State Fiscal Year 2021 Medicaid Managed Care Capitation Rate Certification

July 1, 2020 through June 30, 2021

South Carolina Department of Health and Human Services

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Jeremy D. Palmer, FSA, MAAA, Principal and Consulting Actuary
Marlene T. Howard, FSA, MAAA, Principal and Consulting Actuary
Carmen L. Laudenschlager, ASA, MAAA, Consulting Actuary
Zachary J. Fohl, FSA, MAAA, Actuary

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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, 2020.

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

To facilitate review, this document has been organized in the same manner as the 2019-2020 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in March 2019 (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) 2021 (July 1, 2020 through June 30, 2021). Figure 1 provides a comparison of the SFY 2021 rates relative to the rates effective in SFY 2020. The composite rates illustrated for both SFY 2021 and SFY 2020 are calculated based on projected SFY 2021 enrollment by rate cell. The projected enrollment reflects annualized March 2020 membership with adjustments to reflect anticipated increases in membership due to the Families First Coronavirus Response Act (FFCRA) and changes in unemployment levels. The TANF: 0-2 months old projected member months reflects annualized December 2019 membership and the SFY 2021 projected KICK payments reflect SFY 2019 average enrollment to account for the observed lag in eligibility completion for both rate cells adjusted for COVID-19 related enrollment impacts.

FIGURE 1: COMPARISON WITH SFY 2020 RATES (PMPM RATES)

COMPOSITE	SFY 2020 PMPM	SFY 2021 PMPM	INCREASE/ (DECREASE)
Including Add-Ons	$ 317.47	$ 314.09	(1.1%)
Excluding Add-Ons	$ 299.02	$ 298.35	(0.2%)

Notes:
1. SFY 2020 and SFY 2021 composite rates reflect projected SFY 2021 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 2021 capitation rates to the SFY 2020 capitation rates at the rate cell, both excluding and including the 438.6 Hospital Quality Payment Initiative and the Supplemental Teaching Payment referred to collectively as add-ons. The comparison of SFY 2021 capitation rates to the SFY 2020 capitation rates is also presented in Appendix 2.

FIGURE 2: COMPARISON WITH SFY 2020 RATES BY RATE CELL (PMPM RATES)

		INCLUDING ADD-ONS			EXCLUDING ADD-ONS		
RATE CELL	PROJECTED MONTHS	SFY 2020 RATE	SFY 2021 RATE	INCREASE/ (DECREASE)	SFY 2020 RATE	SFY 2021 RATE	INCREASE/ (DECREASE)
TANF: 0-2 months old (AH3)	89,141	$ 2,356.71	$ 2,284.03	(3.1%)	$ 2,168.35	$ 2,140.61	(1.3%)
TANF: 3-12 months old (AI3)	375,560	260.04	252.81	(2.8%)	230.22	229.28	(0.4%)
TANF: Age 1-6 (AB3)	2,640,042	141.96	140.14	(1.3%)	132.93	132.69	(0.2%)
TANF: Age 7-13 (AC3)	3,045,547	151.38	143.51	(5.2%)	144.05	137.59	(4.5%)
TANF: Age 14-18, Male (AD1)	876,313	164.10	158.43	(3.5%)	155.91	151.41	(2.9%)
TANF: Age 14-18, Female (AD2)	884,369	201.73	200.88	(0.4%)	190.04	190.70	0.3%
TANF: Age 19-44, Male (AE1)	343,007	240.38	218.59	(9.1%)	228.47	208.90	(8.6%)
TANF: Age 19-44, Female (AE2)	1,691,798	339.69	327.36	(3.6%)	317.47	307.81	(3.0%)
TANF: Age 45+ (AF3)	282,214	582.64	575.19	(1.3%)	552.11	547.56	(0.8%)
SSI - Children (SO3)	146,178	682.56	654.16	(4.2%)	642.80	625.45	(2.7%)
SSI - Adults (SP3)	658,622	1,329.85	1,387.67	4.3%	1,267.18	1,330.77	5.0%
OCWI (WG2)	211,427	382.32	370.69	(3.0%)	312.11	306.29	(1.9%)
DUAL	-	165.49	170.72	3.2%	165.49	170.72	3.2%
Foster Care - Children (FG3)	57,351	872.55	928.54	6.4%	846.89	904.05	6.7%
KICK (MG2/NG2)	28,510	6,807.22	6,849.83	0.6%	6,698.30	6,760.78	0.9%
Composite	**11,301,569**	**$ 317.47**	**$ 314.09**	**(1.1%)**	**$ 299.02**	**$ 298.35**	**(0.2%)**

Notes:
1. TANF: 0-2 months old projected member months reflects annualized December 2019 membership adjusted for COVID-19 related impacts.
2. SFY 2021 projected monthly deliveries are consistent with the average of SFY 2019 delivery counts adjusted for COVID-19 related impacts.
3. 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 2021 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 INCREASE/ (DECREASE)	PERCENTAGE INCREASE/ (DECREASE)
	PROJECTED MEMBERSHIP	SFY 2020	SFY 2021		
Composite	11,301,569	$ 3,587.9	$ 3,549.7	($ 38.2)	(1.1%)
Total Federal Only		$ 2,534.1	$ 2,507.1	($ 27.0)	(1.1%)
Total State		$ 1,053.8	$ 1,042.5	($ 11.2)	(1.1%)

Notes:
1. SFY 2020 and SFY 2021 aggregate annual expenditures were developed based on SFY 2021 projected enrollment and estimated SFY 2021 deliveries.
2. State expenditures based on Federal Fiscal Year 2021 FMAP of 70.63%.
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).
- 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 2021 managed care program rating period.
- 2019-2020 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in March 2019.
- 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.”

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, 2020 through June 30, 2021.

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 Actuarial Standards Board, and certifies that the final rates meet the applicable standards in 42 CFR 438 that are effective for the SFY 2021 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 member months illustrated in Figure 2 represent annualized March 2020 membership adjusted for COVID-19 related enrollment increases. To account for the observed lag in eligibility completion, the TANF: 0-2 months old projected member months reflects annualized December 2019 membership and the SFY 2021 projected KICK payments reflect SFY 2019 average enrollment, adjusted for COVID-19 related impacts. These rates represent the contracted capitation rates prior to risk adjustment.

(c) Program information

(i) 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	Home Health Services	Physician Services
Ancillary Medical Services	Hysterectomies, Sterilizations and Abortions (as covered in policy guidelines)	Prescription Drugs
Audiological Services	Independent Laboratory and X-Ray Services	Preventive and Rehabilitative Services for Primary Care Enhancement
Autism Spectrum Disorder Services	Inpatient Hospital Services	Psychiatric, Rehabilitative Behavioral Health, and associated outpatient mental health services
Communicable Disease Services	Institutional Long-Term Care Facilities/Nursing Homes for short-term stays	Rehabilitative Therapies for Children - Non-Hospital Based
Disease Management	Maternity Services	Substance Abuse
Durable Medical Equipment	Medication Assisted Therapy	Tobacco Cessation Coverage
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) / Well Child	Medication-Assisted Treatment in Opioid Treatment Programs	Transplant and Transplant-Related Services
Family Planning Services	Newborn Hearing Screenings	Vision Care Services
Free-Standing Inpatient Psychiatric for Under 21	Outpatient Pediatric AIDS Clinic Services (OPAC)	
Hearing Aids and Hearing Aid Accessories	Outpatient 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%202020.pdf

(ii) Rating period

This actuarial certification is effective for the one year rating period July 1, 2020 through June 30, 2021.

(iii) 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	RSP DESCRIPTION	RSP CODE	RSP DESCRIPTION
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		

Notes:
1. Palmetto Coordinated System of Care (PCSC) Waiver anticipated to be implemented August 1, 2020.

The SFY 2021 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.

(iv) 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 at the following link:

https://msp.scdhhs.gov/managedcare//sites/default/files/Pay%20cats%20and%20Managed%20Care%20Participation%20requirements%204-20-17.pdf

(v) 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 risk mitigation program
- Risk corridor program

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

(vi) Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the SFY 2021 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 2021 capitation rates.

vi. 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 2021 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, 2020 through June 30, 2021.

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 case 1 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. 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.

iii. Different FMAP

All populations receive the regular state FMAP of 70.63% for FFY 2021. The enhanced FMAP percentage for CHIP and family planning expenditures in South Carolina is 79.44% 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. These enhanced amounts are not reflected in the values provided in Appendix 3.

iv. Comparison to final certified rates in the previous rate certification.

The previous rate certification applied to SFY 2020 capitation rates. A comparison to SFY 2020 certified rates by rate cell is provided in Figure 2.

2. Data

This section provides information on the data used to develop the capitation rates. The base SFY 2019 experience data described in this section was provided in the SFY 2021 Capitation Rate Methodology and Data Book, dated March 17, 2020. Additionally, the base SFY 2019 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 2021 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 (SFY 2017 through January 2020);
- FFS claims for dual eligible individuals during SFY 2019;
- FFS claims for Hepatitis C pharmacy expenditures for managed care enrollees;
- FFS claims incurred by managed care enrollees for managed care-covered services;
- SFY 2021 managed care in-rate criteria;
- SFY 2019 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 2021 MCO Rate-Setting Survey completed by each MCO;
- Statutory financial statement data;
- Monthly disenrollment files for January through March 2020;
- American Community Survey (ACS) data from CY 2010 to CY 2018;
- South Carolina and National unemployment rates from the Bureau of Labor Statistics;
- Congressional Budget Office economic projections for 2020 and 2021;
- Therapeutic Foster Care placements during SFY 2019 and October through December 2019; and,
- SFY 2019 financial summary reports provided by the MCOs (EQI reports) for base data validation analysis.

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred during SFY 2019. The encounter data for the SFY 2019 base period reflected encounters adjudicated and submitted through the monthly encounter data warehousing process through January 2020. The FFS data used in the analysis and development of the IMD under 21 carve-in and the Hepatitis C pharmacy carve-in was incurred July 2018 through December 2019, with paid run-out through January 2020.

The encounter data provided by SCDHHS was also used in the capitation rate development for the following purposes:

- For the purposes of trend development, we reviewed encounter experience from SFY 2017 through SFY 2019.
- In addition to SFY 2019 experience, we observed pharmacy, psychiatric rehabilitative treatment facility (PRTF), IMD, Opioid Treatment Programs (OTP), continuous glucose monitoring (CGM) devices, and ASD encounter data incurred from July through December 2019 and paid and submitted through the data warehousing process through January 2020.

We also summarized statutory financial statement data from calendar years 2017, 2018, and 2019, collected using SNL Financial.

(iii) 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.

(iv) 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 (approximately 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 2021 Capitation Rate Methodology and Data Book, dated March 17, 2020, 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%. 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 SFY 2019 data is appropriate for use in the development of the capitation rate.

The annual rate setting process for SFY 2021 uses one year of experience data, with seven months of run-out.

The SFY 2019 encounter data used in the development of the rates was adjudicated through January 31, 2020. The seven 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 SFY 2019. However, as noted in this report, claims completion is applied to the encounter data for estimated SFY 2019 claims adjudicated after January 31, 2020.

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 2021 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, and claims that have been removed because of unmatched eligibility records.

(ii) 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 2021 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 SFY 2019 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 2021 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 0.3% to the SFY 2019 base data.

(iii) 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 SFY 2019 base experience period. As such, expenditure data for populations enrolled in FFS during SFY 2019 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 was utilized to estimate the financial impact of including all IMD services for individuals up to age 21 in the managed care delivery system effective July 1, 2019 and for estimating the financial impact of including Hepatitis C pharmaceutical treatments in the managed care delivery system effective July 1, 2020.

(ii) 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 SFY 2019 encounter data, which were shared with SCDHHS and participating MCOs and also included in the SFY 2019 Base Experience section of Appendix 6.

iii. Data adjustments

Capitation rates were developed primarily from SFY 2019 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 during SFY 2019 (July 1, 2018 through June 30, 2019) and paid through January 2020. 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.

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 SFY 2019 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 SFY 2019 data are illustrated by population and major service category in Figure 8.

FIGURE 8: COMPLETION FACTORS APPLIED TO SFY 2019 EXPERIENCE DATA

CATEGORY OF SERVICE	TANF/FOSTER	SSI	OCWI	DUAL	KICK
Hospital					
Inpatient	1.0167	1.0193	1.0138	1.0398	1.0152
Outpatient	1.0117	1.0146	1.0127	1.0300	1.0373
Pharmacy	1.0000	1.0001	1.0001	1.0027	N/A
Ancillaries	1.0106	1.0090	1.0103	1.0231	N/A
Professional	1.0060	1.0099	1.0061	1.0230	1.0051

Notes:

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 SFY 2019 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 2021 MCO Rate-Setting Survey, an adjustment has been made to increase the base data.

Based on a review of SFY 2019 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 2021. The base data has been increased by approximately $1.8 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 since July 1, 2018, 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 SFY 2019 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, 2019 PPS fee schedule update. We reviewed all FQHC physician claims in the SFY 2019 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 dollars. For claims that were unable to be repriced as a result of unknown provider IDs, the repricing adjustment factor was assumed to be 1.0.

Effective July 1, 2020, 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 approximately $1.6 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 SFY 2019, the entirety of the fee schedule change is not reflected in the SFY 2019 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 SFY 2019 physician expenditures reported in the encounter base data (see 'Base Physician Adjustment' 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 2020, 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 2020 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 93.1% 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. The estimated impact of this rate change is approximately $1.1 million.
- **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 estimated impact of this rate change is approximately $14.8 million

Effective July 1, 2020, SCDHHS is anticipated to implement 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 $0.9 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 $0.4 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 SCHEDULE	BASE PHYSICIAN REPRICING	JULY 2019 DME	JULY 2019 PHYSICIAN SCHEDULE	JULY 2020 VISION	JULY 2020 ANESTHESIA	COMPOSITE ADJUSTMENT
TANF: 0-2 months old (AH3)	$ 0.23	$ 6.50	$ 0.79	$ 28.56	$ 0.04	$ 0.06	$ 36.18
TANF: 3-12 months old (AI3)	0.22	5.88	(0.38)	2.67	0.03	0.05	8.47
TANF: Age 1-6 (AB3)	0.19	3.05	0.09	1.05	0.08	0.03	4.49
TANF: Age 7-13 (AC3)	0.21	2.36	0.10	0.99	0.16	0.01	3.83
TANF: Age 14-18, Male (AD1)	0.18	2.21	0.05	0.80	0.13	0.02	3.39
TANF: Age 14-18, Female (AD2)	0.27	3.56	0.04	0.87	0.20	0.02	4.96
TANF: Age 19-44, Male (AE1)	0.14	1.45	(0.02)	0.90	0.02	0.03	2.52
TANF: Age 19-44, Female (AE2)	0.37	3.75	0.04	1.22	0.02	0.06	5.46
TANF: Age 45+ (AF3)	0.45	3.58	(0.17)	2.22	0.02	0.10	6.20
SSI - Children (SO3)	0.36	6.50	1.20	1.87	0.22	0.06	10.21
SSI - Adults (SP3)	0.50	4.82	0.79	3.44	0.02	0.15	9.72
OCWI (WG2)	0.31	3.51	0.12	2.01	0.02	0.04	6.01
DUAL	-	-	0.19	0.65	-	-	0.84
Foster Care - Children (FG3)	0.94	10.06	0.23	1.51	0.26	0.04	13.04
KICK (MG2/NG2)	6.18	2.34	-	48.39	-	1.70	58.61

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.

Historical Program Change Review

There are no historical program changes applied to the SFY 2019 base data in the development of the SFY 2021 capitation rates.

Prospective Program Change Review

COVID-19 Temporary Policy Changes

SCDHHS has implemented several program changes through various disaster authorities as permitted during emergency periods. All program changes implemented under this authority are assumed to automatically terminate when the national emergency period is lifted. Due to the significant uncertainty around these program changes, we have not quantified a rate impact in the SFY 2021 capitation rate development; however, SCDHHS intends to implement a risk corridor as a risk mitigation mechanism in recognition of the medical expense cost uncertainty attributable to the COVID-19 pandemic and national emergency. Further discussion on the risk corridor is included in Section I, Item 4.C.

Autism Spectrum Disorder Services

Effective July 1, 2017, an Autism Spectrum Disorder (ASD) service array was included in the South Carolina Medicaid State Plan to expand treatment for children diagnosed with ASD up to age 21, and who were not currently enrolled in the state’s Pervasive Development Disorder (PDD) 1915(c) waiver. The ASD service array benefits were included in the managed care program for covered beneficiaries effective July 1, 2017. Figure 10 illustrates the build-up of anticipated SFY 2021 expenditures based on reimbursement increases, utilization ramp up, and provider capacity growth in the ASD market.

FIGURE 10: AUTISM ANALYSIS - SFY 2021 PROJECTED COST

	SFY 2019 BASE DATA		PMPM ADJUSTMENTS		SFY 2021 PROJECTION	
	BASE DATA PMPM	REPRICED PMPM	JULY 2019 RATE CHANGE	EMERGING UTILIZATION	TOTAL AUTISM PMPM	TOTAL AUTISM EXPENDITURES
Composite	**$ 0.52**	**$ 0.53**	**$ 0.06**	**$ 0.05**	**$ 0.64**	**$ 4,600,000**

Notes:
1. Values are rounded.
2. Composite PMPMs are based on impacted rate cells only: TANF 1-6, TANF 7-13, TANF 14-18 Male, TANF 14-18 Female, Foster Care Children, and SSI Children
3. SFY 2021 expenditures are based on projected SFY 2021 member months.

Further detail regarding each adjustment factor in Figure 10 is provided below.

SFY 2019 Paid. Total ASD services reflected in the SFY 2019 base data is approximately $3.3 million.

SFY 2019 Repriced. All SFY 2019 ASD services were repriced at the SFY 2019 FFS ASD fee schedule. The result of this repricing analysis was $0.01 PMPM, indicating that the majority of ASD expenditures are paid at the FFS fee schedules by the MCOs.

July 2019 Rate Change. 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. This increased composite SFY 2019 repriced expenditures by approximately 11%.

Emerging Utilization Ramp Up. We applied an incremental adjustment of 8% to the SFY 2019 repriced data to reflect observed utilization increases from July 2019 through December 2019.

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. Based on observed utilization of emerging SFY 2020 data, we targeted a 75% increase over utilization levels observed with the MCO that offered this benefit in the SFY 2019 base period. An adjustment was made to increase utilization of well visits on the same day as sick visits for all MCOs by rate cell to the target utilization. The adjustment was valued at approximately $3.2 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 SFY 2020 emerging data, observed breast cancer and ovarian cancer prevalence rates in the managed care program for women age 18 and over, and research and guidelines from industry leaders such as the National Cancer Institute, Breastcancer.org, and the National Breast Cancer Coalition, the total number of beneficiaries anticipated to receive the BRCA test in SFY2021 is estimated at approximately 200 beneficiaries. SCDHHS coverage guidelines require two genetic counseling services with each BRCA test, resulting in an average annual cost per beneficiary of approximately $1,800. The estimated value of the program change is approximately $0.4 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 utilization levels in other Medicaid states that cover CGM services, as well as a review of SFY 2019 observed data for the MCO that covered CGM devices during the SFY 2019 base period and emerging SFY 2020 data for all MCOs. Based on this review, the SFY 2021 target utilization levels are as follows:

- Diabetic members utilizing an insulin pump: 72.5% of children and 52.5% of adults
- Diabetic members not utilizing an insulin pump, but receiving an insulin prescription: 35.0% of children and 5.0% of adults
- Diabetic members not utilizing an insulin pump or insulin prescription: 35.0% of children and 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. The estimated value of the program change is approximately $4.1 million. Approximately $1.9 million is reflected in the SFY 2019 base data; therefore, the prospective adjustment to the base data is estimated at $2.2 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, all IMD 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 summarizing all IMD FFS expenditures related to MCO-enrolled members for the period July 2018 through June 2019. Expenditures were summarized and stratified by rate cell.

Figure 11 illustrates the build-up of anticipated SFY 2021 expenditures for the IMD children carve-in.

FIGURE 11: IMD CHILDREN CARVE-IN - SFY 2021 COSTS

	SFY 2019 BASE DATA		ADJUSTMENT FACTORS		SFY 2021 PROJECTION	
	DAYS	PMPM	JAN 2020 RATE CHANGE	COMPLETION & TREND (2 YRS)	PMPM	EXPENDITURES
Composite	26,847	$ 1.48	$ 0.02	$ 0.01	$ 1.51	$ 17,026,000

Notes:
1. IMD children base data includes all SFY 2019 IMD children expenditures in the FFS data for SFY 2019 MCO-enrolled individuals.
2. SFY 2021 rate development reflects a completion adjustment and two years of trend at the rate cell level.
3. SFY 2021 composite PMPM and projected expenditures are based on projected SFY 2021 member months.

Further detail regarding each adjustment factor in Figure 11 is provide below.

SFY 2019 Base Data. Total IMD children services reflected in the SFY 2019 FFS data is approximately $13.9 million, or $1.48 PMPM.

January 2020 Rate Change. Effective January 1, 2020, SCDHHS implemented a rate change to the SC DMH long-term psychiatric facility per diem rates. This increased composite SFY 2019 IMD children expenditures by approximately $0.02 PMPM, or approximately $160,000. The reimbursement rate for each IMD provider in SFY 2021 is anticipated to be consistent with FFS reimbursement rates.

Completion and Trend. We applied adjustments to the base data to reflect anticipated completion and utilization trend from SFY 2019 to SFY 2021. The completion and utilization adjustments were applied by rate cell and are consistent with the factors presented in Figures 8 and 17 of this report.

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 in SFY 2020. Based on this review, we anticipate an estimated utilization increase of 25% to the SFY 2019 Inpatient MH/SA (non-PRTF) base data for the adult population 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 ("new utilization") of approximately $4.5 million in the SFY 2021 contract year.

A review of emerging SFY 2020 IP MH/SA experience indicates a material shift between IP psychiatric utilization and IMD utilization. Through the first 5 months of SFY 2020, IMD utilization accounts for approximately 40% of total IP MH/SA utilization in the adult population. As such, total SFY 2021 projected IP MH/SA expenditures of $25.6 million is anticipated to be split between IP psychiatric services and IMD in-lieu-of as $15.3 million and $10.2 million, respectively. Figure 12 provides a summary of the new utilization anticipated for SFY 2021 and the projected split between IP psychiatric and IMD in-lieu-of services in the SFY 2021 contract year.

FIGURE 12: IMD IN-LIEU OF PROJECTED UTILIZATION

	SFY 2019	ESTIMATED IMD		SFY 2021 - PROJECTED		
	IP PSYCH	NEW UTILIZATION	TOTAL	IP PSYCH	IMD	TOTAL
Utilization (Days)	25,484	6,372	31,856	23,272	15,580	38,852
Utilization per 1000	117.0	29.3	146.3	87.6	58.7	146.3
Cost per Day	$ 657.72	$ 657.72	$ 657.72	$ 657.72	$ 657.72	$ 657.72
Total Expenditures (millions)	$ 16.8	$ 4.2	$ 21.0	$ 15.3	$ 10.2	$ 25.6

Notes:
1. IP psychiatric and IMD base data includes all SFY 2019 IP MH/SA expenditures for the 21 to 64 managed care population.
2. Emerging IP MH/SA experience is split approximately 40% IMD and 60% other. This observation is applied to the projected SFY 2021 utilization.
3. Approximately 300 IMD days are included in the SFY 2019 base data and are reflected in the estimated IMD new utilization column.
4. 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 in the SFY 2019 base data.
5. Total utilization and expenditures are based on the distribution of SFY 2021 projected member months

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. To estimate the impact of this program change, we identified OUD-diagnosed individuals in the SFY 2019 base data. The SFY 2019 OUD-diagnosed individuals were then increased by a factor of 1.25 to recognize the anticipated increase in OUD diagnoses due to increased accessibility of MAT through the carve-in of OTPs. We then applied a methadone treatment prevalence to the OUD-diagnosed individuals based on observed treatment percentages in the emerging data. Because the OTP benefit was added to the state plan January 1, 2019, we have at least 12 months of observed data to evaluate emerging experience. 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 Adult: 15.0% of OUD-diagnosed individuals
- SSI Adult: 10.0% of OUD-diagnosed individuals

Based on guidance from SCDHHS on reimbursement rates, OTP service guidelines, and an estimated treatment duration of 11.0 months, total estimated expenditures for the OTP program in SFY 2021 is anticipated at approximately $9.4 million.

Adult Podiatry

Effective January 1, 2020, SCDHHS added coverage of 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 evaluated the PMPM cost of the adult podiatry benefit on the adult population in calendar year 2010, during the time that this was a covered benefit. We applied 10.5 years of physician trend to the CY 2010 adult PMPM to estimate the SFY 2021 contract period impact. Physician trends were applied by rate cell consistent with the trends presented in Figure 17 in Section I, item 3.B.iii.

