-44 Male: 17.0% of OUD-diagnosed individuals
- TANF – Age 19-44 Female and OCWI: 14.0% of OUD-diagnosed individuals
- TANF – Age 45+: 10.0% of OUD-diagnosed individuals
- SSI Adult: 8.5% of OUD-diagnosed individuals

Based on monthly utilization and reimbursement rates observed in the emerging encounter data, an adjustment of approximately $3.7 million was applied to the base data period, reflecting total annual estimated expenditures of approximately $8.5 million.

Continuous Glucose Monitoring (CGM) Coverage

Effective July 1, 2019, SCDHHS included CGM devices and services as a state plan covered benefit. To estimate the impact of this program change, we identified CGM-eligible recipients based on diabetes diagnosis codes in the SFY 2019 base data. The CGM-eligible recipients were then stratified into the following categories based on SFY 2019 claims experience: diabetic members utilizing an insulin pump, diabetic members receiving an insulin prescription, but not using an insulin pump, and diabetic members without an insulin pump or insulin prescription in the base data.

CGM take-up rates were estimated based on a review of emerging utilization levels in the SC Medicaid managed care program through October 2020. Based on this review, the target utilization levels are as follows:

- Diabetic members utilizing an insulin pump: 70.0% of children and 62.5% of adults
- Diabetic members not utilizing an insulin pump, but receiving an insulin prescription: 32.5% of children and 2.5% of adults
- Diabetic members not utilizing an insulin pump or insulin prescription: 32.5% of children and 2.5% of adults

Based on guidance from SCDHHS, the annual costs of CGM services was estimated based on SCDHHS fee schedules and a 52-week supply of CGM sensors, or approximately $4,425. Utilizing the assumptions described above and $2.6 million of CGM expenditures already included in the base data, an historical adjustment was applied to the base data to reflect a full year of estimated CGM expenditures in the base period. The estimated impact of this adjustment is approximately $0.7 million.

Adult Podiatry

Effective January 1, 2020, SCDHHS added coverage of adult podiatry services for the 21 to 64 year old population as a state plan covered benefit and added it to the managed care program covered services. To estimate the impact of this program change, we reviewed emerging experience of adult podiatry services through October 2020. Based on this review, we observed increasing utilization from January through March 2020, a slight decrease in April and May 2020 at the onset of the COVID-19 public health emergency (PHE), followed by a rebound to higher levels in June 2020 that leveled out through the remainder of the experience period.

Assuming fully ramped-up utilization at the June 2020 through October 2020 level, the estimated annual impact of adding podiatry services to the adult aged 21 to 64 population is approximately $1.0 million. Approximately $0.5 million is reflected in the base period, resulting in a historical adjustment of approximately $0.5 million to increase the base period experience to total estimated expenditures of $1.0 million.

Prospective Program Change Review

COVID-19 Temporary Policy Change – Removal of E&M Copay

Effective March 15, 2020, SCDHHS implemented a temporary policy change to waive copayments for all evaluation and management (E&M) services for copay-eligible populations through the public health emergency (assumed to be December 31, 2021).

To estimate the impact of this policy change, we summarized E&M services in the base data period for the TANF 19-44 female, TANF 19-44 male, TANF 45+, and SSI Adult rate cells for individuals aged 21 and over. For each E&M visit, a copay of $3.30 was added to total service costs. For the dual rate cell, we reviewed emerging experience for E&M services and compared the average cost per E&M service during the COVID-19 PHE to the average cost per service prior to the removal of the copay. The adjustment was developed by repricing E&M services for the dual rate cell to the cost per service observed during the PHE, capped at an increase of $3.30 for each service. To reflect the anticipated effective period of this temporary policy change during the SFY 2022 contract year (July 2021 through December 2021), total estimated costs were multiplied by 0.5.

Utilizing the assumptions described above and projected SFY 2022 member months, total SFY 2022 expenditures were increased by approximately $1.9 million.

COVID-19 Diagnostic Testing

Effective February 4, 2020, SCDHHS implemented coverage of COVID-19 diagnostic testing without prior authorization or copayment for all populations. To estimate the impact of this covered benefit, we reviewed emerging data for July 2020 through December 2020 and stratified the population into two segments: individuals 16 and over, and individuals under age 16, whom the COVID-19 vaccine is not yet available.

- **Individuals 16 and over**: The estimated PMPM for the July 2020 through December 2020 time period was $2.69, split between outpatient hospital ($1.15) and professional services ($1.54). Based on availability of the COVID-19 vaccine for all South Carolina residents aged 16 and over as of March 31, 2021[5] and review of COVID-19 vaccine administration published by the South Carolina Department of Health and Environmental Control, we assumed total COVID-19 diagnostic testing would decrease by approximately 75% during the SFY 2022 contract year relative to the July 2020 through December 2020 time period.

[5] https://scdhec.gov/covid19/covid-19-vaccine/covid-19-vaccine-faqs

- **Individuals under age 16**: The estimated PMPM for the July 2020 through December 2020 time period was $1.72, split between outpatient hospital ($0.76) and professional services ($0.96). Because the COVID-19 vaccine is not yet available for children under age 16, we have assumed COVID-19 diagnostic testing will remain at historical levels through the first 3 months of the contract year, decrease to 75% of historical levels for October through March 2022, and ultimately dropping to 50% of historical levels for April through June 2022 as more of the general population becomes vaccinated.

Utilizing the assumptions described above and projected SFY 2022 member months, total SFY 2022 COVID-19 diagnostic testing expenditures are estimated at approximately $14.3 million.

Extended coverage of up to six (6) month supply of contraceptives

Effective July 1, 2020, SCDHHS implemented a policy change to allow coverage for up to a 6 month supply of systemic contraceptives, including oral contraceptives, vaginal rings, and transdermal patches. To estimate the impact of this program change, we summarized the base data to identify individuals utilizing contraceptives with gaps in their monthly prescriptions.

Based on information from SCDHHS where the FFS program already provides this level of coverage, we assumed that 25% of these individuals would request a 6 month prescription once the coverage period is extended.

We assumed no impact for individuals who filled a prescription each month beginning with their first contraceptive prescription. The average monthly cost of the targeted contraceptives is estimated at approximately $25 (6-month supply = $148). Assuming one new 6-month prescription for each targeted individual results in an estimated impact of approximately $1.2 million.

Hepatitis-C pharmaceutical carve-in

Effective July 1, 2020, SCDHHS carved in all Hepatitis C pharmaceutical costs to the managed care program. Based on our review of emerging SFY 2021 utilization, total Hepatitis C pharmaceutical scripts is estimated at approximately 870 in SFY 2022, based on projected membership levels. The cost per script is assumed to be approximately $10,300, based on anticipated treatment utilization of approximately 45% Mavyret and 55% generic treatments (primarily generic Epclusa). Utilizing the assumptions described above and projected SFY 2022 member months, total SFY 2022 expenditures are estimated at approximately $9.0 million.

FIGURE 12: HEPATITIS C CARVE-IN - PROJECTED COSTS

		SFY 2022 ASSUMPTIONS				
	BASE PERIOD MEMBER MONTHS	TOTAL SCRIPTS	COST PER SCRIPT	PMPM	SFY 2022 MEMBER MONTHS	PROJECTED EXPENDITURES (MILLIONS)
Composite	9,596,592	877	$ 10,312	$ 0.75	11,993,881	$ 9,000,000

Notes:
1. Composite PMPM is developed based on distribution of SFY 2022 projected member months
2. Values are rounded

Foster Care Initial Assessment

Effective July 1, 2020, SCDHHS defined a new procedure code and modifier combination to provide additional reimbursement for comprehensive examinations for foster care children to reflect the added complexity of the administrative and consultative portion of the initial exam. The additional reimbursement is assumed to apply to all new patient E&M visits for foster care children (i.e., both sick and well visits) and is assumed to be reimbursed at $84.44 per visit.

The projected costs associated with the foster care initial assessment were developed by stratifying each unique member in the foster care children rate cell base data into one of three categories:

(1) Utilized only “established patient” well or sick visits in the base period
(2) At least one “new patient” well or sick visit in in the base period
(3) Had neither a “new patient” or “established patient” well or sick visit in in the base period

For individuals in category 1, no additional impact was assumed as a result of this program change. For group 2, we assumed each new patient well or sick visit would be increased by $84.44, and for individuals in category 3, we assumed each individual would have one new patient E&M visit in SFY 2022. The assumed cost of a new patient E&M visit was estimated at $120 to reflect the average new patient well visit reimbursement in the Enhanced Physician Fee Scheduled, effective July 1, 2019. Additionally, each visit is assumed to include the $84.44 per visit add-on code, resulting in a net impact of $204.44 per visit for each individual in group 3. The total impact is applied to the office/home visits/consults category of service and is estimated at approximately $0.8 million.

Therapeutic Foster Care (TFC) Rate Restructure

Effective July 1, 2020, SCDHHS updated the reimbursement methodology for families billing psychosocial rehabilitative services (PRS) for TFC children through the Child Placing Agencies, serving as TFC providers. The PRS reimbursement for TFC children transitioned from a discrete 15-minute unit reimbursement rate to a three-tier per diem structure, based on TFC level of care authorizations established by the Department of Social Services (DSS).

The per diems by TFC level of care are as follows:

(1) TFC Level I = $29.95
(2) TFC Level II = $45.57
(3) TFC Level III = $65.10

To estimate the impact of this program change, we utilized the TFC member lists provided by DSS to stratify each child into the appropriate TFC authorization level. Based on this review, the observed distribution of TFC children was 32% TFC Level I, 31% TFC Level II, and 37% TFC Level III.

Total monthly utilization (reported in 15 minute units) was summarized for each TFC child to estimate the average billed units per day and average daily expenditures under the current 15-minute reimbursement rate. The current expenditures were then compared to estimated expenditures under the updated July 1, 2020 per diem structure for each TFC level. Based on emerging experience, TFC children are anticipated to utilize PRS services approximately 97% of days each month, or 354 days a year. Based on this review, the estimated impact of the TFC rate restructure is approximately $0.4 million. The total impact is applied to the MH/SA professional category of service for the foster care children rate cell.

Group Psychotherapy

Effective July 1, 2021, SCDHHS anticipates increasing the maximum limit of beneficiaries allowed within a group psychotherapy and multi-family group psychotherapy session from 8 to 10 beneficiaries for MUSC and DMH providers.

To estimate the impact of this program change, we reviewed utilization of group psychotherapy services at MUSC and DMH providers in the base data and assumed a 25% increase in utilization to reflect the increase from 8 to 10 beneficiaries per session. The estimated impact of this program change is $0.6 million and is applied to the MH/SA professional category of service for all impacted rate cells.

Circumcision

Effective July 1, 2021, SCDHHS anticipates adding routine newborn circumcisions as a state plan covered benefit. Based on our survey of each MCO, newborn circumcisions are currently covered in the managed care program. Therefore, prior to SCDHHS's decision to include newborn circumcisions as a state plan covered benefit, total physician services related to newborn circumcisions of approximately $0.9 million were removed from the base data through the application of in-rate criteria. To reflect the impact of this policy change, the expenditures removed from the base data were added back in to the applicable service category and rate cell. The application of trend and prospective changes to the base data expenditures results in an estimated impact of $1.0 million.

Changes in Covered Population

Newborn Enrollment

Disruptions in processing eligibility for newborns caused a delay in newborn enrollment into the managed care program. We reviewed FFS data for all MCO-enrolled newborns to quantify the impact of the delayed enrollment into the managed care program. We reviewed FFS expenditures for MCO-enrolled individuals in the 0-2 month capitation rate cell.

An adjustment was made to increase the encounter base data by $0.6 million, an increase of 0.4% to the 0-2 month rate cell, to include these expenditures that are expected to be covered by the MCOs during the SFY 2022 contract year.

Families First Coronavirus Response Act (FFCRA) – Disenrollment Freeze

In response to the FFCRA enacted on March 18, 2020, SCDHHS will treat all individuals eligible for Medicaid as of March 1, 2020 as eligible for such benefits through the end of the month in which the PHE ends. It is possible that the COVID-19 pandemic, as well as future legislative changes to address the pandemic, could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this report. Due to this uncertainty, we have relied on SCDHHS to provide certain COVID-19 assumptions related to the PHE duration and redetermination timing. In consultation with SCDHHS, we have assumed the following related to the FFCRA disenrollment freeze and the redetermination reinstatement process:

- The PHE is anticipated to continue through December 31, 2021.
- Beginning in January 2022, individuals impacted by the disenrollment freeze will be included in an eligibility review process, with the first disenrollments anticipated to occur March 1, 2022 and to be completed over a 12-month period.
- The eligibility review process is anticipated to follow a hierarchy for high priority groups as follows: (1) children over age 19 (in the TANF adult rate cells); (2) pregnant women past post partum period; (3) TANF adults who are no longer categorically eligible.
- Total net reductions in monthly enrollment not to exceed 21,000 members.

The FFCRA disenrollment freeze is anticipated to impact all rate cells, with the exception of the TANF infant rate cells (age 0-12 months), the Foster Care Children rate cell, and the maternity KICK payment.

To estimate the anticipated enrollment growth resulting from the disenrollment freeze, we reviewed emerging managed care enrollment through May 2021.

As a result of this review, we assumed the following monthly enrollment increases through February 2022, prior to the first disenrollments anticipated in March 2022:

- **TANF Children**: Approximately 3,600 individuals per month
- **TANF Adult**: Approximately 3,900 individuals per month
- **OCWI**: Approximately 1,100 individuals per month

To estimate the morbidity impact of this enrollment change to the base data PMPM, we reviewed the last six months of expenditures for each disenrolled monthly cohort in CY 2019 to calculate the relative morbidity to the average PMPM for the total rate cell for that same period.

For the OCWI rate cell, we stratified emerging monthly enrollment through November 2020 into two categories: (1) OCWI individuals within the assumed eligibility period (from 9 months pre-delivery to 2 months post-partum) and (2) OCWI individuals who are 3 or more months post-delivery. For each month in the emerging experience period, we compared the relative costs between the two cohorts described above.

Compositing and averaging these results across the observed experience period, the following relativities were observed and applied to the March 2019 through February 2020 base data for each rate cell:

FIGURE 13: FFCRA - DISENROLLMENT FREEZE REVIEW

RATE CELL	SFY 2022 PROJECTED ENROLLMENT: WITHOUT DISENROLLMENT FREEZE	ANTICIPATED GAIN IN ENROLLMENT	ANTICIPATED MIX (% DISENROLLMENT FREEZE)	RELATIVITY TO BASE DATA	ADJUSTMENT FACTOR
TANF - Age 1 - 6	2,238,753	349,471	13.5%	0.90	0.9865
TANF - Age 7 - 13	2,690,532	309,881	10.3%	0.80	0.9793
TANF - Age 14 - 18, Male	768,350	199,029	20.6%	0.80	0.9589
TANF - Age 14 - 18, Female	775,062	200,703	20.6%	0.80	0.9589
TANF - Age 19 - 44, Male	268,683	288,871	51.8%	0.80	0.8964
TANF - Age 19 - 44, Female	1,380,331	547,180	28.4%	0.80	0.9432
TANF - Age 45+, Male & Female	232,899	101,934	30.4%	0.85	0.9543
SSI - Children	128,585	7,066	5.2%	0.70	0.9844
SSI - Adult	606,172	28,983	4.6%	1.00	1.0000
OCWI	157,736	232,797	59.6%	0.60	0.7616

Program changes deemed immaterial to benefit expenses in the rate period

Adjustment factors were developed for policy and program changes estimated to ***materially*** affect the managed care program during SFY 2022 that are not fully reflected in the base experience.

Program adjustments were made in the rate development process to the extent a policy or reimbursement change is deemed to have a material cost impact to the MCOs. In general, we defined a program adjustment to be 'material' if the total benefit expense for any individual rate cell is impacted by more than 0.1%. The following is a list of program adjustments deemed immaterial based on our review of the experience data and policy change.

- **Removal of ambulatory care 12-visit limit.** Effective March 15, 2020, SCDHHS implemented a temporary policy change to remove the limitation of twelve (12) ambulatory care visits per year for beneficiaries aged 21 and over through the end of the public health emergency (assumed to be December 31, 2021). Based on our survey of each MCO, ambulatory care visits are currently not limited for the adult populations in the managed care program; therefore, we have assumed the impact to be immaterial to the SFY 2022 capitation rates.
- **Removal of early refill edit**. Effective March 15, 2020, SCDHHS implemented a temporary policy change to allow beneficiaries to bypass early refill edits through the end of the PHE (assumed to be December 31, 2021). We reviewed early refills, defined as a refill prior to 75% of the prior prescription used, on 30-day supply prescriptions from March 2020 through December 2020 and summarized the percentage that accumulated more than one additional prescription over the 10 month period. Based on this review, we have assumed the impact to be immaterial to the SFY 2022 capitation rates.
- **Expanded telehealth services.** Effective March 15, 2020, SCDHHS expanded coverage for telephonic and telehealth services. Based on guidance from SCDHHS, we have assumed that expanded telehealth services will continue beyond the termination of the public health emergency. To estimate the impact of this policy change, we reviewed telephonic and telehealth experience from April 2020 through December 2020, identified by procedure code and modifier as documented in SCDHHS provider bulletins published in March and April 2020. Based on this review, we observed that a large portion of the telehealth services appeared to be replacements for in-office visits, as opposed to new utilization; therefore, we assumed the impact to be immaterial to the SFY 2022 capitation rates
- **Exception to the IMD exclusion for certain pregnant and postpartum women.** The Centers for Medicaid and CHIP Services (CMCS) issued an Informational Bulletin on July 26, 2019 providing guidance to states on section 1012 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act)[6].

  Effective October 1, 2020, SCDHHS implemented section 1012 of the SUPPORT for Patients and Communities Act. This policy change permits a new limited exception to the "IMD exclusion rule" for a woman who is eligible on the basis of being pregnant (and up to 60-days postpartum), who is a patient in an IMD receiving treatment for substance use disorder, and who is either enrolled under the state plan immediately

[6] CMCS Information Bulletin (July 26, 2019): https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib072619-1012.pdf, Accessed May 6, 2021.

before becoming a patient in the IMD or who becomes eligible to enroll while a patient in an IMD. This exception is assumed to have no impact on the coverage of IMD stays (i.e., the 15 day limit in a month for IMD "in lieu of" services still applies). The managed care impact is assumed to be limited to coverage of services provided outside the IMD while in an IMD for greater than 15 days in a month. The total impact of this revision is assumed to impact the OCWI population only and is estimated to be less than 0.1% of the OCWI rate cell and therefore deemed immaterial

(e) Exclusion of payments or services from the data

The following section documents exclusions and adjustments made to the base experience data: non-state plan services as identified by the in-rate criteria included in Appendix 5, pharmacy rebates, third party liability recoveries, non-encounter claims payments, pharmacy non-benefit costs, and state plan services not covered by the capitation rate.

Services excluded from initial base data summaries

Non-State Plan Services

We excluded all services included in the encounter data that do not reflect approved state plan services (nor are an approved in-lieu of service). All claims for non-state plan services, totaling approximately $1.3 million, were excluded from the base experience data included in Appendix 6.

Please note that consistent with the "Circumcision" program change described in Section I, item 2.B.iii.(d), circumcision services are anticipated to be added to the state plan effective July 1, 2021 and are included in the rates through the prospective program change adjustment discussed above.

State Plan Services Not Covered by the Capitation Rate

We excluded all services included in the encounter data that do not reflect covered benefits in the managed care program.

These services were identified through the application of in-rate criteria provided by SCDHHS and included in Appendix 5. All claims for non-covered services, totaling approximately $1.1 million, were excluded from the base experience data included in Appendix 6.

Institution for Mental Disease (IMD) Stays Greater than 15 Days

We excluded all costs and associated member months for enrollees aged 21 to 64 associated with an IMD stay of more than 15 days in a calendar month. This exclusion included any other costs outside of the IMD for any services delivered during the time an enrollee was in the IMD for more than 15 days.

All claims and associated member months associated with IMD stays greater than 15 days for the age 21 to 64 population, totaling approximately $0.4 million and 45 member months, respectively, were excluded from the base experience data included in Appendix 6.

Adjustments made to base data

Pharmacy Rebates

Based on analysis of supplemental rebate percentages during SFY 2020 reported by the MCOs in the SFY 2022 MCO Survey, pharmacy expenditures were reduced by approximately 2.5% to reflect aggregate rebate percentage levels achievable by MCOs. Although rebate information for the specific base data period of March 2019 through February 2020 was unavailable, the rebate percentages reported for SFY 2020 are assumed to be representative of the rebate percentages applicable to March 2019 – February 2020. The estimated adjustment factor of 0.975 was uniformly applied to the pharmacy service category of each rate cell, excluding Dual, in Appendix 6.

Third Party Liability/Fraud and Abuse

In addition to actual cost avoidance reflected in the encounter data, we estimated additional third-party liability (TPL) and fraud recoveries based on an analysis of information submitted by the MCOs. Although TPL and fraud recoveries data for the specific March 2019 through February 2020 base data period was unavailable, we utilized summary information for CY 2019 and SFY 2020 reported by the MCOs.

These data sources indicated that approximately 0.06% of total claims were recovered and not reflected in the baseline experience data. The estimated adjustment factor of 0.9994 was uniformly applied to each service category and rate cell, excluding Dual, in Appendix 6.

Non-encounter Claims Payment

We made an adjustment to the encounter base data period to reflect non-claim payments made to providers for items such as shared savings payments, quality incentives, and other similar provider incentive payments that are not reflected in the base data or in other components of the capitation rate. Information on non-claim payments made to providers for the specific base data period of March 2019 through February 2020 was unavailable, however the MCOs reported SFY 2020 non-encounter claims payments in the SFY 2022 MCO Survey. We have reviewed the information provided by the MCOs and included approximately $8.5 million in payments in the benefit cost component of the capitation rate development. This is reflected by an adjustment factor of 1.0033, uniformly applied to each service category and rate cell, excluding Dual, in Appendix 6.

Pharmacy Non-Benefit Cost Adjustment

We made an adjustment to the encounter base data period to reflect non-benefit cost payments made to pharmacy benefit managers for administrative services. We have reviewed the information provided by the MCOs and removed approximately $10.8 million from the benefit cost component of the capitation rate development. This is reflected by an adjustment factor applied to the retail pharmacy category for each rate cell, excluding Dual, in Appendix 6.

Leap Year Adjustment

The base data period of March 2019 through February 2020 included February 29, 2020, resulting in one extra weekend day in the base data relative to the SFY 2022 rating period. We reviewed the relative cost impact of days that fall on a weekend versus a weekday and removed approximately $2.9 million from the base data to account for the removal of one weekend day. This is reflected by an adjustment factor of 0.9989, uniformly applied to each service category and rate cell in Appendix 6.

BabyNet Adjustment

Effective July 1, 2019, SCDHHS carved-in BabyNet services for infants and toddlers under age 3 to the Medicaid managed care program. Because the BabyNet program is funded through a federal grant, expenditures related to this program are not subject to the Federal Medical Assistance Percentage (FMAP). As such, all expenditures related to BabyNet are excluded from the SFY 2022 base capitation rate development and included as a separate BabyNet component to recognize the difference in funding sources.

Because BabyNet services were carved-in to managed care July 1, 2019, the base data period of March 2019 through February 2020 includes BabyNet services for dates of service on or after July 1, 2019. To estimate the BabyNet claims to be removed from the base data, we reviewed SFY 2019 historical experience from Bridges invoice data provided by SCDHHS to estimate the percentage of MCO members accessing BabyNet services through Bridges and the estimated cost per month for those services. Based on this review, we removed approximately $0.8 million from the base data that is assumed to be related to BabyNet expenditures.

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-state plan services as identified by the in-rate criteria included in Appendix 5 have been excluded from the capitation rate development process. Effective July 1, 2019, SCDHHS expanded the use of IMDs as an in lieu of service for MH/SUD treatments for the 21 to 64-year-old population for up to 15 days per month.

ii. Basis for Variation in Assumptions

Any assumption variation between covered populations is the result of program differences and is in no way based on the rate of Federal financial participation associated with the population.

iii. 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. Additionally, consideration of other factors and data sources appropriate for benefit cost trend development is further documented in Section I, item 3.B.iii.

iv. In Lieu Of Services

SCDHHS began permitting the use of IMDs as an in lieu of service provider for substance use disorders effective July 1, 2018. Effective July 1, 2019, SCDHHS expanded the use of IMDs to provide in lieu of services for mental health and substance use disorder treatments for up to 15 days per month. Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment, we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

We reviewed benefit costs for enrollees aged 21 to 64 during the base experience period to identify costs associated with an IMD stay of more than 15 days in a month and any other MCO costs for services delivered in a month when an enrollee had an IMD stay of more than 15 days. These costs and associated enrollment were identified and removed from the encounter data. In addition, as noted above we did not use the unit cost of the IMD as an in lieu of service, and instead utilized the unit cost for that of existing state plan providers.

v. IMDs as an in lieu of service provider

Effective July 1, 2019, SCDHHS began permitting the use of IMDs as an in lieu of service for all MH/SUD services for the 21 to 64-year-old population for up to 15 days per month.

(a) Costs associated with an IMD stay of more than 15 days

We excluded all costs and associated enrollment for enrollees aged 21 to 64 associated with an IMD stay of more than 15 days in a calendar month. This exclusion included any other costs outside of the IMD for any services delivered during the time an enrollee was in the IMD for more than 15 days. All claims associated with IMD stays greater than 15 days for the age 21 to 64 population, approximately $0.4 million, were excluded from the base data experience included in Appendix 6.

(b) Other costs for services during the time an enrollee is in an IMD for more than 15 days

All costs for services delivered during the time an enrollee was in the IMD for more than 15 days in a calendar month were excluded from the base data.

B. APPROPRIATE DOCUMENTATION

i. Projected Benefit Costs

This section provides the 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 unadjusted cost model summaries for the managed care population**

  The capitation rates were primarily developed from historical claims and enrollment data from the managed care enrolled populations. The data utilized to prepare the base period cost models consisted of March 2019 through February 2020 incurred encounter data that has been submitted by the MCOs. The information is summarized in Appendix 6 and is stratified by capitation rate cell and by major category of service. With the exception of removing the items outlined in the "Services excluded from initial base data summaries" section above, the exhibits in Appendix 6 reflect *unadjusted* summaries of the base period data and are the combination of the MCO-specific encounter data summaries that were validated by each MCO.

- **Step 2: Apply historical and other adjustments to cost model summaries**

  As documented in the previous section, utilization and cost per service rates from the base experience period were adjusted for a number of items, including, but not limited to, incomplete data adjustments, pharmacy rebates, TPL, and pharmacy non-benefit costs.

- **Step 3: Adjust for prospective program and policy changes and trend to SFY 2022**

  We adjusted the March 2019 through February 2020 base experience for known policy and program changes that have occurred or are expected to be implemented between the base period and the end of the SFY 2022 rate period. In the previous section, we documented these items and the adjustment factors for each covered population. Assumed trend factors were applied for 28 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 (September 1, 2019) to the midpoint of the rate period (January 1, 2022).

As described later in this section, further adjustments were applied to the base data experience to reflect targeted improvements in managed care efficiency for specific rate cells and service categories that are estimated to impact projected SFY 2022 benefit expense. The PMPMs resulting from the application of these adjustments established the adjusted benefit expense by population rate cell for the rating period.

Material adjustments that were previously noted

The following material adjustments were applied to recognize changes to provider reimbursement, historical program adjustments, prospective program adjustments, and changes to covered populations and were documented in Section I, item 2.B.iii (Data Adjustments):

- Claims completion
- Physician reimbursement, including the following fee schedule updates:
  - July 1, 2020, and July 1, 2021 FQHC PPS fee schedule
  - July 1, 2019 DME fee schedule
  - July 1, 2019 general practice physicians
  - July 1, 2019 ASD fee schedule update for RBTs and BCBAs/BCaBAs
  - July 1, 2020 vision fee schedule
  - July 1, 2020 anesthesia fee schedule
  - July 1, 2020 Therapeutic Foster Care rate restructure
- Inpatient hospital reimbursement changes related to Conway Hospital and MUSC
- IMD services for beneficiaries up to age 21
- MAT services at OTPs

- Addition of CGM coverage for children and adults
- Addition of BRCA genetic testing
- Expansion of IMD in lieu of services
- Program changes for same day sick and well visits
- Addition of adult podiatry services
- Addition of COVID-19 diagnostic testing services
- Addition of foster care initial assessment
- Extended coverage of up to 6-month supply of contraceptives
- Addition of Hepatitis C pharmacy treatment coverage
- Population adjustments as a result of the COVID-19 national emergency
- Increased group psychotherapy limit from 8 to 10 beneficiaries for MUSC and DMH providers
- Addition of circumcision

Additionally, the following adjustments were applied to either reduce or increase the base data benefit cost for certain service and payment exclusions:

- Pharmacy rebates
- Pharmacy non-benefit costs
- Missing encounter data
- TPL/Fraud and Abuse
- Non-encounter claim payments
- Managed care in-rate claims paid FFS for managed care enrollees
- Leap year adjustment
- BabyNet adjustment

Other material adjustments – managed care efficiency

We calculated percentage adjustments to the experience data to reflect the utilization and cost per unit differential between the base experience and the levels targeted for the projection period managed care environment. We developed the targeted managed care efficiency adjustments through a review and analysis of the following:

- March 2019 through February 2020 base period utilization and contracting levels achieved by each MCO
- Potentially avoidable emergency room utilization
- Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI) for inpatient admissions
- Generic drug dispensing rates by therapeutic class
- Mix of vaginal and cesarean section deliveries in the SFY 2019 base period utilization

Emergency Room Services - For the outpatient hospital emergency room service category, multiple potentially avoidable diagnosis groups were clinically developed using the primary diagnosis of each claim. The potentially avoidable diagnosis groups were stratified by severity to target potentially avoidable emergency room visits in the three lowest severity groups. Additionally, potentially avoidable outpatient hospital emergency room visits were summarized by rate cell. Target utilization levels were developed for each diagnosis grouping and rate cell. The following illustrates the adjustments by population group:

- Disabled Children and Adults, TANF Children and OCWI – 5% reduction of potentially avoidable
- TANF Adults – 10% reduction of potentially avoidable

When applying the adjustments listed above, reductions were taken from level 1 emergency room claims first, followed by level 2 and level 3 claims if applicable. No adjustments were made to level 4 or level 5 emergency room claims. In coordination with determination of the managed care adjustments for hospital outpatient emergency room services, we assumed that 95% of emergency room visits reduced would be replaced with an office visit. Additionally, we reviewed historical data, along with data from other Medicaid states, to develop assumptions for additional services that may also be included with an office visit.

