MILLIMAN REPORT

SFY 2026 Medicaid Managed Care Capitation Rate Certification

South Carolina Department of Health and Human Services

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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, 2025.

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

Based on 42 CFR 438.7(c)(3), an amended capitation rate certification is not required for adjustments that increase or decrease capitation rates by 1.5% or less. As a result, we recognize that contracted capitation rates may differ from the information illustrated in this certification within this +/- 1.5% corridor.

To facilitate review, this document has been organized in the same manner as the 2024-2025 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in January 2024 (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) 2026 (July 1, 2025 through June 30, 2026). Figure 1 provides a comparison of the SFY 2026 rates relative to the rates effective January through June 2025 (Jan – Jun 2025) excluding the 438.6 Supplemental Teaching Physician (STP), Health, Access, Workforce, and Quality (HAWQ) program, Independent Community Pharmacy, Physician Directed Payment Program, Private Ambulance, and Public Ambulance state-directed payments, referred to collectively as add-ons.

The composite rates illustrated for both SFY 2026 and Jan - Jun 2025 are calculated based on an estimate of projected SFY 2026 enrollment. Projected enrollment estimates reflect observed program enrollment through March 2025 with adjustments to reflect anticipated changes in membership due to the eligibility unwinding period. The TANF: 0-2 months old projected member months reflect annualized October 2024 membership and the SFY 2026 projected KICK payments reflect annualized average October 2024 through January 2025 deliveries to account for the observed lag in eligibility completion for both rate cells.

FIGURE 1: COMPARISON WITH JAN-JUN 2025 RATES BY RATE CELL (PMPM RATES) - EXCLUDING ADD-ONS

		EXCLUDING ADD-ONS		
RATE CELL	PROJECTED MEMBER MONTHS	JAN-JUN 2025 RATE	SFY 2026 RATE	INCREASE/ (DECREASE)
TANF: 0-2 months old (AH3)	77,252	$ 2,389.19	$ 2,307.65	(3.4%)
TANF: 3-12 months old (AI3)	338,280	291.70	287.54	(1.4%)
TANF: Age 1-6 (AB3)	2,136,221	178.37	193.85	8.7%
TANF: Age 7-13 (AC3)	2,594,528	146.45	160.31	9.5%
TANF: Age 14-18, Male (AD1)	845,513	168.43	162.28	(3.7%)
TANF: Age 14-18, Female (AD2)	817,358	177.71	176.99	(0.4%)
TANF: Age 19-44, Male (AE1)	160,216	210.39	245.93	16.9%
TANF: Age 19-44, Female (AE2)	1,112,937	317.34	357.01	12.5%
TANF: Age 45+ (AF3)	201,585	596.27	625.82	5.0%
SSI - Children (SO3)	149,431	752.02	756.31	0.6%
SSI - Adults (SP3)	423,342	1,374.48	1,360.91	(1.0%)
SMI Children (VV3)	158,287	706.18	727.23	3.0%
SMI TANF Adults (TP3)	224,772	766.21	925.11	20.7%
SMI SSI Adults (UP3)	156,170	1,901.16	1,946.60	2.4%
OCWI (WG2)	288,631	273.51	281.67	3.0%
DUAL	-	178.57	179.00	0.2%
Foster Care - Children (FG3)	42,435	935.94	1,007.26	7.6%
KICK (MG2/NG2)	22,356	7,091.34	7,067.30	(0.3%)
Composite	**9,726,958**	**$ 348.65**	**$ 364.82**	**4.6%**

Notes:
1. Jan-Jun 2025 and SFY 2026 composite rates reflect projected SFY 2026 enrollment by rate cell.
2. Excludes state-directed payment add-ons.

Figure 2 provides a comparison of SFY 2026 capitation rate PMPMs relative to the Jan – Jun 2025 PMPMs consistent with Figure 1; however, illustrated PMPMs reflect the projected total capitation payment including estimated amounts for STP, HAWQ, Independent Pharmacy, Physician Directed Payment Program, Private Ambulance, and Public Ambulance state-directed payments, which are anticipated to be paid through separate payment term arrangements in SFY 2026. Additional information regarding these directed payments can be found in Section I.4.D of this report.

FIGURE 2: COMPARISON WITH JAN-JUN 2025 RATES BY RATE CELL (PMPM RATES) - INCLUDING ADD-ONS

		INCLUDING ADD-ONS		
RATE CELL	PROJECTED MEMBER MONTHS	JAN-JUN 2025 RATE	SFY 2026 RATE	INCREASE/ (DECREASE)
TANF: 0-2 months old (AH3)	77,252	$ 5,753.86	$ 6,170.00	7.2%
TANF: 3-12 months old (AI3)	338,280	498.54	552.98	10.9%
TANF: Age 1-6 (AB3)	2,136,221	266.67	313.49	17.6%
TANF: Age 7-13 (AC3)	2,594,528	202.20	242.16	19.8%
TANF: Age 14-18, Male (AD1)	845,513	257.60	269.98	4.8%
TANF: Age 14-18, Female (AD2)	817,358	279.54	301.97	8.0%
TANF: Age 19-44, Male (AE1)	160,216	385.44	445.84	15.7%
TANF: Age 19-44, Female (AE2)	1,112,937	648.16	709.35	9.4%
TANF: Age 45+ (AF3)	201,585	1,045.55	1,094.75	4.7%
SSI - Children (SO3)	149,431	1,004.38	1,130.05	12.5%
SSI - Adults (SP3)	423,342	2,426.33	2,629.32	8.4%
SMI Children (VV3)	158,287	1,072.52	1,340.96	25.0%
SMI TANF Adults (TP3)	224,772	1,250.29	1,609.33	28.7%
SMI SSI Adults (UP3)	156,170	3,051.51	3,526.45	15.6%
OCWI (WG2)	288,631	866.45	946.69	9.3%
DUAL	-	178.57	179.00	0.2%
Foster Care - Children (FG3)	42,435	1,510.78	1,763.45	16.7%
KICK (MG2/NG2)	22,356	7,091.34	7,067.30	(0.3%)
Composite	**9,726,958**	**$ 588.56**	**$ 661.16**	**12.3%**