Additionally, we reviewed utilization levels in other Medicaid states that cover adult podiatry to validate the reasonableness of the SFY 2021 projected PMPM. Based on this review, the estimated impact of adding podiatry services to the adult aged 21 to 64 population is approximately $2.1 million. Approximately $0.3 million is reflected in the SFY 2019 base data that effectively could be removed as a non-covered service in the base period and subsequently added back in as a prospective adjustment related to the adult podiatry benefit in SFY 2021; however, for simplicity, the amount is left in the base data producing the same results. As a result of the $0.3 million of adult podiatry experience in the base data, the prospective adjustment is estimated at $1.8 million.

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

Effective July 1, 2020, SCDHHS anticipates implementing 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 SFY 2019 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 $27 (6-month supply = $164). Assuming one new 6-month prescription for each targeted individual results in an estimated impact of approximately $1.1 million.

Hepatitis-C pharmaceutical carve-in

Effective July 1, 2020, SCDHHS anticipates carving in all Hepatitis C pharmaceutical costs to the managed care program. We estimated the impact of carving in Hepatitis C pharmaceutical costs to the managed care program by summarizing all Hepatitis C FFS expenditures related to MCO-enrolled members during the SFY 2019 base period. Expenditures were summarized and stratified by rate cell. Based on our review of SFY 2019 experience and emerging SFY 2020 utilization, total Hepatitis C pharmaceutical scripts is estimated at approximately 1,424 in SFY 2021, based on projected membership levels. The cost per script is assumed to be approximately $20,000, based on anticipated treatment utilization of approximately 60% Epclusa and 40% Mavyret. Utilizing the assumptions described above and projected SFY 2021 member months, total SFY 2021 expenditures are estimated at approximately $28.5 million.

FIGURE 13: HEPATITIS C CARVE-IN - PROJECTED COSTS

		SFY 2021 ASSUMPTIONS				
	SFY 2019 MEMBER MONTHS	TOTAL SCRIPTS	COST PER SCRIPT	PMPM	SFY 2021 MEMBER MONTHS	PROJECTED EXPENDITURES (MILLIONS)
Composite	9,388,559	1,424	$ 20,016	$ 2.52	11,301,569	$ 28,500,000

Notes:

1. Composite PMPM is developed based on distribution of SFY 2021 projected member months

Foster Care Initial Assessment

Effective July 1, 2020, SCDHHS anticipates defining 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 SFY 2019 foster care children rate cell into one of three categories:

(1) Utilized only “established patient” well or sick visits in SFY 2019
(2) At least one “new patient” well or sick visit in SFY 2019
(3) Had neither a “new patient” or “established patient” well or sick visit in SFY 2019

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 2021. 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 $0.7 million.

Therapeutic Foster Care (TFC) Rate Restructure

Effective July 1, 2020, SCDHHS anticipates an update to 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 is transitioning 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 anticipated 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 July 1, 2020 anticipated per diem structure for each TFC level. Based on this review, the estimated impact of the TFC rate restructure is approximately $0.7 million. The total impact is applied to the MH/SA professional category of service for the foster care children rate cell.

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 $0.5 million, an increase of 0.3% to the 0-2 month rate cell, to include these expenditures that are expected to be covered by the MCOs during the SFY 2021 contract year.

Transition to Palmetto Coordinated System of Care (PCSC) Waiver

Effective August 1, 2020, SCDHHS anticipates enrolling individuals under the age of 21 into the PCSC waiver. Based on guidance from SCDHHS, the targeted members for transition into the waiver are assumed to meet 2 of the following 3 criteria:

(1) Multiple psychiatric inpatient admissions
(2) Extended lengths of stay in residential settings
(3) Diagnosed with one of the PCSC waiver conditions provided by SCDHHS

We summarized SFY 2019 unique members into the 3 criteria described above to establish a targeted pool of individuals for the PCSC waiver. Additionally, we reviewed the cost profile of the targeted pool of individuals to estimate an assumed monthly PMPM of approximately $4,100. Based on guidance from SCDHHS, we assumed 50 members would transition from managed care into the PCSC waiver on August 1, 2020. Utilizing the distribution of members in the established pool of assumed PCSC-eligible individuals, we identified 50 members to remove from the SFY 2019 base period at approximately $4,100 per month. The estimated impact was a removal of 50 members and approximately $2.3 million from the base data.

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 national emergency period ends. In consultation with SCDHHS, we have assumed the national emergency continues through December 2020. Beginning in January 2021, individuals impacted by the disenrollment freeze will be included in an eligibility review process that is anticipated to be completed over a 12-month period.

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 evaluated monthly disenrollment from managed care during CY 2019. For each of these disenrolled cohorts, we completed a review of historical enrollee reinstatements to evaluate the net impact of this enrollment change.

As a result of this review, we observed the following monthly enrollment metrics:

- **TANF Children**: Approximately 13,700 individuals disenrolled monthly, with approximately 60.5% returning within 12 months
- **TANF Adult**: Approximately 5,300 individuals disenrolled monthly, with approximately 44.0% returning within 12 months
- **Disabled**: Approximately 600 individuals disenrolled monthly with approximately 34.0% returning within 12 months
- **OCWI**: Approximately 800 individuals disenrolled monthly with approximately 57.0% returning within 12 months

To estimate the morbidity impact of this enrollment change to the SFY 2019 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 identified pregnant women in the TANF 19-44 female rate cell and developed a cost curve representing the relative costs of a pregnant woman during the OCWI assumed eligibility period (from 9 months pre-delivery to 2 months post-partum) relative to a pregnant woman costs from 3 to 12 months post-delivery (representing the extension period resulting from the enrollment freeze). Compositing and averaging these results across the observed experience period, the following relativities were observed and applied to the SFY 2019 base data:

FIGURE 14: FFCRA - DISENROLLMENT FREEZE REVIEW

RATE CELL	ANTICIPATED GAIN IN ENROLLMENT (MEMBER MONTHS)	ANTICIPATED GAIN IN ENROLLMENT (% INCREASE)	RELATIVITY TO SFY 2019 BASE DATA	ADJUSTMENT FACTOR
TANF - Age 1 - 6	285,569	13.1%	0.90	0.9884
TANF - Age 7 - 13	208,073	7.9%	0.80	0.9853
TANF - Age 14 - 18, Male	65,281	8.7%	0.80	0.9840
TANF - Age 14 - 18, Female	65,477	8.6%	0.80	0.9841
TANF - Age 19 - 44, Male	55,637	21.4%	0.80	0.9648
TANF - Age 19 - 44, Female	213,804	15.8%	0.80	0.9727
TANF - Age 45+, Male & Female	30,367	13.3%	0.85	0.9824
SSI - Children	8,702	6.6%	0.70	0.9815
SSI - Adult	29,747	4.9%	1.00	1.0000
OCWI	42,941	27.9%	0.75	0.9455

Economic Impact on Enrollment

In response to the COVID pandemic, a national emergency was declared and there have been rising levels of unemployment that are projected to impact managed care enrollment in SFY 2021. To estimate the anticipated Medicaid enrollment growth resulting from the assumed economic environment in South Carolina, we utilized the following data sources:

- American Community Survey (ACS) data from CY 2010 to CY 2018;
- South Carolina Supplemental Nutrition Assistance Program (SNAP) and TANF weekly applications from March 2020 through May 2020 (https://dss.sc.gov/media/2351/covid_19_stats_20200505.pdf)
- South Carolina and National Unemployment Rates from the Bureau of Labor Statistics;
- Department of Labor Unemployment Insurance Weekly Claims for South Carolina;
- Congressional Budget Office's (CBO's) Interim Economic Projections for 2020 and 2021 published May 2020 (https://www.cbo.gov/system/files/2020-05/56351-CBO-interim-projections.pdf); and,
- Emerging South Carolina Medicaid managed care enrollment.

We reviewed historical ACS data for South Carolina to estimate the Medicaid enrollment growth at various unemployment rates. Due to external factors that impact Medicaid enrollment, historical ACS data should not be used in a simple formulaic manner to determine Medicaid enrollment increases at various unemployment rates; actuarial judgment is also required. We also referred to alternative sources, both publicly available and internal Milliman information to help develop our estimate. We relied on the CBO's economic projection, accounting for the contraction of the labor force and adjusting for South Carolina's recent unemployment rate experience, to estimate the anticipated maximum unemployment rate of approximately 19% for South Carolina in SFY 2021. The enrollment projections were adjusted to reflect delayed uptake in Medicaid enrollment, potential capacity limitations in processing Medicaid applications, and the impact of the "FFCRA – Disenrollment Freeze" discussed in the previous section.

To estimate the morbidity of this population anticipated to enroll in managed care relative to the SFY 2019 data, we reviewed the differences in the reported health status of Medicaid members to the commercial insurance market in South Carolina using calendar year 2018 Community Population Survey data calibrated to publicly available data. We developed a claims cost distribution based on SC Medicaid data to estimate a cost distribution by reported health status, gender, and age grouping. To reflect that self-reported health status may not fully correlate with actual medical claims experience, we applied a weighting of 33% to the estimated cost at each health status grouping level and a weighting of 67% to the overall average Medicaid experience for each age and gender grouping.

Figure 15 provides a summary of the assumed morbidity relative to the SFY 2019 data and the adjustment factor applied to the SFY 2019 data to reflect the assumed morbidity of the managed care members anticipated to enroll due to the economic environment in South Carolina:

FIGURE 15: ECONOMIC IMPACT - ENROLLMENT

RATE CELL	ANTICIPATED GAIN IN ENROLLMENT (MEMBER MONTHS)	ANTICIPATED GAIN IN ENROLLMENT (% INCREASE)	RELATIVITY TO SFY 2019 BASE DATA	ADJUSTMENT FACTOR
TANF - 0 - 2 Months	4,541	5.4%	1.00	1.0000
TANF - 3 - 12 Months	30,836	8.9%	1.00	1.0000
TANF - Age 1 - 6	174,949	8.0%	0.78	0.9857
TANF - Age 7 - 13	210,845	8.0%	0.78	0.9853
TANF - Age 14 - 18, Male	60,269	8.0%	0.78	0.9855
TANF - Age 14 - 18, Female	60,855	8.0%	0.78	0.9855
TANF - Age 19 - 44, Male	27,018	10.4%	0.87	0.9921
TANF - Age 19 - 44, Female	125,953	9.3%	0.86	0.9911
TANF - Age 45+, Male & Female	23,679	10.4%	0.76	0.9812
SSI - Children	5,180	3.9%	0.91	0.9974
SSI - Adult	25,610	4.2%	0.91	0.9964
OCWI	14,358	9.3%	0.86	0.9935
KICK	1,816	6.8%	1.00	1.0000

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 2021 that are not fully reflected in the SFY 2019 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. 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 July 1, 2020, SCDHHS anticipates removing the limitation of twelve (12) ambulatory care visits per year for beneficiaries aged 21 and over to support increased management of beneficiaries' healthcare. 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 2021 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)[1].

  Effective October 1 2020, SCDHHS anticipates implementing 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 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
- **Express Lane Eligible Members**. Effective August 2018, SCDHHS updated the algorithm to identify children enrolled in the Supplemental Nutrition Assistance Program (SNAP) through the Department of Social Services (DSS) and enroll them in Medicaid, referred to as Express Lane Eligible (ELE) members. This impacted one month of the SFY 2019 experience period and creates an immaterial impact to the affected rate cells.

(e) Exclusion of payments or services from the data

The following adjustments were made to the base experience data to reflect 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), such as circumcision. All claims for non-state plan services, totaling approximately $1.0 million, were excluded from the SFY 2019 experience data included in Appendix 6.

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 $1.6 million, were excluded from the SFY 2019 experience data included in Appendix 6.

Institution for Mental Disease (IMD) Stays Greater 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.

[1] CMCS Information Bulletin (July 26, 2019): https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib072619-1012.pdf, Accessed May 10, 2020.

All claims associated with IMD stays greater than 15 days for the age 21 to 64 population, less than $0.1 million, were excluded from the SFY 2019 experience data included in Appendix 6.

Adjustments made to base data

Pharmacy Rebates

Based on analysis of supplemental rebate percentages during the SFY 2019 historical experience period reported by the MCOs in the SFY 2021 MCO Survey, pharmacy expenditures were reduced by 3.0% to reflect aggregate rebate percentage levels achievable by MCOs. The estimated adjustment factor of 0.97 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 the base period data and information submitted by the MCOs.

These data sources indicated that approximately 0.1% of total claims were recovered and not reflected in the baseline experience data. The estimated adjustment factor of 0.9990 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. We have reviewed the information provided by the MCOs and included approximately $7.5 million in payments in the benefit cost component of the capitation rate development. This is reflected by an adjustment factor of 1.0031, 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 $28.4 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.

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 is 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 Institution for Mental Diseases (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, less than $0.1 million, were excluded from the SFY 2019 experience data 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 SFY 2019 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 SFY 2019 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 SFY 2019 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 2021**
  We adjusted the SFY 2019 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 2021 rate period. In the previous section, we documented these items and the adjustment factors for each covered population. Assumed trend factors were applied for 24 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 (January 1, 2019) to the midpoint of the rate period (January 1, 2021).

As described later in this section, further adjustments were applied to the SFY 2019 base experience to reflect targeted improvements in managed care efficiency for specific rate cells and service categories that are estimated to impact projected SFY 2021 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, prospective program adjustments, and changes to covered populations and were documented in Section I, item 2.B.iii (Data Adjustments):

- Claims completion
- ASD utilization increase based on emerging SFY 2019 experience and anticipated increase in ASD provider capacity in SFY 2021
- Physician reimbursement, including the following fee schedule updates:
  - July 1, 2019 and July 1, 2020 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

- Addition of IMD services for beneficiaries up to age 21
- Addition of 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 January 1, 2020
- Addition of foster care initial assessment
- Extended coverage of up to 6-month supply of contraceptives
- Addition of Hepatitis C pharmacy treatment coverage
- Population adjustment for transition to PCSC Waiver effective August 1, 2020
- Population adjustments as a result of the COVID-19 national emergency

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

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:

- SFY 2019 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 addition, no adjustments were made to the flu and upper and lower respiratory tract condition categories to recognize the increased severity of the COVID-19 pandemic. 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 $0.7 million.

Inpatient Hospital Services – We applied managed care adjustments to reflect higher levels of care management relative to the SFY 2019 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 16: 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, antiretroviral drugs were excluded from the analysis of GDRs. The shift in the target GDR resulted in a 0.7% managed care savings to the prescription drug category of service, or a reduction of approximately $3.5 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 2020 expectations. This assumption was based on review and consideration of the following:

- SFY 2019 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 0.6%, or $1.1 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.

(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%20-%20Amendment%20I%20Final_1.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 (SFY 2019) to the SFY 2021 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.

(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 2017 through the base experience data period (SFY 2019).

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 2019 fourth Edition (September 2019) found in the location listed below:
  - https://www1.magellanrx.com/documents/2019/09/2019-medicaid-pharmacy-trend-report.pdf/
- *Express Scripts 2019 Drug Trend Report (February 2020*) found in the location listed below:
  - https://www.express-scripts.com/corporate/drug-trend-report#2019-in-review

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

(ii) Methodology

Non-pharmacy trends

For 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 and reimbursement changes. We developed trend rates to adjust the base experience data (midpoint of January 1, 2019) forward 24 months to the midpoint of the contract period, January 1, 2021. 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.

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, 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

We developed a Medicaid pharmacy model (trend model) for the purposes of studying and projecting detailed pharmacy trend information. 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 December 2019, and projected through SFY 2021. Projected values are estimated using the base period data as a starting point and applying anticipated shifts and trends. There are several areas for consideration.

Brand patent loss

When a brand drug loses patent, the utilization often shifts from the brand drug to the new generic alternatives. Our model assumes effective dates of patent expirations and a shift in utilization as a result of patent loss.

Cost per script trends

Projected costs per script for January 2020 are based on the average costs per script in the three previous months (October, November, and December of 2019), adjusted for any anomalies in the data. These starting point costs are trended forward using separate cost trend assumptions by therapeutic class for brand, generic, and specialty products.

In developing cost trends, we relied on a combination of Milliman research, publicly available industry trend reports, and the historical average wholesale price (AWP) trends using the South Carolina Medicaid encounter data.

Changes in utilization

Utilization levels for January 2020 reflect the average utilization in the first six months of SFY 2020, adjusted for anomalies in the data. We applied monthly utilization trends to this starting point to estimate the projection period utilization. To develop these utilization trend assumptions, we relied on a combination of Milliman research, publicly available industry trend reports, and the historical utilization trends using South Carolina Medicaid encounter data. Monthly seasonality is accounted for in our trend development. Each month is projected separately (rather than relying on an average value across all months) such that our non-calendar year projection period accounts for the appropriate seasonality.

Pharmacy risk mitigation program

Effective July 1, 2020, SCDHHS anticipates implementing a pharmacy risk mitigation program for newly-approved high cost pharmacy treatments that are not fully reflected in the base data. Projected pharmacy trends reflect the impact of this risk mitigation program, which is described in greater detail in Section I, Item 4.C.

(iii) 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 2020 capitation rate development to determine if any adjustment to the trend assumption was appropriate for the SFY 2021 rating period. The dual population medical non-pharmacy trends are consistent with trend assumptions developed for the calendar year (CY) 2020 Healthy Connections Prime Community population.

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

(iv) Chosen trend rates

Figure 17 illustrates the utilization component of the trend by rate cell and category of service for the SFY 2021 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 risk mitigation program.

FIGURE 17: ANNUAL UTILIZATION TREND RATES

CATEGORY OF SERVICE	TANF CHILD	TANF ADULT	SSI CHILD	SSI ADULT	OCWI	FOSTER CARE	KICK
Inpatient	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.0%
Outpatient	1.0%	1.0%	1.0%	3.0%	4.0%	2.0%	0.0%
Ancillaries	2.5%	1.5%	3.0%	3.0%	3.0%	2.5%	1.0%
Physician	2.5%	1.5%	3.0%	3.0%	3.0%	2.5%	1.0%
Total Medical	1.6%	1.0%	1.9%	2.1%	3.0%	1.9%	0.3%
Total Pharmacy	3.0%	4.5%	5.5%	6.5%	3.0%	3.0%	N/A
Composite	**1.9%**	**1.8%**	**3.1%**	**3.4%**	**3.0%**	**2.0%**	**0.3%**

Notes:
1. Pharmacy represents both utilization and cost.

(b) Benefit cost trend components

The utilization component of trend illustrated in Figure 17 includes both the trend in number of units as well as the mix or intensity of services provided. 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.ii.(d)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 SFY 2019 base period through the projection period (SFY 2021). Additionally, all pharmacy therapies expected to be included in the pharmacy risk mitigation 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 2021 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%.

(ii) 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.

(iii) 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 time period encompassing the SFY 2019 base period through the projection period (SFY 2021).

(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 and changing populations, 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 risk mitigation program that is anticipated to be implemented on July 1, 2020.

(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.

(ii) Trend changes other than utilization and cost

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

iv. Mental Health Parity and Addiction Equity Act Service Adjustment

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 438.3(c)(1)(ii). 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. Based on the final results, we have not made any rating adjustments to accommodate parity compliance. In addition, SCDHHS is actively working with each MCO to review MCO-specific compliance with MHPAEA financial requirements and treatment limitations.

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 $10.2 million of the SFY 2021 projected expenditures, or 21.2% 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 2020 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 2019: $7.5 million – approximately 0.2% increase over estimated capitation premium
- SFY 2020 (anticipated): $8.7 million – approximately 0.3% increase over estimated capitation premium
- SFY 2021 (anticipated): $7.7 million – approximately 0.2% increase over estimated 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 and purpose

The withhold arrangement is measured on a calendar year basis. The withhold measure evaluates quality-based performance in diabetes care, women's health, and pediatric preventive care.

(ii) 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 has indicated that the quality withhold of 1.5% of the capitation rate will not be withheld from the MCO capitation payments for measurement year 2020; however, the withhold is anticipated to be reinstated for measurement year 2021.

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.

(iii) Estimate of percent to be returned

In reporting year 2019 (CY 2019), based on measurement year 2018, 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, 87.0% of the withhold was earned back through the first pass in reporting year 2019.

The MCO quality withhold and bonus program for reporting year 2020, measurement year 2019, has not changed and is fully documented in Section 15 of the Managed Care Policy and Procedure Manual. Based on guidance from SCDHHS, the MCO quality withhold of 1.5% of the capitation rate will not be applied for measurement year 2020, but is anticipated to be reinstated for measurement year 2021.

Our review of the CY 2019 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. As such, we believe it is reasonably achievable in the context of the SFY 2021 capitation rate development for the MCOs to meet the quality withhold targets for 100% return of the withhold for CY 2021.

(iv) 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 2019 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 2019 audited financial statements, RBC-levels for each MCO are at or greater than 305%. 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 18: MCO FINANCIAL REVIEW

HEALTH PLAN	REPORTED RBC LEVEL	STRESS-TESTED RBC LEVEL
Absolute Total Care	374%	337%
BlueChoice	1185%	1156%
Molina	376%	337%
Select Health	305%	266%
WellCare	540%	501%

Source: CY 2019 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.

(v) Effect on the capitation rates

The SFY 2021 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Capitation payments minus withhold

The SFY 2021 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

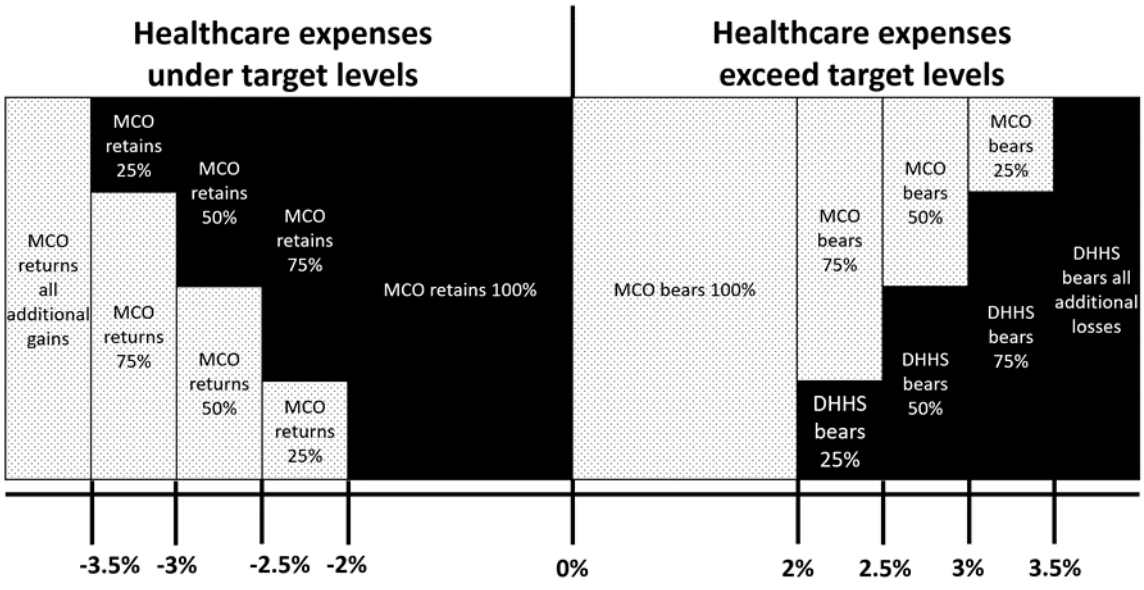
For SFY 2021 SCDHHS will introduce a Risk Corridor program and a Pharmacy Risk Mitigation program.

(i) Methodology

Risk Corridor Program

Effective July 1, 2020, SCDHHS is anticipated to operate a risk corridor program as a risk mitigation mechanism in recognition of the medical expense cost uncertainty attributable to the COVID-19 pandemic and national emergency. For all rate cells, a single risk corridor will be applied for each managed care organization (MCO).

The risk corridor represents a risk mitigation mechanism where SCDHHS will share in the profits and losses for medical expenses on a tiered bases according to the parameters outlined below. The risk corridor settlement will be calculated for an MCO across all capitation rate cells combined. The following graphic outlines the risk sharing responsibility through the various tiers of the risk corridor.



Note: Provided by SCDHHS on June 19, 2020

The risk corridor ratio for each MCO is calculated as medical expenses divided by baseline medical expenses, according to the definitions provided below. The risk corridor financial responsibility parameters are defined as follows.

If the risk corridor ratio is greater than 102.0%, SCDHHS will make a payment to the MCO of the baseline medical expenses multiplied by:

- 25% multiplied by [risk corridor ratio less 102.0%], if the risk corridor ratio is less than or equal to 102.5%;
- 0.125% plus (50% multiplied by [risk corridor ratio less 102.5%]), If the risk corridor ratio is greater than 102.5% and less than or equal to 103.0%;
- 0.375% plus (75% multiplied by [risk corridor ratio less 103.0%]), if the risk corridor ratio is greater than 103.0% and less than or equal to 103.5%;
- 0.75% plus [risk corridor ratio less 103.5%], if the risk corridor ratio is greater than 103.5%.