Based on this review, additional services related to pathology/lab, office administered drugs, and radiology were included with the replacement office visit. The overall impact of the emergency room service efficiency adjustment is a decrease of approximately $1.2 million.

Inpatient Hospital Services – We applied managed care adjustments to reflect higher levels of care management relative to the March 2019 through February 2020 base experience period. We identified potentially avoidable admissions using the AHRQ PQIs. Inpatient hospital managed care adjustments were developed by applying a 10% reduction to readmissions for the same DRG within 30 days, and a 10% reduction to potentially avoidable inpatient admissions for select PQIs. No adjustments were made to corresponding inpatient physician charges to account for the potential shift of these services to an ambulatory setting. Additionally, nursing facility claims were excluded from this analysis. The table below outlines the PQIs included in our analysis.

FIGURE 14: AHRQ PREVENTION QUALITY INDICATORS

NUMBER	DESCRIPTION
PQI #01	Diabetes Short-term Complications Admission Rate
PQI #03	Diabetes Long-term Complications Admission Rate
PQI #05	Chronic Obstructive Pulmonary Disease (COPD) Admission Rate
PQI #07	Hypertension Admission Rate
PQI #08	Congestive Heart Failure (CHF) Admission Rate
PQI #11	Bacterial Pneumonia Admission Rate
PQI #12	Urinary Tract Infection Admission Rate
PQI #14	Uncontrolled Diabetes Admission Rate
PQI #15	Adult Asthma Admission Rate
PQI #16	Rate of Lower-extremity Amputation among Patients with Diabetes

Pharmacy Services – Our review of historical pharmacy experience for managed care efficiencies included an evaluation by capitation rate cell and therapeutic class for each MCO to estimate achievable generic drug dispensing rates (GDR), as well as a review of MCO contracting of discounts for brand and specialty drugs.

For each therapeutic class, we estimated the impact of improvements in GDR amounts by shifting drug utilization in the MCO historical experience to levels achieved by other MCOs during the same time period. Per guidance from SCDHHS and clinical review, antiretroviral and benzisoxazole drugs were excluded from the analysis of GDRs. The shift in the target GDR resulted in a 0.6% managed care savings to the prescription drug category of service, or a reduction of approximately $3.0 million.

In addition, we evaluated pharmacy contracting by repricing brand and generic drugs to average wholesale price (AWP). MCOs were ranked by their ratio of expenditures to AWP for both brand and generic drugs. For each drug type, the aggregate MCO AWP contract value for the lowest-performing MCO was targeted at the AWP contract value of the second lowest-performing MCO. This resulted in a 0.5% managed care savings to the prescription drug category of service, or a reduction of approximately $3.4 million.

Delivery Services – Delivery managed care efficiency adjustments were developed by analyzing the percent of cesarean and vaginal deliveries by hospital. Vaginal delivery percentages were adjusted to target 69% of all deliveries in the managed care program, consistent with SFY 2021 expectations. This assumption was based on review and consideration of the following:

- March 2019 through February 2020 vaginal/cesarean section delivery mix for the top performing hospitals that collectively perform at least 40% of deliveries in the encounter data; and,
- The birth outcomes initiative implemented by SCDHHS to reduce elective induction and cesarean section deliveries prior to 39 weeks gestation.

Managed care savings were estimated by evaluating the cost per delivery difference between cesarean and vaginal deliveries for facility and physician services. No adjustments were made to the total number of deliveries. The overall impact to the KICK rate cell is a decrease of approximately 0.7%, or $1.2 million.

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

All rate development data and material assumptions are documented in this rate certification report and the overall methodology utilized to develop the capitation rates is consistent with the prior rate-setting analysis, with the exception of developing capitation rates from a base data period that is not a state fiscal year. The base data time period for the SFY 2022 capitation rate development has been selected to reflect program experience prior to the declaration of the COVID-19 State of Emergency in South Carolina in March 2020, and therefore reflects the 12-month period ending February 2020.

(c) Overpayments to providers

Consistent with 42 CFR 438.608(d), SCDHHS outlines the program integrity guidelines and reporting requirements related to overpayments, recoveries, and refunds in Section 11.6 of the MCO contract found here: https://msp.scdhhs.gov/managedcare/sites/default/files/2018%20MCO%20Contract%20Boilerplate%20-%20Amendment%20VII%20Final.pdf.

Overpayments to providers as a result of fraud, waste, and abuse and TPL activity are reported by the MCOs in the MCO Survey and discussed in greater detail in Section 2.B.iii.(e), adjustments to base data.

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 (March 2019 – February 2020) to the SFY 2022 rating period of this certification. We evaluated prospective trend rates using historical experience for the South Carolina Medicaid managed care program, as well as external data sources. Our trend analysis included a review of both experience prior to the COVID-19 public health emergency and experience emerging through calendar year 2020 as appropriate to gain an understanding of the impact of COVID-19 on utilization and cost in our development of trend rate assumptions to be applied from the base period to the SFY 2022 contract period.

(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 three years of cost and utilization experience, from SFY 2018 through the base experience period (March 2019 – February 2020), as well as emerging data as appropriate.

External data sources that were referenced for evaluating trend rates developed from SCDHHS data include:

- *National Health Expenditure (NHE) projections* developed by the CMS office of the actuary, specifically those related to Medicaid. Please note that as these are expenditure projections, projected growth reflects not only unit cost and utilization, but also aggregate enrollment growth and enrollment mix changes such as aging. NHE tables and documentation may be found in the location listed below:

  https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html
- Magellan Rx Management – Medicaid Pharmacy Trend Report 2020 Fifth Edition (November 2020) found in the location listed below:

  https://www1.magellanrx.com/read-watch-listen/read/our-publications/medicaid-pharmacy-trend-report

Other sources: We also reviewed internal sources that are not publicly available, such as historical experience from other programs and trends used by other Milliman actuaries

Methodology

Non-pharmacy trends

Using internal SCDHHS data, historical utilization and per member per month cost data was stratified by month, rate cell, and category of service.

The data was adjusted for completion and normalized for historical program, reimbursement changes, and acuity. We developed trend rates to adjust the base experience data (midpoint of September 1, 2019) forward 28 months to the midpoint of the contract period, January 1, 2022. Rolling 12-month, 6-month, and 3-month trends were calculated to identify changes in the underlying patterns over time, and two-year annualized trends were utilized to smooth out significant fluctuations from year to year.

As a result of the COVID-19 public health emergency (PHE), we analyzed both experience prior to the PHE and emerging CY 2020 experience by population and major service category to gain an understanding of the impact of COVID-19 on the managed care program experience. We applied our selected trend to each population and major service category and calculated the residual trend from the emerging experience period to the rate period to assess the reasonableness of our trend rate assumptions that are applied for 28 months from the base period midpoint to the rate period midpoint.

For all non-pharmacy service categories, the trend rates were applied to utilization only, while reimbursement was explicitly addressed in Section I, item 2.B.iii of this certification report.

Trend rates were developed by population (TANF Adult, TANF Child, TANF Infants, SSI Adult, SSI Child, OCWI, Foster, Dual and Kick) and by service category.

Historical trends should not be used in a simple formulaic manner to determine future trends; actuarial judgment is also required. We also referred to alternative sources, both publicly available and internal Milliman information. We also considered shifting population mix and the impact of reimbursement changes on utilization in each specific population.

Pharmacy trends

Using internal SCDHHS data, historical scripts and per member per month cost data was stratified by month and population. The data was normalized for historical pharmacy spread, Hepatitis C claims, and acuity. To account for changes in underlying trend patterns and to understand COVID-19 disruption, we reviewed emerging data through November 2020 by populations. Rolling 12-month, 9-month, 6-month, and 3-month trends were calculated to identify changes in the underlying patterns over time. Pharmacy trends where developed by population (TANF Child, TANF Adult, SSI Adult, SSI Child and OCWI).

Similar to the analysis performed on other medical services, we analyzed both experience prior to the PHE and emerging CY 2020 experience by population to gain an understanding of the impact of COVID-19 on the managed care program experience. We applied our selected pharmacy trend to each population and calculated the residual trend from the emerging experience period to the rate period to assess the reasonableness of our trend rate assumptions that are applied for 28 months from the base period midpoint to the rate period midpoint.

Additionally, we reviewed results from our internal Medicaid pharmacy model (trend model) which was developed to study and project detailed pharmacy trend information. Because of the disruptions in pharmacy utilization related to the COVID-19 public health emergency, we reviewed projected results from the trend model as well as normalized emerging experience described above to gain further insight into emerging trends.

The trend model summarizes pharmacy claims data by month, drug type (brand, generic, specialty brand, and specialty generic), covered population, and therapeutic class (according to GPI-4 assignments). For this analysis, we used data with dates of service incurred through November 2020, and projected through SFY 2022. Projected values are estimated using the base period data as a starting point and applying anticipated shifts and trends. As we reviewed the trend model results, we considered several items such as brand patent loss, cost per script trends, and changes in utilization.

Pharmacy high cost no experience program

Effective July 1, 2020, SCDHHS implemented a pharmacy HCNE program for newly-approved high cost pharmacy treatments that are not fully reflected in the base data. The program is anticipated to continue through the SFY 2022 contract year. Projected pharmacy trends reflect the impact of this program, which is described in greater detail in Section I, Item 4.C.

Comparisons

As noted above, we did not explicitly rely on the historical MCO encounter data trend projections due to anomalies observed in the historical trend data. In addition to referencing external data sources and emerging experience in the encounter data, we also reviewed the utilization trends assumed in the SFY 2021 capitation rate development to determine if any adjustment to the trend assumption was appropriate for the SFY 2022 rating period. The dual population medical non-pharmacy trends are consistent with trend assumptions developed for the calendar year (CY) 2021 Healthy Connections Prime Community population.

Explicit adjustments were made outside of trend to reflect all recent or planned changes in medical reimbursement and anticipated acuity changes from the base period to the rating period.

Chosen trend rates

Figure 15 illustrates the utilization component of the trend by rate cell and category of service for the SFY 2022 capitation rate development. The utilization component includes both the trend in number of units as well as the mix or intensity of services provided. The chosen trend rates do not include any outlier or negative trends. Additionally, these trends reflect the impact of the pharmacy HCNE program.

FIGURE 15: ANNUAL UTILIZATION TREND RATES

SERVICE CATEGORY	TANF INFANTS	TANF CHILD	TANF ADULT	SSI CHILD	SSI ADULT	OCWI	FOSTER CARE	KICK
Inpatient Hospital	1.0%	0.0%	1.0%	0.0%	1.0%	1.0%	0.0%	0.5%
Outpatient Hospital	1.0%	1.0%	0.5%	1.0%	4.0%	4.0%	3.0%	1.0%
Professional	2.5%	2.5%	1.0%	2.0%	2.5%	3.5%	3.0%	2.0%
Ancillary	2.5%	2.5%	1.0%	2.0%	2.5%	3.5%	3.0%	N/A
Total Medical	**1.5%**	**1.9%**	**0.8%**	**1.4%**	**2.2%**	**3.4%**	**2.3%**	**1.0%**
Total Pharmacy	0.5%	0.5%	5.0%	5.5%	6.5%	0.5%	0.5%	N/A
Composite	**1.5%**	**1.6%**	**1.8%**	**2.8%**	**3.5%**	**3.1%**	**2.2%**	**1.0%**

Notes:
1. Pharmacy represents both utilization and cost.
2. TANF Infants reflects the TANF: 0 - 2 months old (AH3) and TANF: 3 - 12 months old (AI3) rate cells.

(b) Benefit cost trend components

The utilization component of trend illustrated in Figure 15 includes both the trend in number of units as well as the mix or intensity of services provided. For the medical trend components, unit cost trends are not applied as a trend adjustment, instead each claim is repriced and adjusted based on reimbursement updates that have occurred or are anticipated to be implemented after the end of the base period. The repricing and reimbursement update analyses are described further in Section I, item 2.B.iii(d).

(c) Variation

To limit the variation in benefit cost that is present across the Medicaid population as a whole, we developed trends by population category and major category of service. We further reviewed experience for specialty, brand and generic drugs, and combined this review with consideration of brand name drugs that have had or are anticipated to have generic launches during the time period encompassing the March 2019 through February 2020 base period through the projection period (SFY 2022). Additionally, all pharmacy therapies expected to be included in the pharmacy HCNE program have been excluded from this analysis.

The variation that occurs between these high-level prescription drug stratifications and further within each major population category contributes to the variation in the pharmacy trend assumptions applied across the managed care program in the SFY 2022 capitation rate development.

(i) Medicaid populations

Trends were developed by population category and major category of service. Minor trend variations between populations and service categories reflect observed variation in the underlying historical experience and actuarial judgement based on the sources listed in the section above. All trend values have been rounded to the nearest 0.5%.

Rate cells

Benefit cost trends are evaluated by population category and major category of service. For population categories comprised of multiple rate cells, the benefit cost trends are consistent across all rate cells.

Subsets of benefits within a category of services

For the pharmacy trend assumption development, we considered experience and projected changes for specialty, brand and generic drugs during the March 2019 through February 2020 base period through the projection period (SFY 2022).

(d) Material adjustments

We made explicit adjustments to the historical data analyzed for trends in an effort to normalize the data for historical reimbursement adjustments, changing populations, and risk score, and extract underlying trend information; however, as noted above, there were still anomalies that were present in the data and contributed to unreasonable trend patterns.

As a result, we used actuarial judgment to adjust the trends derived from historical experience in cases where the resulting trends did not appear reasonably sustainable, or were not within consensus parameters derived from other sources.

For many rate cells and categories of services, raw model output was outside of a range of reasonable results. In these situations, we relied on the sources identified to develop prospective trend.

Additionally, we considered the cost impact of recently released drugs on the pharmacy trend rates in coordination with the pharmacy HCNE program implemented on July 1, 2020 and anticipated to continue for SFY 2022.

(e) Any other adjustments

(i) Impact of managed care

We did not adjust the trend rates to reflect a managed care impact on utilization or unit cost. The capitation rates have an explicit adjustment for the managed care adjustments.

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

We have reviewed SCDHHS's state plan benefits regarding compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as required by 42 CFR 438, subpart K. Results of the analysis indicate full compliance with MHPAEA for financial requirements and both quantitative and non-quantitative treatment limits with no remediation needed that would constitute a program adjustment. In addition, our review of MCO Survey results and MCO-submitted data indicates that all MCOs are compliant with MHPAEA financial requirements. Based on the results of our analysis and guidance from SCDHHS, we believe the certified SFY 2022 capitation rates are adequate to allow MCOs to efficiently deliver covered services in compliance with MHPAEA and contractual requirements. We have not made any rating adjustments to accommodate Mental Health Parity compliance.

v. In Lieu of Services

Effective July 1, 2019, SCDHHS expanded the use of IMDs as an in lieu of service for the 21 to 64-year-old population for all inpatient psychiatric or substance use disorders for up to 15 days per month. This program change was implemented in compliance with the conditions outlined in the final Medicaid managed care regulations.

Consistent with the rate-setting guidance published by CMS, in reviewing the impact of this program adjustment we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

IMD as an in lieu of service represents approximately $9.1 million of estimated annualized expenditures in the adjusted base data expenditures, or 17.7% of the "Inpatient MH/SA" service category, and is not included in any other service categories.

vi. Retrospective Eligibility Periods

(a) MCO responsibility

MCOs are not responsible for paying claims incurred during the retrospective eligibility period.

(b) Claims treatment

As noted earlier, MCOs are not responsible for paying claims incurred during the retrospective eligibility period; therefore, claims for retrospective eligibility periods are not reflected in the base data.

(c) Enrollment treatment

Enrollment is treated consistently with claims. We have not included retrospective eligibility in the base experience period.

(d) Adjustments

No adjustments are necessary.

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 SFY 2021 rating period.

(a) Change to covered benefits

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

(b) Recoveries of overpayments

To the best of our knowledge, all information related to any payment recoveries not reflected in the base period encounter data was provided to us by the MCOs in their survey responses and an adjustment factor was applied to reflect any such recoveries.

(c) Change to payment requirements

Material changes to provider payments have been described in program adjustments described in Section I, item 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, item 2.B.iii Program Change Adjustments. This information includes the data, assumptions, and methodology used in developing the adjustment, and aggregate impact on the managed care program's benefit expense. Non-material changes to covered benefits or provider payments have also been described in that section of the report.

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 South Carolina Medicaid managed care program.

ii. Appropriate Documentation

Incentive payments under this plan are below 105% of the certified capitation rates paid under the contract. An incentive pool is determined by the portion of withhold that is not returned to the MCOs after a first pass review. By design, the incentive amount represented by the bonus pool is significantly less than 5% of the certified rates. Please see Section I, item 4.B.ii for additional discussion on bonus pool distributions.

Incentive payments for "Patient-Centered Medical Homes (PCMH)" are not included within the certified capitation rate. These incentives are paid by SCDHHS to the MCOs through gross level adjustments (GLAs). Additional details about the separate PCMH incentive payment program can be found within the "MCO Policy and Procedure Guide" under the "Provider Quality Incentive Programs" section. Approximate historical and anticipated incentive payments for the PCMH program are as follows:

- SFY 2020: $7.6 million – approximately 0.2% increase of projected SFY 2022 capitation premium
- SFY 2021 (anticipated): $7.6 million – approximately 0.2% of projected SFY 2022 capitation premium
- SFY 2022 (anticipated): $7.9 million – approximately 0.2% of projected SFY 2022 capitation premium

The total amount of incentive payments in the managed care program is below 105% of the certified rates paid under the contract.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

This section provides documentation of the withhold arrangement in the South Carolina Medicaid managed care program.

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period

The withhold arrangement is measured on a calendar year basis.

(ii) Coverage

All enrollees, services, and providers that are part of the Medicaid managed care program are covered by the withhold arrangement.

(iii) Purpose

The withhold measure evaluates quality-based performance in diabetes care, women's health, and pediatric preventive care.

(iv) Description of total percentage withheld

SCDHHS has established a quality withhold of 1.5% of the capitation rate net of supplemental teaching payments and the state-directed hospital quality payment program, and will determine the return of the withhold based on review of each MCO's HEDIS data and the MCO's compliance with the quality measures established in each MCO's contract with SCDHHS. Please note that SCDHHS suspended the quality withhold of 1.5% of the capitation rate from the MCO capitation payments for measurement year 2020; however, the withhold is anticipated to be reinstated for measurement years 2021 and 2022.

The capitation rates shown in this letter are illustrated before application of the withhold amount; however, we consider the full amount of the withhold to be reasonably achievable.

(v) Estimate of percent to be returned

In reporting year 2020 (CY 2020), based on measurement year 2019, the MCOs in aggregate received 100% of available withhold funds from SCDHHS through first pass and bonus pool distributions. Withholds and incentives are treated separately for federal regulations; therefore, we reviewed the first pass and bonus pool distribution as separate components. Based on the design of the withhold program, 92.3% of the withhold was earned back through the first pass in reporting year 2020.

The MCO quality withhold and bonus program for reporting year 2022, measurement year 2021 is fully documented in Section 15 of the Managed Care Policy and Procedure Manual.

Our review of the CY 2020 quality withhold results indicated that at least one plan met all target measures to receive the full return of the 1.5% withhold and at least one other would have only needed to improve by a marginal amount to receive the full withhold return. In addition, our review of the measurement year 2021 quality withhold program reflects minimal changes to the quality measures and performance assessment methodology. As such, we believe it is reasonably achievable in the context of the SFY 2022 capitation rate development for the MCOs to meet the quality withhold targets for 100% return of the withhold for CY 2022.

(vi) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 1.5% of capitation revenue, net of supplemental teaching payments and state-directed hospital quality payment program, indicates that it is reasonable within the context of the capitation rate development and the magnitude of the withhold does not have a detrimental impact on the health plan's financial operating needs and capital reserves. Our interpretation of financial operating needs relates to cash flow needs for the health plan to pay claims and administer benefits for its covered population. We evaluated the reasonableness of the withhold within this context by reviewing the health plan's cash available to cover operating expenses, as well as the capitation rate payment mechanism utilized by SCDHHS. To evaluate the reasonableness of the withhold in relation to capital reserves, we reviewed each health plan's risk-based capital ratio. The data source utilized to calculate these metrics was each plan's calendar year 2020 NAIC annual statement.

(1) Risk-Based Capital (RBC) Levels: RBC levels were reviewed to assess surplus levels and financial stability of each MCO to pay all policyholder obligations. Based on CY 2020 audited financial statements, RBC-levels for each MCO are at or greater than 561%. Although 100% of the withhold is assumed to be reasonably achieved, stress-testing the capital levels for each MCO with the full amount of the 1.5% withhold does not reduce the RBC ratio to a level that would trigger regulatory action.

FIGURE 16: MCO FINANCIAL REVIEW

HEALTH PLAN	REPORTED RBC LEVEL	STRESS-TESTED RBC LEVEL
Absolute Total Care	561%	516%
BlueChoice	1370%	1337%
Molina	455%	418%
Select Health	477%	434%

Source: CY 2020 NAIC Annual Statement ('Five-Year Historical Data', Page 29)

(2) Cash available for operating expenses: We reviewed cash and cash equivalent levels in relation to the withhold arrangement. We believe the withhold arrangement is reasonable based on current cash levels and the following withhold level and SCDHHS payment timing:

- A 1.5% withhold over the SFY is equivalent to approximately 5.5 days of revenue.
- SCDHHS makes capitation payments to MCOs at the beginning of each month (which essentially "pre-pays" the expected claims for the month), contributing favorably to monthly cash flow needs.

(vii) Effect on the capitation rates

The SFY 2022 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Capitation payments minus withhold

The SFY 2022 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable, and the capitation rates are certified as actuarially sound.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

This section provides documentation of the risk-sharing mechanisms in the South Carolina managed care program.

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

(i) Methodology

Risk Mitigation Programs

Pharmacy High Cost No Experience program

Effective July 1, 2020, SCDHHS implemented a pharmacy HCNE (HCNE) program as a risk mitigation mechanism to limit the MCO's exposure to new high cost pharmacy therapies. The HCNE program will include pharmacy therapies approved after the beginning of the base period (March 1, 2019) that are expected to exceed $500,000 per member per year, based on annual estimated cost from the WAC fee schedule.

Newly approved drug therapies will be removed from the pharmacy HCNE program when their FDA approval date is on or before the start of the base data period. The estimated costs of the pharmacy therapies included in the pharmacy risk mitigation program are not part of the base capitation rate.

SCDHHS is anticipated to reimburse the MCOs for the total cost of the pharmaceutical therapy that is equal to the lesser of MCO claim payment and the FFS fee schedule. All claims requested for reimbursement through the pharmacy HCNE program are subject to SCDHHS review and approval. The pharmacy therapies approved for inclusion in the risk mitigation program for SFY 2022 are included in Figure 17. SCDHHS will monitor this list on a quarterly basis and communicate updates through the MCO Policy and Procedure guide, as appropriate.

FIGURE 17: PHARMACY RISK MITIGATION DRUG LIST

DRUG NAME	FDA APPROVAL DATE
Zolgensma	5/24/2019
Vyondys 53	12/12/2019
Viltepso	8/12/2020
Zokinvy	11/20/2020
Oxlumo	11/23/2020
Danyelza	11/25/2020
Amondys 45	2/25/2021
Nulibry	2/26/2021

The specific language from the provider agreement between SCDHHS and the MCOs should be referenced for final contract specifications and definitions.

COVID-19 Vaccine Administration Non-Risk Arrangement

SCDHHS is anticipated to reimburse the MCOs for all costs associated with the administration of COVID-19 vaccines up to current South Carolina Medicaid fee-for-service reimbursement rates during the SFY 2022

contract year. All claims requested for reimbursement through the COVID-19 vaccine administration non-risk contract are subject to SCDHHS reporting requirements as outlined in Section 4.2.28 of the MCO Policy and Procedure Guide.

(ii) Attestation of the use of generally accepted actuarial principles and practices

The SFY 2022 pharmacy HCNE program and COVID-19 vaccine administration non-risk arrangement have been developed in accordance with generally accepted actuarial principles and practices.

(b) Medical Loss Ratio

Description

SCDHHS's provider agreement establishes a minimum medical loss ratio (MLR) of 86.0% for the Medicaid managed care population. The specific language from the provider agreement between SCDHHS and the MCOs should be referenced for final contract specifications and definitions. The MLR is calculated in accordance with guidance presented in the final Medicaid and Children's Health Insurance Program rule, released on May 6, 2016.

Financial consequences

Financial consequences of the minimum MLR requirements are specified in the provider agreement. However, in general, the MCO will be required to repay any revenue amounts below the 86.0% minimum MLR.

(c) Reinsurance Requirements and Effect on Capitation Rates

There are no reinsurance requirements for MCOs contracted with SCDHHS for the Medicaid managed care program.

D. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

i. Rate Development Standards

Consistent with guidance in 42 CFR §438.6(c), the South Carolina managed care capitation rates reflect consideration of the following delivery system and provider payment initiatives:

- Hospital quality payment initiative for all in-state acute care and critical access hospitals; and,
- Alternative Payment Model (APM) contracts linked to provider performance.

(a) Description of Managed Care Plan Requirement

Effective July 1, 2019, SCDHHS is requiring the MCOs to participate in a state directed value-based purchasing model to implement quality payment arrangements for all in-state acute care and critical access hospitals.

(b) How Payment Arrangement is Reflected in Managed Care Rates

Hospital Quality Payment Initiative

The payment arrangement will be reflected through a separate payment term in which an estimated PMPM by rate cell, projected at $48 million in total, will be directed to the hospital quality payment pool and distributed to eligible hospitals based on each hospital's allocation of the overall incentive pool.

(i) Documentation related to separate payment term included in the rate certification

Documentation related to the separate payment term is addressed in Section I, Item 4.D.ii(a)(iii).

(ii) PMPM estimate of state-directed payments addressed through separate payment term

To allocate the projected $48 million Hospital Quality Payment across capitation rate cells, state-directed PMPMs are developed by calculating a uniform percentage increase to the monthly capitation payments, excluding STP payments. Figure 18 illustrates the estimated PMPM for each rate cell.

FIGURE 18: HOSPITAL QUALITY PAYMENT PMPM BY RATE CELL

RATE CELL	PMPM
TANF: 0-2 months old (AH3)	$ 30.15
TANF: 3-12 months old (AI3)	3.21
TANF: Age 1-6 (AB3)	1.88
TANF: Age 7-13 (AC3)	1.87
TANF: Age 14-18, Male (AD1)	2.04
TANF: Age 14-18, Female (AD2)	2.58
TANF: Age 19-44, Male (AE1)	2.61
TANF: Age 19-44, Female (AE2)	4.18
TANF: Age 45+ (AF3)	7.49
SSI - Children (SO3)	8.80
SSI - Adults (SP3)	18.92
OCWI (WG2)	3.46
DUAL	-
Foster Care - Children (FG3)	12.41
KICK (MG2/NG2)	95.56

(iii) Final documentation of total state-directed payment amount by rate cell

To the extent the final state-directed PMPM payments by rate cell vary from the initial estimates presented in Figure 18, the rate certification will be updated to reflect the final aggregate payments made to the hospitals.

(iv) Change from initial base rate certification

As indicated above, the rate certification will be updated through a rate amendment if the total payment amount or distribution methodology varies from the initial estimates presented in Figure 18.