Notes:
1. Jan-Jun 2025 and SFY 2026 composite rates reflect projected SFY 2026 enrollment by rate cell.
2. Includes state-directed payment add-ons.

Figure 3 presents the estimated aggregate annual expenditures under the managed care program, based on SFY 2026 projected membership. Total annual projected expenditures illustrated in Figure 3 include state-directed payments. Further detail by rate cell is illustrated in Appendix 3.

FIGURE 3: ESTIMATED ANNUAL FISCAL IMPACT (MILLIONS)

		ANNUAL PROJECTED EXPENDITURES		DOLLAR	PERCENTAGE
	PROJECTED MEMBERSHIP	JAN-JUN 2025	SFY 2026	INCREASE/ (DECREASE)	INCREASE/ (DECREASE)
Composite	9,726,958	$ 5,724.9	$ 6,431.1	$ 706.2	12.3%
Total Federal Only		$ 3,982.5	$ 4,473.8	$ 491.3	12.3%
Total State		$ 1,742.4	$ 1,957.3	$ 214.9	12.3%

Notes:
1. Jan – Jun 2025 and SFY 2026 aggregate annual expenditures were developed based on SFY 2026 projected enrollment and estimated SFY 2026 deliveries.
2. State expenditures based on a composite of Federal Fiscal Year 2025 FMAP (3 months) and Federal Fiscal Year 2026 FMAP (9 months) for an estimated SFY composite FMAP of 69.57%.
3. Values have been rounded.

I. Medicaid Managed Rates

1. General Information

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

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

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

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

- Actuarial standards of practice applicable to Medicaid managed care rate setting which have been enacted as of the capitation rate certification date, including: ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification for All Practice Areas); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification); and ASOP 56 (Modeling).Actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule (CMS 2390-F) for the provisions effective for the SFY 2026 managed care program rating period.
- 2024-2025 Medicaid Managed Care Rate Development Guide, released by the Centers for Medicare and Medicaid Services in January 2024.
- Throughout this document and consistent with the requirements under 42 CFR 438.4(a), the term “actuarially sound” will be defined as in ASOP 49:

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

A. RATE DEVELOPMENT STANDARDS

i. Application of expectations to rate ranges

Not applicable. There are no rate ranges being developed for the SFY 2026 SCDHHS Medicaid managed care capitation rates.

ii. Annual basis

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

iii. Required elements

(a) Actuarial certification

The actuarial certification, signed by Marlene T. Howard, FSA, is in Appendix 1. Ms. Howard 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 2026 managed care program rating period.

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

(b) Certified capitation rates for each rate cell

The certified capitation rates by rate cell are illustrated in Figure 2. Projected enrollment estimates reflect observed program enrollment through March 2025 with adjustments to reflect anticipated changes in membership due to the unwinding of enrollment as a result of the Consolidated Appropriations Act, 2023 that concluded August 1, 2024. In SFY 2025, SCDHHS created three new capitation rate cells for individuals with Serious Mental Illness (SMI) conditions. This is not a change to the managed care eligibility requirements, but rather a shift of these individuals from their SFY 2024 rate cells into three SMI-specific rate cells: SMI Children, SMI TANF Adults, and SMI SSI Adults. These rates represent the anticipated 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. This certification does not apply to individuals enrolled in dual eligible special needs plans (D-SNPs).

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. In April 2021, two MCOs merged together, and in August 2021, a new MCO entered the South Carolina (SC) managed care program. As of July 1, 2025, 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.

This rate certification reflects SC Medicaid managed care policies and procedures anticipated to be in effect during SFY 2026.

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

FIGURE 4: LIST OF CORE BENEFITS		
Ambulance Transportation	Hearing Aids and Hearing Aid Accessories	Physician Services
Ancillary Medical Services	Home Health Services	Podiatry Services
Audiological Services	Hysterectomies, Sterilizations and Abortions (as covered in policy guidelines)	Prescription Drugs
Autism Spectrum Disorder Services	Independent Laboratory and X-Ray Services	Psychiatric, Rehabilitative Behavioral Health, and associated outpatient mental health services
Communicable Disease Services	Inpatient Hospital Services	Rehabilitative Therapies for Children · Non-Hospital Based
Developmental Evaluation Center (DEC) Services	Institutional Long-Term Care Facilities/Nursing Homes for short-term stays	Substance Abuse
Disease Management	Maternity Services	Tobacco Cessation Coverage
Durable Medical Equipment	Medication Assisted Therapy	Transplant and Transplant-Related Services
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) / Well Child	Newborn Hearing Screenings	Vision Care Services
Family Planning Services	Outpatient Pediatric AIDS Clinic Services (OPAC)	
Free-Standing Inpatient Psychiatric Facilities for Under 21	Outpatient Services	