If the risk corridor ratio is less than 98.0%, SCDHHS will make a recoupment from the MCO of the baseline medical expenses multiplied by:

- 25% multiplied by [98.0% less risk corridor ratio], if the risk corridor ratio is greater than or equal to 97.5%;
- 0.125% plus (50% multiplied by [97.5% less risk corridor ratio], if the risk corridor ratio is less than 97.5% and greater than or equal to 97.0%;
- 0.375% plus (75% multiplied by [97.0% less risk corridor ratio], if the risk corridor ratio is less than 97.0% and greater than or equal to 96.5%;
- 0.75% plus [96.5% less risk corridor ratio], if the risk corridor ratio is less than 96.5%.

For the purposes of risk corridor calculations, medical expenses will be defined as follows:

- Medical expenses will include medical and pharmaceutical claim payments for state plan services incurred in SFY 2021, with 6 months of runout.
- Medical expenses will include appropriate accruals for items such as incurred but not paid amounts.
- Medical expenses will include provider incentive, bonus, and provider withhold payments for the period.
- For all sub-contracted services, medical expense will be defined as the amount paid to providers.
- Pharmaceutical expenses will be defined as the amount paid to pharmacies, and net of any non-benefit payment (pharmacy spread) amounts paid and reported by the MCO.
- Medical expenses shall be offset by third party liability collections, member copays, fraud recoveries, supplemental rebates, and other exclusions of payments or services from the data.
- Supplemental teaching payments, payments for the hospital quality payment initiative, and any other payments for services not included in the benefit expense portion of the certified capitation rate will be excluded from medical expenses.

Baseline medical expenses will be defined as follows:

- The baseline prior to risk adjustment will consist of the medical expense PMPM included in the SFY 2021 capitation rates multiplied by member months.
- Supplemental teaching payments and payments for the hospital quality payment initiative will be excluded from baseline medical expenses.
- Baseline amounts will be risk adjusted consistent with the SFY 2021 capitation rates

All non-benefit expenses will be excluded from risk corridor calculations. This includes administrative expenses, delegated admin, pharmacy benefit manager (PBM) fees or implicit spread, care management activities, taxes, assessments, and fees. Risk corridor settlements will be reflected in the denominator of medical loss ratio (MLR) calculations. Risk corridor reporting will be submitted by the MCOs in a format and frequency determined by SCDHHS.

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

Pharmacy Risk Mitigation program

Effective July 1, 2020, SCDHHS is anticipated to operate a pharmacy risk mitigation program as a risk mitigation mechanism to limit the MCO's exposure to new high cost pharmacy therapies. The risk mitigation program will include pharmacy therapies approved after the beginning of the base period (July 1, 2018) 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 risk mitigation 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 risk mitigation program are subject to SCDHHS review and approval. The pharmacy therapies approved for inclusion in the risk mitigation program for SFY 2021 are included in Figure 19. SCDHHS will monitor this list on a quarterly basis and communicate updates to the MCOs, as appropriate.

FIGURE 19: PHARMACY RISK MITIGATION DRUG LIST

DRUG NAME	FDA APPROVAL DATE
Takhzyro	8/23/2018
Revcovi	10/5/2018
Gamifant	11/20/2018
Esperoct	2/19/2019
Zolgensma	5/24/2019
Vyondys 53	12/12/2019

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

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

The SFY 2021 risk corridor and pharmacy risk mitigation programs 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.

In addition, MCOs are required to meet the APM targets as described in Section 15 of the MCO contract.

(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 1.3% of the monthly capitation rate will be directed to the eligible hospitals based on each hospital's allocation of the overall incentive pool.

(i) Documentation related to 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

State-directed PMPMs are estimated as 1.3% of the monthly capitation payments excluding STP payments. Figure 20 illustrates the estimated PMPM for each rate cell.

FIGURE 20: HOSPITAL QUALITY PAYMENT PMPM BY RATE CELL

RATE CELL	PMPM
TANF: 0-2 months old (AH3)	$ 28.19
TANF: 3-12 months old (AI3)	3.02
TANF: Age 1-6 (AB3)	1.75
TANF: Age 7-13 (AC3)	1.81
TANF: Age 14-18, Male (AD1)	1.99
TANF: Age 14-18, Female (AD2)	2.51
TANF: Age 19-44, Male (AE1)	2.75
TANF: Age 19-44, Female (AE2)	4.05
TANF: Age 45+ (AF3)	7.21
SSI - Children (SO3)	8.24
SSI - Adults (SP3)	17.53
OCWI (WG2)	4.03
DUAL	-
Foster Care - Children (FG3)	11.91
KICK (MG2/NG2)	89.05

(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 20, 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 20.

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, monthly payments are made to eligible hospital agencies from the MCOs.

Alternative Payment Model Contracts

Value-oriented contracts reflected in the SFY 2021 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

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 SFY 2019 base data in Appendix 6. The total amount of payments for these contracts included in the base data adjustment is approximately $6.2 million, or $0.66 PMPM, based on SFY 2019 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 1.3% of the monthly capitation rate, excluding STP, will be directed to the 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 payment is 1.3% of the capitation expenditures excluding STP payments. The estimated amount of state-directed payments for the hospital quality program is $44.4 million.

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 20 in Section I, Item 4.D.i(b).

Consistency with 438.6(c) preprint

We confirm that the state-directed hospital quality payment initiative design, as described in this certification, is consistent with the SFY 2020 438.6(c) pre-print approved by CMS; however, SCDHHS has indicated that the payment amount will change to 1.3% of the capitation expenditures excluding STP payments for SFY 2021. The SFY 2021 payment arrangement described in this certification is consistent with the pre-print SCDHHS intends to submit for CMS review.

SCDHHS has indicated that a 438.6(c) preprint was not required for the APM arrangements.

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 20, the rate certification will be updated to reflect the final payments made to the hospitals.

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 2021 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 2021 capitation rates are calculated under the ACR method. The following methodology was utilized to develop the STP PMPM:

1. Summarize the SFY 2019 encounter expenditures eligible for supplemental teaching payments using the SFY 2019 teaching physician list provided by SCDHHS for the SFY 2021 capitation rate-setting process. 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 SFY 2019 expenditures to develop total payment received by the physician.
3. Reprice each of the SFY 2019 encounter physician claims by multiplying the number of incurred units for each procedure code by the individual STP provider's CY 2019 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 2021 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 2021 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 2021 capitation rates is approximately $133.5 million ($11.81 PMPM). Appendices 8 and 9 document the development of the rate cell-specific STP PMPMs that are added to the SFY 2021 capitation rates.

(iii) 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 during SFY 2019 was provided by SCDHHS for the SFY 2021 capitation rate-setting process.

(iv) 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).

(v) Pass-through payments for previous rating period

The estimated pass-through payments for the STP arrangement incorporated into the SFY 2020 capitation rates is approximately $132.4 million.

(vi) Pass-through payments for rating period in effect on July 5, 2016

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 is approximately $133.5 million.

(b) Hospital Pass-Through Payments

Not applicable. There are no hospital pass-through payments in the South Carolina Medicaid managed care program.

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 2021 capitation rates.

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 2021 non-benefit costs are listed below:

- Calendar Year 2019 administrative costs as reported in the Managed Care Survey completed by each MCO.
- SFY 2019 pharmacy script counts as reported in the SFY 2019 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 2018 report published in June 2019 (National Summary of Medicaid MCO Administrative Costs) is provided here: https://www.milliman.com/en/insight/medicaid-managed-care-financial-results-for-2018

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 National Summary of Medicaid MCO Administrative Costs 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

Effective July 1, 2020, 4 out of the 5 MCOs participating in the Medicaid managed care program will have contracting arrangements with pharmacy benefit managers (PBM) structured as a pass-through pricing model. In consultation with SCDHHS, an amount equal to $3 per script or $22.4 million was added to non-benefit expense amounts to account for PBM administrative expenses previously included in benefit expense through the spread-pricing arrangements. The resulting pharmacy non-benefit cost by rate cell was converted to a percentage of the capitation rate cell for application of the non-benefit cost allowance as illustrated in Figure 21.

(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 2021 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 21 below.

FIGURE 21: NON-BENEFIT COST ALLOWANCE BY RATE CELL

RATE CELL	ADMINISTRATIVE EXPENSES	CARE COORDINATION & CARE MANAGEMENT	RISK MARGIN	SFY 2021 SUBTOTAL	PHARMACY ADMIN	SFY 2021 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%	0.52%	12.77%
TANF: Age 1-6 (AB3)	9.50%	1.75%	1.00%	12.25%	0.82%	13.07%
TANF: Age 7-13 (AC3)	9.50%	1.75%	1.00%	12.25%	1.00%	13.25%
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%	1.01%	13.26%
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%	0.79%	11.04%
TANF: Age 45+ (AF3)	7.75%	1.50%	1.00%	10.25%	0.89%	11.14%
SSI - Children (SO3)	6.00%	1.50%	1.00%	8.50%	0.64%	9.14%
SSI - Adults (SP3)	5.50%	1.25%	1.00%	7.75%	0.54%	8.29%
OCWI (WG2)	7.75%	1.50%	1.00%	10.25%	0.82%	11.07%
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%	0.37%	10.62%
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 2021 capitation rates are illustrated by rate cell in Appendix 4.

iii. 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 2021, based on 2020 data. 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 2021 to reflect the ACA HIF.

(b) Fee year or data year

Not applicable. The HIF is not expected to impact the SFY 2021 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 2021 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 2021 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 model

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 for each of the four defined populations, and the analysis uses generally accepted actuarial principles and practices.

iii. Acuity adjustments

Acuity adjustments are not applicable to the SFY 2021 capitation rates.

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

The South Carolina-specific weights utilized in the CDPS_Rx risk scoring models will be developed using condition category flags from SFY 2018 FFS and encounter data (feature period) and claims costs from SFY 2019 FFS and encounter data (response period), adjusted for program changes to reflect the SFY 2021 contract year. The CDPS+Rx risk adjustment model and the South Carolina-specific weights will be applied to SFY 2019 FFS and encounter data for the population enrolled in managed care at April 2020 as the underlying data source for the development of the July through December 2020 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 2020.

(b) Risk adjustment model

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 2020.

(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.

(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 for the last rating period. The CDPS+Rx risk adjustment model will be updated to reflect South Carolina-specific weights and the inclusion of an additional variable to represent individual member's MH/SA treatment prevalence for the SFY 2021 rating period.

iv. Acuity adjustments

Acuity adjustments are not applicable to the SFY 2021 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 shared with the South Carolina Medicaid MCOs and may be used in a public document. 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.

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.

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.

Milliman has relied on information provided by SCDHHS and the participating Medicaid MCOs in the development of the SFY 2021 capitation rates. We have relied upon SCDHHS and the MCOs for the accuracy of the data and accept it without audit. To the extent that the data provided are not accurate, the capitation rate development would need to be modified to reflect revised information.

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, 2020 through June 30, 2021

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, 2020 through June 30, 2021. 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

October 16, 2020
Date

Appendix 2: Certified Capitation Rates

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Comparison to SFY 2020 Capitation Rates

Rate Cell Description	Rate Cell Code	SFY 2021 Projected Exposure	Including Add-Ons			Excluding Add-Ons		
			SFY 2020 Rates	SFY 2021 Rates	Total Rate Change	SFY 2020 Rates	SFY 2021 Rates	Total Rate Change
TANF Children								
TANF - 0 - 2 Months, Male & Female	**AH3**	89,141	$ 2,356.71	$ 2,284.03	(3.1%)	$ 2,168.35	$ 2,140.61	(1.3%)
TANF - 3 - 12 Months, Male & Female	**AI3**	375,560	260.04	252.81	(2.8%)	230.22	229.28	(0.4%)
TANF - Age 1 - 6, Male & Female	**AB3**	2,640,042	141.96	140.14	(1.3%)	132.93	132.69	(0.2%)
TANF - Age 7 - 13, Male & Female	**AC3**	3,045,547	151.38	143.51	(5.2%)	144.05	137.59	(4.5%)
TANF - Age 14 - 18, Male	**AD1**	876,313	164.10	158.43	(3.5%)	155.91	151.41	(2.9%)
TANF - Age 14 - 18, Female	**AD2**	884,369	201.73	200.88	(0.4%)	190.04	190.70	0.3%
Subtotal TANF Children		**7,910,972**	**$ 185.28**	**$ 179.76**	**(3.0%)**	**$ 173.69**	**$ 170.35**	**(1.9%)**
TANF Adult								
TANF - Age 19 - 44, Male	**AE1**	343,007	$ 240.38	$ 218.59	(9.1%)	$ 228.47	208.90	(8.6%)
TANF - Age 19 - 44, Female	**AE2**	1,691,798	339.69	327.36	(3.6%)	317.47	307.81	(3.0%)
TANF - Age 45+, Male & Female	**AF3**	282,214	582.64	575.19	(1.3%)	552.11	547.56	(0.8%)
Subtotal TANF Adult		**2,317,019**	**$ 354.58**	**$ 341.44**	**(3.7%)**	**$ 332.87**	**$ 322.37**	**(3.2%)**
Disabled								
SSI - Children	**SO3**	146,178	$ 682.56	$ 654.16	(4.2%)	$ 642.80	625.45	(2.7%)
SSI - Adults	**SP3**	658,622	1,329.85	1,387.67	4.3%	1,267.18	1,330.77	5.0%
Subtotal Disabled		**804,800**	**$ 1,212.28**	**$ 1,254.44**	**3.5%**	**$ 1,153.77**	**$ 1,202.66**	**4.2%**
OCWI	**WG2**	**211,427**	**$ 382.32**	**$ 370.69**	**(3.0%)**	**$ 312.11**	**$ 306.29**	**(1.9%)**
DUAL		**-**	**$ 165.49**	**$ 170.72**	**3.2%**	**$ 165.49**	**$ 170.72**	**3.2%**
Foster Care Children	**FG3**	**57,351**	**$ 872.55**	**$ 928.54**	**6.4%**	**$ 846.89**	**$ 904.05**	**6.7%**
KICK	**MG2/NG2**	**28,510**	**$ 6,807.22**	**$ 6,849.83**	**0.6%**	**$ 6,698.30**	**$ 6,760.78**	**0.9%**
Total		**11,301,569**	**$ 317.47**	**$ 314.09**	**(1.1%)**	**$ 299.02**	**$ 298.35**	**(0.2%)**

Appendix 3: Fiscal Impact Summary

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Fiscal Impact Summary ($ Millions)

Region: Statewide	SFY 2021 Projected Exposure	SFY20 Capitation Rates			SFY21 Capitation Rates			Increase/(Decrease)	
		Capitation Rate	Projected Expenditures	FMAP (70.63%) Federal Expenditures	Capitation Rate	Projected Expenditures	FMAP (70.63%) Federal Expenditures	Projected Expenditures	FMAP (70.63%) Federal Expenditures
TANF Children									
TANF - 0 - 2 Months, Male & Female	89,141	$ 2,356.71	$ 210.1	$ 148.4	$ 2,284.03	$ 203.6	$ 143.8	($ 6.5)	($ 4.6)
TANF - 3 - 12 Months, Male & Female	375,560	260.04	97.7	69.0	252.81	94.9	67.1	(2.7)	(1.9)
TANF - Age 1 - 6, Male & Female	2,640,042	141.96	374.8	264.7	140.14	370.0	261.3	(4.8)	(3.4)
TANF - Age 7 - 13, Male & Female	3,045,547	151.38	461.0	325.6	143.51	437.1	308.7	(24.0)	(16.9)
TANF - Age 14 - 18, Male	876,313	164.10	143.8	101.6	158.43	138.8	98.1	(5.0)	(3.5)
TANF - Age 14 - 18, Female	884,369	201.73	178.4	126.0	200.88	177.7	125.5	(0.8)	(0.5)
Subtotal TANF Children	**7,910,972**	**$ 185.28**	**$ 1,465.8**	**$ 1,035.3**	**$ 179.76**	**$ 1,422.1**	**$ 1,004.4**	**($ 43.7)**	**($ 30.9)**
TANF Adult									
TANF - Age 19 - 44, Male	343,007	$ 240.38	$ 82.5	$ 58.2	$ 218.59	$ 75.0	$ 53.0	($ 7.5)	($ 5.3)
TANF - Age 19 - 44, Female	1,691,798	339.69	574.7	405.9	327.36	553.8	391.2	(20.9)	(14.7)
TANF - Age 45+, Male & Female	282,214	582.64	164.4	116.1	575.19	162.3	114.7	(2.1)	(1.5)
Subtotal TANF Adult	**2,317,019**	**$ 354.58**	**$ 821.6**	**$ 580.3**	**$ 341.44**	**$ 791.1**	**$ 558.8**	**($ 30.4)**	**($ 21.5)**
Disabled									
SSI - Children	146,178	$ 682.56	$ 99.8	$ 70.5	$ 654.16	$ 95.6	$ 67.5	($ 4.2)	($ 2.9)
SSI - Adults	658,622	1,329.85	875.9	618.6	1,387.67	914.0	645.5	38.1	26.9
Subtotal Disabled	**804,800**	**$ 1,212.28**	**$ 975.6**	**$ 689.1**	**$ 1,254.44**	**$ 1,009.6**	**$ 713.1**	**$ 33.9**	**$ 24.0**
OCWI	**211,427**	**$ 382.32**	**$ 80.8**	**$ 57.1**	**$ 370.69**	**$ 78.4**	**$ 55.4**	**($ 2.5)**	**($ 1.7)**
DUAL	**-**	**$ 165.49**	**-**	**-**	**$ 170.72**	**-**	**-**	**-**	**-**
Foster Care Children	**57,351**	**$ 872.55**	**$ 50.0**	**$ 35.3**	**$ 928.54**	**$ 53.3**	**$ 37.6**	**$ 3.2**	**$ 2.3**
KICK	**28,510**	**$ 6,807.22**	**$ 194.1**	**$ 137.1**	**$ 6,849.83**	**$ 195.3**	**$ 137.9**	**$ 1.2**	**$ 0.9**
Total	**11,301,569**	**$ 317.47**	**$ 3,587.9**	**$ 2,534.1**	**$ 314.09**	**$ 3,549.7**	**$ 2,507.2**	**($ 38.2)**	**($ 27.0)**

Appendix 4: Rate Change Summary

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Rate Change Summary

	Projected Exposure	Base Benefit Expense	Admin Expense	Care Management	Risk Margin	Non-Benefit Expense	SFY 2021 Capitation Rate w/o Add-Ons	SFY 2020 Capitation Rate w/o Add-Ons	% Change	Hospital Quality Payment	Supplemental Teaching Payment	SFY 2021 Capitation Rate w/ Add-Ons	SFY 2020 Capitation Rate w/ Add-Ons	% Change
TANF Children														
TANF - 0 - 2 Months, Male & Female	89,141	$ 1,979.42	$ 118.38	$ 21.41	$ 21.40	$ 161.19	$ 2,140.61	$ 2,168.35	(1.3%)	$ 28.19	$ 115.23	$ 2,284.03	$ 2,356.71	(3.1%)
TANF - 3 - 12 Months, Male & Female	375,560	200.00	22.97	4.01	2.30	29.28	229.28	230.22	(0.4%)	3.02	20.51	252.81	260.04	(2.8%)
TANF - Age 1 - 6, Male & Female	2,640,042	115.35	13.69	2.32	1.33	17.34	132.69	132.93	(0.2%)	1.75	5.70	140.14	141.96	(1.3%)
TANF - Age 7 - 13, Male & Female	3,045,547	119.36	14.45	2.41	1.37	18.23	137.59	144.05	(4.5%)	1.81	4.11	143.51	151.38	(5.2%)
TANF - Age 14 - 18, Male	876,313	131.56	15.69	2.65	1.51	19.85	151.41	155.91	(2.9%)	1.99	5.03	158.43	164.10	(3.5%)
TANF - Age 14 - 18, Female	884,369	165.41	20.04	3.34	1.91	25.29	190.70	190.04	0.3%	2.51	7.67	200.88	201.73	(0.4%)
Subtotal TANF Children	**7,910,972**	**$ 149.31**	**$ 16.53**	**$ 2.80**	**$ 1.70**	**$ 21.04**	**$ 170.35**	**$ 173.69**	**(1.9%)**	**$ 2.24**	**$ 7.17**	**$ 179.76**	**$ 185.28**	**(3.0%)**
TANF Adult														
TANF - Age 19 - 44, Male	343,007	$ 186.17	$ 17.51	$ 3.13	$ 2.09	$ 22.73	$ 208.90	$ 228.47	(8.6%)	$ 2.75	$ 6.94	$ 218.59	$ 240.38	(9.1%)
TANF - Age 19 - 44, Female	1,691,798	273.83	26.29	4.62	3.07	33.98	307.81	317.47	(3.0%)	4.05	15.50	327.36	339.69	(3.6%)
TANF - Age 45+, Male & Female	282,214	486.56	47.31	8.21	5.48	61.00	547.56	552.11	(0.8%)	7.21	20.42	575.19	582.64	(1.3%)
Subtotal TANF Adult	**2,317,019**	**$ 286.76**	**$ 27.55**	**$ 4.84**	**$ 3.22**	**$ 35.61**	**$ 322.37**	**$ 332.87**	**(3.2%)**	**$ 4.24**	**$ 14.83**	**$ 341.44**	**$ 354.58**	**(3.7%)**
Disabled														
SSI - Children	146,178	$ 568.28	$ 41.53	$ 9.38	$ 6.26	$ 57.17	$ 625.45	$ 642.80	(2.7%)	$ 8.24	$ 20.47	$ 654.16	$ 682.56	(4.2%)
SSI - Adults	658,622	1,220.45	80.38	16.63	13.31	110.32	1,330.77	1,267.18	5.0%	17.53	39.37	1,387.67	1,329.85	4.3%
Subtotal Disabled	**804,800**	**$ 1,101.99**	**$ 73.32**	**$ 15.31**	**$ 12.03**	**$ 100.67**	**$ 1,202.66**	**$ 1,153.77**	**4.2%**	**$ 15.84**	**$ 35.94**	**$ 1,254.44**	**$ 1,212.28**	**3.5%**
OCWI	**211,427**	**$ 272.38**	**$ 26.25**	**$ 4.59**	**$ 3.07**	**$ 33.91**	**$ 306.29**	**$ 312.11**	**(1.9%)**	**$ 4.03**	**$ 60.37**	**$ 370.69**	**$ 382.32**	**(3.0%)**
DUAL	**-**	**$ 70.05**	**$ 73.32**	**$ 15.31**	**$ 12.04**	**$ 100.67**	**$ 170.72**	**$ 165.49**	**3.2%**	**$ 0.00**	**$ 0.00**	**$ 170.72**	**$ 165.49**	**3.2%**
Foster Care Children	**57,351**	**$ 808.04**	**$ 55.33**	**$ 31.64**	**$ 9.04**	**$ 96.01**	**$ 904.05**	**$ 846.89**	**6.7%**	**$ 11.91**	**$ 12.58**	**$ 928.54**	**$ 872.55**	**6.4%**
KICK	**28,510**	**$ 6,557.96**	**$ 118.31**	**$ 16.90**	**$ 67.61**	**$ 202.82**	**$ 6,760.78**	**$ 6,698.30**	**0.9%**	**$ 89.05**	**$ 0.00**	**$ 6,849.83**	**$ 6,807.22**	**0.6%**
Total	**11,301,569**	**$ 267.52**	**$ 23.51**	**$ 4.33**	**$ 2.98**	**$ 30.83**	**$ 298.35**	**$ 299.02**	**(0.2%)**	**$ 3.93**	**$ 11.81**	**$ 314.09**	**$ 317.47**	**(1.1%)**

Appendix 5: In-Rate Criteria

South Carolina Department of Health and Human Services SFY 2021 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, 54,55,70,90	
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	See Methodology and Results - General
Recipient	Long Term Care Exclusion	See Methodology and Results - Medical Benefits
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 Exclude if Category of Service = 10
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 Exclude if Category of Service = 10

South Carolina Department of Health and Human Services SFY 2021 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(1)
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 (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 2021 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
A920	A938

South Carolina Department of Health and Human Services SFY 2021 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**
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
N739	N739
R1111	R1111

South Carolina Department of Health and Human Services SFY 2021 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**
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 SFY 2019 Base Data