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

Hospital Quality Payment Initiative

Effective July 1, 2019, the hospital quality payment initiative was developed to align SCDHHS's quality and transparency-promotion activities with those of CMS and other dominant payers. Based on documentation provided in the SCDHHS-submitted preprint, the value-based purchasing arrangement is a quality payment program in which hospital agencies are paid based on the value of their quality improvement efforts, such as reducing readmissions and hospital-acquired infections, patient experience outcomes, maternal and prenatal care quality programs, and effectiveness of opioids and behavioral health treatment programs and policies. In recognition of implementing and executing quality improvement initiatives, payments are made to eligible hospital agencies from the MCOs.

Alternative Payment Model Contracts

Value-oriented contracts reflected in the SFY 2022 managed care capitation rates include pay for performance incentive programs, shared savings, and shared risk programs.

(ii) Description of payment arrangement if incorporated as a rate adjustment

Not applicable. The state-directed payment is reflected through a separate payment term as described in Section I, Item 4.D.i(b).

The APM contracts are included as an adjustment to the base data in Appendix 6. The total amount of payments for these contracts included in the base data adjustment is approximately $8.0 million, or $0.83 PMPM, based on March 2019 through February 2020 member months.

(iii) Description of payment arrangement if incorporated as a separate payment term

The payment arrangement will be incorporated through a separate payment term in which an estimated PMPM by rate cell, projected at $48 million in total based on projected SFY 2022 enrollment, will be directed to the hospital quality payment pool and distributed to eligible hospitals based on each hospital's allocation of the overall incentive pool

Aggregate amount of payment applicable to rate certification.

The aggregate amount of the state-directed payment is estimated at $48.0 million.

Explicit statement from actuary certifying the amount of the separate payment term

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

Provider types receiving the payment

The hospital quality payment initiative applies to all in-state acute care and critical access hospitals, provided that they:

- Are Medicare-registered;
- Are Medicaid-enrolled;
- Participate in the Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs; and,
- Use a Safe Surgery Checklist and participate in the South Carolina Hospital Association's Zero Harm Collaborative.

Distribution methodology

SCDHHS will supply the MCOs with a list of each hospital's allocation of the overall incentive pool. When an MCO receives a capitation payment from SCDHHS, the MCO must remit the appropriate share to each hospital per SCDHHS requirements as described in the MCO contract.

Estimated PMPM payout by rate cell

The estimated PMPM payout by rate cell is provided in Figure 18 in Section I, Item 4.D.i(b).

Consistency with 438.6(c) preprint

The SFY 2022 payment arrangement described in this certification is consistent with the pre-print submitted by SCDHHS to CMS on June 4, 2021 and currently still under review.

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

To the extent the final state-directed pay-for-performance PMPM payments by rate cell for the hospital quality payment initiative vary from the initial estimates presented in Figure 18, the rate certification will be updated to reflect the final payments made to the hospitals.

(b) Additional Directed Payments Not Addressed in the Certification

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

(c) Confirmation of Reimbursement Rates that Plans Must Pay Providers

There are not any additional requirements regarding the reimbursement rates the 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

Supplemental Teaching Physician (STP) Payments: The STP payment program was developed to provide supplemental teaching payments to providers (i.e. Medical Universities or hospitals) of teaching physicians who are employed by or under contract with South Carolina Medical Universities and/or their component units. The STP payment that is made to qualifying providers accounts for the productivity loss and resulting revenue loss incurred by the teaching physicians from either direct supervision of or involvement with residents and/or medical students who are providing patient care. These amounts are paid by the MCOs to facilities utilizing teaching physicians, but are not included in the contracted rates between the MCOs and the teaching physicians.

i. Rate Development Standards

This section provides documentation of the pass-through payments reflected in the SFY 2022 capitation rates.

ii. Appropriate Documentation

(a) Description of Pass-Through Payments

(i) Description

SCDHHS implemented the original STP payment methodology effective October 1, 2001. The original payment methodology allowed for additional reimbursement at 35% of each teaching physician's billed charges to providers qualifying for STP payments. This payment was made in addition to the regular Medicaid FFS or MCO claims payment amount.

Effective April 1, 2016, SCDHHS follows the Average Commercial Rate (ACR) Model as described in the CMS approved Physician UPL Guidance document. Under the plan amendment submitted to CMS, the STP payment is determined based upon the aggregate difference between the average commercial rate of each STP provider's top 5 commercial carriers (excluding those not subject to market forces) and the Medicaid payment (including TPL and co-pays) for each billable procedure code based upon a base year claims period and commercial rate period.

The STP amounts for the SFY 2022 capitation rates are calculated under the ACR method. The following methodology was utilized to develop the STP PMPM:

1. Summarize the March 2019 through February 2020 encounter expenditures eligible for supplemental teaching payments using the teaching physician lists provided by SCDHHS in April 2020 and April 2021 for all teaching physician claims billed at an eligible teaching facility. Total STP expenditures exclude all services billed under the HCPCS alphanumeric code set and immunization administration services reported with CPT codes 90460, 90461, 90471, 90472, 90473, and 90474.
2. Add estimated patient copay and third-party liability amounts to March 2019 through February 2020 expenditures to develop total payment received by the physician.
3. Reprice each of the March 2019 through February 2020 encounter physician claims by multiplying the number of incurred units for each procedure code by the individual STP provider's CY 2020 ACR for that procedure code.
4. Deduct total physician payment (developed in Step 2) from ACR (developed in Step 3) for each physician claim to calculate the STP amount.
5. Adjust the STP payment amounts obtained in Step 4 using utilization trend and other adjustment factors specific to the physician and ancillary service categories to estimate projected SFY 2022 STP PMPMs.
6. Apply a uniform multiplicative adjustment by rate cell to the STP pass-through PMPMs calculated in Step 5 to cap estimated pass-through payments at $133.5 million based on projected SFY 2022 enrollment in accordance with 42 CFR 438.6(d)(5).

Note that STP expenditures for services covered by the KICK payment are deducted from the KICK rate cell and redistributed across the applicable female capitation rate cells, in proportion to the KICK payments made for individuals in the representative rate cells. Consistent with SCDHHS's payment methodology, supplemental teaching payments are not calculated for the DUAL rate cell.

(ii) Amount

The estimated pass-through payments incorporated into the SFY 2022 capitation rates is approximately $133.5 million ($11.13 PMPM). Appendices 8 and 9 document the development of the rate cell-specific STP PMPMs that are added to the SFY 2022 capitation rates.

(iii) Program

Amounts for the STP payment program are included in the Medicaid managed care program.

(iv) Providers receiving the payment

The payments are received by providers with teaching physicians who are employed by or under contract with South Carolina Medical Universities and/or their component units. A list of teaching physicians to be applied during the March 2019 through February 2020 base period was provided by SCDHHS for the SFY 2022 capitation rate-setting process.

(v) Financing mechanism

The STP payment program is funded via intergovernmental transfers from non-state owned governmental hospitals, the MUSC School of Medicine, the University of South Carolina, and the SC Area Health Education Consortium (which receives annual state appropriations from the SC General Assembly).

(vi) Directed payments targeting the same providers receiving pass-through payments

None of the teaching physicians participating in the STP program receive payments via a 42 CFR 438.6(c) directed payment.

(b) Aggregate Pass-Through Payments by Provider Type

(i) Amounts by provider type

The estimated pass-through payments for the STP program incorporated into the SFY 2022 capitation rates is approximately $133.5 million ($11.13 PMPM), all attributable to the physician provider type. PMPM amounts by rate cell are included in Appendix 9.

(ii) Documentation of historical pass-through payments by provider type

The rating period that includes July 5, 2016 is SFY 2017; however, the SFY 2017 rate certification was not submitted until July 15, 2016. As such, the rating period that complies with 42 CFR 438.6(d)(1)(i) is the SFY 2016 rating period. The estimated pass-through payments for the STP arrangement incorporated into the SFY 2016 capitation rates was approximately $133.5 million.

(c) Hospital Pass-Through Payments

There are no hospital pass-through payments reflected in the SFY 2022 capitation rates.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(e), the non-benefit component of the capitation rate includes reasonable, appropriate and attainable expenses related to MCO operation of the South Carolina Medicaid 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 rate.

ii. PMPM versus percentage

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

iii. Basis for variation in assumptions

Any assumption variation between covered populations is the result of program differences and is in no way based on the rate of federal financial participation associated with the population.

iv. Health insurance providers fee

Health insurance providers fee is not applicable for the SFY 2022 capitation rates as a result of the Further Consolidated Appropriations Act of 2020.

B. APPROPRIATE DOCUMENTATION

i. Development of non-benefit costs

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

Data

The primary data sources used in the development of the state fiscal year 2022 non-benefit costs are listed below:

- Calendar Year 2018, 2019, and 2020 administrative costs as reported in the Managed Care Survey completed by each MCO.
- March 2019 through February 2020 pharmacy script counts as reported in the encounter data submitted by the MCOs.
- Statutory financial statement data for each of the MCOs.
- Average non-benefit costs from the financial statements of Medicaid MCOs nationally, as summarized by Palmer, Pettit, and McCulla. A link to the 2019 report published in July 2020 (Medicaid managed care financial results for 2019) is provided here: https://www.milliman.com/en/insight/medicaid-managed-care-financial-results-for-2019

Assumptions and methodology

In developing non-benefit costs, we reviewed historical administrative expenses for the managed care program along with national Medicaid MCO administrative expenses. We considered the size of participating MCOs and the resulting economies of scale that could be achieved, along with the benefits covered and the demographics of the population.

Historical reported administrative expenses by MCO were compared to statutory financial statements for consistency.

Our review of the non-benefit cost component of the capitation rate (excluding risk margin) in comparison to Appendix 1 of the Medicaid managed care financial results for 2019 referenced above indicates that the allowance reflected in the South Carolina Medicaid managed care rates is reasonable in comparison to this national benchmark for states that have not expanded Medicaid.

This is consistent with non-benefit cost allowance in prior capitation rate setting analyses for this program and we believe this continues to be a reasonable, appropriate and attainable assumption based on our review of historical financial results for the MCOs and continued review of the program.

(b) Material changes

There are no material changes to the data, assumptions, or methodology used to develop the projected non-benefit cost relative to SFY 2022.

(c) Other material adjustments

There are no other material adjustments applicable to the non-benefit cost component of the capitation rate.

ii. Non-benefit costs, by cost category

Administrative expenses have not been developed from the ground up (based on individual components). However, individual components were reviewed within MCO-reported survey information and financial statement data. We did rely on MCO-reported information to estimate the allocation of the administrative expense percentage between general administrative costs and care coordination & care management expenses.

The SFY 2022 non-benefit cost allowance is applied as a percentage of the capitation rates excluding supplemental teaching payments and state-directed hospital quality payments, as illustrated in Figure 19 below.

FIGURE 19: NON-BENEFIT COST ALLOWANCE BY RATE CELL

RATE CELL	ADMINISTRATIVE EXPENSES	CARE COORDINATION & CARE MANAGEMENT	RISK MARGIN	SFY 2022 SUBTOTAL	PHARMACY ADMIN	SFY 2022 TOTAL
TANF: 0-2 months old (AH3)	5.50%	1.00%	1.00%	7.50%	0.03%	7.53%
TANF: 3-12 months old (AI3)	9.50%	1.75%	1.00%	12.25%	0.48%	12.73%
TANF: Age 1-6 (AB3)	9.50%	1.75%	1.00%	12.25%	0.77%	13.02%
TANF: Age 7-13 (AC3)	9.50%	1.75%	1.00%	12.25%	0.98%	13.23%
TANF: Age 14-18, Male (AD1)	9.50%	1.75%	1.00%	12.25%	0.86%	13.11%
TANF: Age 14-18, Female (AD2)	9.50%	1.75%	1.00%	12.25%	1.00%	13.25%
TANF: Age 19-44, Male (AE1)	7.75%	1.50%	1.00%	10.25%	0.63%	10.88%
TANF: Age 19-44, Female (AE2)	7.75%	1.50%	1.00%	10.25%	0.77%	11.02%
TANF: Age 45+ (AF3)	7.75%	1.50%	1.00%	10.25%	0.85%	11.10%
SSI - Children (SO3)	6.00%	1.50%	1.00%	8.50%	0.63%	9.13%
SSI - Adults (SP3)	5.50%	1.25%	1.00%	7.75%	0.48%	8.23%
OCWI (WG2)	7.75%	1.50%	1.00%	10.25%	0.97%	11.22%
DUAL[1]	N/A	N/A	N/A	N/A	N/A	N/A
Foster Care - Children (FG3)	5.75%	3.50%	1.00%	10.25%	0.36%	10.61%
KICK (MG2/NG2)	1.75%	0.25%	1.00%	3.00%	0.00%	3.00%

Notes:
1. The non-benefit cost allowance for the DUAL rate cell was estimated as a weighted average of the non-benefit cost allowance PMPM for the SSI-Children and SSI-Adult rate cells.
2. There are no taxes, licensing and regulatory fees attributed to the South Carolina Medicaid managed care program.

The benefit expense and non-benefit cost allowance components of the SFY 2022 capitation rates are illustrated by rate cell in Appendix 4.

iii. Historical non-benefit cost data

Historical MCO-reported non-benefit cost data net of taxes for CY 2018, CY 2019, and CY 2020 is illustrated in Figure 20. In addition to the average non-benefit cost PMPM reported across all MCOs, we also provided the minimum and maximum MCO non-benefit cost PMPM.

FIGURE 20: MCO REPORTED NON-BENEFIT COST PMPM

CALENDAR YEAR	AVERAGE REPORTED NON BENEFIT COSTS PMPM	MININUM REPORTED NON BENEFIT COSTS PMPM	MAXIMUM REPORTED NON BENEFIT COSTS PMPM
CY 2018	$ 30.48	$ 24.83	$ 40.27
CY 2019	$ 33.26	$ 27.78	$ 43.58
CY 2020	$ 33.25	$ 24.22	$ 41.51

Information related to the manner in which the historical non-benefit cost data was considered in the non-benefit cost assumptions used in the rate development is described in section I, item 5.B.i above. Appendix 4 includes administrative expense and care management amounts on a PMPM basis, comparable to the values in Figure 20.

iv. Health insurance providers fee

(a) Whether the fee is incorporated in the rates

Health insurance issuers are not expected to pay the health insurer fee (HIF) in calendar year 2022. The HIF was repealed for calendar years beginning after December 31, 2020 by the Further Consolidated Appropriations Act, 2020, Division N, Subtitle E § 502. As a result, we do not expect capitation rates to be adjusted in SFY 2022 to reflect the ACA HIF.

(b) Fee year or data year

Not applicable. The HIF is not expected to impact the SFY 2022 capitation rates as a result of the repeal of the HIF for calendar years beginning after December 31, 2020.

(c) Determination of fee impact to rates

Not applicable. The HIF is not expected to impact the SFY 2022 capitation rates as a result of the repeal of the HIF for calendar years beginning after December 31, 2020.

(d) Timing of adjustment for health insurance providers fee

Not applicable. The HIF is not expected to impact the SFY 2022 capitation rates as a result of the repeal of the HIF for calendar years beginning after December 31, 2020.

(e) Identification of long-term care benefits

Not applicable.

(f) Application of health insurance providers fee in 2014, 2015, and 2016 capitation rates

The MCOs in South Carolina were required to pay the HIF in 2014, 2015, and 2016. For each year, the initially certified capitation rates were amended to include the HIF and associated income tax impacts to reflect the non-tax-deductibility of the HIF.

6. Risk Adjustment and Acuity Adjustments

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

A. RATE DEVELOPMENT STANDARDS

i. Overview

In accordance with 42 CFR §438.5(g), we will follow the rate development standards related to budget-neutral risk adjustment for the Medicaid managed care program. The composite rates for TANF Children, TANF Adult, SSI Children, and SSI Adult populations will be prospectively risk adjusted by MCO to reflect estimated prospective morbidity differences in the underlying population enrolling with each MCO.

ii. Risk adjustment methodology

The TANF Adult, TANF Children, SSI Adult, and SSI Children populations will be prospectively risk-adjusted using the Combined Chronic Illness and Pharmacy Payment System (CDPS+Rx) risk scoring models calibrated to South Carolina experience. In addition, a custom variable representing individual member's MH/SA treatment prevalence will be included in the risk score development. Risk adjustment is performed on a budget neutral basis and is anticipated to be updated semi-annually for each of the four defined populations. The analysis uses generally accepted actuarial principles and practices.

iii. Acuity adjustments

Acuity adjustments are not applicable to the SFY 2022 capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

The risk adjustment analysis will use historical FFS and encounter data in the development of South Carolina-specific weights. Claims costs used to calibrate risk weights will be adjusted for reimbursement changes to reflect the SFY 2022 contract year. The CDPS+Rx risk adjustment model and the South Carolina-specific weights will be applied to March 2019 through February 2020 FFS and encounter data for the population enrolled in managed care as of April 2021 as the underlying data source for the development of the July through December 2021 risk scores. We will provide full documentation of the results and methodology for the risk adjustment analysis when it is complete. This is anticipated to be completed in June 2021.

(b) Risk adjustment model

The July through December 2021 risk scores for the TANF Adult, TANF Children, SSI Adult, and SSI Children populations will be risk-adjusted using CDPS+Rx risk scoring models, calibrated to South Carolina-specific experience. An additional variable representing individual member's MH/SA treatment prevalence will also be included in the risk adjustment development. We will provide full documentation of the results and methodology for the risk adjustment analysis when it is complete. This is anticipated to be completed in June 2021.

(c) Risk adjustment methodology

The SCDHHS risk adjustment is designed to be cost neutral for each of the four defined populations. Relative risk scores will be normalized to result in a composite risk score of 1.000 for each population group, across all MCOs. The risk adjustment methodology uses generally accepted actuarial principles and practices.

As we move the data period forward for the January to June 2022 risk adjustment analysis, additional consideration will be given for the impact of COVID-19 on the medical and pharmacy services in the experience period.

(d) Magnitude of the adjustment

The magnitude of the adjustment per MCO is not known at this time. We will provide full documentation of the results and methodology for the risk adjustment analysis when it is complete.

(e) Assessment of predictive value

We will provide full documentation of the results and methodology for the risk adjustment analysis when it is complete.

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

At this time, we have no concerns with the risk adjustment process.

ii. Retrospective risk adjustment

Not applicable. The risk adjustment analysis will utilize a prospective methodology.

iii. Changes to risk adjustment model since last rating period

We used the CDPS+Rx risk adjustment model version 6.4, including an additional MH/SA treatment prevalence variable, calibrated to South Carolina-specific weights for the last rating period. The most recent CDPS+Rx risk adjustment model with MH/SA treatment prevalence variable calibrated to South Carolina-specific weights is anticipated to be used for the SFY 2022 rating period.

iv. Acuity adjustments

Acuity adjustments are not applicable to the SFY 2022 capitation rates.

Section II. Medicaid Managed care rates with long-term services and supports

Section II of the CMS Guide is not applicable to the SCDHHS Medicaid managed care program. Managed long-term services and supports (MLTSS) are not covered benefits. Enrollees who have been approved for long term institutional care, waiver services, or institutional hospice care will be dis-enrolled from the managed care program and served under the FFS delivery system. Skilled nursing facility services are covered under this program only for stays generally less than 90 days. ICF/IID, and home and community based (HCBS) waiver services are not covered.

Section III. New adult group capitation rates

Section III of the CMS Guide is not applicable to the SCDHHS Medicaid managed care program.

Limitations

The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for the Medicaid managed care program in the State of South Carolina. The information may not be appropriate for any other purpose.

The information contained in this letter, including the enclosures, has been prepared for SCDHHS and their consultants and advisors. It is our understanding that the information contained in this letter will be distributed CMS and to each of the MCOs. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed 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 data presented.

At the time of this report, we acknowledge there is uncertainty regarding the impact of the COVID-19 pandemic on future projections, including whether the pandemic will increase or decrease costs in SFY 2022. The capitation rates include adjustments related to morbidity and COVID-19 policy changes as documented in the report. It is possible that the COVID-19 pandemic, as well as future legislative changes to address the pandemic, could have a material impact on morbidity, enrollment, providers, and other factors related to the capitation rates illustrated in this report. Due to this uncertainty, we have relied on SCDHHS to provide certain COVID-19 assumptions related to the Public Health Emergency duration and redetermination timing.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for SCDHHS 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 letter 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 presentation. The intent of the models was to estimate adjustments to be considered in the SFY 2022 capitation rate development process. 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 SCDHHS and the participating MCOs 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.

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

The services provided by Milliman to SCDHHS were performed under the signed consulting agreement between Milliman and SCDHHS effective July 1, 2020.

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

South Carolina Department of Health and Human Services
Risk Based Managed Care Program
Capitation Rates Effective July 1, 2021 through June 30, 2022

Actuarial Certification

I, Jeremy D. Palmer, 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 South Carolina and 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."

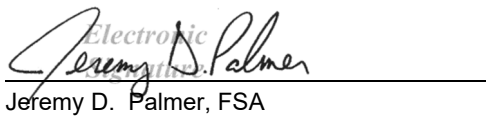
The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with the State of South Carolina. The "actuarially sound" capitation rates that are associated with this certification are effective for the rate period July 1, 2021 through June 30, 2022. I acknowledge that the State may elect to increase or decrease the capitation rates up to 1.5% per rate cell as allowed under 42 CFR 438.7(c)(3) of CMS 2390-F.

The capitation rates are considered actuarially sound after adjustment for the amount of the withhold not expected to be earned.

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. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency.

The capitation rates developed may not be appropriate for any specific 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.



Jeremy D. Palmer, FSA
Member, American Academy of Actuaries

June 4, 2021
Date

Appendix 2: Certified Capitation Rates

South Carolina Department of Health and Human Services Medicaid Managed Care Program State Fiscal Year 2022 Capitation Rate Development Comparison to SFY 2021 Capitation Rates								
			Including Add-Ons			Excluding Add-Ons		
Rate Cell Description	Rate Cell Code	SFY 2022 Projected Exposure	SFY 2021 Rates	SFY 2022 Rates	Total Rate Change	SFY 2021 Rates	SFY 2022 Rates	Total Rate Change
TANF Children								
TANF - 0 - 2 Months, Male & Female	**AH3**	81,947	$ 2,284.03	$ 2,423.36	6.1%	$ 2,140.61	$ 2,225.74	4.0%
TANF - 3 - 12 Months, Male & Female	**AI3**	341,296	252.81	263.20	4.1%	229.28	236.81	3.3%
TANF - Age 1 - 6, Male & Female	**AB3**	2,588,224	140.14	146.98	4.9%	132.69	138.76	4.6%
TANF - Age 7 - 13, Male & Female	**AC3**	3,000,413	143.51	143.95	0.3%	137.59	137.77	0.1%
TANF - Age 14 - 18, Male	**AD1**	967,378	158.43	158.00	(0.3%)	151.41	150.71	(0.5%)
TANF - Age 14 - 18, Female	**AD2**	975,765	200.88	199.98	(0.4%)	190.70	190.41	(0.2%)
Subtotal TANF Children		**7,955,023**	**$ 178.00**	**$ 171.88**	**(3.4%)**	**$ 168.76**	**$ 171.88**	**1.9%**
TANF Adult								
TANF - Age 19 - 44, Male	**AE1**	557,554	$ 218.59	201.32	(7.9%)	$ 208.90	192.68	(7.8%)
TANF - Age 19 - 44, Female	**AE2**	1,927,511	327.36	324.93	(0.7%)	307.81	308.50	0.2%
TANF - Age 45+, Male & Female	**AF3**	334,833	575.19	578.18	0.5%	547.56	552.85	1.0%
Subtotal TANF Adult		**2,819,898**	**$ 335.28**	**$ 330.56**	**(1.4%)**	**$ 316.72**	**$ 314.61**	**(0.7%)**
Disabled								
SSI - Children	**SO3**	135,650	$ 654.16	680.11	4.0%	$ 625.45	649.90	3.9%
SSI - Adults	**SP3**	635,155	1,387.67	1,452.45	4.7%	1,330.77	1,396.61	4.9%
Subtotal Disabled		**770,805**	**$ 1,258.58**	**$ 1,316.53**	**4.6%**	**$ 1,206.64**	**$ 1,265.20**	**4.9%**
OCWI	**WG2**	**390,533**	**$ 370.69**	**$ 285.90**	**(22.9%)**	**$ 306.29**	**$ 255.17**	**(16.7%)**
DUAL		**-**	**$ 170.72**	**$ 176.49**	**3.4%**	**$ 170.72**	**$ 176.49**	**3.4%**
Foster Care Children	**FG3**	**57,622**	**$ 928.54**	**$ 940.02**	**1.2%**	**$ 904.05**	**$ 916.21**	**1.3%**
KICK	**MG2/NG2**	**22,944**	**$ 6,849.83**	**$ 7,150.95**	**4.4%**	**$ 6,760.78**	**$ 7,055.39**	**4.4%**
Total		**11,993,881**	**$ 307.41**	**$ 310.62**	**1.0%**	**$ 291.19**	**$ 295.49**	**1.5%**

Appendix 3: Fiscal Impact Summary

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Fiscal Impact Summary ($ Millions)

Rate Cell	SFY 2022 Projected Exposure	SFY21 Capitation Rates			SFY22 Capitation Rates			Increase/(Decrease)	
		Capitation Rate	Projected Expenditures	FMAP (73.85%) Federal Expenditures	Capitation Rate	Projected Expenditures	FMAP (73.85%) Federal Expenditures	Projected Expenditures	FMAP (73.85%) Federal Expenditures
TANF Children									
TANF - 0 - 2 Months, Male & Female	81,947	$ 2,284.03	$ 187.2	$ 138.2	$ 2,423.36	$ 198.6	$ 146.7	$ 11.4	$ 8.4
TANF - 3 - 12 Months, Male & Female	341,296	252.81	86.3	63.7	263.20	89.8	66.3	3.5	2.6
TANF - Age 1 - 6, Male & Female	2,588,224	140.14	362.7	267.9	146.98	380.4	280.9	17.7	13.1
TANF - Age 7 - 13, Male & Female	3,000,413	143.51	430.6	318.0	143.95	431.9	319.0	1.3	1.0
TANF - Age 14 - 18, Male	967,378	158.43	153.3	113.2	158.00	152.8	112.9	(0.4)	(0.3)
TANF - Age 14 - 18, Female	975,765	200.88	196.0	144.8	199.98	195.1	144.1	(0.9)	(0.6)
Subtotal TANF Children	**7,955,023**	**$ 178.00**	**$ 1,416.0**	**$ 1,045.7**	**$ 182.11**	**$ 1,448.7**	**$ 1,069.9**	**$ 32.7**	**$ 24.1**
TANF Adult									
TANF - Age 19 - 44, Male	557,554	$ 218.59	$ 121.9	$ 90.0	$ 201.32	$ 112.2	$ 82.9	($ 9.6)	($ 7.1)
TANF - Age 19 - 44, Female	1,927,511	327.36	631.0	466.0	324.93	626.3	462.5	(4.7)	(3.5)
TANF - Age 45+, Male & Female	334,833	575.19	192.6	142.2	578.18	193.6	143.0	1.0	0.7
Subtotal TANF Adult	**2,819,898**	**$ 335.28**	**$ 945.5**	**$ 698.2**	**$ 330.56**	**$ 932.1**	**$ 688.4**	**($ 13.3)**	**($ 9.8)**
Disabled									
SSI - Children	135,650	$ 654.16	$ 88.7	$ 65.5	$ 680.11	$ 92.3	$ 68.1	$ 3.5	$ 2.6
SSI - Adults	635,155	1,387.67	881.4	650.9	1,452.45	922.5	681.3	41.1	30.4
Subtotal Disabled	**770,805**	**$ 1,258.58**	**$ 970.1**	**$ 716.4**	**$ 1,316.53**	**$ 1,014.8**	**$ 749.4**	**$ 44.7**	**$ 33.0**
OCWI	**390,533**	**$ 370.69**	**$ 144.8**	**$ 106.9**	**$ 285.90**	**$ 111.7**	**$ 82.5**	**($ 33.1)**	**($ 24.5)**
DUAL	**-**	**$ 170.72**	**-**	**-**	**$ 176.49**	**-**	**-**	**-**	**-**
Foster Care Children	**57,622**	**$ 928.54**	**$ 53.5**	**$ 39.5**	**$ 940.02**	**$ 54.2**	**$ 40.0**	**$ 0.7**	**$ 0.5**
KICK	**22,944**	**$ 6,849.83**	**$ 157.2**	**$ 116.1**	**$ 7,150.95**	**$ 164.1**	**$ 121.2**	**$ 6.9**	**$ 5.1**
Total	**11,993,881**	**$ 307.41**	**$ 3,687.0**	**$ 2,722.9**	**$ 310.62**	**$ 3,725.5**	**$ 2,751.3**	**$ 38.5**	**$ 28.4**

Note: Federal expenditures based on Federal Fiscal Year 2022 FMAP of 70.75% + 6.2% public health emergency enhancement for July through December 2021 and 70.75% for January through June 2022, resulting in an effective FMAP of 73.85% for the full year.