Notes:
1. Free-standing Impatient psychiatric facility coverage applies to individuals under age 21.
2. Medication assisted therapy includes treatment in Opioid Treatment Programs (OTPs).
3. Detailed benefit coverage information for all Core Benefits in this table can be found within the Managed Care Process and Procedure Manual.
4. Source: https://img1.scdhhs.gov/sites/default/files/Process%20and%20Procedure%20Manual-January%202025.pdf

(ii) Rating Period

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

(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 (Foster care/Adoption)	60	Regular Foster Care
16	Pass Along Eligibles	61	Foster Care Adults
17	Early Widows/Widowers	71	Breast and Cervical Cancer
18	Disabled Widows/Widowers	80	SSI
19	Disabled Adult Children	81	SSI With Essential Spouse
20	Pass Along Children	85	Optional Supplement
31	Title IV-E Foster Care	86	Optional Supplement & SSI
32	Aged, Blind, Disabled (ABD)	87	OCWI Pregnant Women /Infants
40	Working Disabled	88	OCWI Partners For Healthy Children
51	Title IV-E Adoption Assistance	91	Ribicoff Children

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

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

FIGURE 6: RSP INDICATORS NOT ELIGIBLE FOR MANAGED CARE ENROLLMENT

RSP CODE	PAYMENT CATEGORY	RSP CODE	PAYMENT CATEGORY
CLTC	Elderly Disabled Waiver	HSCN	Head & Spinal Cord Waiver - New
CSWE	Community Supports Waiver - Established	MCCM	Primary Care Case Management (Medical Care Home)
CSWN	Community Supports Waiver - New	MCHS	Hospice
COVD	COVID Limited Benefits	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

Note:
1. All RSPs provided by SCDHHS on February 14, 2023 and confirmed with no changes as of March 2025

The SFY 2026 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
SMI Children	VV3
SMI TANF Adults	TP3
SMI SSI Adults	UP3
OCWI	WG2
Duals	
Foster Care Children	FG3
KICK	MG2/NG2

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

Eligibility Criteria

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

Special contract provisions

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

- Incentive arrangements
- Withhold arrangements
- Supplemental teaching physician program in accordance with 42 CFR §438.6(c)
- Health Access, Workforce, and Quality payment program in accordance with 42 CFR §438.6(c)
- Independent community pharmacy payments in accordance with 42 CFR §438.6(c)
- Private Ambulance State Directed Payment in accordance with 42 CFR §438.6(c)
- Public Ambulance State Directed Payment in accordance with 42 CFR §438.6(c)
- Physician Directed Payment in accordance with 42 CFR §438.6(c)
- Rural hospital minimum fee schedule in accordance with 42 CFR §438.6(c)

[2] MCO Process and Procedure Manual. Source:
https://img1.scdhhs.gov/sites/default/files/P&P-April2025_Blacklined_Final.pdf (Accessed May 1, 2025)

- IMDs as an in lieu of provider service
- Minimum medical loss ratio requirement
- Psychiatric Residential Treatment Facility (PRTF) risk pool
- Pharmacy high cost no experience program

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

Retroactive adjustment to capitation rates

This rate certification report does not include a retroactive adjustment to the SFY 2026 capitation rates.

iv. Differences among capitation rates

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

v. Cross-subsidization of rate cell payment

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

vi. Effective dates

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

vii. Medical loss ratio

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

Financial consequences of the minimum MLR requirements are specified in Section 7.2 of the MCO contract[3]. SCDHHS requires remittance if the MLR for the reporting year does not meet the minimum MLR requirement of 86%.

viii. Certifying rate changes

Not applicable. The SFY 2026 SCDHHS Medicaid managed care program does not utilize rate ranges.

ix. Actuarial soundness of rate changes

Not applicable. The SFY 2026 SCDHHS Medicaid managed care program does not utilize rate ranges.

x. Generally accepted actuarial practices and principles

(a) Reasonable, appropriate, and attainable

In our judgment, all adjustments to the capitation rates, or to any portion of the capitation rates, reflect reasonable, appropriate, and attainable costs, 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 2026 capitation rates certified in this report represent the final contracted rates by rate cell prior to risk adjustment, excluding the BabyNet Individuals with Disabilities Education Act (IDEA) services which are funded through a federal grant.

xi. Rate certification for effective time periods

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

[3] MCO Contract:
https://www.scdhhs.gov/sites/default/files/managedcare/MCO%20Contract%202024%20Amendment%20I%20%28updated%29.pdf
(Accessed May 1, 2025)

xii. Reflecting the impacts of the COVID-19 public health emergency and related unwinding

We reviewed quarterly experience trends by service category throughout the SFY 2024 base data period to evaluate potential impacts related to underutilization in the base period as a result of the COVID-19 pandemic. In addition, we reviewed emerging experience through November 2024 and considered this experience in trend development. Based on our review of quarterly experience throughout SFY 2024 and emerging experience, we do not believe an explicit adjustment to the SFY 2024 base data is necessary to reflect underutilization of services as a result of the COVID-19 pandemic.

In addition, based on guidance from SCDHHS and a bulletin published on March 21, 2024[4], updates were provided on the following COVID-19 temporary policy changes implemented by SCDHHS during the PHE:

- Removal of pharmacy early refill denials
- Coverage of COVID-19 vaccinations without patient cost-sharing – continue throughout SFY 2026
- Removal of E&M copay
- Removal of ambulatory care 12-visit limit
- Telehealth flexibilities

With the exception of the removal of pharmacy early refill denials (which SCDHHS reinstated upon expiration of the PHE), the remaining temporary policy changes are assumed to continue throughout SFY 2026, consistent with the SFY 2024 base data period.