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - 0 - 2 Months, Male & Female SFY 2019 Member Months: 83,785 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	9,476.3	$ 1,410.92	$ 1,114.19	$ 18.61	$ 0.00	$ (0.75)	$ (0.08)	$ 1.51	$ 2.35	9,641.0	$ 1,413.75	$ 1,135.83
Inpatient Well Newborn	6,972.4	572.00	332.35	5.55	-	(0.22)	(0.06)	0.51	0.71	7,094.9	573.10	338.84
Inpatient MH/SA	25.1	402.17	0.84	0.01	-	-	-	-	0.01	25.4	406.90	0.86
Other Inpatient	0.6	418.93	0.02	-	-	-	-	-	-	0.6	418.93	0.02
Subtotal Inpatient Hospital			**$ 1,447.40**									**$ 1,475.55**
Outpatient Hospital												
Surgery	71.0	$ 1,133.46	$ 6.71	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	71.9	$ 1,135.13	$ 6.80
Non-Surg - Emergency Room	776.8	274.49	17.77	0.21	-	(0.16)	0.08	-	0.04	779.0	276.34	17.94
Non-Surg - Other	1,305.8	122.04	13.28	0.16	-	-	-	0.01	0.03	1,322.5	122.32	13.48
Observation Room	48.6	746.40	3.02	0.04	-	-	-	-	-	49.2	746.40	3.06
Treatment/Therapy/Testing	906.5	67.52	5.10	0.06	-	-	-	-	0.01	917.1	67.65	5.17
Other Outpatient	38.1	47.25	0.15	-	-	-	-	-	-	38.1	47.25	0.15
Subtotal Outpatient Hospital			**$ 46.03**									**$ 46.60**
Retail Pharmacy												
Prescription Drugs	2,916.3	$ 17.32	$ 4.21	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.49)	2,916.3	$ 15.31	$ 3.72
Subtotal Retail Pharmacy			**$ 4.21**									**$ 3.72**
Ancillary												
Transportation	233.0	$ 247.70	$ 4.81	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.07	$ 0.01	238.8	$ 248.20	$ 4.94
DME/Prosthetics	1,695.2	21.24	3.00	0.03	-	-	-	0.04	0.01	1,734.8	21.31	3.08
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	209.4	87.68	1.53	0.02	-	-	-	0.51	-	281.9	87.68	2.06
Subtotal Ancillary			**$ 9.34**									**$ 10.08**
Professional												
Inpatient and Outpatient Surgery	703.7	$ 155.36	$ 9.11	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.12	$ 0.02	716.8	$ 155.69	$ 9.30
Anesthesia	123.7	161.95	1.67	0.01	-	-	-	0.01	-	125.2	161.95	1.69
Inpatient Visits	13,956.0	179.39	208.63	1.25	-	-	-	1.26	0.44	14,123.9	179.76	211.58
MH/SA	220.7	11.42	0.21	-	-	-	-	-	-	220.7	11.42	0.21
Emergency Room	1,009.3	71.22	5.99	0.04	-	(0.05)	-	0.05	0.01	1,016.0	71.34	6.04
Office/Home Visits/Consults	8,109.5	71.71	48.46	0.29	-	0.04	-	0.33	0.10	8,219.9	71.85	49.22
Pathology/Lab	1,771.7	46.26	6.83	0.04	-	0.01	-	0.18	0.01	1,831.3	46.33	7.07
Radiology	2,701.1	12.88	2.90	0.02	-	-	-	0.04	-	2,756.9	12.88	2.96
Office Administered Drugs	53.3	31.53	0.14	-	-	-	-	-	-	53.3	31.53	0.14
Physical Exams	21,019.5	46.19	80.91	0.49	-	-	-	0.42	0.17	21,255.9	46.29	81.99
Therapy	98.3	28.09	0.23	-	-	-	-	-	-	98.3	28.09	0.23
Vision	31.7	56.87	0.15	-	-	-	-	-	-	31.7	56.87	0.15
Other Professional	3,962.9	37.76	12.47	0.07	-	-	-	1.27	0.02	4,388.7	37.82	13.83
Subtotal Professional			**$ 377.70**									**$ 384.41**
Total Medical Costs			**$ 1,884.68**									**$ 1,920.36**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - 3 - 12 Months, Male & Female SFY 2019 Member Months: 347,677 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	197.5	$ 1,691.89	$ 27.84	$ 0.46	$ 0.00	$ (0.18)	$ 0.11	$ 0.00	$ 0.06	199.4	$ 1,702.12	$ 28.29
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 27.84**									**$ 28.29**
Outpatient Hospital												
Surgery	78.8	$ 1,624.12	$ 10.66	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.02	79.8	$ 1,627.13	$ 10.82
Non-Surg - Emergency Room	967.9	211.25	17.04	0.20	-	(0.24)	0.09	0.03	0.03	967.4	212.74	17.15
Non-Surg - Other	719.9	145.18	8.71	0.10	-	-	-	0.02	0.01	729.9	145.34	8.84
Observation Room	15.4	1,003.36	1.29	0.02	-	-	-	-	-	15.7	1,003.36	1.31
Treatment/Therapy/Testing	287.5	171.15	4.10	0.05	-	-	-	-	0.01	291.0	171.56	4.16
Other Outpatient	41.1	55.42	0.19	-	-	-	-	-	-	41.1	55.42	0.19
Subtotal Outpatient Hospital			**$ 41.99**									**$ 42.47**
Retail Pharmacy												
Prescription Drugs	4,748.9	$ 33.28	$ 13.17	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ (1.11)	4,748.9	$ 30.45	$ 12.05
Subtotal Retail Pharmacy			**$ 13.17**									**$ 12.05**
Ancillary												
Transportation	101.1	$ 106.87	$ 0.90	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	103.3	$ 106.87	$ 0.92
DME/Prosthetics	2,556.0	15.54	3.31	0.04	-	-	-	0.08	(0.03)	2,648.6	15.40	3.40
Dental	232.6	16.51	0.32	-	-	-	-	0.01	-	239.9	16.51	0.33
Other Ancillary	47.3	78.61	0.31	-	-	-	-	0.01	-	48.8	78.61	0.32
Subtotal Ancillary			**$ 4.84**									**$ 4.97**
Professional												
Inpatient and Outpatient Surgery	287.3	$ 178.33	$ 4.27	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	290.0	$ 178.74	$ 4.32
Anesthesia	153.8	106.09	1.36	0.01	-	-	-	-	-	155.0	106.09	1.37
Inpatient Visits	644.7	182.97	9.83	0.06	-	-	-	0.13	0.02	657.2	183.33	10.04
MH/SA	600.9	8.59	0.43	-	-	-	-	-	-	600.9	8.59	0.43
Emergency Room	1,029.1	65.42	5.61	0.03	-	(0.07)	-	0.03	0.01	1,027.3	65.53	5.61
Office/Home Visits/Consults	4,899.7	71.56	29.22	0.18	-	0.07	-	0.11	0.07	4,960.1	71.73	29.65
Pathology/Lab	2,101.3	14.51	2.54	0.02	-	-	-	0.01	0.01	2,126.1	14.56	2.58
Radiology	626.8	15.70	0.82	-	-	0.01	-	-	-	634.4	15.70	0.83
Office Administered Drugs	468.2	48.70	1.90	0.01	-	-	-	0.02	-	475.6	48.70	1.93
Physical Exams	10,781.9	36.34	32.65	0.20	-	-	-	0.10	0.07	10,881.0	36.42	33.02
Therapy	1,231.7	22.41	2.30	0.01	-	-	-	0.01	-	1,242.4	22.41	2.32
Vision	48.4	49.56	0.20	-	-	-	-	-	-	48.4	49.56	0.20
Other Professional	1,981.7	20.71	3.42	0.02	-	-	-	0.01	0.01	1,999.1	20.77	3.46
Subtotal Professional			**$ 94.55**									**$ 95.76**
Total Medical Costs			**$ 182.39**									**$ 183.54**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 1 - 6, Male & Female SFY 2019 Member Months: 2,151,707 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	42.7	$ 2,018.19	$ 7.18	$ 0.12	$ 0.00	$ (0.03)	$ 0.00	$ 0.00	$ 0.02	43.2	$ 2,023.74	$ 7.29
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	3.6	363.02	0.11	-	-	-	-	-	-	3.6	363.02	0.11
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.29**									**$ 7.40**
Outpatient Hospital												
Surgery	73.7	$ 1,341.46	$ 8.24	$ 0.10	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	74.7	$ 1,344.67	$ 8.37
Non-Surg - Emergency Room	532.6	235.01	10.43	0.12	-	(0.14)	0.06	0.02	0.02	532.6	236.82	10.51
Non-Surg - Other	294.7	132.34	3.25	0.04	-	-	-	-	0.01	298.3	132.74	3.30
Observation Room	4.8	1,091.99	0.44	0.01	-	-	-	-	-	4.9	1,091.99	0.45
Treatment/Therapy/Testing	215.4	191.12	3.43	0.04	-	-	-	0.01	-	218.5	191.12	3.48
Other Outpatient	29.6	186.40	0.46	0.01	-	-	-	-	-	30.3	186.40	0.47
Subtotal Outpatient Hospital			**$ 26.25**									**$ 26.58**
Retail Pharmacy												
Prescription Drugs	4,363.7	$ 40.89	$ 14.87	$ 0.00	$ 0.00	$ 0.00	$ (0.05)	$ 0.00	$ (1.35)	4,363.7	$ 37.04	$ 13.47
Subtotal Retail Pharmacy			**$ 14.87**									**$ 13.47**
Ancillary												
Transportation	48.2	$ 117.09	$ 0.47	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	49.2	$ 117.09	$ 0.48
DME/Prosthetics	2,312.6	7.21	1.39	0.01	-	-	-	0.01	-	2,345.9	7.21	1.41
Dental	255.9	72.20	1.54	0.02	-	-	-	-	0.01	259.3	72.66	1.57
Other Ancillary	15.4	46.62	0.06	-	-	-	-	-	0.01	15.4	54.39	0.07
Subtotal Ancillary			**$ 3.46**									**$ 3.53**
Professional												
Inpatient and Outpatient Surgery	222.7	$ 137.95	$ 2.56	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	225.3	$ 138.48	$ 2.60
Anesthesia	142.9	94.91	1.13	0.01	-	-	-	-	0.01	144.1	95.75	1.15
Inpatient Visits	68.4	119.38	0.68	-	-	-	-	0.01	-	69.4	119.38	0.69
MH/SA	2,936.2	24.89	6.09	0.04	-	-	-	0.02	0.02	2,965.1	24.97	6.17
Emergency Room	563.5	64.53	3.03	0.02	-	(0.04)	-	0.02	0.01	563.5	64.74	3.04
Office/Home Visits/Consults	3,183.9	71.84	19.06	0.11	-	0.05	-	0.09	0.05	3,225.6	72.02	19.36
Pathology/Lab	1,754.4	14.30	2.09	0.01	-	-	-	0.02	0.01	1,779.6	14.36	2.13
Radiology	321.5	15.31	0.41	-	-	-	-	0.01	-	329.3	15.31	0.42
Office Administered Drugs	233.2	9.78	0.19	-	-	-	-	0.01	-	245.5	9.78	0.20
Physical Exams	1,980.2	47.33	7.81	0.05	-	-	-	0.03	0.02	2,000.4	47.45	7.91
Therapy	5,707.8	22.54	10.72	0.06	-	-	-	0.05	0.02	5,766.4	22.58	10.85
Vision	339.6	31.09	0.88	0.01	-	-	-	-	-	343.5	31.09	0.89
Other Professional	1,933.9	14.95	2.41	0.01	-	-	-	0.02	-	1,957.9	14.95	2.44
Subtotal Professional			**$ 57.06**									**$ 57.85**
Total Medical Costs			**$ 108.93**									**$ 108.83**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 7 - 13, Male & Female SFY 2019 Member Months: 2,552,081 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	24.2	$ 2,334.98	$ 4.70	$ 0.08	$ 0.00	$ (0.02)	$ 0.00	$ 0.06	$ 0.01	24.8	$ 2,339.82	$ 4.83
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	70.8	367.93	2.17	0.04	-	-	-	0.02	-	72.7	367.93	2.23
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 6.87**									**$ 7.06**
Outpatient Hospital												
Surgery	38.9	$ 1,384.25	$ 4.49	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	39.4	$ 1,387.29	$ 4.56
Non-Surg - Emergency Room	319.9	257.73	6.87	0.08	-	(0.07)	0.03	0.02	0.01	321.3	259.22	6.94
Non-Surg - Other	205.8	126.55	2.17	0.03	-	-	-	-	-	208.6	126.55	2.20
Observation Room	2.5	1,073.53	0.22	-	-	-	-	-	-	2.5	1,073.53	0.22
Treatment/Therapy/Testing	171.8	196.25	2.81	0.03	-	-	-	0.01	-	174.3	196.25	2.85
Other Outpatient	20.5	76.20	0.13	-	-	-	-	-	-	20.5	76.20	0.13
Subtotal Outpatient Hospital			**$ 16.69**									**$ 16.90**
Retail Pharmacy												
Prescription Drugs	5,522.4	$ 71.56	$ 32.93	$ 0.00	$ 0.00	$ 0.00	$ (0.10)	$ 0.00	$ (2.65)	5,522.4	$ 65.58	$ 30.18
Subtotal Retail Pharmacy			**$ 32.93**									**$ 30.18**
Ancillary												
Transportation	36.5	$ 101.91	$ 0.31	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	36.5	$ 101.91	$ 0.31
DME/Prosthetics	1,635.5	9.46	1.29	0.01	-	-	-	0.01	-	1,660.9	9.46	1.31
Dental	30.6	66.67	0.17	-	-	-	-	-	-	30.6	66.67	0.17
Other Ancillary	69.1	43.41	0.25	-	-	-	-	-	-	69.1	43.41	0.25
Subtotal Ancillary			**$ 2.02**									**$ 2.04**
Professional												
Inpatient and Outpatient Surgery	149.2	$ 135.13	$ 1.68	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	151.0	$ 135.13	$ 1.70
Anesthesia	52.8	100.06	0.44	-	-	-	-	0.01	-	54.0	100.06	0.45
Inpatient Visits	63.6	83.06	0.44	-	-	-	-	0.01	-	65.0	83.06	0.45
MH/SA	6,497.9	37.78	20.46	0.12	-	-	-	0.08	0.05	6,561.4	37.88	20.71
Emergency Room	339.7	66.76	1.89	0.01	-	(0.02)	-	0.02	-	341.5	66.76	1.90
Office/Home Visits/Consults	2,534.1	76.00	16.05	0.10	-	0.02	-	0.07	0.04	2,564.1	76.19	16.28
Pathology/Lab	1,474.4	12.62	1.55	0.01	-	-	-	0.02	0.01	1,502.9	12.70	1.59
Radiology	373.3	18.97	0.59	-	-	-	-	0.01	-	379.6	18.97	0.60
Office Administered Drugs	956.0	15.82	1.26	0.01	-	-	-	0.12	0.01	1,054.6	15.93	1.40
Physical Exams	962.0	55.64	4.46	0.03	-	-	-	0.02	0.01	972.8	55.76	4.52
Therapy	903.5	21.91	1.65	0.01	-	-	-	0.01	-	914.4	21.91	1.67
Vision	1,085.6	28.19	2.55	0.02	-	-	-	0.01	-	1,098.4	28.19	2.58
Other Professional	2,494.5	11.16	2.32	0.01	-	-	-	0.01	0.01	2,516.1	11.21	2.35
Subtotal Professional			**$ 55.34**									**$ 56.20**
Total Medical Costs			**$ 113.85**									**$ 112.38**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Male SFY 2019 Member Months: 711,938 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	51.6	$ 2,551.44	$ 10.97	$ 0.18	$ 0.00	$ (0.07)	$ 0.02	$ 0.05	$ 0.02	52.3	$ 2,560.61	$ 11.17
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	172.9	357.53	5.15	0.09	-	-	-	0.02	0.01	176.5	358.21	5.27
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 16.12**									**$ 16.44**
Outpatient Hospital												
Surgery	53.4	$ 1,335.73	$ 5.94	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	54.1	$ 1,337.95	$ 6.03
Non-Surg - Emergency Room	341.2	266.94	7.59	0.09	-	(0.06)	0.03	0.01	0.02	343.0	268.69	7.68
Non-Surg - Other	145.9	132.42	1.61	0.02	-	-	-	-	-	147.7	132.42	1.63
Observation Room	3.6	671.64	0.20	-	-	-	-	-	-	3.6	671.64	0.20
Treatment/Therapy/Testing	200.1	268.68	4.48	0.05	-	-	-	0.01	0.01	202.8	269.27	4.55
Other Outpatient	22.5	106.74	0.20	-	-	-	-	-	-	22.5	106.74	0.20
Subtotal Outpatient Hospital			**$ 20.02**									**$ 20.29**
Retail Pharmacy												
Prescription Drugs	5,183.5	$ 79.41	$ 34.30	$ 0.00	$ 0.00	$ 0.00	$ (0.15)	$ 0.00	$ (2.75)	5,183.5	$ 72.69	$ 31.40
Subtotal Retail Pharmacy			**$ 34.30**									**$ 31.40**
Ancillary												
Transportation	87.2	$ 108.72	$ 0.79	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	88.3	$ 108.72	$ 0.80
DME/Prosthetics	1,957.4	12.94	2.11	0.02	-	-	-	0.01	-	1,985.2	12.94	2.14
Dental	6.5	36.70	0.02	-	-	-	-	-	-	6.5	36.70	0.02
Other Ancillary	69.9	46.35	0.27	-	-	-	-	-	-	69.9	46.35	0.27
Subtotal Ancillary			**$ 3.19**									**$ 3.23**
Professional												
Inpatient and Outpatient Surgery	194.1	$ 157.01	$ 2.54	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	196.4	$ 157.62	$ 2.58
Anesthesia	65.9	111.04	0.61	-	-	-	-	0.01	-	67.0	111.04	0.62
Inpatient Visits	139.6	77.34	0.90	0.01	-	-	-	0.02	-	144.3	77.34	0.93
MH/SA	4,579.6	43.24	16.50	0.10	-	-	-	0.08	0.03	4,629.5	43.31	16.71
Emergency Room	372.2	72.86	2.26	0.01	-	(0.01)	-	0.02	-	375.5	72.86	2.28
Office/Home Visits/Consults	2,076.6	76.97	13.32	0.08	-	0.02	-	0.07	0.04	2,103.1	77.20	13.53
Pathology/Lab	1,442.8	14.22	1.71	0.01	-	-	-	0.02	0.01	1,468.1	14.30	1.75
Radiology	571.6	23.93	1.14	0.01	-	-	-	0.01	-	581.6	23.93	1.16
Office Administered Drugs	704.1	36.47	2.14	0.01	-	-	-	0.03	-	717.3	36.47	2.18
Physical Exams	696.0	58.28	3.38	0.02	-	-	-	0.02	0.01	704.2	58.45	3.43
Therapy	464.1	21.72	0.84	0.01	-	-	-	-	-	469.6	21.72	0.85
Vision	906.1	28.21	2.13	0.01	-	-	-	0.01	0.01	914.7	28.34	2.16
Other Professional	1,798.0	12.61	1.89	0.01	-	-	-	0.01	0.01	1,817.1	12.68	1.92
Subtotal Professional			**$ 49.36**									**$ 50.10**
Total Medical Costs			**$ 122.99**									**$ 121.46**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Female SFY 2019 Member Months: 727,595 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	53.1	$ 2,622.59	$ 11.61	$ 0.19	$ 0.00	$ (0.11)	$ 0.05	$ 0.02	$ 0.02	53.6	$ 2,638.27	$ 11.78
Inpatient Well Newborn	0.0	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	163.4	398.67	5.43	0.09	-	-	-	0.01	0.01	166.5	399.39	5.54
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 17.04**									**$ 17.32**
Outpatient Hospital												
Surgery	73.3	$ 1,183.73	$ 7.23	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	74.2	$ 1,186.97	$ 7.34
Non-Surg - Emergency Room	596.1	283.05	14.06	0.16	-	(0.12)	0.06	0.02	0.03	598.6	284.85	14.21
Non-Surg - Other	250.7	149.34	3.12	0.04	-	-	-	-	0.01	253.9	149.81	3.17
Observation Room	8.6	528.65	0.38	-	-	-	-	-	0.01	8.6	542.57	0.39
Treatment/Therapy/Testing	383.9	207.87	6.65	0.08	-	-	-	0.01	0.01	389.1	208.17	6.75
Other Outpatient	36.0	113.37	0.34	-	-	-	-	-	0.01	36.0	116.71	0.35
Subtotal Outpatient Hospital			**$ 31.78**									**$ 32.21**
Retail Pharmacy												
Prescription Drugs	7,722.0	$ 52.39	$ 33.71	$ 0.00	$ 0.00	$ 0.00	$ (0.11)	$ 0.00	$ (2.54)	7,722.0	$ 48.27	$ 31.06
Subtotal Retail Pharmacy			**$ 33.71**									**$ 31.06**
Ancillary												
Transportation	123.4	$ 91.44	$ 0.94	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	124.7	$ 92.40	$ 0.96
DME/Prosthetics	1,742.4	11.85	1.72	0.02	-	-	-	0.01	-	1,772.8	11.85	1.75
Dental	6.5	18.51	0.01	-	-	-	-	-	-	6.5	18.51	0.01
Other Ancillary	85.4	60.42	0.43	-	-	-	-	0.01	-	87.4	60.42	0.44
Subtotal Ancillary			**$ 3.10**									**$ 3.16**
Professional												
Inpatient and Outpatient Surgery	197.2	$ 156.41	$ 2.57	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	199.5	$ 157.01	$ 2.61
Anesthesia	72.0	111.73	0.67	-	-	-	-	0.01	-	73.0	111.73	0.68
Inpatient Visits	181.4	74.77	1.13	0.01	-	-	-	0.03	-	187.8	74.77	1.17
MH/SA	4,624.8	53.06	20.45	0.12	-	-	-	0.11	0.04	4,676.8	53.16	20.72
Emergency Room	624.2	75.93	3.95	0.02	-	(0.03)	-	0.03	0.01	627.4	76.12	3.98
Office/Home Visits/Consults	3,128.3	76.03	19.82	0.12	-	0.03	-	0.12	0.05	3,170.9	76.22	20.14
Pathology/Lab	3,716.8	14.50	4.49	0.03	-	-	-	0.05	0.04	3,783.0	14.62	4.61
Radiology	674.8	29.87	1.68	0.01	-	-	-	0.02	-	686.9	29.87	1.71
Office Administered Drugs	20,733.9	0.83	1.44	0.01	-	0.01	-	0.03	0.01	21,453.8	0.84	1.50
Physical Exams	760.9	58.36	3.70	0.02	-	-	-	0.02	0.01	769.1	58.51	3.75
Therapy	529.1	21.32	0.94	0.01	-	-	-	-	-	534.7	21.32	0.95
Vision	1,443.4	27.93	3.36	0.02	-	-	-	0.02	-	1,460.6	27.93	3.40
Other Professional	2,321.6	21.40	4.14	0.02	-	-	-	0.03	0.01	2,349.7	21.45	4.20
Subtotal Professional			**$ 68.34**									**$ 69.42**
Total Medical Costs			**$ 153.97**									**$ 153.17**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Male SFY 2019 Member Months: 269,831 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	230.0	$ 2,211.46	$ 42.38	$ 0.71	$ 0.00	$ (0.60)	$ 0.15	$ 0.10	$ 0.09	231.1	$ 2,223.92	$ 42.83
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	49.1	756.99	3.10	0.05	-	-	-	0.01	0.01	50.1	759.39	3.17
Other Inpatient	2.4	343.42	0.07	-	-	-	-	-	-	2.4	343.42	0.07
Subtotal Inpatient Hospital			**$ 45.55**									**$ 46.07**
Outpatient Hospital												
Surgery	94.7	$ 1,363.09	$ 10.76	$ 0.13	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	96.0	$ 1,365.59	$ 10.92
Non-Surg - Emergency Room	634.8	283.16	14.98	0.18	-	(0.24)	0.12	0.01	0.03	632.7	286.00	15.08
Non-Surg - Other	85.0	138.30	0.98	0.01	-	-	-	-	-	85.9	138.30	0.99
Observation Room	4.0	539.66	0.18	-	-	-	-	-	-	4.0	539.66	0.18
Treatment/Therapy/Testing	284.0	368.39	8.72	0.10	-	-	-	0.01	0.02	287.6	369.23	8.85
Other Outpatient	31.7	170.54	0.45	0.01	-	-	-	-	-	32.4	170.54	0.46
Subtotal Outpatient Hospital			**$ 36.07**									**$ 36.48**
Retail Pharmacy												
Prescription Drugs	5,295.6	$ 103.26	$ 45.57	$ 0.00	$ 0.00	$ 0.00	$ (0.57)	$ 0.00	$ (4.21)	5,295.6	$ 92.43	$ 40.79
Subtotal Retail Pharmacy			**$ 45.57**									**$ 40.79**
Ancillary												
Transportation	192.5	$ 97.26	$ 1.56	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	194.9	$ 97.26	$ 1.58
DME/Prosthetics	1,866.3	13.37	2.08	0.02	-	-	-	0.02	-	1,902.2	13.37	2.12
Dental	0.1	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	138.1	59.96	0.69	0.01	-	-	-	-	-	140.1	59.96	0.70
Subtotal Ancillary			**$ 4.33**									**$ 4.40**
Professional												
Inpatient and Outpatient Surgery	378.2	$ 150.72	$ 4.75	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.05	$ 0.01	384.6	$ 151.03	$ 4.84
Anesthesia	124.3	110.02	1.14	0.01	-	-	-	0.01	-	126.5	110.02	1.16
Inpatient Visits	392.4	77.37	2.53	0.02	-	-	-	0.03	-	400.1	77.37	2.58
MH/SA	988.4	66.65	5.49	0.03	-	-	-	0.05	0.01	1,002.8	66.77	5.58
Emergency Room	702.3	81.00	4.74	0.03	-	(0.07)	-	0.06	0.01	705.2	81.17	4.77
Office/Home Visits/Consults	1,999.1	75.70	12.61	0.08	-	0.05	-	0.15	0.03	2,043.5	75.87	12.92
Pathology/Lab	2,094.9	15.41	2.69	0.02	-	-	-	0.04	0.02	2,141.6	15.52	2.77
Radiology	999.1	30.51	2.54	0.02	-	-	-	0.03	0.01	1,018.8	30.62	2.60
Office Administered Drugs	9,135.3	8.93	6.80	0.04	-	0.02	-	0.04	0.01	9,269.6	8.95	6.91
Physical Exams	121.5	49.40	0.50	-	-	-	-	0.01	-	123.9	49.40	0.51
Therapy	380.8	22.69	0.72	-	-	-	-	0.01	-	386.1	22.69	0.73
Vision	193.9	35.28	0.57	-	-	-	-	0.01	-	197.3	35.28	0.58
Other Professional	1,085.9	23.32	2.11	0.01	-	-	-	0.03	0.01	1,106.5	23.43	2.16
Subtotal Professional			**$ 47.19**									**$ 48.11**
Total Medical Costs			**$ 178.71**									**$ 175.85**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Female SFY 2019 Member Months: 1,355,396 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	208.4	$ 2,108.83	$ 36.63	$ 0.61	$ 0.00	$ (0.48)	$ 0.07	$ 0.03	$ 0.08	209.3	$ 2,117.43	$ 36.94
Inpatient Well Newborn	0.2	968.14	0.02	-	-	-	-	-	-	0.2	968.14	0.02
Inpatient MH/SA	51.7	719.23	3.10	0.05	-	-	-	-	0.01	52.6	721.51	3.16
Other Inpatient	2.5	285.35	0.06	-	-	-	-	-	-	2.5	285.35	0.06
Subtotal Inpatient Hospital			**$ 39.81**									**$ 40.18**
Outpatient Hospital												
Surgery	209.6	$ 1,193.66	$ 20.85	$ 0.24	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.05	212.2	$ 1,196.49	$ 21.16
Non-Surg - Emergency Room	1,155.5	301.06	28.99	0.34	-	(0.46)	0.21	0.03	0.06	1,151.9	303.88	29.17
Non-Surg - Other	327.4	157.98	4.31	0.05	-	-	-	-	0.01	331.2	158.34	4.37
Observation Room	28.6	428.68	1.02	0.01	-	-	-	-	0.01	28.8	432.85	1.04
Treatment/Therapy/Testing	729.8	256.33	15.59	0.18	-	-	-	0.02	0.03	739.2	256.81	15.82