Appendix 4: Rate Change Summary

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Rate Change Summary

	Projected Exposure	Base Benefit Expense	Admin Expense	Care Management	Risk Margin	Non-Benefit Expense	SFY 2022 Capitation Rate w/o Add-Ons	SFY 2021 Capitation Rate w/o Add-Ons	% Change	Hospital Quality Payment	Supplemental Teaching Payment	SFY 2022 Capitation Rate w/ Add-Ons	SFY 2021 Capitation Rate w/ Add-Ons	% Change
TANF Children														
TANF - 0 - 2 Months, Male & Female	81,947	$ 2,058.14	$ 123.08	$ 22.26	$ 22.26	$ 167.60	$ 2,225.74	$ 2,140.61	4.0%	$ 30.15	$ 167.47	$ 2,423.36	$ 2,284.03	6.1%
TANF - 3 - 12 Months, Male & Female	341,296	206.66	23.63	4.14	2.38	30.15	236.81	229.28	3.3%	3.21	23.18	263.20	252.81	4.1%
TANF - Age 1 - 6, Male & Female	2,588,224	120.69	14.25	2.43	1.39	18.07	138.76	132.69	4.6%	1.88	6.34	146.98	140.14	4.9%
TANF - Age 7 - 13, Male & Female	3,000,413	119.54	14.44	2.41	1.38	18.23	137.77	137.59	0.1%	1.87	4.31	143.95	143.51	0.3%
TANF - Age 14 - 18, Male	967,378	130.95	15.61	2.64	1.51	19.76	150.71	151.41	(0.5%)	2.04	5.25	158.00	158.43	(0.3%)
TANF - Age 14 - 18, Female	975,765	165.18	19.99	3.33	1.91	25.23	190.41	190.70	(0.2%)	2.58	6.99	199.98	200.88	(0.4%)
Subtotal TANF Children	**7,955,023**	**$ 150.61**	**$ 16.71**	**$ 2.84**	**$ 1.72**	**$ 21.27**	**$ 171.88**	**$ 168.76**	**1.9%**	**$ 2.33**	**$ 7.90**	**$ 182.11**	**$ 178.00**	**2.3%**
TANF Adult														
TANF - Age 19 - 44, Male	557,554	$ 171.72	$ 16.15	$ 2.89	$ 1.92	$ 20.96	$ 192.68	$ 208.90	(7.8%)	$ 2.61	$ 6.03	$ 201.32	$ 218.59	(7.9%)
TANF - Age 19 - 44, Female	1,927,511	274.50	26.28	4.63	3.09	34.00	308.50	307.81	0.2%	4.18	12.25	324.93	327.36	(0.7%)
TANF - Age 45+, Male & Female	334,833	491.48	47.55	8.29	5.53	61.37	552.85	547.56	1.0%	7.49	17.84	578.18	575.19	0.5%
Subtotal TANF Adult	**2,819,898**	**$ 279.94**	**$ 26.80**	**$ 4.72**	**$ 3.15**	**$ 34.67**	**$ 314.61**	**$ 316.72**	**(0.7%)**	**$ 4.26**	**$ 11.68**	**$ 330.56**	**$ 335.28**	**(1.4%)**
Disabled														
SSI - Children	135,650	$ 590.56	$ 43.09	$ 9.75	$ 6.50	$ 59.34	$ 649.90	$ 625.45	3.9%	$ 8.80	$ 21.41	$ 680.11	$ 654.16	4.0%
SSI - Adults	635,155	1,281.67	83.52	17.46	13.96	114.94	1,396.61	1,330.77	4.9%	18.92	36.92	1,452.45	1,387.67	4.7%
Subtotal Disabled	**770,805**	**$ 1,160.05**	**$ 76.40**	**$ 16.10**	**$ 12.65**	**$ 105.16**	**$ 1,265.20**	**$ 1,206.64**	**4.9%**	**$ 17.14**	**$ 34.19**	**$ 1,316.53**	**$ 1,258.58**	**4.6%**
OCWI	**390,533**	**$ 226.54**	**$ 22.25**	**$ 3.83**	**$ 2.55**	**$ 28.63**	**$ 255.17**	**$ 306.29**	**(16.7%)**	**$ 3.46**	**$ 27.27**	**$ 285.90**	**$ 370.69**	**(22.9%)**
DUAL	**-**	**$ 71.33**	**$ 76.40**	**$ 16.10**	**$ 12.66**	**$ 105.16**	**$ 176.49**	**$ 170.72**	**3.4%**	**$ 0.00**	**$ 0.00**	**$ 176.49**	**$ 170.72**	**3.4%**
Foster Care Children	**57,622**	**$ 819.00**	**$ 55.98**	**$ 32.07**	**$ 9.16**	**$ 97.21**	**$ 916.21**	**$ 904.05**	**1.3%**	**$ 12.41**	**$ 11.40**	**$ 940.02**	**$ 928.54**	**1.2%**
KICK	**22,944**	**$ 6,843.73**	**$ 123.47**	**$ 17.64**	**$ 70.55**	**$ 211.66**	**$ 7,055.39**	**$ 6,760.78**	**4.4%**	**$ 95.56**	**$ 0.00**	**$ 7,150.95**	**$ 6,849.83**	**4.4%**
Total	**11,993,881**	**$ 264.66**	**$ 23.53**	**$ 4.34**	**$ 2.96**	**$ 30.82**	**$ 295.49**	**$ 291.19**	**1.5%**	**$ 4.00**	**$ 11.13**	**$ 310.62**	**$ 307.41**	**1.0%**

Appendix 5: In-Rate Criteria

South Carolina Department of Health and Human Services
SFY 2022 Medicaid Managed Care Capitation Rate Development
In-Rate Criteria for Services Covered Under Managed Care Capitation Rate

Eligibility Criteria

Eligibility File Type	Criteria	Notes
Recipient	Exclude Recipient Payment Categories:10,14,15,33,48,50,52, 54,55,70,89,90	
Recipient	Exclude Recipient Limited Benefit Indicators: E, I, C, D, J, P, A, B, G	
Recipient	Pol Aux Comment=HMO	Exclude if HMO
Recipient	Exclude if age >= 65 on date of service	
Recipient	Exclude Dual eligible members	
Recipient	Retroactive Eligibility	
Recipient	Long Term Care Exclusion	
RSP	Exclude where RSP Program Indicator is: 3,5,A,C,D,F,J,K,L,M,R,S,T,V,W	

Note: The in-rate criteria only includes claims with a valid member record at the time services were rendered.

Nursing Home Claims Criteria

Claim Type	Provider Type	Provider Specialty	Notes
G	00	Any	Include claims where the last 2 bytes of Billing Provider Number = SB or first byte of Billing Provider Number = V or Service Category = 11

UB-04 Claims Criteria

Claim Type	Provider Type	Provider Specialty	Notes
Y	01	Any	Exclude if Ownership Code = 11
Y	01	Any	Exclude if ICD-10 diagnosis code equals Z94 through z94.9, except for Z94.7
Y	All	Any	Exclude if APR-DRG = 001-1, 001-2, 001-3, 001-4, 002-1, 002-2, 002-3, 002-4, 003-1, 003-2, 003-3, 003-4, 006-1, 006-2, 006-3, 006-4, 007-1, 007-2, 007-3, 007-4, 008-1, 008-2, 008-3, 008-4, 440-1, 440-2, 440-3, 440-4
Y	02	Any	Exclude if Ownership Code = 11

Pharmacy Claims Criteria

Claim Type	Provider Type	Provider Specialty	Notes
D	70	Any	Exclude the following HCNE Pharmaceuticals (Zolgensma, Vyondys 53)

South Carolina Department of Health and Human Services
SFY 2022 Medicaid Managed Care Capitation Rate Development
In-Rate Criteria for Services Covered Under Managed Care Capitation Rate

HIC Claims

Claim Type	Provider Type	Provider Specialty	Criteria
A or B	All (Except Provider Type 22)	Any (Except Provider Type 93)	Exclude all Procedure Codes that begin with “D”
A	All	Any	Exclude if ICD-10 diagnosis code equals Z94 through z94.9, except for Z94.7 and Place of Service =21
A	All	Any	Exclude hearing aid and hearing aid accessories for any one over the age of 21 (Procedure Code V5030-V5299)
A	All	Any	Exclude all vaccine codes for any one under the age of 19 (90476-90749 except 90460 and 90461) Providers must provide vaccinations through the VFC program for Medicaid eligible children
A	10	20	Exclude Procedure Codes (G9004 THROUGH G9011, T1016, T1017, T1023, T1024)
A	10	28	Exclude Procedure Codes (T1016, T1017)
A	10	90	Exclude Procedure Codes (T1016, T1017)
A	10	91	Exclude Provider Type and Specialty
A	10	92	Exclude Procedure Code (H2021, H2022, S9482, T1007, T1015, T1016, T1017, T2023, X2300)
A	19	Any	Exclude Procedure Codes (G9004 THROUGH G9011, T1016, T1017, T1023, T1024)
A	20	27	Exclude if Procedure Code in (H1001, T1001)
A	21	78	Exclude if Provider Number = TR0003/NPI 1669523528
A	22	51	Exclude if Procedure Code in (T1016, T1017, T1027, T1002) AND Provider Number in (DHEC01-DHEC46, DHEC59)
A	22	51	Exclude if Primary Diagnosis in COMDHEC table AND Provider Number in (DHEC01-DHEC46, DHEC59)
A	22	51	Exclude if Procedure Code in (H1001, T1001)
A	22	95	Exclude if provider ID begins with BN and procedure code in (T1018, T1027)
A	22	95	Exclude if legacy provider ID begins with SD AND procedure code is (92500 THROUGH 92599, 97000 THROUGH 97999, L3808, S9445, S9446, S9152, C1000, T1002, T1003, T1015, T1023, T1027, T1024, T1502, T2003, V5011, V5090, V5275)
A	22	96	Exclude if Provider Number begins with MC or PP
A	All	Any	Exclude routine vision care and Procedure code V2020 through V2799 for any one over the age of 21
A	60	0	Exclude if procedure code in (S9126, T1015)
A	61		Exclude Provider Type
A	80	Any	Exclude if Provider Control Facility = 017 AND Primary Diagnosis in COMDHEC table OR procedure code is S3870

South Carolina Department of Health and Human Services SFY 2022 Medicaid Managed Care Capitation Rate Development In-Rate Criteria for Services Covered Under Managed Care Capitation Rate	
COMDHEC Range Table ICD-10	
Min Diagnosis Code	**Max Diagnosis Code**
A0839	A0839
A150	A159
A170	A179
A1801	A1818
A182	A182
A1831	A1839
A184	A1889
A190	A329
A35	A35
A360	A360
A369	A369
A3700	A3791
A380	A409
A4101	A449
A46	A46
A480	A480
A482	A488
A4901	A499
A5001	A5009
A501	A502
A5030	A5042
A5044	A5044
A5049	A5049
A5051	A5059
A506	A506
A507	A519
A5200	A539
A5400	A5433
A5440	A549
A55	A55
A5600	A568
A57	A57
A58	A58
A5900	A5909
A6000	A609
A630	A65
A660	A699
A70	A70
A710	A719
A740	A759
A770	A779
A78	A78
A790	A809
A8100	A819
A820	A858
A86	A86
A870	A888
A89	A89
A90	A90
A91	A91

South Carolina Department of Health and Human Services SFY 2022 Medicaid Managed Care Capitation Rate Development In-Rate Criteria for Services Covered Under Managed Care Capitation Rate	
COMDHEC Range Table ICD-10	
Min Diagnosis Code	**Max Diagnosis Code**
A920	A938
A94	A94
A950	A959
A980	A988
A99	A99
B000	B019
B050	B059
B0600	B079
B08010	B088
B09	B09
B1001	B1089
B150	B199
B20	B20
B250	B269
B2700	B2799
B29	B29
B300	B338
B340	B348
B350	B370
B373	B373
B3741	B3749
B471	B479
B500	B538
B54	B54
B550	B569
B570	B5749
B575	B575
B600	B600
B608	B608
B64	B64
B853	B853
B86	B86
B900	B909
B950	B958
B960	B9689
B970	B970
B9710	B9719
B9721	B9739
B974	B9789
G032	G032
I673	I673
K9081	K9081
L081	L081
L444	L444
M0230	M0239
N341	N341
N476	N476
N481	N481
N72	N72
N735	N735

South Carolina Department of Health and Human Services SFY 2022 Medicaid Managed Care Capitation Rate Development In-Rate Criteria for Services Covered Under Managed Care Capitation Rate	
COMDHEC Range Table ICD-10	
Min Diagnosis Code	**Max Diagnosis Code**
N739	N739
R1111	R1111
R75	R75
R7611	R7612
Z01812	Z01812
Z0184	Z0184
Z0389	Z0389
Z111	Z111
Z113	Z113
Z16341	Z16342
Z201	Z202
Z205	Z206
Z20820	Z20820
Z21	Z21
Z224	Z224
Z2250	Z2259
Z717	Z717
Z7189	Z7189
Z7251	Z7253