We evaluated the impact of reinstating pharmacy early refill edits in SFY 2026 and it was deemed immaterial. Each of the other temporary policy changes noted above are fully reflected in the SFY 2024 base data and are anticipated to continue through SFY 2026; therefore, no adjustment is needed in the capitation rate development.

Please see section I.1.B.xi for details on rate adjustments related to the COVID-19 PHE.

xiii. Procedure for rate certification and amendment

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

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

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

B. APPROPRIATE DOCUMENTATION

i. Capitation rate certification

The SFY 2026 Medicaid managed care capitation rate development specifies capitation rates for each rate cell.

ii. Documentation of required elements

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

iii. Minimum MLR

The SFY 2026 capitation rates and associated assumptions have been developed in accordance with actuarial soundness and rate development requirements in the Medicaid and CHIP Managed Care Final Rule and consistent with the requirements under 42 CFR §438.4(a).

The capitation rates have been developed such that the MCO would reasonably achieve a medical loss ratio (MLR) of at least 85% by using actual managed care program data as the basis for developing the benefit expense component of the rates and by including non-benefit expense costs of less than 15%, which are assumed to be reasonable, appropriate, and attainable.

[4] https://www.scdhhs.gov/communications/extension-telehealth-flexibilities-issued-during-covid-19-federal-public-health (Accessed May 7, 2024)

SCDHHS requires a minimum MLR of 86% in the MCO contract to ensure that at least 85% of capitation expenditures are being used to provide health care services and quality improvement programs and initiatives for Medicaid managed care members. We review and monitor annual medical loss ratios (MLRs) provided by the MCOs to compare to the minimum MLR requirement. Figure 8 provides a summary of the most recent three years of MLR results for the five MCOs participating in the SC Medicaid managed care program, documenting the financial performance and stability of the SC Medicaid program. Note that all MLR results exclude state directed payments with separate payment terms.

FIGURE 8: COMPOSITE MEDICAL LOSS RATIOS (MLR)

MLR CALCULATION	SFY 2022	SFY 2023	SFY 2024
Numerator ($ Millions)	$ 3,117.2	$ 3,294.2	$ 3,193.0
Denominator ($ Millions)	$ 3,550.6	$ 3,722.0	$ 3,600.9
MLR	**87.8%**	**88.5%**	**88.7%**

Notes:
1. Source: SFY 2022 through SFY 2023 MCO Medical Loss Ratio Reports submitted to SCDHHS.
2. SFY 2024 MLR data is preliminary and subject to change upon final review.
3. SFY 2022, SFY 2023 and SFY 2024 MLRs reflect the revenue remitted to SCDHHS from MCOs who did not meet the minimum MLR.

iv. Use of Rate Ranges

This report certifies specific rates for each rate cell in accordance with 42 CFR §438.4(b)(4) and 438.7(c).

v. Certifying rate ranges

Not applicable. The SFY 2026 Medicaid managed care capitation rate development does not utilize rate ranges.

vi. Index

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

vii. Compliance with 42 CFR §438.4(b)(1)

The SFY 2026 Medicaid managed care capitation rate development includes assumptions, methodologies, and/or factors that are based on valid rate development standards and are consistent across covered populations in accordance with 42 CFR §438.4(b)(1) and §438.4(b)(6).

viii. Different FMAP

All populations receive the regular FMAP of 69.57% for SFY 2026. The enhanced FMAP percentage for CHIP and family planning expenditures in South Carolina is 78.70% and 90.00%, respectively. Note that the enhanced amounts for CHIP and family planning expenditures are not reflected in the values provided in Appendix 3.

ix. Comparison to previous rating period

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

The previous rate certification applied to January through June 2025 capitation rates. A comparison to January through June 2025 certified rates by rate cell is provided in Figure 2. All material changes to the capitation rates and rate development process compared to the previous rate certification are described in this report.

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

All material changes to the rate development process are outlined in this report.

(c) Application of de minimis adjustment to previous rate certification

The state did not adjust the actuarially sound January through June 2025 capitation rates by a de minimis amount.

x. Future amendments

Effective December 31, 2025, the Healthy Connections Prime (Prime) dual demonstration program will be ending and SCDHHS anticipates adding Prime members, as well as other members fully dual eligible for Medicare and Medicaid, into the Healthy Connections Medicaid managed care program. As such, a capitation rate amendment to be effective January 1, 2026 is anticipated to be submitted to CMS in December 2025. The current certification cannot account for the anticipated changes as we await final data and programmatic decisions for the new populations.

xi. Approach to addressing the impact of the COVID-19 PHE and related unwinding

As part of the Consolidated Appropriations Act, 2023, continuous enrollment requirements were decoupled from the PHE on March 31, 2023, allowing eligibility reviews to begin prior to the expiration of the PHE. As such, SCDHHS began their COVID-19 unwinding period June 1, 2023, with eligibility redeterminations substantially completed by August 1, 2024. Based on our review of individuals returning to managed care following disenrollment during the unwinding period, we estimate the impact on Medicaid managed care enrollment and acuity to be nearly complete by the end of SFY 2026.