Other Outpatient	105.7	149.91	1.32	0.02	-	-	-	-	-	107.3	149.91	1.34
Subtotal Outpatient Hospital			**$ 72.08**									**$ 72.90**
Retail Pharmacy												
Prescription Drugs	9,783.6	$ 72.06	$ 58.75	$ 0.00	$ 0.00	$ 0.00	$ (0.69)	$ 0.00	$ (5.37)	9,783.6	$ 64.63	$ 52.69
Subtotal Retail Pharmacy			**$ 58.75**									**$ 52.69**
Ancillary												
Transportation	264.8	$ 89.71	$ 1.98	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	268.9	$ 89.71	$ 2.01
DME/Prosthetics	1,513.6	14.51	1.83	0.02	-	-	-	0.01	0.01	1,538.4	14.59	1.87
Dental	0.1	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	160.6	91.89	1.23	0.01	-	-	-	0.01	-	163.2	91.89	1.25
Subtotal Ancillary			**$ 5.04**									**$ 5.13**
Professional												
Inpatient and Outpatient Surgery	504.5	$ 176.49	$ 7.42	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.07	$ 0.02	512.0	$ 176.95	$ 7.55
Anesthesia	216.5	109.74	1.98	0.01	-	-	-	0.02	-	219.8	109.74	2.01
Inpatient Visits	409.0	76.86	2.62	0.02	-	-	-	0.02	-	415.3	76.86	2.66
MH/SA	1,932.5	74.14	11.94	0.07	-	-	-	0.08	0.03	1,956.7	74.33	12.12
Emergency Room	1,241.5	81.48	8.43	0.05	-	(0.12)	-	0.08	0.02	1,243.0	81.67	8.46
Office/Home Visits/Consults	3,962.3	75.20	24.83	0.15	-	0.11	-	0.21	0.06	4,037.3	75.38	25.36
Pathology/Lab	7,476.3	16.31	10.16	0.06	-	0.01	-	0.13	0.12	7,623.5	16.50	10.48
Radiology	1,589.7	36.69	4.86	0.03	-	0.01	-	0.05	-	1,619.1	36.69	4.95
Office Administered Drugs	27,486.2	2.85	6.53	0.04	-	0.02	-	0.05	0.02	27,949.2	2.86	6.66
Physical Exams	364.0	57.70	1.75	0.01	-	-	-	0.01	0.01	368.1	58.02	1.78
Therapy	496.1	22.50	0.93	0.01	-	-	-	-	-	501.4	22.50	0.94
Vision	209.3	40.70	0.71	-	-	-	-	0.01	-	212.3	40.70	0.72
Other Professional	2,205.1	33.20	6.10	0.04	-	-	-	0.05	0.02	2,237.6	33.30	6.21
Subtotal Professional			**$ 88.26**									**$ 89.90**
Total Medical Costs			**$ 263.94**									**$ 260.80**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 45+, Male & Female SFY 2019 Member Months: 227,380 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	533.0	$ 2,337.74	$ 103.84	$ 1.73	$ 0.00	$ (1.46)	$ 0.18	$ 0.00	$ 0.22	534.4	$ 2,346.72	$ 104.51
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	45.7	761.43	2.90	0.05	-	-	-	-	-	46.5	761.43	2.95
Other Inpatient	36.2	262.23	0.79	0.01	-	(0.01)	0.01	-	0.01	36.2	268.87	0.81
Subtotal Inpatient Hospital			**$ 107.53**									**$ 108.27**
Outpatient Hospital												
Surgery	215.4	$ 1,718.30	$ 30.84	$ 0.36	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.07	218.0	$ 1,722.16	$ 31.29
Non-Surg - Emergency Room	795.7	325.60	21.59	0.25	-	(0.32)	0.17	0.01	0.05	793.5	328.93	21.75
Non-Surg - Other	331.2	138.40	3.82	0.04	-	-	-	0.01	0.01	335.6	138.76	3.88
Observation Room	16.7	733.95	1.02	0.01	-	-	-	-	-	16.8	733.95	1.03
Treatment/Therapy/Testing	1,055.9	419.46	36.91	0.43	-	-	-	0.03	0.08	1,069.1	420.36	37.45
Other Outpatient	287.7	138.49	3.32	0.04	-	-	-	-	0.01	291.1	138.90	3.37
Subtotal Outpatient Hospital			**$ 97.50**									**$ 98.77**
Retail Pharmacy												
Prescription Drugs	19,548.9	$ 86.47	$ 140.87	$ 0.00	$ 0.00	$ 0.00	$ (1.07)	$ 0.01	$ (12.76)	19,550.3	$ 77.98	$ 127.05
Subtotal Retail Pharmacy			**$ 140.87**									**$ 127.05**
Ancillary												
Transportation	272.7	$ 100.33	$ 2.28	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	276.3	$ 100.77	$ 2.32
DME/Prosthetics	6,432.2	11.88	6.37	0.07	-	-	-	0.06	(0.01)	6,563.5	11.87	6.49
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	409.2	72.43	2.47	0.03	-	-	-	-	0.01	414.2	72.72	2.51
Subtotal Ancillary			**$ 11.12**									**$ 11.32**
Professional												
Inpatient and Outpatient Surgery	1,125.7	$ 165.54	$ 15.53	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.14	$ 0.03	1,142.4	$ 165.86	$ 15.79
Anesthesia	415.2	103.75	3.59	0.02	-	-	-	0.03	0.01	421.0	104.03	3.65
Inpatient Visits	831.8	78.77	5.46	0.03	-	-	-	0.05	0.01	844.0	78.91	5.55
MH/SA	1,773.4	68.00	10.05	0.06	-	-	-	0.08	0.02	1,798.1	68.14	10.21
Emergency Room	920.5	88.13	6.76	0.04	-	(0.09)	-	0.07	0.01	923.2	88.26	6.79
Office/Home Visits/Consults	5,722.9	77.02	36.73	0.22	-	0.07	-	0.35	0.08	5,822.6	77.18	37.45
Pathology/Lab	7,042.8	13.73	8.06	0.05	-	-	-	0.11	0.03	7,182.6	13.78	8.25
Radiology	2,608.3	35.70	7.76	0.05	-	0.01	-	0.08	0.02	2,655.3	35.79	7.92
Office Administered Drugs	18,962.6	8.37	13.22	0.08	-	0.02	-	0.03	0.03	19,149.0	8.38	13.38
Physical Exams	389.5	55.46	1.80	0.01	-	-	-	0.02	-	396.0	55.46	1.83
Therapy	1,463.5	21.81	2.66	0.02	-	-	-	0.02	-	1,485.5	21.81	2.70
Vision	299.9	49.21	1.23	0.01	-	-	-	0.01	-	304.8	49.21	1.25
Other Professional	3,279.9	25.46	6.96	0.04	-	-	-	0.06	0.03	3,327.0	25.57	7.09
Subtotal Professional			**$ 119.81**									**$ 121.86**
Total Medical Costs			**$ 476.83**									**$ 467.27**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SSI - Children SFY 2019 Member Months: 141,646 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	338.1	$ 1,984.32	$ 55.91	$ 1.08	$ 0.00	$ (0.54)	$ 0.20	$ 0.00	$ 0.12	341.4	$ 1,995.57	$ 56.77
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	804.7	336.59	22.57	0.44	-	-	-	-	0.04	820.3	337.18	23.05
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 78.48**									**$ 79.82**
Outpatient Hospital												
Surgery	112.5	$ 1,724.71	$ 16.17	$ 0.24	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.03	114.3	$ 1,727.86	$ 16.46
Non-Surg - Emergency Room	626.7	287.20	15.00	0.22	-	(0.12)	0.06	0.02	0.03	631.8	288.91	15.21
Non-Surg - Other	702.0	150.09	8.78	0.13	-	-	-	0.01	0.02	713.2	150.43	8.94
Observation Room	14.4	1,474.78	1.77	0.03	-	-	-	-	-	14.6	1,474.78	1.80
Treatment/Therapy/Testing	785.0	374.98	24.53	0.36	-	-	-	0.03	0.05	797.5	375.73	24.97
Other Outpatient	57.6	174.97	0.84	0.01	-	-	-	-	0.01	58.3	177.03	0.86
Subtotal Outpatient Hospital			**$ 67.09**									**$ 68.24**
Retail Pharmacy												
Prescription Drugs	15,908.6	$ 139.46	$ 184.88	$ 0.02	$ 0.00	$ 0.00	$ (0.36)	$ 0.01	$ (10.08)	15,911.1	$ 131.58	$ 174.47
Subtotal Retail Pharmacy			**$ 184.88**									**$ 174.47**
Ancillary												
Transportation	213.8	$ 104.38	$ 1.86	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	216.1	$ 104.38	$ 1.88
DME/Prosthetics	51,809.0	4.22	18.22	0.16	-	-	-	0.05	0.03	52,406.2	4.23	18.46
Dental	94.0	90.68	0.71	0.01	-	-	-	-	-	95.3	90.68	0.72
Other Ancillary	421.2	37.61	1.32	0.01	-	-	-	-	0.01	424.4	37.89	1.34
Subtotal Ancillary			**$ 22.11**									**$ 22.40**
Professional												
Inpatient and Outpatient Surgery	309.5	$ 156.26	$ 4.03	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.03	$ 0.01	314.9	$ 156.65	$ 4.11
Anesthesia	207.5	113.94	1.97	0.02	-	-	-	0.02	-	211.7	113.94	2.01
Inpatient Visits	738.3	100.77	6.20	0.06	-	-	-	0.20	0.14	769.3	102.95	6.60
MH/SA	31,318.9	24.06	62.79	0.62	-	-	-	0.46	0.13	31,857.6	24.11	64.00
Emergency Room	740.4	76.67	4.73	0.05	-	(0.03)	-	0.04	0.01	749.7	76.83	4.80
Office/Home Visits/Consults	4,507.9	85.40	32.08	0.32	-	0.03	-	0.26	0.07	4,593.7	85.58	32.76
Pathology/Lab	2,052.6	17.42	2.98	0.03	-	-	-	0.05	0.02	2,107.7	17.54	3.08
Radiology	844.2	21.18	1.49	0.01	-	0.01	-	0.01	0.01	861.2	21.32	1.53
Office Administered Drugs	9,063.5	12.43	9.39	0.09	-	0.04	-	6.73	0.03	15,685.0	12.46	16.28
Physical Exams	1,005.5	56.93	4.77	0.05	-	-	-	0.03	0.01	1,022.4	57.04	4.86
Therapy	16,302.7	21.69	29.47	0.29	-	-	-	0.22	0.06	16,584.8	21.74	30.04
Vision	1,137.7	30.17	2.86	0.03	-	-	-	0.02	0.01	1,157.6	30.27	2.92
Other Professional	6,002.9	17.11	8.56	0.08	-	-	-	0.07	0.03	6,108.1	17.17	8.74
Subtotal Professional			**$ 171.32**									**$ 181.73**
Total Medical Costs			**$ 523.88**									**$ 526.66**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SSI - Adults SFY 2019 Member Months: 599,853 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	1,836.8	$ 2,018.54	$ 308.97	$ 5.96	$ 0.00	$ (5.79)	$ 0.12	$ 0.62	$ 0.64	1,841.5	$ 2,023.50	$ 310.52
Inpatient Well Newborn	0.1	1,999.51	0.02	-	-	-	-	-	-	0.1	1,999.51	0.02
Inpatient MH/SA	379.6	618.03	19.55	0.38	-	-	-	0.04	0.04	387.7	619.27	20.01
Other Inpatient	301.5	272.28	6.84	0.13	-	(0.13)	0.02	0.02	0.01	302.3	273.47	6.89
Subtotal Inpatient Hospital			**$ 335.38**									**$ 337.44**
Outpatient Hospital												
Surgery	311.6	$ 1,605.33	$ 41.69	$ 0.61	$ 0.00	$ 0.00	$ 0.00	$ 0.04	$ 0.09	316.5	$ 1,608.74	$ 42.43
Non-Surg - Emergency Room	1,515.1	369.81	46.69	0.68	-	(0.30)	0.16	0.06	0.09	1,529.3	371.77	47.38
Non-Surg - Other	688.8	151.22	8.68	0.13	-	-	-	0.01	0.01	699.9	151.39	8.83
Observation Room	41.8	734.40	2.56	0.04	-	-	-	-	0.01	42.5	737.22	2.61
Treatment/Therapy/Testing	1,408.1	671.79	78.83	1.15	-	-	-	0.09	0.16	1,430.3	673.13	80.23
Other Outpatient	267.8	207.48	4.63	0.07	-	-	-	-	0.01	271.8	207.92	4.71
Subtotal Outpatient Hospital			**$ 183.08**									**$ 186.19**
Retail Pharmacy												
Prescription Drugs	28,793.0	$ 141.58	$ 339.70	$ 0.03	$ 0.00	$ 0.00	$ (2.57)	$ 0.01	$ (24.83)	28,796.4	$ 130.16	$ 312.34
Subtotal Retail Pharmacy			**$ 339.70**									**$ 312.34**
Ancillary												
Transportation	1,312.3	$ 89.07	$ 9.74	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.04	$ 0.02	1,329.8	$ 89.25	$ 9.89
DME/Prosthetics	31,988.8	7.57	20.18	0.18	-	-	-	0.14	0.10	32,496.0	7.61	20.60
Dental	0.3	428.47	0.01	-	-	-	-	-	-	0.3	428.47	0.01
Other Ancillary	1,734.5	68.91	9.96	0.09	-	-	-	0.05	0.02	1,758.8	69.05	10.12
Subtotal Ancillary			**$ 39.89**									**$ 40.62**
Professional												
Inpatient and Outpatient Surgery	1,361.8	$ 172.45	$ 19.57	$ 0.19	$ 0.00	$ 0.00	$ 0.00	$ 0.20	$ 0.04	1,388.9	$ 172.79	$ 20.00
Anesthesia	555.0	106.81	4.94	0.05	-	-	-	0.04	0.01	565.1	107.02	5.04
Inpatient Visits	3,416.4	75.87	21.60	0.21	-	-	-	0.22	0.06	3,484.4	76.08	22.09
MH/SA	10,875.3	23.86	21.62	0.21	-	-	-	0.15	0.05	11,056.4	23.91	22.03
Emergency Room	1,947.2	90.22	14.64	0.14	-	(0.07)	-	0.13	0.03	1,973.8	90.40	14.87
Office/Home Visits/Consults	6,855.5	84.79	48.44	0.48	-	0.07	-	0.41	0.10	6,991.3	84.96	49.50
Pathology/Lab	8,459.3	13.93	9.82	0.10	-	-	-	0.14	0.11	8,666.0	14.08	10.17
Radiology	3,993.6	36.78	12.24	0.12	-	0.02	-	0.13	0.04	4,081.7	36.90	12.55
Office Administered Drugs	61,910.5	8.53	44.03	0.44	-	0.11	-	0.38	0.05	63,218.2	8.54	45.01
Physical Exams	448.2	46.59	1.74	0.02	-	-	-	0.01	0.01	455.9	46.85	1.78
Therapy	961.6	22.84	1.83	0.02	-	-	-	0.01	-	977.4	22.84	1.86
Vision	323.4	49.73	1.34	0.01	-	-	-	0.01	0.01	328.2	50.09	1.37
Other Professional	4,483.6	47.13	17.61	0.17	-	-	-	0.16	0.05	4,567.7	47.26	17.99
Subtotal Professional			**$ 219.42**									**$ 224.26**
Total Medical Costs			**$ 1,117.47**									**$ 1,100.85**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: OCWI SFY 2019 Member Months: 160,738 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	223.7	$ 1,607.92	$ 29.97	$ 0.41	$ 0.00	$ (0.18)	$ 0.01	$ 0.01	$ 0.07	225.5	$ 1,612.17	$ 30.29
Inpatient Well Newborn	0.9	803.69	0.06	-	-	-	-	-	-	0.9	803.69	0.06
Inpatient MH/SA	26.0	632.79	1.37	0.02	-	-	-	-	-	26.4	632.79	1.39
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 31.40**									**$ 31.74**
Outpatient Hospital												
Surgery	671.2	$ 439.43	$ 24.58	$ 0.31	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.06	680.0	$ 440.49	$ 24.96
Non-Surg - Emergency Room	1,035.3	370.09	31.93	0.41	-	(0.13)	0.08	0.01	0.07	1,044.7	371.81	32.37
Non-Surg - Other	1,083.1	151.34	13.66	0.17	-	-	-	0.01	0.03	1,097.4	151.67	13.87
Observation Room	184.8	286.41	4.41	0.06	-	-	-	-	0.01	187.3	287.05	4.48
Treatment/Therapy/Testing	1,700.9	137.72	19.52	0.25	-	-	-	0.01	0.04	1,723.5	138.00	19.82
Other Outpatient	79.3	145.30	0.96	0.01	-	-	-	-	-	80.1	145.30	0.97
Subtotal Outpatient Hospital			**$ 95.06**									**$ 96.47**
Retail Pharmacy												
Prescription Drugs	10,082.2	$ 42.23	$ 35.48	$ 0.00	$ 0.00	$ 0.00	$ (0.10)	$ 0.00	$ (3.51)	10,082.2	$ 37.93	$ 31.87
Subtotal Retail Pharmacy			**$ 35.48**									**$ 31.87**
Ancillary												
Transportation	324.9	$ 97.14	$ 2.63	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.07	$ 0.00	337.3	$ 97.14	$ 2.73
DME/Prosthetics	499.5	33.39	1.39	0.01	-	-	-	0.04	0.01	517.5	33.62	1.45
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	324.6	112.38	3.04	0.03	-	-	-	0.09	-	337.4	112.38	3.16
Subtotal Ancillary			**$ 7.06**									**$ 7.34**
Professional												
Inpatient and Outpatient Surgery	357.6	$ 146.64	$ 4.37	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.02	361.7	$ 147.31	$ 4.44
Anesthesia	154.3	103.43	1.33	0.01	-	-	-	-	0.01	155.5	104.20	1.35
Inpatient Visits	808.6	68.86	4.64	0.03	-	-	-	0.03	0.02	819.1	69.15	4.72
MH/SA	1,273.7	88.00	9.34	0.06	-	-	-	0.03	0.01	1,286.0	88.09	9.44
Emergency Room	1,346.8	80.10	8.99	0.05	-	(0.02)	-	0.09	0.02	1,364.8	80.28	9.13
Office/Home Visits/Consults	2,521.6	70.05	14.72	0.09	-	0.02	-	0.11	0.06	2,559.3	70.33	15.00
Pathology/Lab	14,434.4	14.32	17.22	0.11	-	0.01	-	0.20	0.48	14,702.7	14.71	18.02
Radiology	1,451.7	56.29	6.81	0.04	-	0.01	-	0.05	0.01	1,473.0	56.37	6.92
Office Administered Drugs	18,993.1	2.87	4.54	0.03	-	0.01	-	0.03	0.01	19,285.9	2.87	4.62
Physical Exams	855.4	24.69	1.76	0.01	-	-	-	0.01	0.01	865.1	24.83	1.79
Therapy	155.1	22.44	0.29	-	-	-	-	-	-	155.1	22.44	0.29
Vision	210.8	37.58	0.66	-	-	-	-	0.01	-	213.9	37.58	0.67
Other Professional	2,932.8	71.56	17.49	0.11	-	-	-	0.09	0.02	2,966.4	71.64	17.71
Subtotal Professional			**$ 92.16**									**$ 94.10**
Total Medical Costs			**$ 261.16**									**$ 261.52**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: DUAL SFY 2019 Member Months: 593,117 Category of Service	FFS Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	587.9	$ 282.09	$ 13.82	$ 0.55	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	611.3	$ 282.09	$ 14.37
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	37.0	223.76	0.69	0.03	-	-	-	-	-	38.6	223.76	0.72
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 14.51**									**$ 15.09**
Outpatient Hospital												
Surgery	63.4	$ 208.04	$ 1.10	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	65.2	$ 208.04	$ 1.13
Non-Surg - Emergency Room	442.4	66.19	2.44	0.07	-	-	-	-	-	455.1	66.19	2.51
Non-Surg - Other	321.8	24.62	0.66	0.02	-	-	-	-	-	331.5	24.62	0.68
Observation Room	13.1	64.27	0.07	-	-	-	-	-	-	13.1	64.27	0.07
Treatment/Therapy/Testing	460.6	71.38	2.74	0.08	-	-	-	-	-	474.1	71.38	2.82
Other Outpatient	43.8	46.62	0.17	0.01	-	-	-	-	-	46.3	46.62	0.18
Subtotal Outpatient Hospital			**$ 7.18**									**$ 7.39**
Retail Pharmacy												
Prescription Drugs	352.5	$ 53.44	$ 1.57	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	352.5	$ 53.44	$ 1.57
Subtotal Retail Pharmacy			**$ 1.57**									**$ 1.57**
Ancillary												
Transportation	26.1	$ 36.78	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	26.1	$ 36.78	$ 0.08
DME/Prosthetics	15,303.2	3.87	4.94	0.11	-	-	-	-	-	15,643.9	3.87	5.05
Dental	0.5	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	156.6	29.12	0.38	0.01	-	-	-	-	-	160.7	29.12	0.39
Subtotal Ancillary			**$ 5.40**									**$ 5.52**
Professional												
Inpatient and Outpatient Surgery	448.5	$ 25.15	$ 0.94	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	458.1	$ 25.15	$ 0.96
Anesthesia	111.2	17.27	0.16	-	-	-	-	-	-	111.2	17.27	0.16
Inpatient Visits	966.9	20.11	1.62	0.04	-	-	-	-	-	990.8	20.11	1.66
MH/SA	11,361.7	13.53	12.81	0.29	-	-	-	-	-	11,618.9	13.53	13.10
Emergency Room	188.6	34.35	0.54	0.01	-	-	-	-	-	192.1	34.35	0.55
Office/Home Visits/Consults	2,732.9	35.79	8.15	0.19	-	-	-	-	-	2,796.6	35.79	8.34
Pathology/Lab	566.9	6.98	0.33	0.01	-	-	-	-	-	584.1	6.98	0.34
Radiology	673.1	14.44	0.81	0.02	-	-	-	-	-	689.7	14.44	0.83
Office Administered Drugs	36,460.5	2.51	7.63	0.18	-	-	-	-	-	37,320.6	2.51	7.81
Physical Exams	43.6	22.02	0.08	-	-	-	-	-	-	43.6	22.02	0.08
Therapy	243.2	3.45	0.07	-	-	-	-	-	-	243.2	3.45	0.07
Vision	84.7	28.33	0.20	-	-	-	-	-	-	84.7	28.33	0.20
Other Professional	1,544.7	8.31	1.07	0.02	-	-	-	-	-	1,573.6	8.31	1.09
Subtotal Professional			**$ 34.41**									**$ 35.19**
Total Medical Costs			**$ 63.07**									**$ 64.76**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: Foster Care Children SFY 2019 Member Months: 58,932 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	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	141.7	$ 1,368.31	$ 16.16	$ 0.27	$ 0.00	$ (0.31)	$ 0.18	$ 0.00	$ 0.03	141.4	$ 1,386.13	$ 16.33
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	4,796.4	323.59	129.34	2.16	-	-	-	-	0.27	4,876.5	324.26	131.77
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 145.50**									**$ 148.10**
Outpatient Hospital												
Surgery	100.2	$ 1,456.53	$ 12.16	$ 0.14	$ 0.00	$ 0.00	$ 0.00	$ 0.03	$ 0.02	101.6	$ 1,458.89	$ 12.35
Non-Surg - Emergency Room	579.5	294.66	14.23	0.17	-	(0.09)	0.03	0.03	0.03	584.0	295.89	14.40
Non-Surg - Other	551.8	147.22	6.77	0.08	-	-	-	0.01	0.02	559.2	147.65	6.88
Observation Room	5.7	1,094.45	0.52	0.01	-	-	-	-	-	5.8	1,094.45	0.53
Treatment/Therapy/Testing	438.4	209.94	7.67	0.09	-	-	-	0.02	0.01	444.7	210.21	7.79
Other Outpatient	45.6	147.33	0.56	0.01	-	-	-	-	-	46.4	147.33	0.57
Subtotal Outpatient Hospital			**$ 41.91**									**$ 42.52**
Retail Pharmacy												
Prescription Drugs	13,418.7	$ 54.63	$ 61.09	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.72)	13,418.7	$ 53.09	$ 59.37
Subtotal Retail Pharmacy			**$ 61.09**									**$ 59.37**
Ancillary												
Transportation	254.9	$ 85.20	$ 1.81	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	257.8	$ 85.20	$ 1.83
DME/Prosthetics	11,396.0	4.57	4.34	0.05	-	-	-	-	0.01	11,527.3	4.58	4.40
Dental	155.6	66.34	0.86	0.01	-	-	-	-	-	157.4	66.34	0.87
Other Ancillary	373.9	44.30	1.38	0.01	-	-	-	-	0.01	376.6	44.61	1.40
Subtotal Ancillary			**$ 8.39**									**$ 8.50**
Professional												
Inpatient and Outpatient Surgery	332.7	$ 133.08	$ 3.69	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.02	336.3	$ 133.80	$ 3.75
Anesthesia	155.4	97.32	1.26	0.01	-	-	-	0.01	-	157.8	97.32	1.28
Inpatient Visits	796.8	65.97	4.38	0.03	-	-	-	0.17	0.01	833.2	66.11	4.59
MH/SA	452,051.5	9.65	363.44	2.18	-	-	-	1.43	0.77	456,541.7	9.67	367.82
Emergency Room	649.8	76.83	4.16	0.02	-	(0.02)	-	0.06	0.01	659.1	77.01	4.23
Office/Home Visits/Consults	4,782.9	84.37	33.63	0.20	-	0.03	-	0.21	0.09	4,845.5	84.60	34.16
Pathology/Lab	2,964.8	15.91	3.93	0.02	-	0.01	-	0.10	0.05	3,062.8	16.10	4.11
Radiology	586.0	20.48	1.00	0.01	-	-	-	0.01	0.01	597.8	20.68	1.03
Office Administered Drugs	7,333.7	4.70	2.87	0.02	-	0.01	-	-	0.01	7,410.4	4.71	2.91
Physical Exams	2,515.2	44.04	9.23	0.06	-	-	-	0.05	0.02	2,545.1	44.13	9.36
Therapy	10,153.9	21.49	18.18	0.11	-	-	-	0.07	0.04	10,254.5	21.53	18.40
Vision	1,351.5	36.14	4.07	0.02	-	-	-	0.02	0.01	1,364.7	36.23	4.12
Other Professional	2,164.7	23.84	4.30	0.03	-	-	-	0.04	0.09	2,200.0	24.33	4.46
Subtotal Professional			**$ 454.14**									**$ 460.22**
Total Medical Costs			**$ 711.03**									**$ 718.71**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: KICK SFY 2019 Deliveries: 26,694 Category of Service	MCO Encounter Data SFY 2019 Base Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		SFY 2019 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 per 1,000	Cost per Service	Cost per Delivery
Inpatient Hospital												
Inpatient Maternity Delivery	2,487.7	$ 1,716.46	$ 4,270.07	$ 64.91	$ 0.00	$ 0.00	$ (41.35)	$ 0.58	$ 8.92	2,525.9	$ 1,703.63	$ 4,303.13
Subtotal Inpatient Hospital			**$ 4,270.07**									**$ 4,303.13**
Outpatient Hospital												
Outpatient Hospital - Maternity	56.9	$ 416.76	$ 23.70	$ 0.88	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.05	59.0	$ 417.61	$ 24.65
Subtotal Outpatient Hospital			**$ 23.70**									**$ 24.65**
Professional												
Maternity Delivery	930.0	$ 1,036.57	$ 964.03	$ 4.92	$ 0.00	$ 0.00	$ 1.25	$ 3.57	$ 1.98	938.2	$ 1,040.01	$ 975.75
Maternity Anesthesia	1,155.3	296.90	343.00	1.75	-	-	-	1.65	0.70	1,166.7	297.50	347.10
Maternity Office Visits	8,405.1	58.50	491.73	2.51	-	-	-	2.35	1.09	8,488.2	58.63	497.68
Maternity Radiology	4,237.8	71.80	304.28	1.55	-	-	-	1.63	0.66	4,282.1	71.95	308.12
Maternity Non-Delivery	1.9	73.28	0.14	-	-	-	-	-	-	1.9	73.28	0.14
Subtotal Professional			**$ 2,103.18**									**$ 2,128.79**
Total Medical Costs			**$ 6,396.95**									**$ 6,456.57**