Appendix 6: Adjusted March 2019 through February 2020 Base Data

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - 0 - 2 Months, Male & Female Base Year Member Months: 83,277 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	9,576.4	$ 1,390.72	$ 1,109.84	$ 9.88	$ 0.00	$ (0.77)	$ (0.02)	$ (0.59)	$ 3.08	$ 0.00	$ 0.00	9,649.9	$ 1,394.52	$ 1,121.42
Inpatient Well Newborn	7,095.5	562.35	332.51	2.96	-	(0.23)	(0.01)	(0.12)	0.92	-	-	7,151.2	563.87	336.03
Inpatient MH/SA	14.8	242.55	0.30	-	-	-	-	-	-	-	-	14.8	242.55	0.30
Other Inpatient	0.3	832.77	0.02	-	-	-	-	-	-	-	-	0.3	832.77	0.02
Subtotal Inpatient Hospital			**$ 1,442.67**											**$ 1,457.77**
Outpatient Hospital														
Surgery	75.1	$ 1,131.67	$ 7.08	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.02	$ 0.00	$ 0.00	75.2	$ 1,134.86	$ 7.11
Non-Surg - Emergency Room	797.6	275.63	18.32	0.05	-	(0.30)	0.14	(0.02)	0.05	-	-	785.8	278.54	18.24
Non-Surg - Other	1,366.2	120.07	13.67	0.04	-	-	-	(0.01)	0.03	-	-	1,369.2	120.33	13.73
Observation Room	56.8	870.82	4.12	0.01	-	-	-	-	0.01	-	-	56.9	872.92	4.14
Treatment/Therapy/Testing	939.5	72.55	5.68	0.02	-	-	-	(0.01)	0.01	-	-	941.2	72.68	5.70
Other Outpatient	37.3	57.88	0.18	-	-	-	-	-	-	-	-	37.3	57.88	0.18
Subtotal Outpatient Hospital			**$ 49.05**											**$ 49.10**
Retail Pharmacy														
Prescription Drugs	2,860.0	$ 16.99	$ 4.05	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ (0.01)	$ (0.27)	$ 0.00	$ 0.00	2,853.0	$ 15.82	$ 3.76
Subtotal Retail Pharmacy			**$ 4.05**											**$ 3.76**
Ancillary														
Transportation	199.1	$ 279.00	$ 4.63	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.12	$ 0.02	$ 0.00	$ 0.00	204.7	$ 280.17	$ 4.78
DME/Prosthetics	2,323.4	18.13	3.51	0.01	-	-	-	0.07	0.01	-	-	2,376.4	18.18	3.60
Dental	0.3	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	137.8	89.72	1.03	-	-	-	-	0.72	0.01	-	-	234.1	90.24	1.76
Subtotal Ancillary			**$ 9.17**											**$ 10.14**
Professional														
Inpatient and Outpatient Surgery	681.0	$ 183.26	$ 10.40	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.08	$ 0.03	$ 0.00	$ 0.00	688.2	$ 183.78	$ 10.54
Anesthesia	120.0	171.95	1.72	-	-	-	-	0.01	-	-	-	120.7	171.95	1.73
Inpatient Visits	14,195.6	185.96	219.99	0.57	-	-	-	1.66	0.61	-	-	14,339.5	186.47	222.83
MH/SA	46.7	20.56	0.08	-	-	-	-	-	-	-	-	46.7	20.56	0.08
Emergency Room	1,044.1	73.78	6.42	0.02	-	(0.08)	-	0.08	0.02	-	-	1,047.4	74.01	6.46
Office/Home Visits/Consults	7,909.8	78.21	51.55	0.13	-	0.09	-	0.81	0.15	-	-	8,067.8	78.43	52.73
Pathology/Lab	1,734.5	45.52	6.58	0.02	-	-	-	0.18	0.02	-	-	1,787.2	45.66	6.80
Radiology	2,963.1	13.08	3.23	0.01	-	0.01	-	0.05	0.01	-	-	3,027.3	13.12	3.31
Office Administered Drugs	41.6	92.21	0.32	-	-	-	-	-	-	-	-	41.6	92.21	0.32
Physical Exams	22,361.5	50.32	93.76	0.24	-	-	-	0.98	0.26	0.24	0.19	22,709.7	50.55	95.67
Therapy	99.4	26.55	0.22	-	-	-	-	-	-	-	-	99.4	26.55	0.22
Vision	28.1	55.52	0.13	-	-	-	-	-	-	-	-	28.1	55.52	0.13
Other Professional	4,328.8	43.72	15.77	0.04	-	-	-	0.66	0.05	-	-	4,521.0	43.85	16.52
Subtotal Professional			**$ 410.17**											**$ 417.34**
Total Medical Costs			**$ 1,915.11**											**$ 1,938.11**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - 3 - 12 Months, Male & Female Base Year Member Months: 349,063 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	217.5	$ 1,581.98	$ 28.67	$ 0.26	$ 0.00	$ (0.07)	$ 0.00	$ (0.03)	$ 0.08	$ 0.00	$ 0.00	218.7	$ 1,586.37	$ 28.91
Inpatient Well Newborn	0.1	872.66	0.01	-	-	-	-	-	-	-	-	0.1	872.66	0.01
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 28.68**											**$ 28.92**
Outpatient Hospital														
Surgery	80.3	$ 1,605.54	$ 10.74	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	80.4	$ 1,610.02	$ 10.79
Non-Surg - Emergency Room	961.6	219.37	17.58	0.05	-	(0.43)	0.15	(0.02)	0.05	-	-	939.8	221.93	17.38
Non-Surg - Other	742.4	142.57	8.82	0.02	-	-	-	(0.01)	0.03	-	-	743.2	143.05	8.86
Observation Room	15.0	1,011.08	1.26	-	-	-	-	-	0.01	-	-	15.0	1,019.10	1.27
Treatment/Therapy/Testing	301.2	162.96	4.09	0.01	-	-	-	-	0.01	-	-	301.9	163.35	4.11
Other Outpatient	41.2	55.41	0.19	-	-	-	-	-	-	-	-	41.2	55.41	0.19
Subtotal Outpatient Hospital			**$ 42.68**											**$ 42.60**
Retail Pharmacy														
Prescription Drugs	4,544.3	$ 31.27	$ 11.84	$ 0.00	$ 0.00	$ 0.00	$ (0.09)	$ (0.02)	$ (0.51)	$ 0.00	$ 0.00	4,536.6	$ 29.68	$ 11.22
Subtotal Retail Pharmacy			**$ 11.84**											**$ 11.22**
Ancillary														
Transportation	93.1	$ 116.01	$ 0.90	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	94.1	$ 116.01	$ 0.91
DME/Prosthetics	3,478.4	12.97	3.76	0.01	-	-	-	0.09	(0.03)	-	-	3,571.0	12.87	3.83
Dental	237.1	16.19	0.32	-	-	-	-	-	-	-	-	237.1	16.19	0.32
Other Ancillary	52.4	70.96	0.31	-	-	-	-	0.01	0.01	-	-	54.1	73.17	0.33
Subtotal Ancillary			**$ 5.29**											**$ 5.39**
Professional														
Inpatient and Outpatient Surgery	275.8	$ 181.40	$ 4.17	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.02	$ 0.00	$ 0.00	277.8	$ 182.27	$ 4.22
Anesthesia	151.6	105.25	1.33	-	-	-	-	0.01	-	-	-	152.8	105.25	1.34
Inpatient Visits	600.4	179.47	8.98	0.02	-	-	-	0.16	-	-	-	612.5	179.47	9.16
MH/SA	555.4	9.07	0.42	-	-	-	-	-	-	-	-	555.4	9.07	0.42
Emergency Room	1,034.7	67.85	5.85	0.02	-	(0.14)	-	0.04	0.02	-	-	1,020.6	68.08	5.79
Office/Home Visits/Consults	4,939.4	76.87	31.64	0.08	-	0.14	-	0.14	0.12	-	-	4,995.6	77.16	32.12
Pathology/Lab	2,186.5	13.67	2.49	0.01	-	-	-	0.02	0.02	-	-	2,212.9	13.77	2.54
Radiology	607.5	15.61	0.79	-	-	-	-	0.01	-	-	-	615.2	15.61	0.80
Office Administered Drugs	451.7	54.72	2.06	0.01	-	-	-	-	-	-	-	453.9	54.72	2.07
Physical Exams	11,606.1	37.59	36.36	0.09	-	-	-	0.08	0.10	0.11	0.15	11,695.5	37.85	36.89
Therapy	1,357.7	22.63	2.56	0.01	-	-	-	(0.06)	0.01	-	-	1,331.2	22.72	2.52
Vision	93.4	30.83	0.24	-	-	-	-	-	-	-	-	93.4	30.83	0.24
Other Professional	1,945.3	22.52	3.65	0.01	-	-	-	0.01	0.01	-	-	1,955.9	22.58	3.68
Subtotal Professional			**$ 100.54**											**$ 101.79**
Total Medical Costs			**$ 189.03**											**$ 189.92**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 1 - 6, Male & Female Base Year Member Months: 2,196,819 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	40.5	$ 2,208.36	$ 7.46	$ 0.07	$ 0.00	$ (0.02)	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	40.8	$ 2,214.25	$ 7.53
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	1.7	504.19	0.07	-	-	-	-	-	-	0.01	-	1.9	504.19	0.08
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.53**											**$ 7.61**
Outpatient Hospital														
Surgery	72.7	$ 1,341.05	$ 8.13	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	72.8	$ 1,346.00	$ 8.17
Non-Surg - Emergency Room	543.5	243.09	11.01	0.03	-	(0.26)	0.10	(0.02)	0.03	-	-	531.2	246.02	10.89
Non-Surg - Other	294.1	133.01	3.26	0.01	-	-	-	-	-	-	-	295.0	133.01	3.27
Observation Room	5.5	1,270.34	0.58	-	-	-	-	-	-	-	-	5.5	1,270.34	0.58
Treatment/Therapy/Testing	226.5	191.28	3.61	0.01	-	-	-	-	0.01	-	-	227.1	191.80	3.63
Other Outpatient	30.0	260.43	0.65	-	-	-	-	-	-	-	-	30.0	260.43	0.65
Subtotal Outpatient Hospital			**$ 27.24**											**$ 27.19**
Retail Pharmacy														
Prescription Drugs	4,255.3	$ 37.90	$ 13.44	$ 0.00	$ 0.00	$ 0.00	$ (0.16)	$ (0.01)	$ (0.60)	$ 0.00	$ 0.00	4,252.1	$ 35.76	$ 12.67
Subtotal Retail Pharmacy			**$ 13.44**											**$ 12.67**
Ancillary														
Transportation	46.5	$ 118.59	$ 0.46	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	46.5	$ 118.59	$ 0.46
DME/Prosthetics	2,629.0	7.49	1.64	-	-	-	-	0.02	-	-	-	2,661.1	7.49	1.66
Dental	247.8	69.25	1.43	-	-	-	-	0.02	0.01	-	-	251.3	69.72	1.46
Other Ancillary	14.5	49.81	0.06	-	-	-	-	-	0.02	-	-	14.5	66.42	0.08
Subtotal Ancillary			**$ 3.59**											**$ 3.66**
Professional														
Inpatient and Outpatient Surgery	219.8	$ 138.12	$ 2.53	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	222.4	$ 138.12	$ 2.56
Anesthesia	140.1	95.10	1.11	-	-	-	-	0.01	0.01	-	-	141.3	95.95	1.13
Inpatient Visits	65.5	128.22	0.70	-	-	-	-	0.01	-	-	-	66.4	128.22	0.71
MH/SA	2,552.9	26.04	5.54	0.01	-	-	-	0.01	0.02	0.19	(0.15)	2,649.6	25.45	5.62
Emergency Room	578.6	66.78	3.22	0.01	-	(0.07)	-	0.02	-	-	-	571.4	66.78	3.18
Office/Home Visits/Consults	3,228.0	77.51	20.85	0.05	-	0.08	-	0.09	0.07	-	-	3,262.1	77.77	21.14
Pathology/Lab	1,797.9	14.08	2.11	0.01	-	-	-	0.03	-	-	-	1,832.0	14.08	2.15
Radiology	329.7	16.38	0.45	-	-	-	-	0.01	-	-	-	337.0	16.38	0.46
Office Administered Drugs	290.2	9.93	0.24	-	-	-	-	-	-	-	-	290.2	9.93	0.24
Physical Exams	2,073.5	49.19	8.50	0.02	-	-	-	0.03	0.02	0.04	0.04	2,095.5	49.53	8.65
Therapy	6,318.5	22.58	11.89	0.03	-	-	-	(0.28)	0.03	-	-	6,185.7	22.64	11.67
Vision	398.3	28.32	0.94	-	-	-	-	-	0.01	-	-	398.3	28.62	0.95
Other Professional	2,869.4	12.88	3.08	0.01	-	-	-	-	0.01	-	-	2,878.7	12.92	3.10
Subtotal Professional			**$ 61.16**											**$ 61.56**
Total Medical Costs			**$ 112.96**											**$ 112.69**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 7 - 13, Male & Female Base Year Member Months: 2,635,374 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	25.7	$ 2,155.24	$ 4.61	$ 0.04	$ 0.00	$ (0.03)	$ 0.01	$ (0.01)	$ 0.02	$ 0.00	$ 0.00	25.7	$ 2,169.26	$ 4.64
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	81.4	418.43	2.84	0.03	-	-	-	(0.01)	0.01	0.32	0.12	91.2	435.54	3.31
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.45**											**$ 7.95**
Outpatient Hospital														
Surgery	39.7	$ 1,400.57	$ 4.63	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	39.8	$ 1,403.59	$ 4.65
Non-Surg - Emergency Room	323.8	261.65	7.06	0.02	-	(0.12)	0.05	(0.01)	0.02	-	-	318.7	264.29	7.02
Non-Surg - Other	203.2	128.72	2.18	0.01	-	-	-	(0.01)	0.01	-	-	203.2	129.32	2.19
Observation Room	2.6	1,172.32	0.25	-	-	-	-	-	-	-	-	2.6	1,172.32	0.25
Treatment/Therapy/Testing	178.9	190.51	2.84	0.01	-	-	-	(0.01)	0.01	-	-	178.9	191.18	2.85
Other Outpatient	20.4	106.10	0.18	-	-	-	-	-	-	-	-	20.4	106.10	0.18
Subtotal Outpatient Hospital			**$ 17.14**											**$ 17.14**
Retail Pharmacy														
Prescription Drugs	5,377.6	$ 67.46	$ 30.23	$ 0.00	$ 0.00	$ 0.00	$ (0.36)	$ (0.03)	$ (1.21)	$ 0.00	$ 0.00	5,372.3	$ 63.95	$ 28.63
Subtotal Retail Pharmacy			**$ 30.23**											**$ 28.63**
Ancillary														
Transportation	35.1	$ 102.50	$ 0.30	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	35.1	$ 102.50	$ 0.30
DME/Prosthetics	1,764.0	9.73	1.43	-	-	-	-	0.01	0.01	-	-	1,776.3	9.80	1.45
Dental	32.4	59.21	0.16	-	-	-	-	-	-	-	-	32.4	59.21	0.16
Other Ancillary	70.3	42.65	0.25	-	-	-	-	-	-	-	-	70.3	42.65	0.25
Subtotal Ancillary			**$ 2.14**											**$ 2.16**
Professional														
Inpatient and Outpatient Surgery	147.4	$ 133.55	$ 1.64	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	149.2	$ 133.55	$ 1.66
Anesthesia	53.2	99.25	0.44	-	-	-	-	-	-	-	-	53.2	99.25	0.44
Inpatient Visits	73.3	85.16	0.52	-	-	-	-	0.01	-	-	-	74.7	85.16	0.53
MH/SA	6,074.0	40.60	20.55	0.05	-	-	-	0.02	0.05	0.10	(0.09)	6,124.2	40.52	20.68
Emergency Room	345.3	68.81	1.98	0.01	-	(0.03)	-	0.01	-	-	-	343.5	68.81	1.97
Office/Home Visits/Consults	2,536.8	81.69	17.27	0.04	-	0.04	-	0.07	0.05	-	-	2,558.9	81.93	17.47
Pathology/Lab	1,439.4	12.59	1.51	-	-	0.01	-	0.02	0.01	-	-	1,468.0	12.67	1.55
Radiology	385.4	19.31	0.62	-	-	-	-	0.01	-	-	-	391.6	19.31	0.63
Office Administered Drugs	899.6	13.34	1.00	-	-	0.01	-	-	-	-	-	908.6	13.34	1.01
Physical Exams	1,000.0	59.04	4.92	0.01	-	-	-	0.02	0.01	0.03	0.03	1,012.2	59.51	5.02
Therapy	959.1	21.90	1.75	-	-	-	-	-	0.01	-	-	959.1	22.02	1.76
Vision	1,155.2	26.28	2.53	0.01	-	-	-	-	0.01	-	-	1,159.8	26.38	2.55
Other Professional	2,593.2	11.06	2.39	0.01	-	-	-	0.01	0.01	-	-	2,614.9	11.11	2.42
Subtotal Professional			**$ 57.12**											**$ 57.69**
Total Medical Costs			**$ 114.08**											**$ 113.57**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Male Base Year Member Months: 744,863 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	45.8	$ 2,477.63	$ 9.45	$ 0.08	$ 0.00	$ (0.06)	$ 0.02	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	45.8	$ 2,490.73	$ 9.51
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	197.6	423.22	6.97	0.06	-	-	-	(0.01)	0.02	1.08	0.31	229.7	440.47	8.43
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 16.42**											**$ 17.94**
Outpatient Hospital														
Surgery	54.7	$ 1,384.01	$ 6.31	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.02	$ 0.00	$ 0.00	54.8	$ 1,388.39	$ 6.34
Non-Surg - Emergency Room	351.4	269.78	7.90	0.02	-	(0.09)	0.04	(0.01)	0.02	-	-	347.8	271.85	7.88
Non-Surg - Other	143.7	134.43	1.61	-	-	-	-	-	0.01	-	-	143.7	135.26	1.62
Observation Room	3.3	903.96	0.25	-	-	-	-	-	-	-	-	3.3	903.96	0.25
Treatment/Therapy/Testing	216.5	247.81	4.47	0.01	-	-	-	-	0.01	-	-	216.9	248.36	4.49
Other Outpatient	22.4	117.64	0.22	-	-	-	-	-	-	-	-	22.4	117.64	0.22
Subtotal Outpatient Hospital			**$ 20.76**											**$ 20.80**
Retail Pharmacy														
Prescription Drugs	5,188.4	$ 79.56	$ 34.40	$ 0.00	$ 0.00	$ 0.00	$ (0.35)	$ (0.04)	$ (1.39)	$ 0.00	$ 0.00	5,182.3	$ 75.53	$ 32.62
Subtotal Retail Pharmacy			**$ 34.40**											**$ 32.62**
Ancillary														
Transportation	83.4	$ 110.74	$ 0.77	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	83.4	$ 110.74	$ 0.77
DME/Prosthetics	1,676.5	15.75	2.20	0.01	-	-	-	-	-	0.04	0.17	1,714.6	16.94	2.42
Dental	8.7	41.38	0.03	-	-	-	-	-	-	-	-	8.7	41.38	0.03
Other Ancillary	72.9	46.06	0.28	-	-	-	-	-	-	-	-	72.9	46.06	0.28
Subtotal Ancillary			**$ 3.28**											**$ 3.50**
Professional														
Inpatient and Outpatient Surgery	194.1	$ 160.14	$ 2.59	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	196.3	$ 160.14	$ 2.62
Anesthesia	65.1	112.44	0.61	-	-	-	-	-	0.01	-	-	65.1	114.28	0.62
Inpatient Visits	145.9	77.32	0.94	-	-	-	-	0.03	-	-	-	150.5	77.32	0.97
MH/SA	4,646.8	43.36	16.79	0.04	-	-	-	0.02	0.05	-	-	4,663.4	43.49	16.90
Emergency Room	383.2	74.54	2.38	0.01	-	(0.03)	-	0.02	-	-	-	383.2	74.54	2.38
Office/Home Visits/Consults	2,109.0	81.93	14.40	0.04	-	0.03	-	0.07	0.05	-	-	2,129.5	82.22	14.59
Pathology/Lab	1,377.1	13.77	1.58	-	-	0.01	-	0.03	0.01	-	-	1,412.0	13.85	1.63
Radiology	592.7	23.69	1.17	-	-	0.01	-	0.01	-	-	-	602.8	23.69	1.19
Office Administered Drugs	2,254.4	15.01	2.82	0.01	-	0.01	-	0.01	-	-	-	2,278.4	15.01	2.85
Physical Exams	722.5	61.45	3.70	0.01	-	-	-	0.01	0.01	0.02	0.02	730.4	61.94	3.77
Therapy	546.5	21.52	0.98	-	-	-	-	-	0.01	-	-	546.5	21.74	0.99
Vision	939.1	26.45	2.07	0.01	-	-	-	-	-	-	-	943.6	26.45	2.08
Other Professional	2,027.0	18.06	3.05	0.01	-	-	-	0.02	-	-	-	2,046.9	18.06	3.08
Subtotal Professional			**$ 53.08**											**$ 53.67**
Total Medical Costs			**$ 127.94**											**$ 128.53**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Female Base Year Member Months: 757,039 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	60.4	$ 2,469.12	$ 12.42	$ 0.11	$ 0.00	$ (0.10)	$ 0.03	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	60.4	$ 2,481.05	$ 12.48
Inpatient Well Newborn	0.1	1,892.60	0.01	-	-	-	-	-	-	-	-	0.1	1,892.60	0.01
Inpatient MH/SA	210.2	454.42	7.96	0.07	-	-	-	(0.01)	0.02	1.25	0.27	244.8	468.63	9.56
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 20.39**											**$ 22.05**
Outpatient Hospital														
Surgery	69.1	$ 1,293.86	$ 7.45	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.02	$ 0.00	$ 0.00	69.2	$ 1,297.33	$ 7.48
Non-Surg - Emergency Room	587.6	286.12	14.01	0.04	-	(0.19)	0.08	(0.01)	0.04	-	-	580.9	288.60	13.97
Non-Surg - Other	241.9	150.80	3.04	0.01	-	-	-	(0.01)	0.01	-	-	241.9	151.30	3.05
Observation Room	9.2	497.71	0.38	-	-	-	-	-	-	-	-	9.2	497.71	0.38
Treatment/Therapy/Testing	395.5	202.40	6.67	0.02	-	-	-	(0.01)	0.02	-	-	396.0	203.00	6.70
Other Outpatient	35.2	136.53	0.40	-	-	-	-	-	-	-	-	35.2	136.53	0.40
Subtotal Outpatient Hospital			**$ 31.95**											**$ 31.98**
Retail Pharmacy														
Prescription Drugs	7,609.6	$ 52.94	$ 33.57	$ 0.00	$ 0.00	$ 0.00	$ (0.36)	$ (0.04)	$ (1.28)	$ 0.00	$ 0.00	7,600.6	$ 50.35	$ 31.89
Subtotal Retail Pharmacy			**$ 33.57**											**$ 31.89**
Ancillary														
Transportation	114.0	$ 94.76	$ 0.90	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	114.0	$ 95.81	$ 0.91
DME/Prosthetics	1,543.0	13.92	1.79	-	-	-	-	0.02	-	0.05	0.26	1,603.3	15.87	2.12
Dental	8.5	28.14	0.02	-	-	-	-	-	-	-	-	8.5	28.14	0.02
Other Ancillary	88.7	59.51	0.44	-	-	-	-	-	-	-	-	88.7	59.51	0.44
Subtotal Ancillary			**$ 3.15**											**$ 3.49**
Professional														
Inpatient and Outpatient Surgery	196.1	$ 159.69	$ 2.61	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	198.4	$ 159.69	$ 2.64
Anesthesia	73.3	112.99	0.69	-	-	-	-	0.01	-	-	-	74.3	112.99	0.70
Inpatient Visits	207.8	77.38	1.34	-	-	-	-	0.04	-	-	-	214.0	77.38	1.38
MH/SA	4,106.8	60.75	20.79	0.05	-	-	-	0.03	0.06	0.03	(0.02)	4,128.6	60.86	20.94
Emergency Room	620.9	77.70	4.02	0.01	-	(0.05)	-	0.02	0.01	-	-	617.8	77.89	4.01
Office/Home Visits/Consults	3,129.4	81.37	21.22	0.06	-	0.05	-	0.11	0.07	-	-	3,161.8	81.64	21.51
Pathology/Lab	3,534.4	13.75	4.05	0.01	-	-	-	0.08	0.08	-	-	3,613.0	14.02	4.22
Radiology	675.9	29.12	1.64	-	-	0.01	-	0.01	-	-	-	684.1	29.12	1.66
Office Administered Drugs	20,166.7	1.01	1.70	-	-	0.02	-	0.01	-	-	-	20,522.6	1.01	1.73
Physical Exams	803.4	60.79	4.07	0.01	-	-	-	0.02	-	0.03	0.03	815.2	61.23	4.16
Therapy	593.9	21.42	1.06	-	-	-	-	-	0.01	-	-	593.9	21.62	1.07
Vision	1,508.8	26.17	3.29	0.01	-	-	-	-	0.01	-	-	1,513.4	26.25	3.31
Other Professional	2,204.3	22.76	4.18	0.01	-	-	-	0.02	0.02	-	-	2,220.1	22.86	4.23
Subtotal Professional			**$ 70.66**											**$ 71.56**
Total Medical Costs			**$ 159.72**											**$ 160.97**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Male Base Year Member Months: 270,094 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	213.0	$ 2,261.49	$ 40.14	$ 0.36	$ 0.00	$ (0.48)	$ 0.06	$ (0.04)	$ 0.11	$ 0.00	$ 0.00	212.1	$ 2,271.10	$ 40.15
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	85.2	677.35	4.81	0.04	-	-	-	-	0.01	0.46	(0.03)	94.1	674.80	5.29
Other Inpatient	2.8	342.98	0.08	-	-	-	-	-	-	-	-	2.8	342.98	0.08
Subtotal Inpatient Hospital			**$ 45.03**											**$ 45.52**
Outpatient Hospital														
Surgery	92.9	$ 1,426.72	$ 11.04	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	93.0	$ 1,430.59	$ 11.09
Non-Surg - Emergency Room	615.8	282.18	14.48	0.04	-	(0.29)	0.12	(0.02)	0.04	-	-	604.3	285.35	14.37
Non-Surg - Other	85.9	145.32	1.04	-	-	-	-	-	-	-	-	85.9	145.32	1.04
Observation Room	5.1	616.00	0.26	-	-	-	-	-	-	-	-	5.1	616.00	0.26
Treatment/Therapy/Testing	290.3	360.40	8.72	0.02	-	-	-	(0.01)	0.03	-	-	290.7	361.64	8.76
Other Outpatient	32.3	182.04	0.49	-	-	-	-	-	-	-	-	32.3	182.04	0.49
Subtotal Outpatient Hospital			**$ 36.03**											**$ 36.01**
Retail Pharmacy														
Prescription Drugs	4,885.0	$ 108.13	$ 44.02	$ 0.00	$ 0.00	$ 0.00	$ (0.46)	$ (0.05)	$ (2.22)	$ 0.00	$ 0.00	4,879.5	$ 101.54	$ 41.29
Subtotal Retail Pharmacy			**$ 44.02**											**$ 41.29**
Ancillary														
Transportation	178.5	$ 104.22	$ 1.55	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	179.6	$ 104.22	$ 1.56
DME/Prosthetics	1,911.7	16.45	2.62	0.01	-	-	-	0.03	(0.01)	-	0.02	1,940.9	16.51	2.67
Dental	0.1	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	124.8	61.52	0.64	-	-	-	-	-	-	-	-	124.8	61.52	0.64
Subtotal Ancillary			**$ 4.81**											**$ 4.87**
Professional														
Inpatient and Outpatient Surgery	359.3	$ 149.94	$ 4.49	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.04	$ 0.02	$ 0.00	$ 0.01	363.3	$ 150.93	$ 4.57
Anesthesia	120.8	110.30	1.11	-	-	-	-	0.01	-	-	-	121.8	110.30	1.12
Inpatient Visits	420.6	79.32	2.78	0.01	-	-	-	0.05	-	-	-	429.6	79.32	2.84
MH/SA	1,438.4	68.16	8.17	0.02	-	-	-	0.19	0.12	1.15	0.62	1,677.9	73.45	10.27
Emergency Room	688.1	81.96	4.70	0.01	-	(0.08)	-	0.04	0.02	-	-	683.7	82.31	4.69
Office/Home Visits/Consults	1,961.9	80.86	13.22	0.03	-	0.08	-	0.18	0.06	-	0.03	2,005.0	81.40	13.60
Pathology/Lab	2,005.3	14.30	2.39	0.01	-	-	-	0.06	0.04	-	-	2,064.0	14.53	2.50
Radiology	976.1	28.52	2.32	0.01	-	-	-	0.03	0.01	-	-	993.0	28.64	2.37
Office Administered Drugs	6,001.6	9.52	4.76	0.01	-	0.02	-	0.11	(0.08)	-	-	6,178.1	9.36	4.82
Physical Exams	139.3	50.83	0.59	-	-	-	-	0.01	-	-	-	141.6	50.83	0.60
Therapy	429.2	22.92	0.82	-	-	-	-	-	0.01	-	-	429.2	23.20	0.83
Vision	230.0	32.35	0.62	-	-	-	-	-	-	-	-	230.0	32.35	0.62
Other Professional	1,111.7	27.85	2.58	0.01	-	-	-	0.03	0.04	-	-	1,129.0	28.27	2.66
Subtotal Professional			**$ 48.55**											**$ 51.49**
Total Medical Costs			**$ 178.44**											**$ 179.18**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Female Base Year Member Months: 1,374,559 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	204.1	$ 2,129.36	$ 36.22	$ 0.32	$ 0.00	$ (0.53)	$ 0.08	$ (0.04)	$ 0.10	$ 0.00	$ 0.00	202.7	$ 2,140.01	$ 36.15
Inpatient Well Newborn	0.2	624.80	0.01	-	-	-	-	-	-	-	-	0.2	624.80	0.01
Inpatient MH/SA	67.2	685.94	3.84	0.03	-	-	-	-	0.01	0.30	0.04	73.0	694.16	4.22
Other Inpatient	6.2	311.96	0.16	-	-	-	-	-	-	-	-	6.2	311.96	0.16
Subtotal Inpatient Hospital			**$ 40.23**											**$ 40.54**
Outpatient Hospital														
Surgery	205.2	$ 1,222.06	$ 20.90	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	$ 0.06	$ 0.00	$ 0.00	205.5	$ 1,225.57	$ 20.99
Non-Surg - Emergency Room	1,138.5	303.35	28.78	0.08	-	(0.69)	0.30	(0.03)	0.08	-	-	1,113.2	307.44	28.52
Non-Surg - Other	319.0	160.64	4.27	0.01	-	-	-	-	0.01	-	-	319.7	161.01	4.29
Observation Room	28.9	456.66	1.10	-	-	-	-	-	-	-	-	28.9	456.66	1.10