(a) Available applicable data to address the COVID-19 PHE in capitation rate setting

The following data sources were utilized in developing rate setting adjustments for the COVID-19 PHE:

- South Carolina Medicaid managed care encounter data through November 30, 2024, inclusive of estimated incurred but not paid (IBNP) expenditures, to evaluate emerging experience following the end of the PHE.
- MCO submitted Encounter Quality Initiative (EQI) reports for SFY 2024 and first quarter of SFY 2025.
- Emerging financial experience reported by the MCOs.
- South Carolina Medicaid managed care enrollment data through March 2025 to monitor changes in per member costs and estimated acuity changes by rate cell related to enrollment changes from the unwinding period.
- Direct testing, treatment, and vaccine costs related to COVID-19 in MCO encounter data incurred from the start of the COVID-19 national health emergency through November 2024.

(b) How capitation rates account for COVID-19 PHE impacts

Using the data sources described in the previous section, we considered pandemic-related impacts on SFY 2024 base data utilization levels and projected trends used in the development of the SFY 2026 capitation rates. We also considered changes in acuity of the covered population by reviewing and evaluating the estimated mix and morbidity of members in SFY 2024 impacted by the continuous enrollment provisions relative to the anticipated mix and morbidity in SFY 2026. In consultation with SCDHHS, we evaluated the impact of the unwinding period by month and by population based on observed enrollment through March 2025.

In addition, we reviewed base data and emerging experience at the population and service category level to estimate the aggregate impact of items such as consumer behavior and changes in population mix on observed utilization and service experience during the PHE and the unwinding period. These considerations were evaluated in the development of the prospective trends, and COVID-19 diagnostic testing, hospital treatments, pharmaceutical treatments, and vaccination adjustments described in further detail in sections I.2.B and I.3.B.

We also performed an analysis of upper respiratory condition treatment costs. Our review included the following:

- **COVID-19 treatment**. COVID-19 treatment was based on primary or admitting diagnosis code. Note that COVID-19 testing and pharmaceutical treatments are excluded from this analysis as both were evaluated and documented separately in Section I.2.B.iii. below.
- **Flu-related costs**. Flu treatment and testing costs were based on primary or admitting diagnosis codes, procedure codes, and flu-related pharmaceutical treatments identified by NDC code.
- **Respiratory Syncytial Virus (RSV)**. RSV treatment was based on primary or admitting diagnosis codes, procedure codes, and RSV-related pharmaceutical treatments identified by NDC code.

To estimate the impact of differences in the expected treatment cost related to COVID-19, flu, and RSV between the SFY 2024 base period and the projected SFY 2026 contract period for the adult and children populations, we reviewed SFY 2021 through December 2024 PMPM claim expenses by service category for members receiving COVID-19, flu, or RSV treatment. Based on our review of emerging experience, we believe that total upper respiratory condition treatment costs by population in the SFY 2024 data are indicative of those anticipated in the SFY 2026 contract year. Therefore, no adjustment was made to the base data for these conditions.

Effective February 4, 2020, SCDHHS implemented coverage of COVID-19 diagnostic testing without prior authorization or copayment for all populations. Based on guidance from SCDHHS, coverage of COVID-19 testing without prior authorization or copayment is anticipated to remain in effect as a permanent policy in South Carolina's Medicaid program. As such, coverage of COVID-19 diagnostic testing as a covered benefit is fully reflected in the SFY 2024 base data and is anticipated to remain in effect in the SFY 2026 contract period.

To estimate the impact of ongoing non-Over-the-Counter (non-OTC) COVID-19 diagnostic testing in SFY 2026, we reviewed emerging non-OTC COVID-19 testing experience through February 2025. Based on this review, we believe that non-OTC COVID-19 testing costs in the SFY 2024 base data are indicative of those anticipated in the SFY 2026 contract year. Therefore, no adjustment was made to the base data for non-OTC COVID-19 diagnostic testing.

(c) Non-risk payments

Effective for the SFY 2026 contract year, SCDHHS has not implemented any non-risk arrangements for COVID-19 related costs. All COVID-19 related costs, such as COVID-19 testing, vaccine administration, treatments, etc. are covered through the managed care program on a full risk basis.

(d) Risk mitigation strategies utilized for COVID-19 PHE

SCDHHS has not implemented risk mitigation strategies in the SFY 2026 managed care program specifically to address the COVID-19 PHE. The SFY 2026 managed care program includes the following risk mitigation strategies, consistent with the prior rating period:

- Minimum medical loss ratio (MLR) requirement of 86%
- Non-risk high cost no experience pharmacy arrangement
- Budget-neutral risk pool for PRTF services

Further detail and documentation for all risk sharing arrangements is included in section I.4.C.

2. Data

This section provides information on the SFY 2024 base data used to develop the capitation rates. The base experience data described in this section is illustrated in Appendix 6, with adjustments for incomplete data and current program reimbursement.

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 2026 capitation rate development. Additionally, Appendix 6 summarizes the unadjusted and adjusted base data.

ii. Data used to develop the capitation rates

(a) Description of the data

(i) Types of Data

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

- Encounter data submitted by the MCOs and accepted through the monthly encounter data warehousing process through December 2024;
- Supplemental encounter data submitted by the MCOs during the base data validation process
- FFS claims for dual eligible individuals incurred in SFY 2024, and paid through December 2024;
- FFS claims incurred by managed care enrollees for managed care-covered services;
- SFY 2026 managed care in-rate criteria;
- FFS claims for analysis of newborn enrollment delays;
- SFY 2026 MCO Rate-Setting Survey completed by each MCO;
- SFY 2026 MCO Administrative Cost Template completed by each MCO;
- Statutory financial statement data;
- March 2019 through February 2020 Bridges invoice data for managed care enrollees;
- SFY 2024 financial summary reports provided by the MCOs (EQI reports) for base data validation analysis.
- SCDHHS fee schedules for inpatient, outpatient, and professional claims.
- Weekly preferred drug list (PDL) files through February 2025 and April Pharmacy and Therapeutics (P&T) updates provided by SCDHHS.
- Supplemental eligibility data provided by SCDHHS related to foster care assignment updates and out of state member terminations

(ii) Age of the data

The data serving as the base experience in the capitation rate development process was incurred July 2023 through June 2024. The encounter data for the base period reflected encounters adjudicated and submitted through the monthly encounter data warehousing process through December 2024 and supplemental encounter data provided by the MCOs during the base data validation process.