Appendix 7: SFY 2021 Capitation Rate Development

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - 0 - 2 Months, Male & Female SFY 2021 Member Months: 89,141 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	9,641.0	$ 1,413.75	$ 1,135.83	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	9,641.0	$ 1,413.75	$ 1,135.83
Inpatient Well Newborn	7,094.9	573.10	338.84	-	-	-	-	-	-	7,094.9	573.10	338.84
Inpatient MH/SA	25.4	406.90	0.86	-	-	-	-	-	-	25.4	406.90	0.86
Other Inpatient	0.6	418.93	0.02	-	-	-	-	-	-	0.6	418.93	0.02
Subtotal Inpatient Hospital			**$ 1,475.55**									**$ 1,475.55**
Outpatient Hospital												
Surgery	71.9	$ 1,135.13	$ 6.80	$ 0.14	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	73.4	$ 1,135.13	$ 6.94
Non-Surg - Emergency Room	779.0	276.34	17.94	0.36	-	-	-	-	-	794.7	276.34	18.30
Non-Surg - Other	1,322.5	122.32	13.48	0.27	-	-	-	-	-	1,349.0	122.32	13.75
Observation Room	49.2	746.40	3.06	0.06	-	-	-	-	-	50.2	746.40	3.12
Treatment/Therapy/Testing	917.1	67.65	5.17	0.10	-	-	-	-	-	934.9	67.65	5.27
Other Outpatient	38.1	47.25	0.15	-	-	-	-	-	-	38.1	47.25	0.15
Subtotal Outpatient Hospital			**$ 46.60**									**$ 47.53**
Retail Pharmacy												
Prescription Drugs	2,916.3	$ 15.31	$ 3.72	$ 0.00	$ 0.23	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,916.3	$ 16.25	$ 3.95
Subtotal Retail Pharmacy			**$ 3.72**									**$ 3.95**
Ancillary												
Transportation	238.8	$ 248.20	$ 4.94	$ 0.25	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	250.9	$ 247.72	$ 5.18
DME/Prosthetics	1,734.8	21.31	3.08	0.16	-	-	1.16	-	-	1,824.9	28.93	4.40
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	281.9	87.68	2.06	0.10	-	-	-	-	-	295.6	87.68	2.16
Subtotal Ancillary			**$ 10.08**									**$ 11.74**
Professional												
Inpatient and Outpatient Surgery	716.8	$ 155.69	$ 9.30	$ 0.47	$ 0.00	$ 0.00	$ 1.16	$ 0.00	$ 0.00	753.0	$ 174.18	$ 10.93
Anesthesia	125.2	161.95	1.69	0.09	-	-	0.06	-	-	131.9	167.40	1.84
Inpatient Visits	14,123.9	179.76	211.58	10.71	-	-	9.92	-	-	14,838.8	187.79	232.21
MH/SA	220.7	11.42	0.21	0.01	-	-	-	-	-	231.2	11.42	0.22
Emergency Room	1,016.0	71.34	6.04	0.31	-	-	0.24	-	-	1,068.2	74.03	6.59
Office/Home Visits/Consults	8,219.9	71.85	49.22	2.49	-	(0.03)	6.86	-	-	8,630.7	81.39	58.54
Pathology/Lab	1,831.3	46.33	7.07	0.36	-	(0.03)	0.42	-	-	1,916.8	48.96	7.82
Radiology	2,756.9	12.88	2.96	0.15	-	-	0.17	-	-	2,896.7	13.59	3.28
Office Administered Drugs	53.3	31.53	0.14	0.01	-	-	(0.01)	-	-	57.1	29.43	0.14
Physical Exams	21,255.9	46.29	81.99	4.15	-	(0.54)	13.06	0.84	0.90	22,409.6	53.76	100.40
Therapy	98.3	28.09	0.23	0.01	-	-	-	-	-	102.5	28.09	0.24
Vision	31.7	56.87	0.15	0.01	-	-	0.02	-	-	33.8	63.98	0.18
Other Professional	4,388.7	37.82	13.83	0.70	-	(0.20)	3.93	-	-	4,547.4	48.19	18.26
Subtotal Professional			**$ 384.41**									**$ 440.65**
Total Medical Costs			**$ 1,920.36**									**$ 1,979.42**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - 3 - 12 Months, Male & Female SFY 2021 Member Months: 375,560 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	199.4	$ 1,702.12	$ 28.29	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	199.4	$ 1,702.12	$ 28.29
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 28.29**									**$ 28.29**
Outpatient Hospital												
Surgery	79.8	$ 1,627.13	$ 10.82	$ 0.22	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	81.4	$ 1,627.13	$ 11.04
Non-Surg - Emergency Room	967.4	212.74	17.15	0.34	-	-	-	-	-	986.5	212.74	17.49
Non-Surg - Other	729.9	145.34	8.84	0.18	-	-	-	-	-	744.7	145.34	9.02
Observation Room	15.7	1,003.36	1.31	0.03	-	-	-	-	-	16.0	1,003.36	1.34
Treatment/Therapy/Testing	291.0	171.56	4.16	0.08	-	-	-	-	-	296.6	171.56	4.24
Other Outpatient	41.1	55.42	0.19	-	-	-	-	-	-	41.1	55.42	0.19
Subtotal Outpatient Hospital			**$ 42.47**									**$ 43.32**
Retail Pharmacy												
Prescription Drugs	4,748.9	$ 30.45	$ 12.05	$ 0.00	$ 0.73	$ 0.00	$ 0.00	$ 0.00	$ 0.00	4,748.9	$ 32.29	$ 12.78
Subtotal Retail Pharmacy			**$ 12.05**									**$ 12.78**
Ancillary												
Transportation	103.3	$ 106.87	$ 0.92	$ 0.05	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	108.9	$ 105.77	$ 0.96
DME/Prosthetics	2,648.6	15.40	3.40	0.17	-	-	(0.08)	-	-	2,781.1	15.06	3.49
Dental	239.9	16.51	0.33	0.02	-	(0.01)	(0.12)	-	-	247.1	10.68	0.22
Other Ancillary	48.8	78.61	0.32	0.02	-	-	-	-	-	51.9	78.61	0.34
Subtotal Ancillary			**$ 4.97**									**$ 5.01**
Professional												
Inpatient and Outpatient Surgery	290.0	$ 178.74	$ 4.32	$ 0.22	$ 0.00	$ 0.00	$ 0.22	$ 0.00	$ 0.00	304.8	$ 187.40	$ 4.76
Anesthesia	155.0	106.09	1.37	0.07	-	-	0.02	-	-	162.9	107.56	1.46
Inpatient Visits	657.2	183.33	10.04	0.51	-	-	0.52	-	-	690.5	192.37	11.07
MH/SA	600.9	8.59	0.43	0.02	-	-	0.02	-	-	628.9	8.97	0.47
Emergency Room	1,027.3	65.53	5.61	0.28	-	-	0.18	-	-	1,078.5	67.54	6.07
Office/Home Visits/Consults	4,960.1	71.73	29.65	1.50	-	(0.03)	3.89	-	-	5,206.0	80.70	35.01
Pathology/Lab	2,126.1	14.56	2.58	0.13	-	(0.01)	0.19	-	-	2,225.0	15.59	2.89
Radiology	634.4	15.70	0.83	0.04	-	-	0.03	-	-	665.0	16.24	0.90
Office Administered Drugs	475.6	48.70	1.93	0.10	-	(0.01)	(0.13)	-	-	497.8	45.56	1.89
Physical Exams	10,881.0	36.42	33.02	1.67	-	(0.30)	3.98	0.49	0.81	11,493.9	41.42	39.67
Therapy	1,242.4	22.41	2.32	0.12	-	-	0.07	-	-	1,306.7	23.05	2.51
Vision	48.4	49.56	0.20	0.01	-	-	0.02	-	-	50.8	54.28	0.23
Other Professional	1,999.1	20.77	3.46	0.18	-	(0.06)	0.09	-	-	2,068.4	21.29	3.67
Subtotal Professional			**$ 95.76**									**$ 110.60**
Total Medical Costs			**$ 183.54**									**$ 200.00**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 1 - 6, Male & Female SFY 2021 Member Months: 2,640,042 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	43.2	$ 2,023.74	$ 7.29	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.19)	$ 0.00	42.1	$ 2,023.74	$ 7.10
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	3.6	363.02	0.11	-	-	-	-	0.02	0.01	4.3	390.94	0.14
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.40**									**$ 7.24**
Outpatient Hospital												
Surgery	74.7	$ 1,344.67	$ 8.37	$ 0.17	$ 0.00	$ 0.00	$ 0.00	$ (0.22)	$ 0.00	74.2	$ 1,344.67	$ 8.32
Non-Surg - Emergency Room	532.6	236.82	10.51	0.21	-	-	-	(0.27)	-	529.5	236.82	10.45
Non-Surg - Other	298.3	132.74	3.30	0.07	-	-	-	(0.09)	-	296.5	132.74	3.28
Observation Room	4.9	1,091.99	0.45	0.01	-	-	-	(0.01)	-	4.9	1,091.99	0.45
Treatment/Therapy/Testing	218.5	191.12	3.48	0.07	-	-	-	(0.09)	-	217.2	191.12	3.46
Other Outpatient	30.3	186.40	0.47	0.01	-	-	-	(0.01)	-	30.3	186.40	0.47
Subtotal Outpatient Hospital			**$ 26.58**									**$ 26.43**
Retail Pharmacy												
Prescription Drugs	4,363.7	$ 37.04	$ 13.47	$ 0.00	$ 0.82	$ 0.00	$ 0.00	$ (0.37)	$ 0.00	4,243.8	$ 39.36	$ 13.92
Subtotal Retail Pharmacy			**$ 13.47**									**$ 13.92**
Ancillary												
Transportation	49.2	$ 117.09	$ 0.48	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	50.2	$ 117.09	$ 0.49
DME/Prosthetics	2,345.9	7.21	1.41	0.07	-	-	0.20	(0.05)	0.01	2,379.2	8.27	1.64
Dental	259.3	72.66	1.57	0.08	-	(0.03)	(0.10)	(0.04)	-	260.9	68.07	1.48
Other Ancillary	15.4	54.39	0.07	-	-	-	-	-	-	15.4	54.39	0.07
Subtotal Ancillary			**$ 3.53**									**$ 3.68**
Professional												
Inpatient and Outpatient Surgery	225.3	$ 138.48	$ 2.60	$ 0.13	$ 0.00	$ 0.00	$ (0.03)	$ (0.07)	$ 0.00	230.5	$ 136.92	$ 2.63
Anesthesia	144.1	95.75	1.15	0.06	-	-	(0.01)	(0.03)	-	147.9	94.94	1.17
Inpatient Visits	69.4	119.38	0.69	0.03	-	-	0.05	(0.02)	-	70.4	127.91	0.75
MH/SA	2,965.1	24.97	6.17	0.31	-	-	0.03	0.86	(0.86)	3,527.4	22.15	6.51
Emergency Room	563.5	64.74	3.04	0.15	-	-	0.10	(0.08)	-	576.5	66.82	3.21
Office/Home Visits/Consults	3,225.6	72.02	19.36	0.98	-	(0.03)	2.64	(0.59)	-	3,285.6	81.67	22.36
Pathology/Lab	1,779.6	14.36	2.13	0.11	-	(0.02)	0.05	(0.06)	-	1,804.6	14.70	2.21
Radiology	329.3	15.31	0.42	0.02	-	-	0.02	(0.01)	-	337.1	16.02	0.45
Office Administered Drugs	245.5	9.78	0.20	0.01	-	-	-	(0.01)	-	245.5	9.78	0.20
Physical Exams	2,000.4	47.45	7.91	0.40	-	(0.09)	0.86	(0.05)	0.22	2,066.2	53.72	9.25
Therapy	5,766.4	22.58	10.85	0.55	-	-	0.66	(0.31)	-	5,893.9	23.92	11.75
Vision	343.5	31.09	0.89	0.05	-	-	0.19	(0.03)	-	351.2	37.59	1.10
Other Professional	1,957.9	14.95	2.44	0.12	-	(0.01)	0.01	(0.07)	-	1,990.0	15.01	2.49
Subtotal Professional			**$ 57.85**									**$ 64.08**
Total Medical Costs			**$ 108.83**									**$ 115.35**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 7 - 13, Male & Female SFY 2021 Member Months: 3,045,547 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	24.8	$ 2,339.82	$ 4.83	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.14)	$ (0.01)	24.1	$ 2,334.83	$ 4.68
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	72.7	367.93	2.23	-	-	-	-	0.72	0.38	96.2	415.32	3.33
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.06**									**$ 8.01**
Outpatient Hospital												
Surgery	39.4	$ 1,387.29	$ 4.56	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ (0.13)	$ (0.01)	39.1	$ 1,384.23	$ 4.51
Non-Surg - Emergency Room	321.3	259.22	6.94	0.14	-	-	-	(0.21)	(0.01)	318.0	258.84	6.86
Non-Surg - Other	208.6	126.55	2.20	0.04	-	-	-	(0.06)	-	206.7	126.55	2.18
Observation Room	2.5	1,073.53	0.22	-	-	-	-	-	-	2.5	1,073.53	0.22
Treatment/Therapy/Testing	174.3	196.25	2.85	0.06	-	-	-	(0.09)	-	172.4	196.25	2.82
Other Outpatient	20.5	76.20	0.13	-	-	-	-	-	-	20.5	76.20	0.13
Subtotal Outpatient Hospital			**$ 16.90**									**$ 16.72**
Retail Pharmacy												
Prescription Drugs	5,522.4	$ 65.58	$ 30.18	$ 0.00	$ 1.84	$ 0.00	$ 0.00	$ (0.94)	$ 0.01	5,350.4	$ 69.73	$ 31.09
Subtotal Retail Pharmacy			**$ 30.18**									**$ 31.09**
Ancillary												
Transportation	36.5	$ 101.91	$ 0.31	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	37.7	$ 101.91	$ 0.32
DME/Prosthetics	1,660.9	9.46	1.31	0.07	-	-	0.17	(0.04)	0.08	1,698.9	11.23	1.59
Dental	30.6	66.67	0.17	0.01	-	-	(0.02)	-	-	32.4	59.27	0.16
Other Ancillary	69.1	43.41	0.25	0.01	-	-	-	-	(0.01)	71.9	41.74	0.25
Subtotal Ancillary			**$ 2.04**									**$ 2.32**
Professional												
Inpatient and Outpatient Surgery	151.0	$ 135.13	$ 1.70	$ 0.09	$ 0.00	$ 0.00	$ (0.01)	$ (0.05)	$ 0.00	154.5	$ 134.36	$ 1.73
Anesthesia	54.0	100.06	0.45	0.02	-	-	-	(0.01)	-	55.2	100.06	0.46
Inpatient Visits	65.0	83.06	0.45	0.02	-	-	0.06	(0.02)	-	65.0	94.14	0.51
MH/SA	6,561.4	37.88	20.71	1.05	-	-	0.10	(0.30)	(0.36)	6,799.0	37.42	21.20
Emergency Room	341.5	66.76	1.90	0.10	-	-	0.06	(0.06)	-	348.7	68.83	2.00
Office/Home Visits/Consults	2,564.1	76.19	16.28	0.82	-	(0.02)	2.19	(0.56)	(0.03)	2,601.9	86.15	18.68
Pathology/Lab	1,502.9	12.70	1.59	0.08	-	(0.01)	0.08	(0.05)	-	1,521.8	13.33	1.69
Radiology	379.6	18.97	0.60	0.03	-	-	0.03	(0.02)	-	386.0	19.90	0.64
Office Administered Drugs	1,054.6	15.93	1.40	0.07	-	-	0.02	(0.05)	-	1,069.7	16.15	1.44
Physical Exams	972.8	55.76	4.52	0.23	-	(0.05)	0.57	0.06	0.18	1,024.4	64.54	5.51
Therapy	914.4	21.91	1.67	0.08	-	-	0.11	(0.06)	-	925.4	23.34	1.80
Vision	1,098.4	28.19	2.58	0.13	-	-	0.57	(0.09)	(0.01)	1,115.4	34.21	3.18
Other Professional	2,516.1	11.21	2.35	0.12	-	(0.01)	(0.01)	(0.07)	-	2,558.9	11.16	2.38
Subtotal Professional			**$ 56.20**									**$ 61.22**
Total Medical Costs			**$ 112.38**									**$ 119.36**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Male SFY 2021 Member Months: 876,313 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	52.3	$ 2,560.61	$ 11.17	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.34)	$ (0.04)	50.8	$ 2,551.15	$ 10.79
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	176.5	358.21	5.27	-	-	-	-	3.52	1.65	294.5	425.45	10.44
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 16.44**									**$ 21.23**
Outpatient Hospital												
Surgery	54.1	$ 1,337.95	$ 6.03	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ (0.18)	$ (0.03)	53.5	$ 1,331.22	$ 5.94
Non-Surg - Emergency Room	343.0	268.69	7.68	0.15	-	-	-	(0.23)	(0.03)	339.4	267.63	7.57
Non-Surg - Other	147.7	132.42	1.63	0.03	-	-	-	(0.05)	-	145.9	132.42	1.61
Observation Room	3.6	671.64	0.20	-	-	-	-	-	-	3.6	671.64	0.20
Treatment/Therapy/Testing	202.8	269.27	4.55	0.09	-	-	-	(0.14)	(0.02)	200.5	268.07	4.48
Other Outpatient	22.5	106.74	0.20	-	-	-	-	-	-	22.5	106.74	0.20
Subtotal Outpatient Hospital			**$ 20.29**									**$ 20.00**
Retail Pharmacy												
Prescription Drugs	5,183.5	$ 72.69	$ 31.40	$ 0.00	$ 1.91	$ 0.00	$ 0.00	$ (1.00)	$ (0.12)	5,018.4	$ 76.97	$ 32.19
Subtotal Retail Pharmacy			**$ 31.40**									**$ 32.19**
Ancillary												
Transportation	88.3	$ 108.72	$ 0.80	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ (0.02)	$ (0.01)	90.5	$ 107.40	$ 0.81
DME/Prosthetics	1,985.2	12.94	2.14	0.11	-	-	0.22	(0.02)	0.29	2,068.7	15.89	2.74
Dental	6.5	36.70	0.02	-	-	-	-	-	-	6.5	36.70	0.02
Other Ancillary	69.9	46.35	0.27	0.01	-	-	-	(0.01)	-	69.9	46.35	0.27
Subtotal Ancillary			**$ 3.23**									**$ 3.84**
Professional												
Inpatient and Outpatient Surgery	196.4	$ 157.62	$ 2.58	$ 0.13	$ 0.00	$ 0.00	$ 0.04	$ (0.08)	$ (0.01)	200.2	$ 159.42	$ 2.66
Anesthesia	67.0	111.04	0.62	0.03	-	-	0.01	(0.02)	-	68.1	112.80	0.64
Inpatient Visits	144.3	77.34	0.93	0.05	-	-	0.13	(0.03)	-	147.4	87.92	1.08
MH/SA	4,629.5	43.31	16.71	0.85	-	-	0.09	(0.45)	(0.13)	4,740.4	43.21	17.07
Emergency Room	375.5	72.86	2.28	0.12	-	-	0.07	(0.08)	(0.01)	382.1	74.74	2.38
Office/Home Visits/Consults	2,103.1	77.20	13.53	0.68	-	(0.01)	1.82	(0.49)	(0.05)	2,131.0	87.17	15.48
Pathology/Lab	1,468.1	14.30	1.75	0.09	-	(0.01)	0.05	(0.06)	-	1,484.9	14.71	1.82
Radiology	581.6	23.93	1.16	0.06	-	-	-	(0.04)	-	591.6	23.93	1.18
Office Administered Drugs	717.3	36.47	2.18	0.11	-	-	0.02	(0.07)	-	730.4	36.80	2.24
Physical Exams	704.2	58.45	3.43	0.17	-	(0.04)	0.47	0.06	0.15	743.3	68.46	4.24
Therapy	469.6	21.72	0.85	0.04	-	-	0.05	(0.03)	-	475.1	22.98	0.91
Vision	914.7	28.34	2.16	0.11	-	-	0.48	(0.09)	(0.01)	923.1	34.45	2.65
Other Professional	1,817.1	12.68	1.92	0.10	-	(0.01)	0.01	(0.06)	(0.01)	1,845.5	12.68	1.95
Subtotal Professional			**$ 50.10**									**$ 54.30**
Total Medical Costs			**$ 121.46**									**$ 131.56**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Female SFY 2021 Member Months: 884,369 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	53.6	$ 2,638.27	$ 11.78	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.36)	$ (0.04)	51.9	$ 2,629.03	$ 11.38
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	166.5	399.39	5.54	-	-	-	-	3.90	1.30	283.6	454.39	10.74
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 17.32**									**$ 22.12**
Outpatient Hospital												
Surgery	74.2	$ 1,186.97	$ 7.34	$ 0.15	$ 0.00	$ 0.00	$ 0.00	$ (0.23)	$ (0.02)	73.4	$ 1,183.70	$ 7.24
Non-Surg - Emergency Room	598.6	284.85	14.21	0.29	-	-	-	(0.44)	(0.05)	592.3	283.84	14.01
Non-Surg - Other	253.9	149.81	3.17	0.06	-	-	-	(0.09)	(0.02)	251.5	148.86	3.12
Observation Room	8.6	542.57	0.39	0.01	-	-	-	(0.01)	(0.01)	8.6	528.65	0.38
Treatment/Therapy/Testing	389.1	208.17	6.75	0.14	-	-	-	(0.21)	(0.03)	385.1	207.24	6.65
Other Outpatient	36.0	116.71	0.35	0.01	-	-	-	(0.01)	-	36.0	116.71	0.35
Subtotal Outpatient Hospital			**$ 32.21**									**$ 31.75**
Retail Pharmacy												
Prescription Drugs	7,722.0	$ 48.27	$ 31.06	$ 0.00	$ 1.89	$ 0.00	$ 0.00	$ (0.99)	$ 0.30	7,475.9	$ 51.78	$ 32.26
Subtotal Retail Pharmacy			**$ 31.06**									**$ 32.26**
Ancillary												
Transportation	124.7	$ 92.40	$ 0.96	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	$ (0.01)	127.3	$ 91.46	$ 0.97
DME/Prosthetics	1,772.8	11.85	1.75	0.09	-	-	0.16	-	0.37	1,864.0	15.26	2.37
Dental	6.5	18.51	0.01	-	-	-	-	-	-	6.5	18.51	0.01
Other Ancillary	87.4	60.42	0.44	0.02	-	-	-	(0.01)	-	89.4	60.42	0.45
Subtotal Ancillary			**$ 3.16**									**$ 3.80**
Professional												
Inpatient and Outpatient Surgery	199.5	$ 157.01	$ 2.61	$ 0.13	$ 0.00	$ 0.00	$ 0.04	$ (0.09)	$ 0.00	202.5	$ 159.38	$ 2.69
Anesthesia	73.0	111.73	0.68	0.03	-	-	0.01	(0.02)	(0.01)	74.1	111.73	0.69
Inpatient Visits	187.8	74.77	1.17	0.06	-	-	0.18	(0.04)	(0.01)	191.0	85.45	1.36
MH/SA	4,676.8	53.16	20.72	1.05	-	-	0.13	(0.57)	(0.16)	4,785.2	53.09	21.17
Emergency Room	627.4	76.12	3.98	0.20	-	-	0.14	(0.13)	(0.02)	638.4	78.38	4.17
Office/Home Visits/Consults	3,170.9	76.22	20.14	1.02	-	(0.04)	2.68	(0.72)	(0.08)	3,211.8	85.93	23.00
Pathology/Lab	3,783.0	14.62	4.61	0.23	-	(0.01)	0.38	(0.16)	(0.02)	3,832.2	15.75	5.03
Radiology	686.9	29.87	1.71	0.09	-	-	0.05	(0.06)	(0.01)	698.9	30.56	1.78
Office Administered Drugs	21,453.8	0.84	1.50	0.08	-	-	-	(0.05)	(0.01)	21,882.9	0.83	1.52
Physical Exams	769.1	58.51	3.75	0.19	-	(0.06)	0.50	0.07	0.16	810.1	68.29	4.61
Therapy	534.7	21.32	0.95	0.05	-	-	0.05	(0.03)	-	546.0	22.42	1.02
Vision	1,460.6	27.93	3.40	0.17	-	-	0.75	(0.13)	(0.01)	1,477.7	33.94	4.18
Other Professional	2,349.7	21.45	4.20	0.21	-	(0.01)	0.01	(0.14)	(0.01)	2,383.2	21.45	4.26
Subtotal Professional			**$ 69.42**									**$ 75.48**
Total Medical Costs			**$ 153.17**									**$ 165.41**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Male SFY 2021 Member Months: 343,007 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	231.1	$ 2,223.92	$ 42.83	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.83)	$ 0.00	221.2	$ 2,223.92	$ 41.00
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	50.1	759.39	3.17	-	-	-	-	1.56	(0.47)	74.7	683.93	4.26
Other Inpatient	2.4	343.42	0.07	-	-	-	-	-	-	2.4	343.42	0.07
Subtotal Inpatient Hospital			**$ 46.07**									**$ 45.33**
Outpatient Hospital												
Surgery	96.0	$ 1,365.59	$ 10.92	$ 0.22	$ 0.00	$ 0.00	$ 0.00	$ (0.48)	$ 0.00	93.7	$ 1,365.59	$ 10.66
Non-Surg - Emergency Room	632.7	286.00	15.08	0.30	-	-	-	(0.66)	-	617.6	286.00	14.72
Non-Surg - Other	85.9	138.30	0.99	0.02	-	-	-	(0.04)	-	84.2	138.30	0.97
Observation Room	4.0	539.66	0.18	-	-	-	-	-	-	4.0	539.66	0.18
Treatment/Therapy/Testing	287.6	369.23	8.85	0.18	-	-	-	(0.39)	-	280.8	369.23	8.64
Other Outpatient	32.4	170.54	0.46	0.01	-	-	-	(0.02)	-	31.7	170.54	0.45
Subtotal Outpatient Hospital			**$ 36.48**									**$ 35.62**
Retail Pharmacy												
Prescription Drugs	5,295.6	$ 92.43	$ 40.79	$ 0.00	$ 3.75	$ 0.00	$ 0.00	$ (1.88)	$ 4.37	5,051.5	$ 111.72	$ 47.03
Subtotal Retail Pharmacy			**$ 40.79**									**$ 47.03**
Ancillary												
Transportation	194.9	$ 97.26	$ 1.58	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ (0.07)	$ 0.00	192.5	$ 97.26	$ 1.56
DME/Prosthetics	1,902.2	13.37	2.12	0.06	-	-	0.24	(0.05)	0.15	1,911.1	15.82	2.52
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	140.1	59.96	0.70	0.02	-	-	-	(0.03)	-	138.1	59.96	0.69
Subtotal Ancillary			**$ 4.40**									**$ 4.77**
Professional												
Inpatient and Outpatient Surgery	384.6	$ 151.03	$ 4.84	$ 0.15	$ 0.00	$ (0.01)	$ (0.08)	$ (0.13)	$ 0.00	385.4	$ 148.54	$ 4.77
Anesthesia	126.5	110.02	1.16	0.04	-	-	-	(0.05)	-	125.4	110.02	1.15
Inpatient Visits	400.1	77.37	2.58	0.08	-	-	0.28	(0.12)	-	393.9	85.90	2.82
MH/SA	1,002.8	66.77	5.58	0.17	-	-	0.04	1.99	1.32	1,391.0	78.50	9.10
Emergency Room	705.2	81.17	4.77	0.14	-	-	0.17	(0.22)	-	693.4	84.11	4.86
Office/Home Visits/Consults	2,043.5	75.87	12.92	0.39	-	(0.03)	1.77	(0.55)	-	2,013.4	86.42	14.50
Pathology/Lab	2,141.6	15.52	2.77	0.08	-	(0.01)	0.01	(0.12)	-	2,103.0	15.58	2.73
Radiology	1,018.8	30.62	2.60	0.08	-	-	(0.03)	(0.10)	-	1,010.9	30.27	2.55
Office Administered Drugs	9,269.6	8.95	6.91	0.21	-	-	(0.12)	(0.30)	-	9,148.9	8.79	6.70
Physical Exams	123.9	49.40	0.51	0.02	-	(0.01)	0.05	(0.01)	0.02	123.9	56.18	0.58
Therapy	386.1	22.69	0.73	0.02	-	-	0.03	(0.04)	-	375.5	23.65	0.74
Vision	197.3	35.28	0.58	0.02	-	-	0.07	(0.03)	-	193.9	39.62	0.64
Other Professional	1,106.5	23.43	2.16	0.07	-	(0.01)	0.16	(0.10)	-	1,086.0	25.19	2.28
Subtotal Professional			**$ 48.11**									**$ 53.42**
Total Medical Costs			**$ 175.85**									**$ 186.17**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Female SFY 2021 Member Months: 1,691,798 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	209.3	$ 2,117.43	$ 36.94	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.33)	$ 0.00	201.8	$ 2,117.43	$ 35.61
Inpatient Well Newborn	0.2	968.14	0.02	-	-	-	-	-	-	0.2	968.14	0.02
Inpatient MH/SA	52.6	721.51	3.16	-	-	-	-	0.72	(0.06)	64.5	710.35	3.82
Other Inpatient	2.5	285.35	0.06	-	-	-	-	-	-	2.5	285.35	0.06
Subtotal Inpatient Hospital			**$ 40.18**									**$ 39.51**
Outpatient Hospital												
Surgery	212.2	$ 1,196.49	$ 21.16	$ 0.43	$ 0.00	$ 0.00	$ 0.00	$ (0.78)	$ 0.00	208.7	$ 1,196.49	$ 20.81
Non-Surg - Emergency Room	1,151.9	303.88	29.17	0.59	-	-	-	(1.07)	(0.01)	1,133.0	303.77	28.68
Non-Surg - Other	331.2	158.34	4.37	0.09	-	-	-	(0.16)	-	325.9	158.34	4.30
Observation Room	28.8	432.85	1.04	0.02	-	-	-	(0.04)	-	28.3	432.85	1.02
Treatment/Therapy/Testing	739.2	256.81	15.82	0.32	-	-	-	(0.38)	(0.18)	736.4	253.88	15.58