Treatment/Therapy/Testing	751.5	264.28	16.55	0.04	-	-	-	(0.01)	0.04	-	-	752.8	264.92	16.62
Other Outpatient	106.0	147.17	1.30	-	-	-	-	-	0.01	-	-	106.0	148.30	1.31
Subtotal Outpatient Hospital			**$ 72.90**											**$ 72.83**
Retail Pharmacy														
Prescription Drugs	9,441.3	$ 76.79	$ 60.42	$ 0.01	$ 0.00	$ 0.00	$ (0.78)	$ (0.07)	$ (3.01)	$ 0.00	$ 0.00	9,431.9	$ 71.97	$ 56.57
Subtotal Retail Pharmacy			**$ 60.42**											**$ 56.57**
Ancillary														
Transportation	254.4	$ 88.68	$ 1.88	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	255.7	$ 89.15	$ 1.90
DME/Prosthetics	1,691.2	15.40	2.17	-	-	-	-	0.03	-	0.03	0.15	1,738.0	16.43	2.38
Dental	0.1	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	172.6	98.04	1.41	-	-	-	-	0.01	0.01	-	-	173.8	98.73	1.43
Subtotal Ancillary			**$ 5.46**											**$ 5.71**
Professional														
Inpatient and Outpatient Surgery	487.4	$ 179.01	$ 7.27	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.07	$ 0.03	$ 0.00	$ 0.05	493.4	$ 180.95	$ 7.44
Anesthesia	217.8	110.17	2.00	0.01	-	-	-	0.02	-	-	-	221.1	110.17	2.03
Inpatient Visits	430.7	78.85	2.83	0.01	-	-	-	0.02	0.01	-	-	435.3	79.12	2.87
MH/SA	2,217.9	75.37	13.93	0.04	-	-	-	0.14	0.08	1.04	0.43	2,412.1	77.91	15.66
Emergency Room	1,238.8	82.73	8.54	0.02	-	(0.19)	-	0.08	0.03	-	-	1,225.7	83.02	8.48
Office/Home Visits/Consults	3,955.6	80.15	26.42	0.07	-	0.17	-	0.28	0.08	-	0.04	4,033.5	80.51	27.06
Pathology/Lab	7,181.9	15.64	9.36	0.02	-	0.01	-	0.21	0.18	-	0.03	7,366.0	15.98	9.81
Radiology	1,559.0	37.64	4.89	0.01	-	0.01	-	0.06	-	-	0.01	1,584.5	37.72	4.98
Office Administered Drugs	27,842.1	3.34	7.75	0.02	-	0.04	-	0.08	(0.01)	-	-	28,345.0	3.34	7.88
Physical Exams	380.4	59.30	1.88	-	-	-	-	0.02	-	-	-	384.5	59.30	1.90
Therapy	534.6	22.45	1.00	-	-	-	-	-	0.01	-	-	534.6	22.67	1.01
Vision	232.2	38.75	0.75	-	-	-	-	-	0.01	-	-	232.2	39.27	0.76
Other Professional	2,281.4	35.66	6.78	0.02	-	-	-	0.07	0.05	-	-	2,311.7	35.92	6.92
Subtotal Professional			**$ 93.40**											**$ 96.80**
Total Medical Costs			**$ 272.41**											**$ 272.45**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 45+, Male & Female Base Year Member Months: 230,738 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	480.8	$ 2,450.41	$ 98.17	$ 0.87	$ 0.00	$ (1.16)	$ 0.14	$ (0.11)	$ 0.27	$ 0.00	$ 0.00	478.8	$ 2,460.68	$ 98.18
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	61.5	732.04	3.75	0.03	-	-	-	-	0.01	0.23	0.10	65.7	752.12	4.12
Other Inpatient	31.7	336.65	0.89	0.01	-	(0.01)	0.01	-	-	-	-	31.7	340.43	0.90
Subtotal Inpatient Hospital			**$ 102.81**											**$ 103.20**
Outpatient Hospital														
Surgery	220.2	$ 1,745.11	$ 32.03	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	$ 0.09	$ 0.00	$ 0.00	220.6	$ 1,750.01	$ 32.17
Non-Surg - Emergency Room	778.3	331.19	21.48	0.06	-	(0.41)	0.20	(0.03)	0.06	-	-	764.5	335.27	21.36
Non-Surg - Other	335.3	143.88	4.02	0.01	-	-	-	-	0.01	-	-	336.1	144.23	4.04
Observation Room	17.4	936.73	1.36	-	-	-	-	-	0.01	-	-	17.4	943.62	1.37
Treatment/Therapy/Testing	1,106.8	456.34	42.09	0.11	-	-	-	(0.04)	0.11	-	-	1,108.7	457.53	42.27
Other Outpatient	294.4	143.06	3.51	0.01	-	-	-	-	0.01	-	-	295.3	143.47	3.53
Subtotal Outpatient Hospital			**$ 104.49**											**$ 104.74**
Retail Pharmacy														
Prescription Drugs	18,777.2	$ 90.34	$ 141.36	$ 0.01	$ 0.00	$ 0.00	$ (1.88)	$ (0.15)	$ (6.91)	$ 0.00	$ 0.00	18,758.6	$ 84.72	$ 132.43
Subtotal Retail Pharmacy			**$ 141.36**											**$ 132.43**
Ancillary														
Transportation	258.8	$ 100.16	$ 2.16	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	260.0	$ 100.16	$ 2.17
DME/Prosthetics	7,619.9	10.95	6.95	0.02	-	-	-	0.06	0.02	0.01	0.16	7,718.5	11.22	7.22
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	391.1	72.10	2.35	0.01	-	-	-	-	0.01	-	-	392.8	72.40	2.37
Subtotal Ancillary			**$ 11.46**											**$ 11.76**
Professional														
Inpatient and Outpatient Surgery	1,119.2	$ 161.47	$ 15.06	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.13	$ 0.04	$ 0.00	$ 0.14	1,131.8	$ 163.38	$ 15.41
Anesthesia	413.5	106.21	3.66	0.01	-	-	-	0.03	-	-	-	418.0	106.21	3.70
Inpatient Visits	773.2	81.79	5.27	0.01	-	-	-	0.05	0.01	-	-	782.0	81.94	5.34
MH/SA	1,860.9	74.55	11.56	0.03	-	-	-	0.13	0.07	0.72	0.30	2,002.5	76.76	12.81
Emergency Room	919.1	90.22	6.91	0.02	-	(0.11)	-	0.05	0.02	-	-	913.7	90.48	6.89
Office/Home Visits/Consults	5,713.0	82.36	39.21	0.10	-	0.10	-	0.38	0.12	-	0.10	5,797.5	82.82	40.01
Pathology/Lab	6,819.4	12.70	7.22	0.02	-	0.01	-	0.15	0.10	-	0.03	6,989.4	12.93	7.53
Radiology	2,628.3	38.17	8.36	0.02	-	0.02	-	0.11	0.02	-	0.01	2,675.4	38.30	8.54
Office Administered Drugs	20,673.7	9.11	15.70	0.04	-	0.04	-	0.08	0.02	-	-	20,884.4	9.12	15.88
Physical Exams	419.4	57.23	2.00	0.01	-	-	-	0.01	-	-	-	423.6	57.23	2.02
Therapy	1,572.6	21.67	2.84	0.01	-	-	-	0.01	-	-	-	1,583.7	21.67	2.86
Vision	324.8	47.66	1.29	-	-	-	-	0.01	-	-	-	327.3	47.66	1.30
Other Professional	3,851.1	24.30	7.80	0.02	-	-	-	0.07	0.06	-	-	3,895.6	24.49	7.95
Subtotal Professional			**$ 126.88**											**$ 130.24**
Total Medical Costs			**$ 487.00**											**$ 482.37**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SSI - Children Base Year Member Months: 136,398 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	365.4	$ 1,741.02	$ 53.01	$ 0.71	$ 0.00	$ (0.63)	$ 0.16	$ (0.06)	$ 0.15	$ 0.00	$ 0.00	365.5	$ 1,751.20	$ 53.34
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	915.0	366.70	27.96	0.37	-	-	-	(0.03)	0.08	1.83	1.09	986.0	380.94	31.30
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 80.97**											**$ 84.64**
Outpatient Hospital														
Surgery	115.9	$ 1,580.44	$ 15.26	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ (0.02)	$ 0.04	$ 0.00	$ 0.00	116.1	$ 1,584.57	$ 15.33
Non-Surg - Emergency Room	646.5	301.27	16.23	0.05	-	(0.21)	0.10	(0.02)	0.05	-	-	639.3	304.09	16.20
Non-Surg - Other	718.0	157.27	9.41	0.03	-	-	-	(0.01)	0.02	-	-	719.5	157.61	9.45
Observation Room	16.4	1,745.31	2.38	0.01	-	-	-	(0.01)	0.01	-	-	16.4	1,752.64	2.39
Treatment/Therapy/Testing	816.5	358.30	24.38	0.07	-	-	-	(0.02)	0.06	-	-	818.2	359.18	24.49
Other Outpatient	62.8	328.58	1.72	0.01	-	-	-	(0.01)	0.01	-	-	62.8	330.49	1.73
Subtotal Outpatient Hospital			**$ 69.38**											**$ 69.59**
Retail Pharmacy														
Prescription Drugs	16,268.9	$ 141.93	$ 192.42	$ 0.04	$ 0.00	$ 0.00	$ (1.71)	$ (0.22)	$ (5.81)	$ 0.00	$ 0.00	16,253.6	$ 136.38	$ 184.72
Subtotal Retail Pharmacy			**$ 192.42**											**$ 184.72**
Ancillary														
Transportation	223.7	$ 101.91	$ 1.90	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	223.7	$ 102.45	$ 1.91
DME/Prosthetics	53,138.8	4.38	19.38	0.04	-	-	-	0.06	0.07	-	-	53,413.0	4.39	19.55
Dental	83.3	80.66	0.56	-	-	-	-	0.01	-	-	-	84.8	80.66	0.57
Other Ancillary	438.7	38.03	1.39	-	-	-	-	-	0.01	-	-	438.7	38.30	1.40
Subtotal Ancillary			**$ 23.23**											**$ 23.43**
Professional														
Inpatient and Outpatient Surgery	308.8	$ 166.32	$ 4.28	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.05	$ 0.10	$ 0.00	$ 0.00	313.9	$ 170.14	$ 4.45
Anesthesia	207.5	115.69	2.00	0.01	-	-	-	0.01	0.02	-	-	209.5	116.84	2.04
Inpatient Visits	827.7	99.02	6.83	0.03	-	-	-	0.21	0.09	-	-	856.8	100.28	7.16
MH/SA	28,261.8	25.53	60.12	0.27	-	-	-	0.03	0.17	2.25	(1.56)	29,460.6	24.96	61.28
Emergency Room	767.9	81.42	5.21	0.02	-	(0.05)	-	0.02	0.01	-	-	766.4	81.58	5.21
Office/Home Visits/Consults	4,615.1	90.56	34.83	0.16	-	0.06	-	0.10	0.11	-	-	4,657.5	90.85	35.26
Pathology/Lab	2,017.9	15.64	2.63	0.01	-	-	-	0.08	0.02	-	-	2,087.0	15.75	2.74
Radiology	907.3	21.43	1.62	0.01	-	-	-	0.02	-	-	-	924.1	21.43	1.65
Office Administered Drugs	8,704.9	20.09	14.57	0.07	-	0.07	-	0.02	0.04	-	-	8,800.5	20.14	14.77
Physical Exams	1,047.2	60.16	5.25	0.02	-	-	-	0.01	0.01	0.06	0.03	1,065.2	60.61	5.38
Therapy	16,491.0	21.71	29.84	0.13	-	-	-	(0.52)	0.08	-	-	16,275.5	21.77	29.53
Vision	1,219.8	28.23	2.87	0.01	-	-	-	0.01	-	-	-	1,228.3	28.23	2.89
Other Professional	13,729.5	13.68	15.65	0.07	-	-	-	0.04	0.05	-	-	13,826.0	13.72	15.81
Subtotal Professional			**$ 185.70**											**$ 188.17**
Total Medical Costs			**$ 551.70**											**$ 550.55**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SSI - Adults Base Year Member Months: 599,191 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	1,863.5	$ 2,004.73	$ 311.31	$ 4.14	$ 0.00	$ (5.74)	$ (0.06)	$ (0.25)	$ 0.85	$ 0.00	$ 0.00	1,852.4	$ 2,009.85	$ 310.25
Inpatient Well Newborn	0.1	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	465.4	598.19	23.20	0.31	-	-	-	(0.02)	0.06	1.76	0.93	506.5	621.64	26.24
Other Inpatient	413.9	267.02	9.21	0.12	-	(0.17)	(0.01)	(0.01)	0.03	-	-	411.2	267.61	9.17
Subtotal Inpatient Hospital			**$ 343.72**											**$ 345.66**
Outpatient Hospital														
Surgery	309.6	$ 1,687.83	$ 43.54	$ 0.13	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	$ 0.11	$ 0.00	$ 0.00	310.2	$ 1,692.08	$ 43.74
Non-Surg - Emergency Room	1,533.5	376.09	48.06	0.14	-	(0.35)	0.19	(0.05)	0.14	-	-	1,525.2	378.69	48.13
Non-Surg - Other	700.3	151.30	8.83	0.03	-	-	-	(0.01)	0.02	-	-	701.9	151.64	8.87
Observation Room	44.8	862.88	3.22	0.01	-	-	-	-	0.01	-	-	44.9	865.55	3.24
Treatment/Therapy/Testing	1,458.5	749.44	91.09	0.27	-	-	-	(0.09)	0.25	-	-	1,461.4	751.49	91.52
Other Outpatient	267.2	216.50	4.82	0.01	-	-	-	-	0.01	-	-	267.7	216.95	4.84
Subtotal Outpatient Hospital			**$ 199.56**											**$ 200.34**
Retail Pharmacy														
Prescription Drugs	26,910.1	$ 157.18	$ 352.48	$ 0.07	$ 0.00	$ 0.00	$ (4.33)	$ (0.39)	$ (13.71)	$ 0.00	$ 0.00	26,885.6	$ 149.13	$ 334.12
Subtotal Retail Pharmacy			**$ 352.48**											**$ 334.12**
Ancillary														
Transportation	1,284.9	$ 89.66	$ 9.60	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.05	$ 0.03	$ 0.00	$ 0.00	1,294.3	$ 89.93	$ 9.70
DME/Prosthetics	32,464.9	8.18	22.12	0.04	-	-	-	0.28	0.23	0.01	0.04	32,949.2	8.27	22.72
Dental	0.3	352.47	0.01	-	-	-	-	-	-	-	-	0.3	352.47	0.01
Other Ancillary	1,706.9	70.51	10.03	0.02	-	-	-	0.06	0.03	-	-	1,720.5	70.72	10.14
Subtotal Ancillary			**$ 41.76**											**$ 42.57**
Professional														
Inpatient and Outpatient Surgery	1,387.1	$ 168.61	$ 19.49	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.22	$ 0.14	$ 0.00	$ 0.14	1,409.2	$ 171.00	$ 20.08
Anesthesia	564.1	108.50	5.10	0.02	-	-	-	0.05	0.03	-	-	571.8	109.12	5.20
Inpatient Visits	3,576.4	78.28	23.33	0.10	-	-	-	0.33	0.07	-	-	3,642.3	78.51	23.83
MH/SA	11,678.6	24.55	23.89	0.11	-	-	-	0.08	0.14	0.35	1.16	11,942.6	25.85	25.73
Emergency Room	1,998.2	91.82	15.29	0.07	-	(0.09)	-	0.12	0.04	-	-	2,011.2	92.06	15.43
Office/Home Visits/Consults	6,806.1	90.32	51.23	0.23	-	0.08	-	0.46	0.15	-	0.16	6,908.4	90.86	52.31
Pathology/Lab	8,149.1	13.03	8.85	0.04	-	0.01	-	0.20	0.15	-	0.03	8,379.3	13.29	9.28
Radiology	3,975.9	36.70	12.16	0.05	-	0.03	-	0.17	0.03	-	0.01	4,057.7	36.82	12.45
Office Administered Drugs	62,085.2	8.58	44.40	0.20	-	0.17	-	0.37	0.03	-	-	63,119.9	8.59	45.17
Physical Exams	470.9	53.26	2.09	0.01	-	-	-	0.01	0.01	-	-	475.4	53.51	2.12
Therapy	1,104.1	22.82	2.10	0.01	-	-	-	-	0.01	-	-	1,109.4	22.93	2.12
Vision	337.4	48.73	1.37	0.01	-	-	-	-	-	-	-	339.8	48.73	1.38
Other Professional	5,766.6	45.01	21.63	0.10	-	-	-	0.20	0.10	-	-	5,846.6	45.22	22.03
Subtotal Professional			**$ 230.93**											**$ 237.13**
Total Medical Costs			**$ 1,168.45**											**$ 1,159.82**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: OCWI Base Year Member Months: 160,497 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	272.0	$ 1,383.94	$ 31.37	$ 0.13	$ 0.00	$ (0.20)	$ 0.02	$ (0.03)	$ 0.08	$ 0.00	$ 0.00	271.1	$ 1,388.37	$ 31.37
Inpatient Well Newborn	1.3	534.99	0.06	-	-	-	-	-	-	-	-	1.3	534.99	0.06
Inpatient MH/SA	28.6	574.10	1.37	0.01	-	-	-	(0.01)	0.01	0.15	0.04	31.8	592.99	1.57
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 32.80**											**$ 33.00**
Outpatient Hospital														
Surgery	649.7	$ 463.21	$ 25.08	$ 0.11	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	$ 0.07	$ 0.00	$ 0.00	651.8	$ 464.50	$ 25.23
Non-Surg - Emergency Room	1,024.5	379.60	32.41	0.14	-	(0.20)	0.11	(0.04)	0.09	-	-	1,021.4	381.95	32.51
Non-Surg - Other	1,036.3	154.36	13.33	0.06	-	-	-	(0.02)	0.04	-	-	1,039.4	154.82	13.41
Observation Room	185.9	293.63	4.55	0.02	-	-	-	(0.01)	0.02	-	-	186.4	294.92	4.58
Treatment/Therapy/Testing	1,709.9	151.02	21.52	0.09	-	-	-	(0.02)	0.06	-	-	1,715.5	151.44	21.65
Other Outpatient	82.3	131.20	0.90	-	-	-	-	-	0.01	-	-	82.3	132.65	0.91
Subtotal Outpatient Hospital			**$ 97.79**											**$ 98.29**
Retail Pharmacy														
Prescription Drugs	9,918.1	$ 38.91	$ 32.16	$ 0.00	$ 0.00	$ 0.00	$ (0.41)	$ (0.04)	$ (2.19)	$ 0.00	$ 0.00	9,905.8	$ 35.76	$ 29.52
Subtotal Retail Pharmacy			**$ 32.16**											**$ 29.52**
Ancillary														
Transportation	297.9	$ 97.89	$ 2.43	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	299.1	$ 97.89	$ 2.44
DME/Prosthetics	636.3	39.41	2.09	-	-	-	-	0.02	-	0.21	0.23	706.4	43.32	2.55
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	377.7	143.60	4.52	0.01	-	-	-	0.03	(0.01)	-	-	381.1	143.28	4.55
Subtotal Ancillary			**$ 9.04**											**$ 9.54**
Professional														
Inpatient and Outpatient Surgery	343.3	$ 153.47	$ 4.39	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.04	$ 0.01	$ 0.00	$ 0.03	347.2	$ 154.85	$ 4.48
Anesthesia	146.5	104.05	1.27	-	-	-	-	0.04	0.01	-	-	151.1	104.84	1.32
Inpatient Visits	872.9	74.37	5.41	0.01	-	-	-	0.08	0.01	-	-	887.4	74.51	5.51
MH/SA	1,244.6	88.32	9.16	0.02	-	-	-	0.11	0.03	0.42	0.06	1,319.3	89.14	9.80
Emergency Room	1,357.6	82.65	9.35	0.02	-	(0.05)	-	0.17	0.03	-	-	1,377.9	82.91	9.52
Office/Home Visits/Consults	2,601.8	74.72	16.20	0.03	-	0.03	-	0.27	0.11	-	0.02	2,654.8	75.30	16.66
Pathology/Lab	13,746.6	13.84	15.85	0.03	-	0.01	-	0.46	0.83	-	0.05	14,180.2	14.58	17.23
Radiology	1,412.4	63.38	7.46	0.01	-	0.02	-	0.10	-	-	-	1,437.0	63.38	7.59
Office Administered Drugs	19,404.3	3.22	5.20	0.01	-	0.03	-	0.03	(0.01)	-	-	19,665.5	3.21	5.26
Physical Exams	915.3	26.35	2.01	-	-	-	-	0.02	0.02	-	-	924.4	26.61	2.05
Therapy	236.8	21.79	0.43	-	-	-	-	-	-	-	-	236.8	21.79	0.43
Vision	257.1	34.08	0.73	-	-	-	-	-	-	-	-	257.1	34.08	0.73
Other Professional	2,879.5	82.14	19.71	0.03	-	-	-	0.22	0.03	-	-	2,916.1	82.26	19.99
Subtotal Professional			**$ 97.17**											**$ 100.57**
Total Medical Costs			**$ 268.96**											**$ 270.92**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: DUAL Base Year Member Months: 587,070 Category of Service	FFS Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	584.9	$ 259.12	$ 12.63	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ 0.00	590.0	$ 259.12	$ 12.74
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	46.7	215.91	0.84	0.01	-	-	-	-	-	-	-	47.2	215.91	0.85
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 13.47**											**$ 13.59**
Outpatient Hospital														
Surgery	58.7	$ 204.41	$ 1.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	59.3	$ 204.41	$ 1.01
Non-Surg - Emergency Room	420.2	67.68	2.37	0.02	-	-	-	-	-	-	-	423.7	67.68	2.39
Non-Surg - Other	302.5	24.59	0.62	0.01	-	-	-	(0.01)	-	-	-	302.5	24.59	0.62
Observation Room	12.3	68.04	0.07	-	-	-	-	-	-	-	-	12.3	68.04	0.07
Treatment/Therapy/Testing	495.5	90.33	3.73	0.03	-	-	-	-	-	-	-	499.5	90.33	3.76
Other Outpatient	46.3	59.64	0.23	-	-	-	-	-	-	-	-	46.3	59.64	0.23
Subtotal Outpatient Hospital			**$ 8.02**											**$ 8.08**
Retail Pharmacy														
Prescription Drugs	346.4	$ 69.29	$ 2.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	346.4	$ 69.29	$ 2.00
Subtotal Retail Pharmacy			**$ 2.00**											**$ 2.00**
Ancillary														
Transportation	24.0	$ 40.07	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	24.0	$ 40.07	$ 0.08
DME/Prosthetics	15,261.2	4.33	5.51	0.02	-	-	-	(0.01)	-	0.01	0.15	15,316.6	4.45	5.68
Dental	1.2	97.85	0.01	-	-	-	-	-	-	-	-	1.2	97.85	0.01
Other Ancillary	122.0	29.52	0.30	-	-	-	-	-	-	-	-	122.0	29.52	0.30
Subtotal Ancillary			**$ 5.90**											**$ 6.07**
Professional														
Inpatient and Outpatient Surgery	342.1	$ 24.90	$ 0.71	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.07	342.1	$ 27.36	$ 0.78
Anesthesia	112.6	17.05	0.16	-	-	-	-	-	-	-	-	112.6	17.05	0.16
Inpatient Visits	840.3	20.71	1.45	0.01	-	-	-	-	-	-	-	846.1	20.71	1.46
MH/SA	11,327.3	15.20	14.35	0.07	-	-	-	(0.01)	-	(0.22)	(1.26)	11,201.0	13.85	12.93
Emergency Room	181.2	37.09	0.56	-	-	-	-	-	-	-	-	181.2	37.09	0.56
Office/Home Visits/Consults	2,786.0	38.42	8.92	0.05	-	-	-	(0.01)	-	-	0.09	2,798.5	38.81	9.05
Pathology/Lab	508.4	6.14	0.26	-	-	-	-	-	-	-	-	508.4	6.14	0.26
Radiology	525.2	16.91	0.74	-	-	-	-	-	-	-	-	525.2	16.91	0.74
Office Administered Drugs	43,320.1	2.29	8.28	0.04	-	-	-	(0.01)	-	-	-	43,477.0	2.29	8.31
Physical Exams	56.8	19.02	0.09	-	-	-	-	-	-	-	-	56.8	19.02	0.09
Therapy	288.9	3.32	0.08	-	-	-	-	-	-	-	-	288.9	3.32	0.08
Vision	76.5	29.82	0.19	-	-	-	-	-	-	-	-	76.5	29.82	0.19
Other Professional	1,827.5	10.97	1.67	0.01	-	-	-	-	-	-	-	1,838.5	10.97	1.68
Subtotal Professional			**$ 37.46**											**$ 36.29**
Total Medical Costs			**$ 66.85**											**$ 66.03**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: Foster Care Children Base Year Member Months: 58,680 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital														
Inpatient Medical/Surgical/Non-Delivery	142.1	$ 1,563.67	$ 18.52	$ 0.16	$ 0.00	$ (0.08)	$ 0.00	$ (0.02)	$ 0.05	$ 0.00	$ 0.00	142.6	$ 1,567.88	$ 18.63
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	4,470.8	344.37	128.30	1.14	-	-	-	(0.14)	0.35	6.15	3.49	4,719.9	354.13	139.29
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 146.82**											**$ 157.92**
Outpatient Hospital														
Surgery	97.5	$ 1,529.12	$ 12.43	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	97.7	$ 1,532.81	$ 12.48
Non-Surg - Emergency Room	588.8	301.45	14.79	0.04	-	(0.18)	0.09	(0.02)	0.04	-	-	582.4	304.13	14.76
Non-Surg - Other	576.1	140.40	6.74	0.02	-	-	-	(0.01)	0.02	-	-	576.9	140.81	6.77
Observation Room	8.6	880.20	0.63	-	-	-	-	-	-	-	-	8.6	880.20	0.63
Treatment/Therapy/Testing	440.1	214.32	7.86	0.02	-	-	-	(0.01)	0.02	-	-	440.6	214.87	7.89
Other Outpatient	46.2	140.21	0.54	-	-	-	-	-	-	-	-	46.2	140.21	0.54
Subtotal Outpatient Hospital			**$ 42.99**											**$ 43.07**
Retail Pharmacy														
Prescription Drugs	13,321.1	$ 56.81	$ 63.06	$ 0.01	$ 0.00	$ 0.00	$ (0.22)	$ (0.07)	$ (1.40)	$ 0.00	$ 0.00	13,308.4	$ 55.35	$ 61.38
Subtotal Retail Pharmacy			**$ 63.06**											**$ 61.38**
Ancillary														
Transportation	237.0	$ 88.10	$ 1.74	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	237.0	$ 88.60	$ 1.75
DME/Prosthetics	12,010.2	4.42	4.42	0.01	-	-	-	0.01	0.05	0.01	0.14	12,091.7	4.60	4.64
Dental	160.7	66.44	0.89	-	-	-	-	0.02	0.01	-	-	164.3	67.17	0.92
Other Ancillary	303.1	43.55	1.10	-	-	-	-	-	-	-	-	303.1	43.55	1.10
Subtotal Ancillary			**$ 8.15**											**$ 8.41**
Professional														
Inpatient and Outpatient Surgery	343.8	$ 138.58	$ 3.97	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.07	$ 0.03	$ 0.00	$ 0.00	350.7	$ 139.61	$ 4.08
Anesthesia	166.3	98.16	1.36	-	-	-	-	0.03	-	-	-	169.9	98.16	1.39
Inpatient Visits	958.7	78.11	6.24	0.02	-	-	-	0.28	(0.02)	-	-	1,004.8	77.87	6.52
MH/SA	453,001.0	9.64	363.78	0.95	-	-	-	0.13	1.05	0.07	(0.05)	454,433.1	9.66	365.93
Emergency Room	673.8	80.85	4.54	0.01	-	(0.05)	-	0.09	0.01	-	-	681.2	81.03	4.60
Office/Home Visits/Consults	5,084.5	90.53	38.36	0.10	-	0.05	-	0.42	0.17	-	-	5,160.0	90.93	39.10
Pathology/Lab	2,857.7	13.86	3.30	0.01	-	-	-	0.20	0.07	-	-	3,039.5	14.13	3.58
Radiology	649.3	19.78	1.07	-	-	0.01	-	0.03	-	-	-	673.6	19.78	1.11
Office Administered Drugs	7,254.0	10.92	6.60	0.02	-	0.03	-	0.09	(0.06)	-	-	7,407.9	10.82	6.68
Physical Exams	2,774.8	47.70	11.03	0.03	-	-	-	0.08	0.05	0.08	0.09	2,822.6	48.30	11.36
Therapy	11,273.6	21.10	19.82	0.05	-	-	-	(0.41)	0.05	-	-	11,068.9	21.15	19.51
Vision	1,419.0	36.11	4.27	0.01	-	-	-	0.01	0.01	-	-	1,425.7	36.19	4.30
Other Professional	3,151.1	20.22	5.31	0.01	-	-	-	0.16	0.01	-	-	3,252.0	20.26	5.49
Subtotal Professional			**$ 469.65**											**$ 473.65**
Total Medical Costs			**$ 730.67**											**$ 744.43**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: KICK Base Year Deliveries: 25,962 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	Cost per Delivery	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	Cost per Delivery
Inpatient Hospital														
Inpatient Maternity Delivery	2,563.7	$ 1,693.83	$ 4,342.54	$ 22.58	$ 0.00	$ 0.00	$ (46.22)	$ (4.86)	$ 11.86	$ 0.00	$ 0.00	2,574.2	$ 1,680.48	$ 4,325.90
Subtotal Inpatient Hospital			**$ 4,342.54**											**$ 4,325.90**
Outpatient Hospital														
Outpatient Hospital - Maternity	64.1	$ 433.12	$ 27.76	$ 0.24	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	$ 0.08	$ 0.00	$ 0.00	64.6	$ 434.35	$ 28.05
Subtotal Outpatient Hospital			**$ 27.76**											**$ 28.05**
Professional														
Maternity Delivery	959.5	$ 1,031.29	$ 989.54	$ 1.58	$ 0.00	$ 0.00	$ 1.17	$ 2.21	$ 2.55	$ 0.00	$ 0.00	963.2	$ 1,035.15	$ 997.05
Maternity Anesthesia	1,159.5	292.72	339.42	0.54	-	-	-	2.30	1.02	-	-	1,169.2	293.59	343.28
Maternity Office Visits	8,552.7	65.12	556.97	0.89	-	-	-	3.12	1.55	-	-	8,614.2	65.30	562.53
Maternity Radiology	4,469.9	77.63	346.98	0.56	-	-	-	2.31	0.93	-	-	4,506.9	77.83	350.78
Maternity Non-Delivery	2.0	78.38	0.16	-	-	-	-	-	-	-	-	2.0	78.38	0.16
Subtotal Professional			**$ 2,233.07**											**$ 2,253.80**
Total Medical Costs			**$ 6,603.37**											**$ 6,607.75**