The base data time period for the SFY 2026 capitation rate development has been selected to reflect the most current program experience available; however a thorough review and analysis of quarter over quarter changes in SFY 2024 and emerging experience was completed to evaluate potential impacts of the COVID-19 PHE on the SFY 2024 period.

For the purposes of non-pharmacy trend development, we reviewed encounter experience from July 2021 through June 2024 and paid and submitted through the data warehousing process through December 2024, to the extent it is credible by major category of service.

For pharmacy trend development, we reviewed quarterly pharmacy expenditures on an incurred basis over the period from July 2021 through February 2025.

We also summarized statutory financial statement data from calendar years 2022, 2023, and 2024, 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-contracting

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 0.8% 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.

(v) Base data requirement exceptions

No exception to base data requirements was requested. The data serving as the base experience in the SFY 2026 capitation rate development process was incurred July 2023 through June 2024, which follows the rate development standards related to base data in 42 CFR 438.5(c).

(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 2026 Capitation Rate Methodology and Data Book, dated March 17, 2025, 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 and 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 and individual encounters to each of the MCOs to confirm that their summarized data including SFY 2024 incurred claims is appropriate for use in the development of the capitation rate.

The SFY 2024 base encounter data used in the development of the rates was adjudicated through December 31, 2024. The six 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 2024. However, as noted in this report, claims completion is applied to the encounter data for estimated SFY 2024 claims adjudicated after December 31, 2024.

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 2026 capitation rates, a summary was provided to each MCO that starts with total submitted encounter claims and identifies claims that have been removed from the base data summaries, such as voided claims, expenditures for non-state plan services, expenditures for services not covered in the capitation rate, expenditures related to members over age 21 who were in an IMD for at least 15 days in a calendar month, expenditures related to high cost no experience pharmaceutical treatments, and claims that have been removed because of unmatched eligibility records and members not eligible during the base data period, such as dual-eligible individuals and individuals beyond their date of death.

(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 2026 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 2024 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 2026 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 approximately $4.2 million to the base data.

Additionally, an adjustment was applied for supplemental data received from the MCOs related to physician paid amounts that were truncated in the encounter data files received from SCDHHS due to data field limitations. An adjustment has been made to increase the base data by approximately $8.1 million.

(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 2024 base experience period. As such, expenditure data for populations enrolled in FFS during SFY 2024 is not reflected in the base experience cost models used to develop the capitation rates, with the exception of the dual rate cell. FFS claims experience for managed care enrollees related to managed care covered benefits was utilized to estimate the financial impact of transitioning these expenditures to the MCOs responsibility in SFY 2026.

(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 2024 encounter data, which were shared with SCDHHS and participating MCOs.

iii. Data Adjustments

Capitation rates were developed primarily from SFY 2024 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 2024 and paid through December 2024. Separate sets of completion factors for the two data sources were developed by summarizing the claims data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability.

Completion factors were developed by summarizing the data and applying traditional actuarial techniques to develop estimates of incurred but not paid (IBNP) liability, using Milliman's Robust Time-Series Analysis System (RTS)5. First, we stratified the data by category of service, in the population groupings illustrated in Figure 9. Claims for each of these population-service category stratifications were analyzed and formed into lag triangles by paid and incurred month. Claim completion factors were developed for each month of the base experience period, based on historical completion patterns. The monthly completion factors were applied to base data experience to estimate the remaining claims liability for the fiscal year. Results were aggregated into annual completion factors for the fiscal year.

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

The claim completion factors applied to the base data are illustrated by population and major service category in Figure 9.

FIGURE 9: COMPLETION FACTORS APPLIED TO BASE EXPERIENCE DATA

CATEGORY OF SERVICE	TANF/FOSTER	SSI	OCWI	SMI	DUAL	KICK
Hospital						
Inpatient	1.0435	1.0504	1.0320	1.0271	1.0179	1.0343
Outpatient	1.0161	1.0244	1.0164	1.0173	1.0197	1.0190
Pharmacy	1.0001	1.0006	1.0000	1.0000	1.0009	N/A
Ancillary	1.0172	1.0144	1.0081	1.0077	1.0362	N/A
Professional	1.0107	1.0113	1.0129	1.0087	1.0328	1.0107

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

(c) Errors found in data

Encounter data validation letters were submitted to each of the MCOs to confirm that their summarized base data is appropriate for use in the development of the capitation rates. For MCOs that reported valid encounters missing from the encounter data submissions in their response to the SFY 2026 MCO Rate-Setting Survey and in supplemental data files, an adjustment has been made to increase the base data.

Based on a review of SFY 2024 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 2026. The base data has been increased by approximately $0.5 million for the FFS claims related to managed care covered services.

(d) Program change adjustments

All program and reimbursement changes that have occurred in the Medicaid managed care program on or after July 1, 2023, 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.