Other Outpatient	107.3	149.91	1.34	0.03	-	-	-	(0.05)	-	105.7	149.91	1.32
Subtotal Outpatient Hospital			**$ 72.90**									**$ 71.71**
Retail Pharmacy												
Prescription Drugs	9,783.6	$ 64.63	$ 52.69	$ 0.00	$ 4.85	$ 0.00	$ 0.00	$ (2.06)	$ 3.32	9,401.1	$ 75.05	$ 58.80
Subtotal Retail Pharmacy			**$ 52.69**									**$ 58.80**
Ancillary												
Transportation	268.9	$ 89.71	$ 2.01	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ (0.08)	$ 0.00	266.2	$ 89.71	$ 1.99
DME/Prosthetics	1,538.4	14.59	1.87	0.06	-	-	0.21	0.04	0.32	1,620.6	18.51	2.50
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	163.2	91.89	1.25	0.04	-	-	-	(0.05)	-	161.9	91.89	1.24
Subtotal Ancillary			**$ 5.13**									**$ 5.73**
Professional												
Inpatient and Outpatient Surgery	512.0	$ 176.95	$ 7.55	$ 0.23	$ 0.00	$ (0.01)	$ (0.03)	$ (0.09)	$ 0.00	520.8	$ 176.26	$ 7.65
Anesthesia	219.8	109.74	2.01	0.06	-	-	-	(0.07)	-	218.7	109.74	2.00
Inpatient Visits	415.3	76.86	2.66	0.08	-	-	0.29	(0.11)	-	410.6	85.34	2.92
MH/SA	1,956.7	74.33	12.12	0.37	-	-	0.12	1.76	0.96	2,300.6	79.96	15.33
Emergency Room	1,243.0	81.67	8.46	0.26	-	-	0.31	(0.33)	-	1,232.7	84.69	8.70
Office/Home Visits/Consults	4,037.3	75.38	25.36	0.77	-	(0.10)	3.44	(0.86)	-	4,007.0	85.68	28.61
Pathology/Lab	7,623.5	16.50	10.48	0.32	-	(0.03)	0.49	(0.40)	0.13	7,543.5	17.48	10.99
Radiology	1,619.1	36.69	4.95	0.15	-	-	0.24	(0.17)	-	1,612.6	38.47	5.17
Office Administered Drugs	27,949.2	2.86	6.66	0.20	-	-	(0.13)	(0.24)	-	27,781.4	2.80	6.49
Physical Exams	368.1	58.02	1.78	0.05	-	(0.01)	0.20	(0.07)	-	361.9	64.66	1.95
Therapy	501.4	22.50	0.94	0.03	-	-	0.05	(0.04)	-	496.1	23.71	0.98
Vision	212.3	40.70	0.72	0.02	-	-	0.07	(0.03)	-	209.3	44.72	0.78
Other Professional	2,237.6	33.30	6.21	0.19	-	(0.01)	0.36	(0.24)	-	2,216.0	35.25	6.51
Subtotal Professional			**$ 89.90**									**$ 98.08**
Total Medical Costs			**$ 260.80**									**$ 273.83**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 45+, Male & Female SFY 2021 Member Months: 282,214 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	534.4	$ 2,346.72	$ 104.51	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (3.77)	$ 0.00	515.1	$ 2,346.72	$ 100.74
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	46.5	761.43	2.95	-	-	-	-	0.56	(0.01)	55.3	759.26	3.50
Other Inpatient	36.2	268.87	0.81	-	-	-	-	(0.03)	-	34.8	268.87	0.78
Subtotal Inpatient Hospital			**$ 108.27**									**$ 105.02**
Outpatient Hospital												
Surgery	218.0	$ 1,722.16	$ 31.29	$ 0.63	$ 0.00	$ 0.00	$ 0.00	$ (1.15)	$ 0.00	214.4	$ 1,722.16	$ 30.77
Non-Surg - Emergency Room	793.5	328.93	21.75	0.44	-	-	-	(0.80)	-	780.3	328.93	21.39
Non-Surg - Other	335.6	138.76	3.88	0.08	-	-	-	(0.14)	-	330.4	138.76	3.82
Observation Room	16.8	733.95	1.03	0.02	-	-	-	(0.04)	-	16.5	733.95	1.01
Treatment/Therapy/Testing	1,069.1	420.36	37.45	0.75	-	-	-	(1.14)	(0.22)	1,058.0	417.86	36.84
Other Outpatient	291.1	138.90	3.37	0.07	-	-	-	(0.13)	-	286.0	138.90	3.31
Subtotal Outpatient Hospital			**$ 98.77**									**$ 97.14**
Retail Pharmacy												
Prescription Drugs	19,550.3	$ 77.98	$ 127.05	$ 0.00	$ 11.69	$ 0.00	$ 0.00	$ (4.97)	$ 8.50	18,785.6	$ 90.88	$ 142.27
Subtotal Retail Pharmacy			**$ 127.05**									**$ 142.27**
Ancillary												
Transportation	276.3	$ 100.77	$ 2.32	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ (0.09)	$ 0.00	273.9	$ 100.77	$ 2.30
DME/Prosthetics	6,563.5	11.87	6.49	0.20	-	-	0.55	(0.13)	0.13	6,634.3	13.10	7.24
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	414.2	72.72	2.51	0.08	-	-	-	(0.10)	-	410.9	72.72	2.49
Subtotal Ancillary			**$ 11.32**									**$ 12.03**
Professional												
Inpatient and Outpatient Surgery	1,142.4	$ 165.86	$ 15.79	$ 0.48	$ 0.00	$ (0.01)	$ (0.39)	$ (0.19)	$ 0.00	1,162.7	$ 161.83	$ 15.68
Anesthesia	421.0	104.03	3.65	0.11	-	-	(0.02)	(0.13)	-	418.7	103.46	3.61
Inpatient Visits	844.0	78.91	5.55	0.17	-	-	0.60	(0.23)	-	834.9	87.53	6.09
MH/SA	1,798.1	68.14	10.21	0.31	-	-	0.12	1.32	0.95	2,085.2	74.30	12.91
Emergency Room	923.2	88.26	6.79	0.21	-	-	0.30	(0.26)	-	916.4	92.18	7.04
Office/Home Visits/Consults	5,822.6	77.18	37.45	1.13	-	(0.15)	4.72	(1.13)	-	5,799.3	86.95	42.02
Pathology/Lab	7,182.6	13.78	8.25	0.25	-	(0.03)	0.06	(0.30)	0.10	7,113.0	14.05	8.33
Radiology	2,655.3	35.79	7.92	0.24	-	-	0.19	(0.25)	-	2,652.0	36.65	8.10
Office Administered Drugs	19,149.0	8.38	13.38	0.40	-	-	(0.26)	(0.49)	-	19,020.2	8.22	13.03
Physical Exams	396.0	55.46	1.83	0.06	-	(0.03)	0.19	(0.07)	-	387.3	61.35	1.98
Therapy	1,485.5	21.81	2.70	0.08	-	-	0.12	(0.10)	-	1,474.5	22.79	2.80
Vision	304.8	49.21	1.25	0.04	-	-	0.08	(0.05)	-	302.4	52.39	1.32
Other Professional	3,327.0	25.57	7.09	0.21	-	(0.01)	0.17	(0.27)	-	3,294.2	26.19	7.19
Subtotal Professional			**$ 121.86**									**$ 130.10**
Total Medical Costs			**$ 467.27**									**$ 486.56**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SSI - Children SFY 2021 Member Months: 146,178 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	341.4	$ 1,995.57	$ 56.77	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.20)	$ (0.27)	334.2	$ 1,985.87	$ 55.30
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	820.3	337.18	23.05	-	-	-	-	5.43	3.87	1,013.6	382.99	32.35
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 79.82**									**$ 87.65**
Outpatient Hospital												
Surgery	114.3	$ 1,727.86	$ 16.46	$ 0.33	$ 0.00	$ 0.00	$ 0.00	$ (0.35)	$ (0.08)	114.2	$ 1,719.45	$ 16.36
Non-Surg - Emergency Room	631.8	288.91	15.21	0.31	-	-	-	(0.33)	(0.08)	630.9	287.39	15.11
Non-Surg - Other	713.2	150.43	8.94	0.18	-	-	-	(0.19)	(0.05)	712.4	149.59	8.88
Observation Room	14.6	1,474.78	1.80	0.04	-	-	-	(0.04)	(0.01)	14.6	1,466.59	1.79
Treatment/Therapy/Testing	797.5	375.73	24.97	0.50	-	-	-	(0.54)	(0.12)	796.2	373.93	24.81
Other Outpatient	58.3	177.03	0.86	0.02	-	-	-	(0.02)	(0.01)	58.3	174.97	0.85
Subtotal Outpatient Hospital			**$ 68.24**									**$ 67.80**
Retail Pharmacy												
Prescription Drugs	15,911.1	$ 131.58	$ 174.47	$ 0.00	$ 19.72	$ 0.00	$ 0.00	$ (4.10)	$ (0.68)	15,537.2	$ 146.29	$ 189.41
Subtotal Retail Pharmacy			**$ 174.47**									**$ 189.41**
Ancillary												
Transportation	216.1	$ 104.38	$ 1.88	$ 0.11	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	$ (0.01)	224.2	$ 103.85	$ 1.94
DME/Prosthetics	52,406.2	4.23	18.46	1.12	-	-	2.30	(0.45)	-	54,308.2	4.74	21.43
Dental	95.3	90.68	0.72	0.04	-	-	(0.04)	(0.01)	(0.01)	99.2	84.64	0.70
Other Ancillary	424.4	37.89	1.34	0.08	-	-	-	(0.03)	-	440.2	37.89	1.39
Subtotal Ancillary			**$ 22.40**									**$ 25.46**
Professional												
Inpatient and Outpatient Surgery	314.9	$ 156.65	$ 4.11	$ 0.25	$ 0.00	$ 0.00	$ 0.03	$ (0.09)	$ (0.02)	327.1	$ 157.01	$ 4.28
Anesthesia	211.7	113.94	2.01	0.12	-	-	0.03	(0.04)	(0.01)	220.1	115.03	2.11
Inpatient Visits	769.3	102.95	6.60	0.40	-	-	0.71	(0.16)	(0.04)	797.3	113.04	7.51
MH/SA	31,857.6	24.11	64.00	3.90	-	-	0.44	9.55	(9.58)	38,552.7	21.26	68.31
Emergency Room	749.7	76.83	4.80	0.29	-	-	0.23	(0.11)	(0.03)	777.9	79.91	5.18
Office/Home Visits/Consults	4,593.7	85.58	32.76	2.00	-	(0.03)	3.52	(0.80)	(0.19)	4,757.7	93.98	37.26
Pathology/Lab	2,107.7	17.54	3.08	0.19	-	(0.02)	(0.17)	(0.06)	(0.02)	2,182.9	16.49	3.00
Radiology	861.2	21.32	1.53	0.09	-	-	0.08	(0.04)	(0.01)	889.4	22.26	1.65
Office Administered Drugs	15,685.0	12.46	16.28	0.99	-	-	(0.17)	(0.36)	(0.09)	16,291.9	12.26	16.65
Physical Exams	1,022.4	57.04	4.86	0.30	-	(0.07)	0.61	0.25	0.28	1,123.4	66.55	6.23
Therapy	16,584.8	21.74	30.04	1.83	-	-	1.86	(0.71)	(0.16)	17,203.1	22.92	32.86
Vision	1,157.6	30.27	2.92	0.18	-	-	0.63	(0.08)	(0.02)	1,197.2	36.38	3.63
Other Professional	6,108.1	17.17	8.74	0.53	-	(0.01)	0.28	(0.20)	(0.05)	6,331.7	17.61	9.29
Subtotal Professional			**$ 181.73**									**$ 197.96**
Total Medical Costs			**$ 526.66**									**$ 568.28**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SSI - Adults SFY 2021 Member Months: 658,622 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	1,841.5	$ 2,023.50	$ 310.52	$ 6.24	$ 0.00	$ 0.00	$ 0.00	$ (1.13)	$ (0.02)	1,871.8	$ 2,023.37	$ 315.61
Inpatient Well Newborn	0.1	1,999.51	0.02	-	-	-	-	-	-	0.1	1,999.51	0.02
Inpatient MH/SA	387.7	619.27	20.01	0.40	-	-	-	5.23	(0.13)	496.8	616.13	25.51
Other Inpatient	302.3	273.47	6.89	0.14	-	-	-	(0.03)	-	307.2	273.47	7.00
Subtotal Inpatient Hospital			**$ 337.44**									**$ 348.14**
Outpatient Hospital												
Surgery	316.5	$ 1,608.74	$ 42.43	$ 2.58	$ 0.00	$ 0.00	$ 0.00	$ (0.16)	$ 0.00	334.5	$ 1,608.74	$ 44.85
Non-Surg - Emergency Room	1,529.3	371.77	47.38	2.89	-	-	-	(0.18)	(0.01)	1,616.8	371.70	50.08
Non-Surg - Other	699.9	151.39	8.83	0.54	-	-	-	(0.04)	-	739.5	151.39	9.33
Observation Room	42.5	737.22	2.61	0.16	-	-	-	(0.01)	-	44.9	737.22	2.76
Treatment/Therapy/Testing	1,430.3	673.13	80.23	4.89	-	-	-	(0.05)	(0.25)	1,516.6	671.15	84.82
Other Outpatient	271.8	207.92	4.71	0.29	-	-	-	(0.02)	-	287.4	207.92	4.98
Subtotal Outpatient Hospital			**$ 186.19**									**$ 196.82**
Retail Pharmacy												
Prescription Drugs	28,796.4	$ 130.16	$ 312.34	$ 0.00	$ 41.92	$ 0.00	$ 0.00	$ (1.06)	$ 28.53	28,698.7	$ 159.62	$ 381.73
Subtotal Retail Pharmacy			**$ 312.34**									**$ 381.73**
Ancillary												
Transportation	1,329.8	$ 89.25	$ 9.89	$ 0.60	$ 0.00	$ 0.00	$ (0.02)	$ (0.03)	$ 0.00	1,406.4	$ 89.08	$ 10.44
DME/Prosthetics	32,496.0	7.61	20.60	1.25	-	-	2.71	0.06	0.24	34,562.5	8.63	24.86
Dental	0.3	428.47	0.01	-	-	-	-	-	-	0.3	428.47	0.01
Other Ancillary	1,758.8	69.05	10.12	0.62	-	-	-	(0.04)	-	1,859.6	69.05	10.70
Subtotal Ancillary			**$ 40.62**									**$ 46.01**
Professional												
Inpatient and Outpatient Surgery	1,388.9	$ 172.79	$ 20.00	$ 1.22	$ 0.00	$ (0.01)	$ (0.49)	$ 0.45	$ 0.00	1,504.2	$ 168.89	$ 21.17
Anesthesia	565.1	107.02	5.04	0.31	-	-	0.05	(0.02)	-	597.6	108.02	5.38
Inpatient Visits	3,484.4	76.08	22.09	1.35	-	-	2.23	(0.09)	-	3,683.1	83.34	25.58
MH/SA	11,056.4	23.91	22.03	1.34	-	-	0.20	0.47	1.90	11,964.7	26.02	25.94
Emergency Room	1,973.8	90.40	14.87	0.91	-	-	0.63	(0.06)	-	2,086.6	94.03	16.35
Office/Home Visits/Consults	6,991.3	84.96	49.50	3.01	-	(0.44)	4.86	0.36	(0.01)	7,405.2	92.82	57.28
Pathology/Lab	8,666.0	14.08	10.17	0.62	-	(0.06)	0.17	(0.03)	0.06	9,117.7	14.39	10.93
Radiology	4,081.7	36.90	12.55	0.76	-	-	0.13	0.01	-	4,332.1	37.26	13.45
Office Administered Drugs	63,218.2	8.54	45.01	2.74	-	(0.01)	(0.56)	(0.17)	-	66,813.8	8.44	47.01
Physical Exams	455.9	46.85	1.78	0.11	-	(0.04)	0.13	-	0.01	473.8	50.40	1.99
Therapy	977.4	22.84	1.86	0.11	-	-	0.06	(0.01)	-	1,029.9	23.54	2.02
Vision	328.2	50.09	1.37	0.08	-	-	0.09	-	-	347.3	53.20	1.54
Other Professional	4,567.7	47.26	17.99	1.10	-	(0.06)	0.15	(0.06)	(0.01)	4,816.5	47.61	19.11
Subtotal Professional			**$ 224.26**									**$ 247.75**
Total Medical Costs			**$ 1,100.85**									**$ 1,220.45**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: OCWI SFY 2021 Member Months: 211,427 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	225.5	$ 1,612.17	$ 30.29	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (1.84)	$ 0.00	211.8	$ 1,612.17	$ 28.45
Inpatient Well Newborn	0.9	803.69	0.06	-	-	-	-	-	-	0.9	803.69	0.06
Inpatient MH/SA	26.4	632.79	1.39	-	-	-	-	0.29	(0.02)	31.9	625.26	1.66
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 31.74**									**$ 30.17**
Outpatient Hospital												
Surgery	680.0	$ 440.49	$ 24.96	$ 2.04	$ 0.00	$ 0.00	$ 0.00	$ (1.64)	$ 0.00	690.9	$ 440.49	$ 25.36
Non-Surg - Emergency Room	1,044.7	371.81	32.37	2.64	-	-	-	(2.12)	-	1,061.5	371.81	32.89
Non-Surg - Other	1,097.4	151.67	13.87	1.13	-	-	-	(0.91)	-	1,114.8	151.67	14.09
Observation Room	187.3	287.05	4.48	0.37	-	-	-	(0.30)	-	190.2	287.05	4.55
Treatment/Therapy/Testing	1,723.5	138.00	19.82	1.62	-	-	-	(1.13)	(0.13)	1,766.1	137.11	20.18
Other Outpatient	80.1	145.30	0.97	0.08	-	-	-	(0.06)	-	81.8	145.30	0.99
Subtotal Outpatient Hospital			**$ 96.47**									**$ 98.06**
Retail Pharmacy												
Prescription Drugs	10,082.2	$ 37.93	$ 31.87	$ 0.00	$ 1.94	$ 0.00	$ 0.00	$ (2.04)	$ 2.13	9,436.8	$ 43.11	$ 33.90
Subtotal Retail Pharmacy			**$ 31.87**									**$ 33.90**
Ancillary												
Transportation	337.3	$ 97.14	$ 2.73	$ 0.17	$ 0.00	$ 0.00	$ (0.01)	$ (0.17)	$ 0.00	337.3	$ 96.78	$ 2.72
DME/Prosthetics	517.5	33.62	1.45	0.09	-	-	0.02	0.34	0.63	671.0	45.25	2.53
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	337.4	112.38	3.16	0.19	-	-	-	(0.20)	-	336.3	112.38	3.15
Subtotal Ancillary			**$ 7.34**									**$ 8.40**
Professional												
Inpatient and Outpatient Surgery	361.7	$ 147.31	$ 4.44	$ 0.27	$ 0.00	$ (0.01)	$ 0.10	$ (0.26)	$ 0.00	361.7	$ 150.63	$ 4.54
Anesthesia	155.5	104.20	1.35	0.08	-	-	-	(0.09)	-	154.3	104.20	1.34
Inpatient Visits	819.1	69.15	4.72	0.29	-	-	0.24	(0.32)	-	813.8	72.69	4.93
MH/SA	1,286.0	88.09	9.44	0.57	-	-	0.07	1.18	0.36	1,524.4	91.47	11.62
Emergency Room	1,364.8	80.28	9.13	0.56	-	-	0.43	(0.61)	-	1,357.3	84.08	9.51
Office/Home Visits/Consults	2,559.3	70.33	15.00	0.91	-	(0.03)	1.94	(1.04)	-	2,532.0	79.53	16.78
Pathology/Lab	14,702.7	14.71	18.02	1.10	-	(0.03)	0.93	(1.21)	0.21	14,588.5	15.65	19.02
Radiology	1,473.0	56.37	6.92	0.42	-	-	0.47	(0.47)	-	1,462.4	60.23	7.34
Office Administered Drugs	19,285.9	2.87	4.62	0.28	-	-	(0.10)	(0.29)	-	19,244.2	2.81	4.51
Physical Exams	865.1	24.83	1.79	0.11	-	(0.01)	0.05	(0.12)	-	855.5	25.53	1.82
Therapy	155.1	22.44	0.29	0.02	-	-	0.01	(0.02)	-	155.1	23.22	0.30
Vision	213.9	37.58	0.67	0.04	-	-	0.06	(0.04)	-	213.9	40.94	0.73
Other Professional	2,966.4	71.64	17.71	1.08	-	(0.03)	1.91	(1.26)	-	2,931.2	79.46	19.41
Subtotal Professional			**$ 94.10**									**$ 101.85**
Total Medical Costs			**$ 261.52**									**$ 272.38**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: DUAL	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 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 per 1,000	Cost per Service	PMPM
Inpatient Hospital												
Inpatient Medical/Surgical/Non-Delivery	611.3	$ 282.09	$ 14.37	$ 0.58	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	636.0	$ 282.09	$ 14.95
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	38.6	223.76	0.72	0.03	-	-	-	-	-	40.2	223.76	0.75
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 15.09**									**$ 15.70**
Outpatient Hospital												
Surgery	65.2	$ 208.04	$ 1.13	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	69.8	$ 208.04	$ 1.21
Non-Surg - Emergency Room	455.1	66.19	2.51	0.18	-	-	-	-	-	487.7	66.19	2.69
Non-Surg - Other	331.5	24.62	0.68	0.05	-	-	-	-	-	355.9	24.62	0.73
Observation Room	13.1	64.27	0.07	-	-	-	-	-	-	13.1	64.27	0.07
Treatment/Therapy/Testing	474.1	71.38	2.82	0.20	-	-	-	-	-	507.7	71.38	3.02
Other Outpatient	46.3	46.62	0.18	0.01	-	-	-	-	-	48.9	46.62	0.19
Subtotal Outpatient Hospital			**$ 7.39**									**$ 7.91**
Retail Pharmacy												
Prescription Drugs	352.5	$ 53.44	$ 1.57	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	352.5	$ 53.44	$ 1.57
Subtotal Retail Pharmacy			**$ 1.57**									**$ 1.57**
Ancillary												
Transportation	26.1	$ 36.78	$ 0.08	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	29.4	$ 36.78	$ 0.09
DME/Prosthetics	15,643.9	3.87	5.05	0.36	-	-	0.25	0.09	0.20	17,037.9	4.19	5.95
Dental	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	160.7	29.12	0.39	0.03	-	-	-	-	-	173.1	29.12	0.42
Subtotal Ancillary			**$ 5.52**									**$ 6.46**
Professional												
Inpatient and Outpatient Surgery	458.1	$ 25.15	$ 0.96	$ 0.07	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	$ 0.00	491.5	$ 24.42	$ 1.00
Anesthesia	111.2	17.27	0.16	0.01	-	-	-	-	-	118.1	17.27	0.17
Inpatient Visits	990.8	20.11	1.66	0.12	-	-	0.06	-	-	1,062.4	20.78	1.84
MH/SA	11,618.9	13.53	13.10	0.93	-	-	0.06	-	-	12,443.8	13.59	14.09
Emergency Room	192.1	34.35	0.55	0.04	-	-	0.02	-	-	206.1	35.52	0.61
Office/Home Visits/Consults	2,796.6	35.79	8.34	0.59	-	-	0.52	0.04	-	3,007.9	37.86	9.49
Pathology/Lab	584.1	6.98	0.34	0.02	-	-	(0.04)	-	-	618.5	6.21	0.32
Radiology	689.7	14.44	0.83	0.06	-	-	0.03	-	-	739.6	14.93	0.92
Office Administered Drugs	37,320.6	2.51	7.81	0.56	-	-	(0.06)	-	-	39,996.6	2.49	8.31
Physical Exams	43.6	22.02	0.08	0.01	-	-	-	-	-	49.1	22.02	0.09
Therapy	243.2	3.45	0.07	-	-	-	0.01	-	-	243.2	3.95	0.08
Vision	84.7	28.33	0.20	0.01	-	-	0.01	-	-	88.9	29.68	0.22
Other Professional	1,573.6	8.31	1.09	0.08	-	-	0.01	0.09	-	1,819.0	8.38	1.27
Subtotal Professional			**$ 35.19**									**$ 38.41**
Total Medical Costs			**$ 64.76**									**$ 70.05**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: Foster Care Children SFY 2021 Member Months: 57,351 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	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	141.4	$ 1,386.13	$ 16.33	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.26)	141.4	$ 1,364.06	$ 16.07
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	4,876.5	324.26	131.77	-	-	-	-	20.32	7.81	5,628.5	340.91	159.90
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 148.10**									**$ 175.97**
Outpatient Hospital												
Surgery	101.6	$ 1,458.89	$ 12.35	$ 0.50	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.21)	105.7	$ 1,435.05	$ 12.64
Non-Surg - Emergency Room	584.0	295.89	14.40	0.58	-	-	-	-	(0.24)	607.5	291.15	14.74
Non-Surg - Other	559.2	147.65	6.88	0.28	-	-	-	-	(0.12)	581.9	145.18	7.04
Observation Room	5.8	1,094.45	0.53	0.02	-	-	-	-	(0.01)	6.0	1,074.55	0.54
Treatment/Therapy/Testing	444.7	210.21	7.79	0.31	-	-	-	-	(0.13)	462.4	206.84	7.97
Other Outpatient	46.4	147.33	0.57	0.02	-	-	-	-	(0.01)	48.1	144.83	0.58
Subtotal Outpatient Hospital			**$ 42.52**									**$ 43.51**
Retail Pharmacy												
Prescription Drugs	13,418.7	$ 53.09	$ 59.37	$ 0.00	$ 3.62	$ 0.00	$ 0.00	$ 0.00	$ (0.95)	13,418.7	$ 55.48	$ 62.04
Subtotal Retail Pharmacy			**$ 59.37**									**$ 62.04**
Ancillary												
Transportation	257.8	$ 85.20	$ 1.83	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	270.4	$ 83.87	$ 1.89
DME/Prosthetics	11,527.3	4.58	4.40	0.22	-	-	0.51	0.02	0.26	12,156.1	5.34	5.41
Dental	157.4	66.34	0.87	0.04	-	(0.02)	(0.05)	-	(0.02)	161.0	61.12	0.82
Other Ancillary	376.6	44.61	1.40	0.07	-	-	-	-	(0.02)	395.4	44.01	1.45
Subtotal Ancillary			**$ 8.50**									**$ 9.57**
Professional												
Inpatient and Outpatient Surgery	336.3	$ 133.80	$ 3.75	$ 0.19	$ 0.00	$ 0.00	$ (0.05)	$ 0.00	$ (0.06)	353.4	$ 130.06	$ 3.83
Anesthesia	157.8	97.32	1.28	0.06	-	-	(0.02)	-	(0.02)	165.2	94.41	1.30
Inpatient Visits	833.2	66.11	4.59	0.23	-	-	0.96	-	(0.09)	874.9	78.04	5.69
MH/SA	456,541.7	9.67	367.82	18.62	-	-	0.89	(218.35)	224.69	208,634.9	22.64	393.67
Emergency Room	659.1	77.01	4.23	0.21	-	-	0.18	-	(0.08)	691.9	78.74	4.54
Office/Home Visits/Consults	4,845.5	84.60	34.16	1.73	-	0.13	5.38	13.82	1.11	7,069.7	95.61	56.33
Pathology/Lab	3,062.8	16.10	4.11	0.21	-	-	(0.24)	-	(0.06)	3,219.3	14.98	4.02
Radiology	597.8	20.68	1.03	0.05	-	-	0.07	-	(0.02)	626.8	21.63	1.13
Office Administered Drugs	7,410.4	4.71	2.91	0.15	-	-	0.03	-	(0.05)	7,792.4	4.68	3.04
Physical Exams	2,545.1	44.13	9.36	0.47	-	-	1.83	0.31	0.15	2,757.2	52.75	12.12
Therapy	10,254.5	21.53	18.40	0.93	-	-	2.15	-	(0.34)	10,772.8	23.55	21.14
Vision	1,364.7	36.23	4.12	0.21	-	-	1.23	-	(0.09)	1,434.3	45.76	5.47
Other Professional	2,200.0	24.33	4.46	0.23	-	(0.01)	0.07	-	(0.08)	2,308.5	24.28	4.67
Subtotal Professional			**$ 460.22**									**$ 516.95**
Total Medical Costs			**$ 718.71**									**$ 808.04**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: KICK SFY 2021 Deliveries: 28,510 Category of Service	SFY 2019 Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		SFY 2021 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	Cost per Delivery	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	2,525.9	$ 1,703.63	$ 4,303.13	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,525.9	$ 1,703.63	$ 4,303.13
Subtotal Inpatient Hospital			**$ 4,303.13**									**$ 4,303.13**
Outpatient Hospital												
Outpatient Hospital - Maternity	59.0	$ 417.61	$ 24.65	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	59.0	$ 417.61	$ 24.65
Subtotal Outpatient Hospital			**$ 24.65**									**$ 24.65**
Professional												
Maternity Delivery	938.2	$ 1,040.01	$ 975.75	$ 19.61	$ 0.00	$ (0.59)	$ (29.16)	$ 0.00	$ 0.00	956.5	$ 1,009.52	$ 965.61
Maternity Anesthesia	1,166.7	297.50	347.10	6.98	-	-	(4.16)	-	-	1,190.2	294.00	349.92
Maternity Office Visits	8,488.2	58.63	497.68	10.00	-	(1.36)	79.80	-	-	8,635.5	67.87	586.12
Maternity Radiology	4,282.1	71.95	308.12	6.19	-	(0.10)	14.19	-	-	4,366.8	75.20	328.40
Maternity Non-Delivery	1.9	73.28	0.14	-	-	-	(0.01)	-	-	1.9	68.04	0.13
Subtotal Professional			**$ 2,128.79**									**$ 2,230.18**
Total Medical Costs			**$ 6,456.57**									**$ 6,557.96**