Appendix 7: SFY 2022 Capitation Rate Development

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - 0 - 2 Months, Male & Female SFY 2022 Member Months: 81,947 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	9,649.9	$ 1,394.52	$ 1,121.42	$ 26.34	$ 0.00	$ 0.00	$ 42.68	$ 0.00	$ 0.00	$ 0.00	9,876.6	$ 1,446.38	$ 1,190.44
Inpatient Well Newborn	7,151.2	563.87	336.03	7.89	-	-	3.20	-	-	-	7,319.1	569.12	347.12
Inpatient MH/SA	14.8	242.55	0.30	0.01	-	-	0.02	-	-	-	15.3	258.20	0.33
Other Inpatient	0.3	832.77	0.02	-	-	-	-	-	-	-	0.3	832.77	0.02
Subtotal Inpatient Hospital			**$ 1,457.77**										**$ 1,537.91**
Outpatient Hospital													
Surgery	75.2	$ 1,134.86	$ 7.11	$ 0.17	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	77.0	$ 1,134.86	$ 7.28
Non-Surg - Emergency Room	785.8	278.54	18.24	0.43	-	-	-	-	-	-	804.3	278.54	18.67
Non-Surg - Other	1,369.2	120.33	13.73	0.32	-	-	-	-	-	-	1,401.1	120.33	14.05
Observation Room	56.9	872.92	4.14	0.10	-	-	-	-	-	-	58.3	872.92	4.24
Treatment/Therapy/Testing	941.2	72.68	5.70	0.13	-	-	-	-	-	-	962.6	72.68	5.83
Other Outpatient	37.3	57.88	0.18	-	-	-	-	0.11	0.10	-	60.1	77.83	0.39
Subtotal Outpatient Hospital			**$ 49.10**										**$ 50.46**
Retail Pharmacy													
Prescription Drugs	2,853.0	$ 15.82	$ 3.76	$ 0.00	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,853.0	$ 15.98	$ 3.80
Subtotal Retail Pharmacy			**$ 3.76**										**$ 3.80**
Ancillary													
Transportation	204.7	$ 280.17	$ 4.78	$ 0.28	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	216.7	$ 280.17	$ 5.06
DME/Prosthetics	2,376.4	18.18	3.60	0.21	-	-	0.81	-	-	-	2,515.0	22.04	4.62
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	234.1	90.24	1.76	0.10	-	-	-	-	-	-	247.4	90.24	1.86
Subtotal Ancillary			**$ 10.14**										**$ 11.54**
Professional													
Inpatient and Outpatient Surgery	688.2	$ 183.78	$ 10.54	$ 0.63	$ 0.00	$ (0.01)	$ 0.48	$ 21.42	$ (11.09)	$ 0.00	2,127.3	$ 123.93	$ 21.97
Anesthesia	120.7	171.95	1.73	0.10	-	-	0.07	-	-	-	127.7	178.53	1.90
Inpatient Visits	14,339.5	186.47	222.83	13.22	-	-	(6.65)	-	-	-	15,190.2	181.22	229.40
MH/SA	46.7	20.56	0.08	-	-	-	-	-	-	-	46.7	20.56	0.08
Emergency Room	1,047.4	74.01	6.46	0.38	-	-	(0.01)	-	-	-	1,109.0	73.90	6.83
Office/Home Visits/Consults	8,067.8	78.43	52.73	3.13	-	(0.04)	2.91	-	-	-	8,540.6	82.52	58.73
Pathology/Lab	1,787.2	45.66	6.80	0.40	-	(0.03)	0.06	-	-	-	1,884.5	46.04	7.23
Radiology	3,027.3	13.12	3.31	0.20	-	-	0.06	-	-	-	3,210.2	13.34	3.57
Office Administered Drugs	41.6	92.21	0.32	0.02	-	-	(0.03)	-	-	-	44.2	84.07	0.31
Physical Exams	22,709.7	50.55	95.67	5.67	-	(0.43)	5.76	-	-	-	23,953.5	53.44	106.67
Therapy	99.4	26.55	0.22	0.01	-	-	-	-	-	-	103.9	26.55	0.23
Vision	28.1	55.52	0.13	0.01	-	-	0.01	-	-	-	30.3	59.48	0.15
Other Professional	4,521.0	43.85	16.52	0.98	-	(0.36)	(0.14)	0.26	0.10	-	4,761.8	43.75	17.36
Subtotal Professional			**$ 417.34**										**$ 454.43**
Total Medical Costs			**$ 1,938.11**										**$ 2,058.14**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - 3 - 12 Months, Male & Female SFY 2022 Member Months: 341,296 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	218.7	$ 1,586.37	$ 28.91	$ 0.68	$ 0.00	$ 0.00	$ 2.33	$ 0.00	$ 0.00	$ 0.00	223.8	$ 1,711.29	$ 31.92
Inpatient Well Newborn	0.1	872.66	0.01	-	-	-	-	-	-	-	0.1	872.66	0.01
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 28.92**										**$ 31.93**
Outpatient Hospital													
Surgery	80.4	$ 1,610.02	$ 10.79	$ 0.25	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	82.3	$ 1,610.02	$ 11.04
Non-Surg - Emergency Room	939.8	221.93	17.38	0.41	-	-	-	-	-	-	961.9	221.93	17.79
Non-Surg - Other	743.2	143.05	8.86	0.21	-	-	-	-	-	-	760.8	143.05	9.07
Observation Room	15.0	1,019.10	1.27	0.03	-	-	-	-	-	-	15.3	1,019.10	1.30
Treatment/Therapy/Testing	301.9	163.35	4.11	0.10	-	-	-	-	-	-	309.3	163.35	4.21
Other Outpatient	41.2	55.41	0.19	-	-	-	-	0.30	0.33	-	106.1	92.72	0.82
Subtotal Outpatient Hospital			**$ 42.60**										**$ 44.23**
Retail Pharmacy													
Prescription Drugs	4,536.6	$ 29.68	$ 11.22	$ 0.00	$ 0.13	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	4,536.6	$ 30.02	$ 11.35
Subtotal Retail Pharmacy			**$ 11.22**										**$ 11.35**
Ancillary													
Transportation	94.1	$ 116.01	$ 0.91	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	99.3	$ 116.01	$ 0.96
DME/Prosthetics	3,571.0	12.87	3.83	0.23	-	-	0.51	-	-	-	3,785.4	14.49	4.57
Dental	237.1	16.19	0.32	0.02	-	(0.01)	-	-	-	-	244.5	16.19	0.33
Other Ancillary	54.1	73.17	0.33	0.02	-	-	-	-	-	-	57.4	73.17	0.35
Subtotal Ancillary			**$ 5.39**										**$ 6.21**
Professional													
Inpatient and Outpatient Surgery	277.8	$ 182.27	$ 4.22	$ 0.25	$ 0.00	$ 0.00	$ 0.15	$ 0.27	$ (0.10)	$ 0.00	312.1	$ 184.19	$ 4.79
Anesthesia	152.8	105.25	1.34	0.08	-	-	0.03	-	-	-	161.9	107.47	1.45
Inpatient Visits	612.5	179.47	9.16	0.54	-	-	(0.07)	-	-	-	648.6	178.17	9.63
MH/SA	555.4	9.07	0.42	0.02	-	-	0.01	-	-	-	581.8	9.28	0.45
Emergency Room	1,020.6	68.08	5.79	0.34	-	-	0.02	-	-	-	1,080.5	68.30	6.15
Office/Home Visits/Consults	4,995.6	77.16	32.12	1.90	-	(0.03)	1.71	-	-	-	5,286.4	81.04	35.70
Pathology/Lab	2,212.9	13.77	2.54	0.15	-	(0.02)	0.34	-	-	-	2,326.1	15.53	3.01
Radiology	615.2	15.61	0.80	0.05	-	-	0.01	-	-	-	653.6	15.79	0.86
Office Administered Drugs	453.9	54.72	2.07	0.12	-	-	(0.14)	-	-	-	480.2	51.23	2.05
Physical Exams	11,695.5	37.85	36.89	2.19	-	(0.14)	2.03	-	-	-	12,345.4	39.82	40.97
Therapy	1,331.2	22.72	2.52	0.15	-	-	0.07	-	-	-	1,410.4	23.31	2.74
Vision	93.4	30.83	0.24	0.01	-	-	0.03	-	-	-	97.3	34.53	0.28
Other Professional	1,955.9	22.58	3.68	0.22	-	(0.07)	0.10	0.34	0.59	-	2,216.4	26.31	4.86
Subtotal Professional			**$ 101.79**										**$ 112.94**
Total Medical Costs			**$ 189.92**										**$ 206.66**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 1 - 6, Male & Female SFY 2022 Member Months: 2,588,224 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	40.8	$ 2,214.25	$ 7.53	$ 0.00	$ 0.00	$ 0.00	$ 0.38	$ 0.00	$ 0.00	$ (0.10)	40.3	$ 2,327.49	$ 7.81
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	1.9	504.19	0.08	-	-	-	-	-	-	-	1.9	504.19	0.08
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.61**										**$ 7.89**
Outpatient Hospital													
Surgery	72.8	$ 1,346.00	$ 8.17	$ 0.19	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.11)	73.6	$ 1,346.00	$ 8.25
Non-Surg - Emergency Room	531.2	246.02	10.89	0.26	-	-	-	-	-	(0.15)	536.5	246.02	11.00
Non-Surg - Other	295.0	133.01	3.27	0.08	-	-	-	-	-	(0.05)	297.7	133.01	3.30
Observation Room	5.5	1,270.34	0.58	0.01	-	-	-	-	-	-	5.6	1,270.34	0.59
Treatment/Therapy/Testing	227.1	191.80	3.63	0.09	-	-	-	-	-	(0.05)	229.6	191.80	3.67
Other Outpatient	30.0	260.43	0.65	0.02	-	-	-	1.60	(0.90)	(0.02)	103.7	156.26	1.35
Subtotal Outpatient Hospital			**$ 27.19**										**$ 28.16**
Retail Pharmacy													
Prescription Drugs	4,252.1	$ 35.76	$ 12.67	$ 0.00	$ 0.15	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.17)	4,195.1	$ 36.19	$ 12.65
Subtotal Retail Pharmacy			**$ 12.67**										**$ 12.65**
Ancillary													
Transportation	46.5	$ 118.59	$ 0.46	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	48.6	$ 118.59	$ 0.48
DME/Prosthetics	2,661.1	7.49	1.66	0.10	-	-	0.25	-	-	(0.02)	2,789.4	8.56	1.99
Dental	251.3	69.72	1.46	0.09	-	(0.02)	(0.03)	-	-	(0.02)	259.9	68.34	1.48
Other Ancillary	14.5	66.42	0.08	-	-	-	-	-	-	-	14.5	66.42	0.08
Subtotal Ancillary			**$ 3.66**										**$ 4.03**
Professional													
Inpatient and Outpatient Surgery	222.4	$ 138.12	$ 2.56	$ 0.15	$ 0.00	$ 0.00	$ 0.02	$ 0.02	$ 0.00	$ (0.04)	233.7	$ 139.15	$ 2.71
Anesthesia	141.3	95.95	1.13	0.07	-	-	-	-	-	(0.02)	147.6	95.95	1.18
Inpatient Visits	66.4	128.22	0.71	0.04	-	-	0.03	-	-	(0.01)	69.3	133.42	0.77
MH/SA	2,649.6	25.45	5.62	0.33	-	-	0.03	-	0.01	(0.08)	2,767.5	25.63	5.91
Emergency Room	571.4	66.78	3.18	0.19	-	-	0.02	-	-	(0.04)	598.3	67.19	3.35
Office/Home Visits/Consults	3,262.1	77.77	21.14	1.25	-	(0.03)	1.14	-	-	(0.32)	3,400.9	81.79	23.18
Pathology/Lab	1,832.0	14.08	2.15	0.13	-	(0.02)	0.23	-	-	(0.03)	1,900.2	15.54	2.46
Radiology	337.0	16.38	0.46	0.03	-	-	0.01	-	-	(0.01)	351.7	16.72	0.49
Office Administered Drugs	290.2	9.93	0.24	0.01	-	-	0.01	-	-	(0.01)	290.2	10.34	0.25
Physical Exams	2,095.5	49.53	8.65	0.51	-	(0.05)	0.46	-	-	(0.13)	2,175.4	52.07	9.44
Therapy	6,185.7	22.64	11.67	0.69	-	-	0.69	-	-	(0.18)	6,456.0	23.92	12.87
Vision	398.3	28.62	0.95	0.06	-	-	0.21	-	-	(0.02)	415.1	34.69	1.20
Other Professional	2,878.7	12.92	3.10	0.18	-	(0.01)	0.05	0.19	0.69	(0.05)	3,166.6	15.73	4.15
Subtotal Professional			**$ 61.56**										**$ 67.96**
Total Medical Costs			**$ 112.69**										**$ 120.69**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 7 - 13, Male & Female SFY 2022 Member Months: 3,000,413 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	25.7	$ 2,169.26	$ 4.64	$ 0.00	$ 0.00	$ 0.00	$ 0.24	$ 0.00	$ 0.00	$ (0.10)	25.1	$ 2,283.94	$ 4.78
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	91.2	435.54	3.31	-	-	-	0.07	-	-	(0.07)	89.3	444.95	3.31
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.95**										**$ 8.09**
Outpatient Hospital													
Surgery	39.8	$ 1,403.59	$ 4.65	$ 0.11	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.10)	39.8	$ 1,403.59	$ 4.66
Non-Surg - Emergency Room	318.7	264.29	7.02	0.16	-	-	-	-	-	(0.14)	319.7	264.29	7.04
Non-Surg - Other	203.2	129.32	2.19	0.05	-	-	-	-	-	(0.04)	204.2	129.32	2.20
Observation Room	2.6	1,172.32	0.25	0.01	-	-	-	-	-	(0.01)	2.6	1,172.32	0.25
Treatment/Therapy/Testing	178.9	191.18	2.85	0.07	-	-	-	-	-	(0.06)	179.5	191.18	2.86
Other Outpatient	20.4	106.10	0.18	-	-	-	-	0.51	0.03	(0.02)	75.8	110.85	0.70
Subtotal Outpatient Hospital			**$ 17.14**										**$ 17.71**
Retail Pharmacy													
Prescription Drugs	5,372.3	$ 63.95	$ 28.63	$ 0.00	$ 0.34	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ (0.60)	5,259.7	$ 64.75	$ 28.38
Subtotal Retail Pharmacy			**$ 28.63**										**$ 28.38**
Ancillary													
Transportation	35.1	$ 102.50	$ 0.30	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	36.3	$ 102.50	$ 0.31
DME/Prosthetics	1,776.3	9.80	1.45	0.09	-	-	0.15	-	-	(0.03)	1,849.8	10.77	1.66
Dental	32.4	59.21	0.16	0.01	-	-	(0.01)	-	-	-	34.5	55.72	0.16
Other Ancillary	70.3	42.65	0.25	0.01	-	-	-	-	-	-	73.2	42.65	0.26
Subtotal Ancillary			**$ 2.16**										**$ 2.39**
Professional													
Inpatient and Outpatient Surgery	149.2	$ 133.55	$ 1.66	$ 0.10	$ 0.00	$ 0.00	$ 0.03	$ 0.00	$ 0.00	$ (0.03)	155.4	$ 135.86	$ 1.76
Anesthesia	53.2	99.25	0.44	0.03	-	-	-	-	-	(0.01)	55.6	99.25	0.46
Inpatient Visits	74.7	85.16	0.53	0.03	-	-	0.05	-	-	(0.01)	77.5	92.90	0.60
MH/SA	6,124.2	40.52	20.68	1.23	-	-	0.08	0.04	0.04	(0.45)	6,367.0	40.75	21.62
Emergency Room	343.5	68.81	1.97	0.12	-	-	0.01	-	-	(0.04)	357.5	69.15	2.06
Office/Home Visits/Consults	2,558.9	81.93	17.47	1.04	-	(0.02)	1.00	-	-	(0.40)	2,649.7	86.46	19.09
Pathology/Lab	1,468.0	12.67	1.55	0.09	-	(0.01)	0.17	-	-	(0.04)	1,505.9	14.02	1.76
Radiology	391.6	19.31	0.63	0.04	-	-	0.02	-	-	(0.02)	404.0	19.90	0.67
Office Administered Drugs	908.6	13.34	1.01	0.06	-	-	0.03	-	-	(0.02)	944.6	13.72	1.08
Physical Exams	1,012.2	59.51	5.02	0.30	-	(0.03)	0.30	-	-	(0.12)	1,042.4	62.97	5.47
Therapy	959.1	22.02	1.76	0.10	-	-	0.11	-	-	(0.04)	991.8	23.35	1.93
Vision	1,159.8	26.38	2.55	0.15	-	-	0.58	-	-	(0.07)	1,196.2	32.20	3.21
Other Professional	2,614.9	11.11	2.42	0.14	-	-	0.02	0.13	0.62	(0.07)	2,831.0	13.82	3.26
Subtotal Professional			**$ 57.69**										**$ 62.97**
Total Medical Costs			**$ 113.57**										**$ 119.54**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Male SFY 2022 Member Months: 967,378 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	45.8	$ 2,490.73	$ 9.51	$ 0.00	$ 0.00	$ 0.00	$ 0.33	$ 0.00	$ 0.00	$ (0.40)	43.9	$ 2,580.95	$ 9.44
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	229.7	440.47	8.43	-	-	-	0.09	-	-	(0.35)	220.1	445.37	8.17
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 17.94**										**$ 17.61**
Outpatient Hospital													
Surgery	54.8	$ 1,388.39	$ 6.34	$ 0.15	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.27)	53.8	$ 1,388.39	$ 6.22
Non-Surg - Emergency Room	347.8	271.85	7.88	0.19	-	-	-	-	-	(0.34)	341.2	271.85	7.73
Non-Surg - Other	143.7	135.26	1.62	0.04	-	-	-	-	-	(0.07)	141.1	135.26	1.59
Observation Room	3.3	903.96	0.25	0.01	-	-	-	-	-	(0.01)	3.3	903.96	0.25
Treatment/Therapy/Testing	216.9	248.36	4.49	0.11	-	-	-	-	-	(0.19)	213.1	248.36	4.41
Other Outpatient	22.4	117.64	0.22	0.01	-	-	-	0.38	(0.01)	(0.02)	60.2	115.64	0.58
Subtotal Outpatient Hospital			**$ 20.80**										**$ 20.78**
Retail Pharmacy													
Prescription Drugs	5,182.3	$ 75.53	$ 32.62	$ 0.00	$ 0.38	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.36)	4,966.3	$ 76.45	$ 31.64
Subtotal Retail Pharmacy			**$ 32.62**										**$ 31.64**
Ancillary													
Transportation	83.4	$ 110.74	$ 0.77	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	84.5	$ 110.74	$ 0.78
DME/Prosthetics	1,714.6	16.94	2.42	0.14	-	-	0.18	-	-	(0.11)	1,735.8	18.18	2.63
Dental	8.7	41.38	0.03	-	-	-	-	-	-	-	8.7	41.38	0.03
Other Ancillary	72.9	46.06	0.28	0.02	-	-	-	-	-	(0.02)	72.9	46.06	0.28
Subtotal Ancillary			**$ 3.50**										**$ 3.72**
Professional													
Inpatient and Outpatient Surgery	196.3	$ 160.14	$ 2.62	$ 0.16	$ 0.00	$ (0.01)	$ 0.05	$ 0.00	$ 0.00	$ (0.12)	198.6	$ 163.16	$ 2.70
Anesthesia	65.1	114.28	0.62	0.04	-	-	0.01	-	-	(0.03)	66.2	116.10	0.64
Inpatient Visits	150.5	77.32	0.97	0.06	-	-	0.13	-	-	(0.05)	152.1	87.58	1.11
MH/SA	4,663.4	43.49	16.90	1.00	-	-	0.08	0.02	0.02	(0.75)	4,737.9	43.74	17.27
Emergency Room	383.2	74.54	2.38	0.14	-	-	0.02	-	-	(0.10)	389.6	75.15	2.44
Office/Home Visits/Consults	2,129.5	82.22	14.59	0.87	-	(0.02)	0.88	-	-	(0.67)	2,155.8	87.11	15.65
Pathology/Lab	1,412.0	13.85	1.63	0.10	-	(0.01)	0.18	-	-	(0.08)	1,420.7	15.37	1.82
Radiology	602.8	23.69	1.19	0.07	-	-	0.03	-	-	(0.06)	607.9	24.28	1.23
Office Administered Drugs	2,278.4	15.01	2.85	0.17	-	-	0.06	-	-	(0.13)	2,310.3	15.32	2.95
Physical Exams	730.4	61.94	3.77	0.22	-	(0.03)	0.26	-	-	(0.17)	734.2	66.19	4.05
Therapy	546.5	21.74	0.99	0.06	-	-	0.05	-	-	(0.04)	557.6	22.81	1.06
Vision	943.6	26.45	2.08	0.12	-	-	0.47	-	-	(0.11)	948.1	32.40	2.56
Other Professional	2,046.9	18.06	3.08	0.18	-	(0.01)	0.05	0.16	0.42	(0.16)	2,159.9	20.67	3.72
Subtotal Professional			**$ 53.67**										**$ 57.20**
Total Medical Costs			**$ 128.53**										**$ 130.95**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Female SFY 2022 Member Months: 975,765 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	60.4	$ 2,481.05	$ 12.48	$ 0.00	$ 0.00	$ 0.00	$ 0.52	$ 0.00	$ 0.00	$ (0.53)	57.8	$ 2,589.01	$ 12.47
Inpatient Well Newborn	0.1	1,892.60	0.01	-	-	-	-	-	-	-	0.1	1,892.60	0.01
Inpatient MH/SA	244.8	468.63	9.56	-	-	-	0.15	-	-	(0.40)	234.6	476.31	9.31
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 22.05**										**$ 21.79**
Outpatient Hospital													
Surgery	69.2	$ 1,297.33	$ 7.48	$ 0.18	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.32)	67.9	$ 1,297.33	$ 7.34
Non-Surg - Emergency Room	580.9	288.60	13.97	0.33	-	-	-	-	-	(0.59)	570.1	288.60	13.71
Non-Surg - Other	241.9	151.30	3.05	0.07	-	-	-	-	-	(0.13)	237.1	151.30	2.99
Observation Room	9.2	497.71	0.38	0.01	-	-	-	-	-	(0.02)	8.9	497.71	0.37
Treatment/Therapy/Testing	396.0	203.00	6.70	0.16	-	-	-	-	-	(0.28)	389.0	203.00	6.58
Other Outpatient	35.2	136.53	0.40	0.01	-	-	-	0.53	(0.08)	(0.04)	79.1	124.39	0.82
Subtotal Outpatient Hospital			**$ 31.98**										**$ 31.81**
Retail Pharmacy													
Prescription Drugs	7,600.6	$ 50.35	$ 31.89	$ 0.00	$ 0.37	$ 0.00	$ 0.00	$ 0.00	$ 0.33	$ (1.34)	7,281.2	$ 51.50	$ 31.25
Subtotal Retail Pharmacy			**$ 31.89**										**$ 31.25**
Ancillary													
Transportation	114.0	$ 95.81	$ 0.91	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	115.2	$ 95.81	$ 0.92
DME/Prosthetics	1,603.3	15.87	2.12	0.13	-	-	0.16	-	-	(0.10)	1,626.0	17.05	2.31
Dental	8.5	28.14	0.02	-	-	-	-	-	-	-	8.5	28.14	0.02
Other Ancillary	88.7	59.51	0.44	0.03	-	-	-	-	-	(0.02)	90.7	59.51	0.45
Subtotal Ancillary			**$ 3.49**										**$ 3.70**
Professional													
Inpatient and Outpatient Surgery	198.4	$ 159.69	$ 2.64	$ 0.16	$ 0.00	$ (0.01)	$ 0.04	$ 0.00	$ 0.00	$ (0.11)	201.4	$ 162.08	$ 2.72
Anesthesia	74.3	112.99	0.70	0.04	-	-	0.01	-	-	(0.03)	75.4	114.58	0.72
Inpatient Visits	214.0	77.38	1.38	0.08	-	-	0.18	-	-	(0.06)	217.1	87.33	1.58
MH/SA	4,128.6	60.86	20.94	1.24	-	-	0.09	0.06	0.02	(0.92)	4,203.5	61.18	21.43
Emergency Room	617.8	77.89	4.01	0.24	-	-	0.05	-	-	(0.18)	627.0	78.85	4.12
Office/Home Visits/Consults	3,161.8	81.64	21.51	1.28	-	(0.05)	1.37	-	-	(0.99)	3,197.1	86.78	23.12
Pathology/Lab	3,613.0	14.02	4.22	0.25	-	(0.02)	0.57	-	-	(0.20)	3,638.7	15.90	4.82
Radiology	684.1	29.12	1.66	0.10	-	-	0.07	-	-	(0.08)	692.4	30.33	1.75
Office Administered Drugs	20,522.6	1.01	1.73	0.10	-	-	-	-	-	(0.07)	20,878.4	1.01	1.76
Physical Exams	815.2	61.23	4.16	0.25	-	(0.04)	0.28	-	-	(0.19)	819.2	65.33	4.46
Therapy	593.9	21.62	1.07	0.06	-	-	0.06	-	-	(0.05)	599.4	22.82	1.14
Vision	1,513.4	26.25	3.31	0.20	-	-	0.73	-	-	(0.17)	1,527.1	31.98	4.07
Other Professional	2,220.1	22.86	4.23	0.25	-	(0.02)	0.01	0.23	0.46	(0.22)	2,346.1	25.27	4.94
Subtotal Professional			**$ 71.56**										**$ 76.63**
Total Medical Costs			**$ 160.97**										**$ 165.18**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Male SFY 2022 Member Months: 557,554 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	212.1	$ 2,271.10	$ 40.15	$ 0.94	$ 0.00	$ 0.00	$ 0.79	$ 0.00	$ 0.00	$ (4.34)	194.2	$ 2,319.93	$ 37.54
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	94.1	674.80	5.29	0.12	-	-	0.08	-	-	(0.57)	86.1	685.95	4.92
Other Inpatient	2.8	342.98	0.08	-	-	-	-	-	-	(0.01)	2.4	342.98	0.07
Subtotal Inpatient Hospital			**$ 45.52**										**$ 42.53**
Outpatient Hospital													
Surgery	93.0	$ 1,430.59	$ 11.09	$ 0.13	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.16)	84.4	$ 1,430.59	$ 10.06
Non-Surg - Emergency Room	604.3	285.35	14.37	0.17	-	-	-	-	-	(1.51)	548.0	285.35	13.03
Non-Surg - Other	85.9	145.32	1.04	0.01	-	-	-	-	-	(0.11)	77.6	145.32	0.94
Observation Room	5.1	616.00	0.26	-	-	-	-	-	-	(0.02)	4.7	616.00	0.24
Treatment/Therapy/Testing	290.7	361.64	8.76	0.10	-	-	-	-	-	(0.92)	263.5	361.64	7.94
Other Outpatient	32.3	182.04	0.49	0.01	-	-	-	0.36	(0.13)	(0.08)	51.4	151.70	0.65
Subtotal Outpatient Hospital			**$ 36.01**										**$ 32.86**
Retail Pharmacy													
Prescription Drugs	4,879.5	$ 101.54	$ 41.29	$ 0.00	$ 4.98	$ 0.00	$ 0.00	$ 0.01	$ 0.86	$ (4.79)	4,314.6	$ 117.79	$ 42.35
Subtotal Retail Pharmacy			**$ 41.29**										**$ 42.35**
Ancillary													
Transportation	179.6	$ 104.22	$ 1.56	$ 0.04	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ (0.16)	165.8	$ 103.49	$ 1.43
DME/Prosthetics	1,940.9	16.51	2.67	0.06	-	-	0.31	-	-	(0.31)	1,759.1	18.62	2.73
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	124.8	61.52	0.64	0.02	-	-	(0.01)	-	-	(0.06)	117.0	60.49	0.59
Subtotal Ancillary			**$ 4.87**										**$ 4.75**
Professional													
Inpatient and Outpatient Surgery	363.3	$ 150.93	$ 4.57	$ 0.11	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ (0.49)	333.1	$ 150.57	$ 4.18
Anesthesia	121.8	110.30	1.12	0.03	-	-	-	-	-	(0.12)	112.1	110.30	1.03
Inpatient Visits	429.6	79.32	2.84	0.07	-	-	0.28	-	-	(0.33)	390.3	87.93	2.86
MH/SA	1,677.9	73.45	10.27	0.24	-	-	0.05	0.01	-	(1.09)	1,540.6	73.84	9.48
Emergency Room	683.7	82.31	4.69	0.11	-	-	0.07	-	-	(0.50)	626.9	83.65	4.37
Office/Home Visits/Consults	2,005.0	81.40	13.60	0.32	-	(0.03)	0.71	-	0.27	(1.54)	1,820.7	87.86	13.33
Pathology/Lab	2,064.0	14.53	2.50	0.06	-	(0.01)	0.16	-	-	(0.28)	1,874.1	15.56	2.43
Radiology	993.0	28.64	2.37	0.06	-	-	0.04	-	-	(0.26)	909.2	29.17	2.21
Office Administered Drugs	6,178.1	9.36	4.82	0.11	-	-	0.03	-	-	(0.52)	5,652.6	9.43	4.44
Physical Exams	141.6	50.83	0.60	0.01	-	-	0.02	-	-	(0.06)	129.8	52.68	0.57
Therapy	429.2	23.20	0.83	0.02	-	-	0.02	-	-	(0.09)	393.0	23.82	0.78
Vision	230.0	32.35	0.62	0.01	-	-	0.09	-	-	(0.07)	207.7	37.55	0.65
Other Professional	1,129.0	28.27	2.66	0.06	-	-	0.12	0.14	0.25	(0.33)	1,073.8	32.41	2.90
Subtotal Professional			**$ 51.49**										**$ 49.23**
Total Medical Costs			**$ 179.18**										**$ 171.72**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Female SFY 2022 Member Months: 1,927,511 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	202.7	$ 2,140.01	$ 36.15	$ 0.85	$ 0.00	$ 0.00	$ 0.77	$ 0.00	$ 0.00	$ (2.15)	195.4	$ 2,187.30	$ 35.62
Inpatient Well Newborn	0.2	624.80	0.01	-	-	-	-	-	-	-	0.2	624.80	0.01
Inpatient MH/SA	73.0	694.16	4.22	0.10	-	-	0.06	-	-	(0.25)	70.4	704.40	4.13
Other Inpatient	6.2	311.96	0.16	-	-	-	-	-	-	(0.01)	5.8	311.96	0.15
Subtotal Inpatient Hospital			**$ 40.54**										**$ 39.91**
Outpatient Hospital													
Surgery	205.5	$ 1,225.57	$ 20.99	$ 0.25	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.21)	196.1	$ 1,225.57	$ 20.03
Non-Surg - Emergency Room	1,113.2	307.44	28.52	0.33	-	-	-	-	-	(1.63)	1,062.4	307.44	27.22
Non-Surg - Other	319.7	161.01	4.29	0.05	-	-	-	-	-	(0.25)	304.8	161.01	4.09
Observation Room	28.9	456.66	1.10	0.01	-	-	-	-	-	(0.06)	27.6	456.66	1.05
Treatment/Therapy/Testing	752.8	264.92	16.62	0.19	-	-	-	-	-	(0.95)	718.4	264.92	15.86
Other Outpatient	106.0	148.30	1.31	0.02	-	-	-	0.50	(0.11)	(0.10)	140.0	138.87	1.62
Subtotal Outpatient Hospital			**$ 72.83**										**$ 69.87**
Retail Pharmacy													
Prescription Drugs	9,431.9	$ 71.97	$ 56.57	$ 0.00	$ 6.82	$ 0.00	$ 0.00	$ 0.01	$ 1.23	$ (3.62)	8,830.0	$ 82.91	$ 61.01
Subtotal Retail Pharmacy			**$ 56.57**										**$ 61.01**
Ancillary													
Transportation	255.7	$ 89.15	$ 1.90	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.11)	246.3	$ 89.15	$ 1.83
DME/Prosthetics	1,738.0	16.43	2.38	0.06	-	-	0.25	-	-	(0.15)	1,672.2	18.23	2.54
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	173.8	98.73	1.43	0.03	-	-	-	-	-	(0.08)	167.7	98.73	1.38
Subtotal Ancillary			**$ 5.71**										**$ 5.75**
Professional													
Inpatient and Outpatient Surgery	493.4	$ 180.95	$ 7.44	$ 0.17	$ 0.00	$ (0.01)	$ 0.10	$ 0.00	$ 0.00	$ (0.44)	474.8	$ 183.48	$ 7.26
Anesthesia	221.1	110.17	2.03	0.05	-	-	-	-	-	(0.11)	214.6	110.17	1.97
Inpatient Visits	435.3	79.12	2.87	0.07	-	-	0.26	-	-	(0.19)	417.1	86.61	3.01
MH/SA	2,412.1	77.91	15.66	0.37	-	-	0.10	0.01	-	(0.91)	2,330.5	78.42	15.23
Emergency Room	1,225.7	83.02	8.48	0.20	-	-	0.16	-	-	(0.50)	1,182.4	84.64	8.34
Office/Home Visits/Consults	4,033.5	80.51	27.06	0.64	-	(0.10)	1.72	-	0.43	(1.69)	3,862.1	87.19	28.06
Pathology/Lab	7,366.0	15.98	9.81	0.23	-	(0.03)	0.96	-	-	(0.62)	7,050.7	17.62	10.35
Radiology	1,584.5	37.72	4.98	0.12	-	-	0.22	-	-	(0.31)	1,524.0	39.45	5.01
Office Administered Drugs	28,345.0	3.34	7.88	0.19	-	(0.01)	(0.05)	-	-	(0.45)	27,373.8	3.31	7.56
Physical Exams	384.5	59.30	1.90	0.04	-	-	0.12	-	0.01	(0.12)	368.3	63.53	1.95
Therapy	534.6	22.67	1.01	0.02	-	-	0.04	-	-	(0.06)	513.4	23.61	1.01
Vision	232.2	39.27	0.76	0.02	-	-	0.09	-	-	(0.05)	223.1	44.11	0.82
Other Professional	2,311.7	35.92	6.92	0.16	-	(0.01)	0.17	0.28	0.32	(0.45)	2,305.0	38.47	7.39
Subtotal Professional			**$ 96.80**										**$ 97.96**
Total Medical Costs			**$ 272.45**										**$ 274.50**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 45+, Male & Female SFY 2022 Member Months: 334,833 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	478.8	$ 2,460.68	$ 98.18	$ 2.31	$ 0.00	$ 0.00	$ 1.47	$ 0.00	$ 0.00	$ (4.66)	467.3	$ 2,498.43	$ 97.30
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	65.7	752.12	4.12	0.10	-	-	0.10	-	-	(0.20)	64.1	770.83	4.12
Other Inpatient	31.7	340.43	0.90	0.02	-	-	-	-	-	(0.04)	31.0	340.43	0.88
Subtotal Inpatient Hospital			**$ 103.20**										**$ 102.30**
Outpatient Hospital													
Surgery	220.6	$ 1,750.01	$ 32.17	$ 0.38	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.49)	213.0	$ 1,750.01	$ 31.06
Non-Surg - Emergency Room	764.5	335.27	21.36	0.25	-	-	-	-	-	(0.99)	738.0	335.27	20.62
Non-Surg - Other	336.1	144.23	4.04	0.05	-	-	-	-	-	(0.19)	324.5	144.23	3.90
Observation Room	17.4	943.62	1.37	0.02	-	-	-	-	-	(0.07)	16.8	943.62	1.32
Treatment/Therapy/Testing	1,108.7	457.53	42.27	0.49	-	-	-	-	-	(1.95)	1,070.4	457.53	40.81
Other Outpatient	295.3	143.47	3.53	0.04	-	-	-	0.53	(0.10)	(0.19)	327.0	139.80	3.81
Subtotal Outpatient Hospital			**$ 104.74**										**$ 101.52**
Retail Pharmacy													
Prescription Drugs	18,758.6	$ 84.72	$ 132.43	$ 0.00	$ 15.97	$ 0.00	$ 0.00	$ 0.02	$ 1.95	$ (6.78)	17,801.1	$ 96.80	$ 143.59
Subtotal Retail Pharmacy			**$ 132.43**										**$ 143.59**
Ancillary													
Transportation	260.0	$ 100.16	$ 2.17	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.10)	254.0	$ 100.16	$ 2.12
DME/Prosthetics	7,718.5	11.22	7.22	0.17	-	-	0.99	-	-	(0.38)	7,494.0	12.81	8.00
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	392.8	72.40	2.37	0.06	-	-	-	-	-	(0.11)	384.5	72.40	2.32
Subtotal Ancillary			**$ 11.76**										**$ 12.44**
Professional													
Inpatient and Outpatient Surgery	1,131.8	$ 163.38	$ 15.41	$ 0.36	$ 0.00	$ 0.00	$ (0.06)	$ 0.00	$ 0.00	$ (0.72)	1,105.4	$ 162.73	$ 14.99
Anesthesia	418.0	106.21	3.70	0.09	-	-	(0.01)	-	-	(0.17)	409.0	105.92	3.61
Inpatient Visits	782.0	81.94	5.34	0.13	-	-	0.47	-	-	(0.27)	761.5	89.35	5.67
MH/SA	2,002.5	76.76	12.81	0.30	-	0.01	0.12	0.03	-	(0.60)	1,961.9	77.50	12.67
Emergency Room	913.7	90.48	6.89	0.16	-	-	0.16	-	-	(0.33)	891.2	92.64	6.88
Office/Home Visits/Consults	5,797.5	82.82	40.01	0.94	-	(0.14)	1.93	-	0.77	(1.99)	5,625.0	88.58	41.52
Pathology/Lab	6,989.4	12.93	7.53	0.18	-	(0.03)	0.54	-	-	(0.38)	6,775.9	13.88	7.84
Radiology	2,675.4	38.30	8.54	0.20	-	-	0.16	-	-	(0.41)	2,609.6	39.04	8.49
Office Administered Drugs	20,884.4	9.12	15.88	0.37	-	(0.01)	(0.16)	-	-	(0.74)	20,384.6	9.03	15.34
Physical Exams	423.6	57.23	2.02	0.05	-	(0.01)	0.11	-	-	(0.10)	411.0	60.44	2.07
Therapy	1,583.7	21.67	2.86	0.07	-	-	0.11	-	-	(0.14)	1,544.9	22.53	2.90
Vision	327.3	47.66	1.30	0.03	-	-	0.11	-	-	(0.07)	317.2	51.82	1.37
Other Professional	3,895.6	24.49	7.95	0.19	-	(0.02)	0.07	0.16	0.33	(0.40)	3,861.3	25.73	8.28
Subtotal Professional			**$ 130.24**										**$ 131.63**
Total Medical Costs			**$ 482.37**										**$ 491.48**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SSI - Children SFY 2022 Member Months: 135,650 Category of Service	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trend Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Acuity Adjustments Utilization Adjustment	SFY 2022 Projected Benefit Expense Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	365.5	$ 1,751.20	$ 53.34	$ 0.00	$ 0.00	$ 0.00	$ 3.46	$ 0.00	$ 0.00	$ (0.88)	359.5	$ 1,866.70	$ 55.92
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	986.0	380.94	31.30	-	-	-	0.57	-	-	(0.49)	970.5	387.99	31.38
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 84.64**										**$ 87.30**
Outpatient Hospital													
Surgery	116.1	$ 1,584.57	$ 15.33	$ 0.36	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.25)	116.9	$ 1,584.57	$ 15.44
Non-Surg - Emergency Room	639.3	304.09	16.20	0.38	-	-	-	-	-	(0.26)	644.0	304.09	16.32
Non-Surg - Other	719.5	157.61	9.45	0.22	-	-	-	-	-	(0.15)	724.8	157.61	9.52
Observation Room	16.4	1,752.64	2.39	0.06	-	-	-	-	-	(0.04)	16.5	1,752.64	2.41
Treatment/Therapy/Testing	818.2	359.18	24.49	0.58	-	-	-	-	-	(0.40)	824.2	359.18	24.67
Other Outpatient	62.8	330.49	1.73	0.04	-	-	-	2.67	(1.74)	(0.04)	159.8	199.80	2.66
Subtotal Outpatient Hospital			**$ 69.59**										**$ 71.02**
Retail Pharmacy													
Prescription Drugs	16,253.6	$ 136.38	$ 184.72	$ 0.00	$ 24.58	$ 0.00	$ 0.00	$ 0.00	$ 0.04	$ (3.27)	15,965.9	$ 154.88	$ 206.07
Subtotal Retail Pharmacy			**$ 184.72**										**$ 206.07**
Ancillary													
Transportation	223.7	$ 102.45	$ 1.91	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	230.8	$ 102.45	$ 1.97
DME/Prosthetics	53,413.0	4.39	19.55	0.92	-	-	1.53	-	-	(0.34)	54,997.6	4.73	21.66
Dental	84.8	80.66	0.57	0.03	-	(0.01)	(0.01)	-	-	(0.01)	86.3	79.27	0.57
Other Ancillary	438.7	38.30	1.40	0.07	-	-	-	-	-	(0.02)	454.3	38.30	1.45
Subtotal Ancillary			**$ 23.43**										**$ 25.65**
Professional													
Inpatient and Outpatient Surgery	313.9	$ 170.14	$ 4.45	$ 0.21	$ 0.00	$ 0.00	$ 0.08	$ 0.01	$ 0.00	$ (0.08)	323.7	$ 173.11	$ 4.67
Anesthesia	209.5	116.84	2.04	0.10	-	-	0.02	-	-	(0.03)	216.7	117.94	2.13
Inpatient Visits	856.8	100.28	7.16	0.34	-	-	0.48	-	-	(0.12)	883.1	106.80	7.86
MH/SA	29,460.6	24.96	61.28	2.90	-	-	0.14	0.07	0.17	(1.01)	30,402.8	25.08	63.55
Emergency Room	766.4	81.58	5.21	0.25	-	-	0.05	-	-	(0.09)	789.9	82.34	5.42
Office/Home Visits/Consults	4,657.5	90.85	35.26	1.67	-	(0.03)	1.62	-	-	(0.60)	4,794.8	94.90	37.92
Pathology/Lab	2,087.0	15.75	2.74	0.13	-	(0.01)	0.25	-	-	(0.05)	2,140.3	17.16	3.06
Radiology	924.1	21.43	1.65	0.08	-	-	0.05	-	-	(0.03)	952.1	22.06	1.75
Office Administered Drugs	8,800.5	20.14	14.77	0.70	-	(0.01)	0.23	-	-	(0.24)	9,068.6	20.44	15.45
Physical Exams	1,065.2	60.61	5.38	0.25	-	(0.03)	0.34	-	-	(0.09)	1,090.9	64.35	5.85
Therapy	16,275.5	21.77	29.53	1.40	-	-	1.75	-	-	(0.51)	16,766.0	23.03	32.17
Vision	1,228.3	28.23	2.89	0.14	-	-	0.62	-	-	(0.06)	1,262.3	34.13	3.59
Other Professional	13,826.0	13.72	15.81	0.75	-	(0.01)	0.13	0.15	0.54	(0.27)	14,368.2	14.28	17.10
Subtotal Professional			**$ 188.17**										**$ 200.52**
Total Medical Costs			**$ 550.55**										**$ 590.56**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SSI - Adults SFY 2022 Member Months: 635,155 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	1,852.4	$ 2,009.85	$ 310.25	$ 7.29	$ 0.00	$ 0.00	$ 5.23	$ 0.00	$ 0.00	$ 0.00	1,895.9	$ 2,042.95	$ 322.77
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	506.5	621.64	26.24	0.62	-	-	0.78	-	-	-	518.5	639.69	27.64
Other Inpatient	411.2	267.61	9.17	0.22	-	-	-	-	-	-	421.1	267.61	9.39
Subtotal Inpatient Hospital			**$ 345.66**										**$ 359.80**
Outpatient Hospital													
Surgery	310.2	$ 1,692.08	$ 43.74	$ 4.19	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	339.9	$ 1,692.08	$ 47.93
Non-Surg - Emergency Room	1,525.2	378.69	48.13	4.61	-	-	-	-	-	-	1,671.3	378.69	52.74
Non-Surg - Other	701.9	151.64	8.87	0.85	-	-	-	-	-	-	769.2	151.64	9.72
Observation Room	44.9	865.55	3.24	0.31	-	-	-	-	-	-	49.2	865.55	3.55
Treatment/Therapy/Testing	1,461.4	751.49	91.52	8.77	-	-	-	-	-	-	1,601.4	751.49	100.29
Other Outpatient	267.7	216.95	4.84	0.46	-	-	-	0.70	(0.33)	-	331.9	205.02	5.67
Subtotal Outpatient Hospital			**$ 200.34**										**$ 219.90**
Retail Pharmacy													
Prescription Drugs	26,885.6	$ 149.13	$ 334.12	$ 0.00	$ 52.89	$ 0.00	$ 0.00	$ 0.14	$ 9.32	$ 0.00	26,896.9	$ 176.88	$ 396.47
Subtotal Retail Pharmacy			**$ 334.12**										**$ 396.47**
Ancillary													
Transportation	1,294.3	$ 89.93	$ 9.70	$ 0.58	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	$ 0.00	$ 0.00	1,371.7	$ 89.67	$ 10.25
DME/Prosthetics	32,949.2	8.27	22.72	1.35	-	-	3.06	-	-	-	34,907.0	9.33	27.13
Dental	0.3	352.47	0.01	-	-	-	-	-	-	-	0.3	352.47	0.01
Other Ancillary	1,720.5	70.72	10.14	0.60	-	-	0.01	-	-	-	1,822.3	70.79	10.75
Subtotal Ancillary			**$ 42.57**										**$ 48.14**
Professional													
Inpatient and Outpatient Surgery	1,409.2	$ 171.00	$ 20.08	$ 1.19	$ 0.00	$ (0.01)	$ (0.11)	$ 0.00	$ 0.00	$ 0.00	1,492.0	$ 170.11	$ 21.15
Anesthesia	571.8	109.12	5.20	0.31	-	-	0.08	-	-	-	605.9	110.71	5.59
Inpatient Visits	3,642.3	78.51	23.83	1.41	-	-	1.96	-	-	-	3,857.8	84.61	27.20
MH/SA	11,942.6	25.85	25.73	1.53	-	-	0.17	0.05	0.10	-	12,676.0	26.11	27.58
Emergency Room	2,011.2	92.06	15.43	0.92	-	-	0.29	-	-	-	2,131.1	93.70	16.64
Office/Home Visits/Consults	6,908.4	90.86	52.31	3.10	-	(0.29)	1.65	-	0.93	-	7,279.5	95.12	57.70
Pathology/Lab	8,379.3	13.29	9.28	0.55	-	(0.05)	0.73	-	-	-	8,830.7	14.28	10.51
Radiology	4,057.7	36.82	12.45	0.74	-	-	0.03	-	-	-	4,298.9	36.90	13.22
Office Administered Drugs	63,119.9	8.59	45.17	2.68	-	(0.02)	(0.19)	-	-	-	66,837.0	8.55	47.64
Physical Exams	475.4	53.51	2.12	0.13	-	(0.01)	0.04	-	0.01	-	502.3	54.71	2.29
Therapy	1,109.4	22.93	2.12	0.13	-	-	0.07	-	-	-	1,177.4	23.65	2.32
Vision	339.8	48.73	1.38	0.08	-	-	0.11	-	-	-	359.5	52.40	1.57
Other Professional	5,846.6	45.22	22.03	1.31	-	(0.08)	0.37	0.19	0.13	-	6,223.4	46.18	23.95
Subtotal Professional			**$ 237.13**										**$ 257.36**
Total Medical Costs			**$ 1,159.82**										**$ 1,281.67**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: OCWI SFY 2022 Member Months: 390,533 Category of Service	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trend Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Acuity Adjustments Utilization Adjustment	SFY 2022 Projected Benefit Expense Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	271.1	$ 1,388.37	$ 31.37	$ 0.74	$ 0.00	$ 0.00	$ 0.74	$ 0.00	$ 0.00	$ (7.83)	209.9	$ 1,430.68	$ 25.02
Inpatient Well Newborn	1.3	534.99	0.06	-	-	-	-	-	-	(0.01)	1.1	534.99	0.05
Inpatient MH/SA	31.8	592.99	1.57	0.04	-	-	0.02	-	-	(0.39)	24.7	602.71	1.24
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 33.00**										**$ 26.31**
Outpatient Hospital													
Surgery	651.8	$ 464.50	$ 25.23	$ 2.42	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (6.59)	544.1	$ 464.50	$ 21.06
Non-Surg - Emergency Room	1,021.4	381.95	32.51	3.12	-	-	-	-	-	(8.50)	852.4	381.95	27.13
Non-Surg - Other	1,039.4	154.82	13.41	1.29	-	-	-	-	-	(3.51)	867.3	154.82	11.19
Observation Room	186.4	294.92	4.58	0.44	-	-	-	-	-	(1.20)	155.4	294.92	3.82
Treatment/Therapy/Testing	1,715.5	151.44	21.65	2.07	-	-	-	-	-	(5.65)	1,431.8	151.44	18.07
Other Outpatient	82.3	132.65	0.91	0.09	-	-	-	0.47	(0.05)	(0.34)	102.2	126.78	1.08
Subtotal Outpatient Hospital			**$ 98.29**										**$ 82.35**
Retail Pharmacy													
Prescription Drugs	9,905.8	$ 35.76	$ 29.52	$ 0.00	$ 0.35	$ 0.00	$ 0.00	$ 0.00	$ 0.89	$ (7.27)	7,466.2	$ 37.75	$ 23.49
Subtotal Retail Pharmacy			**$ 29.52**										**$ 23.49**
Ancillary													
Transportation	299.1	$ 97.89	$ 2.44	$ 0.20	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ (0.62)	247.6	$ 97.41	$ 2.01
DME/Prosthetics	706.4	43.32	2.55	0.21	-	-	0.12	-	-	(0.69)	573.4	45.83	2.19
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	381.1	143.28	4.55	0.38	-	-	-	-	-	(1.17)	314.9	143.28	3.76
Subtotal Ancillary			**$ 9.54**										**$ 7.96**
Professional													
Inpatient and Outpatient Surgery	347.2	$ 154.85	$ 4.48	$ 0.37	$ 0.00	$ 0.00	$ 0.12	$ 0.00	$ 0.00	$ (1.19)	283.6	$ 159.93	$ 3.78
Anesthesia	151.1	104.84	1.32	0.11	-	-	-	-	-	(0.34)	124.8	104.84	1.09
Inpatient Visits	887.4	74.51	5.51	0.46	-	-	0.21	-	-	(1.47)	724.8	77.98	4.71
MH/SA	1,319.3	89.14	9.80	0.82	-	-	0.08	-	-	(2.55)	1,086.4	90.02	8.15
Emergency Room	1,377.9	82.91	9.52	0.80	-	-	0.24	-	-	(2.52)	1,128.9	85.46	8.04
Office/Home Visits/Consults	2,654.8	75.30	16.66	1.39	-	(0.04)	1.16	-	-	(4.57)	2,141.7	81.80	14.60
Pathology/Lab	14,180.2	14.58	17.23	1.44	-	(0.03)	1.26	-	-	(4.74)	11,439.6	15.90	15.16
Radiology	1,437.0	63.38	7.59	0.63	-	-	0.52	-	-	(2.08)	1,162.5	68.75	6.66
Office Administered Drugs	19,665.5	3.21	5.26	0.44	-	-	(0.09)	-	-	(1.33)	16,338.1	3.14	4.28
Physical Exams	924.4	26.61	2.05	0.17	-	-	-	-	-	(0.53)	762.1	26.61	1.69
Therapy	236.8	21.79	0.43	0.04	-	-	0.01	-	-	(0.11)	198.2	22.40	0.37
Vision	257.1	34.08	0.73	0.06	-	-	0.10	-	-	(0.21)	204.2	39.95	0.68
Other Professional	2,916.1	82.26	19.99	1.67	-	(0.07)	0.49	0.58	(0.04)	(5.40)	2,446.3	84.47	17.22
Subtotal Professional			**$ 100.57**										**$ 86.43**
Total Medical Costs			**$ 270.92**										**$ 226.54**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: DUAL	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	590.0	$ 259.12	$ 12.74	$ 0.60	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	617.8	$ 259.12	$ 13.34
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	47.2	215.91	0.85	0.04	-	-	-	-	-	-	49.5	215.91	0.89
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 13.59**										**$ 14.23**
Outpatient Hospital													
Surgery	59.3	$ 204.41	$ 1.01	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	64.0	$ 204.41	$ 1.09
Non-Surg - Emergency Room	423.7	67.68	2.39	0.20	-	-	-	-	-	-	459.2	67.68	2.59
Non-Surg - Other	302.5	24.59	0.62	0.05	-	-	-	-	-	-	326.9	24.59	0.67
Observation Room	12.3	68.04	0.07	0.01	-	-	-	-	-	-	14.1	68.04	0.08
Treatment/Therapy/Testing	499.5	90.33	3.76	0.31	-	-	-	-	-	-	540.7	90.33	4.07
Other Outpatient	46.3	59.64	0.23	0.02	-	-	-	-	-	-	50.3	59.64	0.25
Subtotal Outpatient Hospital			**$ 8.08**										**$ 8.75**
Retail Pharmacy													
Prescription Drugs	346.4	$ 69.29	$ 2.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	346.4	$ 69.29	$ 2.00
Subtotal Retail Pharmacy			**$ 2.00**										**$ 2.00**
Ancillary													
Transportation	24.0	$ 40.07	$ 0.08	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	27.0	$ 40.07	$ 0.09
DME/Prosthetics	15,316.6	4.45	5.68	0.47	-	-	-	-	-	-	16,584.0	4.45	6.15
Dental	1.2	97.85	0.01	-	-	-	-	-	-	-	1.2	97.85	0.01
Other Ancillary	122.0	29.52	0.30	0.03	-	-	-	-	-	-	134.2	29.52	0.33
Subtotal Ancillary			**$ 6.07**										**$ 6.58**
Professional													
Inpatient and Outpatient Surgery	342.1	$ 27.36	$ 0.78	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	372.8	$ 27.36	$ 0.85
Anesthesia	112.6	17.05	0.16	0.01	-	-	0.01	-	-	-	119.6	18.06	0.18
Inpatient Visits	846.1	20.71	1.46	0.12	-	-	-	-	-	-	915.6	20.71	1.58
MH/SA	11,201.0	13.85	12.93	1.08	-	-	-	0.02	0.06	-	12,153.9	13.91	14.09
Emergency Room	181.2	37.09	0.56	0.05	-	-	-	-	-	-	197.4	37.09	0.61
Office/Home Visits/Consults	2,798.5	38.81	9.05	0.76	-	-	-	-	0.34	-	3,033.5	40.15	10.15
Pathology/Lab	508.4	6.14	0.26	0.02	-	-	-	-	-	-	547.5	6.14	0.28
Radiology	525.2	16.91	0.74	0.06	-	-	-	-	-	-	567.7	16.91	0.80
Office Administered Drugs	43,477.0	2.29	8.31	0.69	-	-	-	-	-	-	47,087.1	2.29	9.00
Physical Exams	56.8	19.02	0.09	0.01	-	-	-	-	-	-	63.1	19.02	0.10
Therapy	288.9	3.32	0.08	0.01	-	-	-	-	-	-	325.0	3.32	0.09
Vision	76.5	29.82	0.19	0.02	-	-	0.01	-	-	-	84.5	31.24	0.22
Other Professional	1,838.5	10.97	1.68	0.14	-	-	-	-	-	-	1,991.7	10.97	1.82
Subtotal Professional			**$ 36.29**										**$ 39.77**
Total Medical Costs			**$ 66.03**										**$ 71.33**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: Foster Care Children SFY 2022 Member Months: 57,622 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	142.6	$ 1,567.88	$ 18.63	$ 0.00	$ 0.00	$ 0.00	$ 0.80	$ 0.00	$ 0.00	$ 0.00	142.6	$ 1,635.21	$ 19.43
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	4,719.9	354.13	139.29	-	-	-	0.79	-	-	-	4,719.9	356.14	140.08
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 157.92**										**$ 159.51**
Outpatient Hospital													
Surgery	97.7	$ 1,532.81	$ 12.48	$ 0.89	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	104.7	$ 1,532.81	$ 13.37
Non-Surg - Emergency Room	582.4	304.13	14.76	1.05	-	-	-	-	-	-	623.8	304.13	15.81
Non-Surg - Other	576.9	140.81	6.77	0.48	-	-	-	-	-	-	617.8	140.81	7.25
Observation Room	8.6	880.20	0.63	0.04	-	-	-	-	-	-	9.1	880.20	0.67
Treatment/Therapy/Testing	440.6	214.87	7.89	0.56	-	-	-	-	-	-	471.9	214.87	8.45
Other Outpatient	46.2	140.21	0.54	0.04	-	-	-	1.34	(0.25)	-	164.3	121.95	1.67
Subtotal Outpatient Hospital			**$ 43.07**										**$ 47.22**
Retail Pharmacy													
Prescription Drugs	13,308.4	$ 55.35	$ 61.38	$ 0.00	$ 0.72	$ 0.00	$ 0.00	$ 0.00	$ 0.06	$ 0.00	13,308.4	$ 56.05	$ 62.16
Subtotal Retail Pharmacy			**$ 61.38**										**$ 62.16**
Ancillary													
Transportation	237.0	$ 88.60	$ 1.75	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	253.3	$ 88.60	$ 1.87
DME/Prosthetics	12,091.7	4.60	4.64	0.33	-	-	0.51	-	-	-	12,951.7	5.08	5.48
Dental	164.3	67.17	0.92	0.07	-	(0.02)	(0.01)	-	-	-	173.3	66.48	0.96
Other Ancillary	303.1	43.55	1.10	0.08	-	-	-	-	-	-	325.1	43.55	1.18
Subtotal Ancillary			**$ 8.41**										**$ 9.49**
Professional													
Inpatient and Outpatient Surgery	350.7	$ 139.61	$ 4.08	$ 0.29	$ 0.00	$ 0.00	$ 0.01	$ 0.04	$ 0.00	$ 0.00	379.1	$ 139.93	$ 4.42
Anesthesia	169.9	98.16	1.39	0.10	-	-	(0.02)	-	-	-	182.1	96.84	1.47
Inpatient Visits	1,004.8	77.87	6.52	0.47	-	-	1.06	-	-	-	1,077.2	89.68	8.05
MH/SA	454,433.1	9.66	365.93	26.13	-	-	0.94	(221.92)	228.68	-	211,289.7	22.70	399.76
Emergency Room	681.2	81.03	4.60	0.33	-	-	0.05	-	-	-	730.1	81.85	4.98
Office/Home Visits/Consults	5,160.0	90.93	39.10	2.79	-	0.14	3.05	13.79	0.41	-	7,366.5	96.57	59.28
Pathology/Lab	3,039.5	14.13	3.58	0.26	-	(0.01)	0.36	-	-	-	3,251.8	15.46	4.19
Radiology	673.6	19.78	1.11	0.08	-	-	0.05	-	-	-	722.1	20.61	1.24
Office Administered Drugs	7,407.9	10.82	6.68	0.48	-	-	0.08	-	-	-	7,940.2	10.94	7.24
Physical Exams	2,822.6	48.30	11.36	0.81	-	-	1.20	-	-	-	3,023.9	53.06	13.37
Therapy	11,068.9	21.15	19.51	1.39	-	-	2.34	-	-	-	11,857.5	23.52	23.24
Vision	1,425.7	36.19	4.30	0.31	-	-	1.31	-	-	-	1,528.4	46.48	5.92
Other Professional	3,252.0	20.26	5.49	0.39	-	-	0.18	0.45	0.95	-	3,749.6	23.87	7.46
Subtotal Professional			**$ 473.65**										**$ 540.62**
Total Medical Costs			**$ 744.43**										**$ 819.00**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: KICK	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2022 Projected Benefit Expense		
SFY 2022 Deliveries: 22,944 Category of Service	Utilization per 1,000	Cost per Service	Cost per Delivery	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	Cost per Delivery
Inpatient Hospital													
Inpatient Maternity Delivery	2,574.2	$ 1,680.48	$ 4,325.90	$ 50.64	$ 0.00	$ 0.00	$ 43.38	$ 0.00	$ 0.00	$ 0.00	2,604.3	$ 1,697.13	$ 4,419.92
Subtotal Inpatient Hospital			**$ 4,325.90**										**$ 4,419.92**
Outpatient Hospital													
Outpatient Hospital - Maternity	64.6	$ 434.35	$ 28.05	$ 0.66	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	66.1	$ 434.35	$ 28.71
Subtotal Outpatient Hospital			**$ 28.05**										**$ 28.71**
Professional													
Maternity Delivery	963.2	$ 1,035.15	$ 997.05	$ 47.15	$ 0.00	$ (0.53)	$ (32.06)	$ 0.00	$ 0.00	$ 0.00	1,008.2	$ 1,003.35	$ 1,011.61
Maternity Anesthesia	1,169.2	293.59	343.28	16.23	-	-	(10.05)	-	-	-	1,224.5	285.38	349.46
Maternity Office Visits	8,614.2	65.30	562.53	26.60	-	(1.76)	52.95	-	-	-	8,994.6	71.19	640.32
Maternity Radiology	4,506.9	77.83	350.78	16.59	-	(0.06)	26.22	-	-	-	4,719.2	83.39	393.53
Maternity Non-Delivery	2.0	78.38	0.16	0.01	-	-	0.01	-	-	-	2.2	82.99	0.18
Subtotal Professional			**$ 2,253.80**										**$ 2,395.10**
Total Medical Costs			**$ 6,607.75**										**$ 6,843.73**