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 the application of the July 1, 2024, March 1, 2025 and July 1, 2025 PPS fee schedule updates. We reviewed all FQHC physician claims in the base data and applied the FQHC reimbursement methodology, state plan copayments for eligible populations, and current PPS rates. The repricing analysis captured approximately 99.4% of total FQHC claims. For claims that were unable to be repriced due to unknown provider IDs, the repricing adjustment factor was assumed to be 1.0.

Additionally, effective October 1, 2024, SCDHHS updated the list of procedure codes included in the FQHC wrap methodology. The FQHC provider-specific PPS rates reflect the full payment to the FQHC, including the wrap-around payment.

The estimated impact of all FQHC reimbursement updates is approximately $2.0 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 July 2021, the entirety of the fee schedule change is not reflected in the SFY 2024 base data as some MCOs do not reflect the entire increase through the encounter claims. Therefore, the repricing of all qualifying physician claims to the enhanced fee schedule increases the physician expenditures reported in the encounter base data (see ‘Base Physician Repricing’ in Figure 10).

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 2024 base data for the repricing and reimbursement adjustment analyses. Similar to SFY 2025, 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 2025 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 91.9% of total non-FQHC physician dollars.

The ‘Base Physician Repricing’ column in Figure 10 represents the impact of repricing to the Medicaid fee schedule effective July 1, 2023, including the enhanced fee schedule discussed above. Additionally, consistent with SFY 2025, claims provided by teaching physicians and billed by a non-teaching facility qualify for the enhanced fee schedule, while claims provided by teaching physicians and billed by a teaching facility are assumed to be reimbursed at the standard fee schedule, where appropriate. Note that the fee schedule updates that were implemented on July 1, 2024 are excluded from the ‘Base Physician Repricing’ impacts and stratified separately for additional transparency. The estimated impact of the repricing adjustment based on SFY 2026 projected enrollment is approximately $11.7 million.

Effective July 1, 2024, SCDHHS made the following updates to the physician fee schedule:

- Updated rehabilitative health service rates for licensed psychologists
- Increased a subset of physical therapy, occupational therapy, and speech-language pathology service rates
- Updated the physician fee schedule to benchmark rates to the 2024 Medicare Fee Relative Value Unit (RVU) and Clinical Lab fee schedules for a subset of providers. This fee schedule update is related to family practice, obstetrics and gynecology, pediatric subspecialists, neonatologists, lab and radiology, podiatrists, chiropractors, enhanced qualifying physicians, and other medical professionals.

The estimated impact of the July 1, 2024 physician fee schedule updates in composite is $19.1 million, and the PMPM impact is captured in the ‘7/1/2024 Update’ column in Figure 10.

Figure 10 presents the combined results of the FQHC and non-FQHC repricing analyses.

FIGURE 10: COMPOSITE PHYSICIAN AND ANCILLARIES PMPM ADJUSTMENTS BY RATE CELL				
RATE CELL	FQHC FEE SCHEDULE	BASE PHYSICIAN REPRICING	7/1/2024 UPDATE	COMPOSITE ADJUSTMENT
TANF: 0-2 months old (AH3)	$ 0.65	$ (1.38)	$ (14.84)	**$ (15.57)**
TANF: 3-12 months old (AI3)	(0.36)	(0.76)	3.17	**2.05**
TANF: Age 1-6 (AB3)	(0.16)	0.83	3.16	**3.83**
TANF: Age 7-13 (AC3)	0.09	1.19	1.05	**2.33**
TANF: Age 14-18, Male (AD1)	0.09	0.90	0.76	**1.75**
TANF: Age 14-18, Female (AD2)	0.14	1.53	0.75	**2.42**
TANF: Age 19-44, Male (AE1)	0.16	0.38	0.49	**1.03**
TANF: Age 19-44, Female (AE2)	0.42	1.21	1.31	**2.94**
TANF: Age 45+ (AF3)	0.64	0.41	1.54	**2.59**
SSI - Children (SO3)	0.13	7.01	3.94	**11.08**
SSI - Adults (SP3)	0.92	1.43	2.75	**5.10**
SMI Children (VV3)	1.00	7.16	(0.01)	**8.15**
SMI TANF Adults (TP3)	1.30	2.33	4.61	**8.24**
SMI SSI Adults (UP3)	1.58	1.66	4.55	**7.79**
OCWI (WG2)	0.42	1.49	1.58	**3.49**
DUAL	0.15	-	1.36	**1.51**
Foster Care - Children (FG3)	0.48	11.82	4.96	**17.26**
KICK (MG2/NG2)	6.36	(36.39)	107.17	**77.14**

For each rate cell, more detailed PMPM adjustments are applied at the category of service level and can be found in the “program and policy” section of Appendix 6 and the “reimbursement adjustment” section of Appendix 7.

Autism Spectrum Disorder (ASD) Services

The following reimbursement updates and program changes related to ASD services were evaluated for the SFY 2026 contract year:

- Effective July 1, 2023, SCDHHS implemented a rate of $59.52 per hour for therapy services provided by Registered Behavioral Technicians (RBTs), an increase of 32.3% over January 1, 2022 rates.
- Effective July 1, 2023, SCDHHS expanded the ABA service array to include two new group therapy ABA codes (97154 and 97158)
- Effective July 1, 2024, SCDHHS expanded the ABA service array to include four new ABA codes (97152, 97157, 0362T, and 0373T).

Consistent with SFY 2025 assumptions and emerging experience, utilization of a subset of ASD services is anticipated to increase by 25% due to provider capacity increases resulting from the July 1, 2023 ASD fee schedule update.