Appendix 8: Supplemental Teaching Payment Development – Unadjusted STP

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Supplemental Teaching Payment Development
Unadjusted STP Pass-through

Rate Cell Description	Rate Cell Code	[A] SFY 2019 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] SFY 2019 STP Pass-through Amount	[G] / [A] [H] SFY 2019 STP Pass-through PMPM
TANF Children									
TANF - 0 - 2 Months, Male & Female	**AH3**	83,785	$ 8,246,627	$ 242,451	$ 0	2.4561	$ 20,254,861	$ 11,765,784	$ 140.43
TANF - 3 - 12 Months, Male & Female	**AI3**	347,677	8,120,424	238,740	-	2.1140	17,166,215	8,807,051	25.33
TANF - Age 1 - 6, Male & Female	**AB3**	2,151,707	15,677,849	460,929	-	2.0192	31,656,511	15,517,733	7.21
TANF - Age 7 - 13, Male & Female	**AC3**	2,552,081	13,294,108	390,847	-	2.0299	26,985,787	13,300,832	5.21
TANF - Age 14 - 18, Male	**AD1**	711,938	3,806,540	111,912	-	2.2246	8,467,884	4,549,432	6.39
TANF - Age 14 - 18, Female	**AD2**	727,595	5,509,936	161,992	-	2.1554	11,876,040	6,204,112	8.53
Subtotal TANF Children		**6,574,783**	**$ 54,655,484**	**$ 1,606,871**	**$ 0**		**$ 116,407,297**	**$ 60,144,942**	**$ 9.15**
TANF Adult									
TANF - Age 19 - 44, Male	**AE1**	269,831	$ 1,584,477	$ 46,584	$ 18,338	2.5768	$ 4,082,879	$ 2,433,480	$ 9.02
TANF - Age 19 - 44, Female	**AE2**	1,355,396	14,249,538	418,936	145,680	2.5056	35,703,982	20,889,828	15.41
TANF - Age 45+, Male & Female	**AF3**	227,380	3,381,180	99,407	49,724	2.8073	9,491,900	5,961,589	26.22
Subtotal TANF Adult		**1,852,607**	**$ 19,215,194**	**$ 564,927**	**$ 213,742**		**$ 49,278,761**	**$ 29,284,898**	**$ 15.81**
Disabled									
SSI - Children	**SO3**	141,646	$ 2,987,837	$ 87,842	$ 0	2.2212	$ 6,636,570	$ 3,560,891	$ 25.14
SSI - Adults	**SP3**	599,853	17,379,335	510,952	187,045	2.6683	46,373,498	28,296,165	47.17
Subtotal Disabled		**741,499**	**$ 20,367,172**	**$ 598,795**	**$ 187,045**		**$ 53,010,069**	**$ 31,857,056**	**$ 42.96**
OCWI	**WG2**	**160,738**	**$ 2,791,497**	**$ 82,070**	**$ 0**	**2.4235**	**$ 6,765,322**	**$ 3,891,754**	**$ 24.21**
DUAL		**N/A**	**$ 0**	**$ 0**	**$ 0**	**1.0000**	**$ 0**	**$ 0**	**$ 0.00**
Foster Care Children	**FG3**	**58,932**	**$ 849,699**	**$ 24,981**	**$ 0**	**1.9962**	**$ 1,696,130**	**$ 821,450**	**$ 13.94**
KICK	**MG2/NG2**	**26,694**	**$ 15,813,451**	**$ 464,915**	**$ 0**	**2.0255**	**$ 32,030,648**	**$ 15,752,282**	**$ 590.11**
Total		**9,388,559**	**$ 113,692,498**	**$ 3,342,559**	**$ 400,787**		**$ 259,188,226**	**$ 141,752,382**	**$ 15.10**

Appendix 9: Supplemental Teaching Payment Development – Final STP PMPM

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2021 Supplemental Teaching Payment Development
Final STP PMPM

Rate Cell Description	Rate Cell Code	[A] SFY 2021 Projected Exposure	[B] SFY 2019 STP Pass-through PMPM	[C] SFY 2019 Retrospective Adjustments	[D] SFY 2021 Prospective Adjustments	[B] x [C] x [D] [E] Projected SFY 2021 STP Pass-through	[F] KICK Payment Allocation	[E] + [F] [G] Final SFY 2021 STP Pass-through (pre Cap)	[H] Pass-through Cap Adjustment	[G] x [H] [I] Final SFY 2021 STP Pass-through (Capped)	[A] x [I] [J] Final Pass-through Expenditures
TANF Children											
TANF - 0 - 2 Months, Male & Female	**AH3**	89,141	$ 140.43	1.0225	1.0515	$ 150.98	$ 0.00	$ 150.98	0.7632	$ 115.23	$ 10,271,464
TANF - 3 - 12 Months, Male & Female	**AI3**	375,560	25.33	1.0079	1.0528	26.88	-	26.88	0.7632	20.51	7,703,631
TANF - Age 1 - 6, Male & Female	**AB3**	2,640,042	7.21	1.0092	1.0262	7.47	-	7.47	0.7632	5.70	15,048,832
TANF - Age 7 - 13, Male & Female	**AC3**	3,045,547	5.21	1.0094	1.0235	5.38	-	5.38	0.7632	4.11	12,515,191
TANF - Age 14 - 18, Male	**AD1**	876,313	6.39	1.0105	1.0210	6.59	-	6.59	0.7632	5.03	4,408,879
TANF - Age 14 - 18, Female	**AD2**	884,369	8.53	1.0105	1.0207	8.79	1.26	10.05	0.7632	7.67	6,783,209
Subtotal TANF Children		**7,910,972**	**$ 8.86**			**$ 9.26**		**$ 9.40**		**$ 7.17**	**$ 56,731,205**
TANF Adult											
TANF - Age 19 - 44, Male	**AE1**	343,007	$ 9.02	1.0139	0.9944	$ 9.09	$ 0.00	$ 9.09	0.7632	$ 6.94	$ 2,380,287
TANF - Age 19 - 44, Female	**AE2**	1,691,798	15.41	1.0117	1.0037	15.65	4.65	20.30	0.7632	15.50	26,215,091
TANF - Age 45+, Male & Female	**AF3**	282,214	26.22	1.0131	1.0073	26.76	-	26.76	0.7632	20.42	5,763,003
Subtotal TANF Adult		**2,317,019**	**$ 15.78**			**$ 16.03**		**$ 19.43**		**$ 14.83**	**$ 34,358,380**
Disabled											
SSI - Children	**SO3**	146,178	$ 25.14	1.0231	1.0399	$ 26.75	$ 0.07	$ 26.82	0.7632	$ 20.47	$ 2,991,906
SSI - Adults	**SP3**	658,622	47.17	1.0167	1.0697	51.30	0.29	51.59	0.7632	39.37	25,932,753
Subtotal Disabled		**804,800**	**$ 43.17**			**$ 46.84**		**$ 47.09**		**$ 35.94**	**$ 28,924,659**
OCWI	**WG2**	**211,427**	**$ 24.21**	**1.0089**	**0.9980**	**$ 24.38**	**$ 54.73**	**$ 79.11**	**0.7632**	**$ 60.37**	**$ 12,764,426**
DUAL		**N/A**	**$ 0.00**	**1.0000**	**1.0000**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**N/A**	**$ 0.00**	**$ 0**
Foster Care Children	**FG3**	**57,351**	**$ 13.94**	**1.0096**	**1.1711**	**$ 16.48**	**$ 0.00**	**$ 16.48**	**0.7632**	**$ 12.58**	**$ 721,329**
KICK	**MG2/NG2**	**28,510**	**$ 590.11**	**1.0083**	**1.0201**	**$ 606.99**	**$ (606.99)**	**$ 0.00**	**0.7632**	**$ 0.00**	**$ 0**
Total		**11,301,569**	**$ 14.52**			**$ 15.17**		**$ 15.48**		**$ 11.81**	**$ 133,500,000**

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