Appendix 8: Supplemental Teaching Payment Development – Unadjusted STP

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Supplemental Teaching Payment Development
Unadjusted STP Pass-through

Rate Cell Description	Rate Cell Code	[A] Base Member Months	[B] STP Claims Paid Amount	[C] Estimated TPL	[D] Estimated Copay	[E] ACR Repricing Factor	[B] x [E] [F] STP Claims Repriced to ACR	[F] - ([B]+[C]+[D]) [G] Base Year STP Pass-through Amount	[G] / [A] [I] Base Year STP Pass-through PMPM
TANF Children									
TANF - 0 - 2 Months, Male & Female	**AH3**	83,277	$ 7,946,139	$ 214,546	$ 0	2.5303	$ 20,105,952	$ 11,945,267	$ 143.44
TANF - 3 - 12 Months, Male & Female	**AI3**	349,063	6,609,931	178,468	-	2.1454	14,181,162	7,392,763	21.18
TANF - Age 1 - 6, Male & Female	**AB3**	2,196,819	12,627,806	340,951	-	2.0583	25,992,372	13,023,614	5.93
TANF - Age 7 - 13, Male & Female	**AC3**	2,635,374	10,957,636	295,856	-	1.9957	21,868,446	10,614,954	4.03
TANF - Age 14 - 18, Male	**AD1**	744,863	3,267,659	88,227	-	2.1897	7,155,204	3,799,318	5.10
TANF - Age 14 - 18, Female	**AD2**	757,039	4,630,506	125,024	-	2.0529	9,506,177	4,750,647	6.28
Subtotal TANF Children		**6,766,435**	**$ 46,039,678**	**$ 1,243,071**	**$ 0**		**$ 98,809,312**	**$ 51,526,563**	**$ 7.62**
TANF Adult									
TANF - Age 19 - 44, Male	**AE1**	270,094	$ 1,109,700	$ 29,962	$ 13,843	2.6339	$ 2,922,869	$ 1,769,363	$ 6.55
TANF - Age 19 - 44, Female	**AE2**	1,374,559	11,395,608	307,681	107,534	2.3014	26,225,807	14,414,983	10.49
TANF - Age 45+, Male & Female	**AF3**	230,738	2,654,404	71,669	37,270	2.6244	6,966,237	4,202,894	18.22
Subtotal TANF Adult		**1,875,391**	**$ 15,159,712**	**$ 409,312**	**$ 158,647**		**$ 36,114,912**	**$ 20,387,240**	**$ 10.87**
Disabled									
SSI - Children	**SO3**	136,398	$ 2,424,855	$ 65,471	$ 0	2.1774	$ 5,279,866	$ 2,789,540	$ 20.45
SSI - Adults	**SP3**	599,191	13,869,492	374,476	138,372	2.5296	35,083,758	20,701,417	34.55
Subtotal Disabled		**735,589**	**$ 16,294,347**	**$ 439,947**	**$ 138,372**		**$ 40,363,624**	**$ 23,490,957**	**$ 31.93**
OCWI	**WG2**	**160,497**	**$ 2,728,618**	**$ 73,673**	**$ 0**	**1.9668**	**$ 5,366,583**	**$ 2,564,292**	**$ 15.98**
DUAL		**N/A**	**$ 0**	**$ 0**	**$ 0**	**1.0000**	**$ 0**	**$ 0**	**$ 0.00**
Foster Care Children	**FG3**	**58,680**	**$ 607,229**	**$ 16,395**	**$ 0**	**1.9478**	**$ 1,182,782**	**$ 559,158**	**$ 9.53**
KICK	**MG2/NG2**	**25,962**	**$ 15,282,914**	**$ 412,639**	**$ 0**	**1.7538**	**$ 26,803,377**	**$ 11,107,824**	**$ 427.85**
Total		**9,596,592**	**$ 96,112,498**	**$ 2,595,037**	**$ 297,020**		**$ 208,640,590**	**$ 109,636,034**	**$ 11.42**

Appendix 9: Supplemental Teaching Payment Development – Final STP PMPM

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2022 Supplemental Teaching Payment Development
Final STP PMPM

		[A]	[B]	[A] x [B] [C]	[D]	[E]	[C] x [D] X [E] [F]	[G]	([F] + [G]) / [A] [H]	[I]	[H] x [I] [J]	[A] x [J] [K]
Rate Cell Description	Rate Cell Code	SFY 2022 Projected Exposure	Base Year STP Pass-through PMPM	Base Year STP with SFY 2022 Exposure	Base Year Retrospective Adjustments	SFY 2022 Prospective Adjustments	SFY 2022 STP Projected Expenditures	KICK Allocation	Final SFY 2022 STP Pass-through (pre Cap)	Pass-through Cap Adjustment	Final SFY 2022 STP Pass-through (Capped)	Final Pass-through Expenditures
TANF Children												
TANF - 0 - 2 Months, Male & Female	**AH3**	81,947	$ 143.44	$ 11,754,491	1.0146	1.1711	$ 13,966,739	$ 0	$ 170.44	0.9826	$ 167.47	$ 13,723,474
TANF - 3 - 12 Months, Male & Female	**AI3**	341,296	21.18	7,228,267	1.0092	1.1037	8,050,988	-	23.59	0.9826	23.18	7,910,760
TANF - Age 1 - 6, Male & Female	**AB3**	2,588,224	5.93	15,344,018	1.0070	1.0811	16,704,052	-	6.45	0.9826	6.34	16,413,111
TANF - Age 7 - 13, Male & Female	**AC3**	3,000,413	4.03	12,085,285	1.0082	1.0812	13,172,981	-	4.39	0.9826	4.31	12,943,541
TANF - Age 14 - 18, Male	**AD1**	967,378	5.10	4,934,299	1.0092	1.0383	5,170,475	-	5.34	0.9826	5.25	5,080,419
TANF - Age 14 - 18, Female	**AD2**	975,765	6.28	6,123,219	1.0094	1.0341	6,391,513	554,906	7.12	0.9826	6.99	6,825,429
Subtotal TANF Children		**7,955,023**	**$ 7.22**	**$ 57,469,578**			**$ 63,456,747**		**$ 8.05**		**$ 7.91**	**$ 62,896,734**
TANF Adult												
TANF - Age 19 - 44, Male	**AE1**	557,554	$ 6.55	$ 3,652,489	1.0157	0.9227	$ 3,423,238	$ 0	$ 6.14	0.9826	$ 6.03	$ 3,363,615
TANF - Age 19 - 44, Female	**AE2**	1,927,511	10.49	$ 20,213,784	1.0152	0.9699	19,901,873	$ 4,122,041	12.46	0.9826	12.25	23,605,480
TANF - Age 45+, Male & Female	**AF3**	334,833	18.22	$ 6,098,985	1.0171	0.9798	6,078,018	$ 0	18.15	0.9826	17.84	5,972,155
Subtotal TANF Adult		**2,819,898**	**$ 10.63**	**$ 29,965,258**			**$ 29,403,130**		**$ 11.89**		**$ 11.68**	**$ 32,941,250**
Disabled												
SSI - Children	**SO3**	135,650	$ 20.45	$ 2,774,242	1.0224	1.0393	$ 2,947,899	$ 7,191	$ 21.78	0.9826	21.41	$ 2,903,620
SSI - Adults	**SP3**	635,155	34.55	$ 21,943,936	1.0213	1.0602	23,760,545	$ 105,868	37.58	0.9826	36.92	23,450,721
Subtotal Disabled		**770,805**	**$ 32.07**	**$ 24,718,178**			**$ 26,708,444**		**$ 34.80**		**$ 34.19**	**$ 26,354,341**
OCWI	**WG2**	**390,533**	**$ 15.98**	**$ 6,239,622**	**1.0186**	**0.8303**	**$ 5,277,183**	**$ 5,562,639**	**$ 27.76**	**0.9826**	**$ 27.27**	**$ 10,651,020**
DUAL		**N/A**	**$ 0.00**	**$ 0**	**1.0000**	**1.0000**	**$ 0**	**$ 0**	**$ 0.00**	**N/A**	**$ 0.00**	**$ 0**
Foster Care Children	**FG3**	**57,622**	**$ 9.53**	**$ 549,076**	**1.0248**	**1.1877**	**$ 668,296**	**$ 0**	**$ 11.60**	**0.9826**	**$ 11.40**	**$ 656,656**
KICK	**MG2/NG2**	**22,944**	**$ 427.85**	**$ 9,816,575**	**1.0070**	**1.0473**	**$ 10,352,644**	**$ (10,352,644)**	**$ 0.00**	**0.9826**	**$ 0.00**	**$ 0**
Total		**11,993,881**	**$ 10.74**	**$ 128,758,288**			**$ 135,866,443**	**$ 0**	**$ 11.33**		**$ 11.13**	**$ 133,500,000**

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