To estimate the impact of the ABA service array expansion, we reviewed ASD experience in two comparison states who offer both the services included in SC’s current ASD service array, as well as the additional group therapy services. In addition, we reviewed emerging utilization and anticipated utilization by procedure code provided by SCDHHS.

Based on SFY 2026 projected membership and the utilization sources described above, the ASD policy and program changes reflect an increase to professional MH/SA expenditures of approximately $7.7 million.

Psychiatric Residential Treatment Facilities (PRTF) Per Diem Rate Changes

Effective July 1, 2024, SCDHHS implemented a reimbursement update of $525 per day for all in-state PRTF providers. Additionally, SCDHHS established a reimbursement rate of $788 per day for PRTFs that specialize in the treatment of ASD. We estimated the impact of this reimbursement change by repricing all PRTF claims in the SFY 2024 base data to the July 1, 2024 fee schedule. Note that PRTF services in the SFY 2024 base data that reflected a higher reimbursement rate than the July 1, 2024 fee schedule were not adjusted in the repricing analysis. The estimated impact of this program change based on SFY 2026 projected membership is an increase to SFY 2024 PRTF base expenditures of approximately $0.3 million and is applied to the Inpatient MH/SA category of service.

SC Free-Standing Psychiatric Facility Per Diem Rate Changes

Effective July 1, 2024, SCDHHS implemented an increase to the SC DMH long-term psychiatric facility per diem rates to $800 per day and transitioned all other short-term free-standing psychiatric facilities from APR DRG reimbursement to a per diem rate of $800. We estimated the impact of this rate change by repricing all impacted claims for the under age 21 population to the anticipated July 1, 2024 fee schedule. Note that the age 21 to 64 adult population is subject to the IMD exclusion and is not repriced to the $800 per diem rate, but instead is repriced to the unit cost for that of existing state plan providers as documented in the "IMD In Lieu Of Services for Individuals Age 21 to 64" section below.

Based on SFY 2026 projected membership, this program change reflects an increase of approximately $4.4 million to inpatient hospital MH/SA expenditures for the SFY 2026 contract period.

Inpatient and Outpatient Hospital Reimbursement Changes

Effective July 1, 2025, SCDHHS anticipates adding a facility, MUSC Black River Health, to be reimbursed under the state directed rural hospital minimum fee schedule established July 1, 2023. As such, SCDHHS anticipates updating the inpatient hospital-specific base rate and outpatient multiplier for MUSC Black River Health and requiring all MCOs to reimburse at no less than the applicable Medicaid fee-for-service rate. An adjustment is applied to the inpatient and outpatient categories of service and is estimated at approximately $0.4 million and $2.2 million, respectively, based on SFY 2026 projected membership.

Opioid Treatment Programs (OTP) Reimbursement Updates

Effective October 1, 2025, SCDHHS anticipates increasing reimbursement rates for methadone and buprenorphine (procedure codes G2067 and G2068) treatment. We estimated the impact of this rate change by repricing all impacted claims to the anticipated October 1, 2025 fee schedule. Additionally, based on SCDHHS guidance, we have assumed that utilization of procedure codes G2067 and G2068 will increase by approximately 10%. To account for the October 1, 2025 effective date, the estimated increase for nine months of the SFY 2026 contract year is spread over the full 12 month period. An adjustment is applied to the professional MH/SA category of service and is estimated at approximately $5.5 million based on SFY 2026 projected membership.

Historical Program Change Review

IMD In Lieu Of Services for Individuals Age 21 to 64

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 the IMD in lieu of service, we did not use the unit cost of the IMD, and instead utilized the unit cost for that of existing state plan providers.

Figure 11 provides a summary of the adjusted base data to reflect the repriced unit costs for IMD services represented in the base data. The estimated impact of this adjustment is approximately $4.6 million.

FIGURE 11: IMD IN-LIEU OF PROJECTED UTILIZATION

	BASE DATA			ADJUSTED BASE DATA		
	IP PSYCH	IMD	TOTAL	IP PSYCH	IMD	TOTAL
Utilization (Days)	16,321	19,924	36,245	16,321	19,924	36,245
Utilization per 1000	55.4	67.6	122.9	55.4	67.6	122.9
Cost per Day	$ 731.55	$ 509.10	$ 609.27	$ 731.55	$ 731.55	$ 731.55
Total Expenditures (millions)	$ 11.9	$ 10.1	$ 22.1	$ 11.9	$ 14.6	$ 26.5

Note:
1. IP psychiatric and IMD base data includes all SFY 2023 IP MH/SA expenditures for the 21 to 64-year old managed care population.

COVID-19 Pharmaceutical Treatment

On October 13, 2023, HHS and Pfizer reached an agreement to transition Paxlovid to the commercial market in November 2023 while ensuring individuals on Medicaid will continue to have access to Paxlovid without member copays through calendar year 2024.

As a result of this agreement, the MCOs are responsible for paying for Paxlovid treatments beginning in November 2023, at an estimated average treatment cost of approximately $1,401 per script, based on emerging data. Based on a review of emerging utilization of Paxlovid, the estimated impact to pharmacy expenditures as a result of MCOs covering Paxlovid treatments at an assumed cost of $1,401 per treatment is an increase to the projected SFY 2026 expenditures of approximately $2.5 million.

Nutritional Counseling Reimbursement and Coverage Updates

Effective January 1, 2024, SCDHHS implemented reimbursement rate increases for dieticians and increased benefit frequency limits for nutritional counseling services to support SCDHHS's anti-obesity initiative. Based on discussions with SCDHHS and a review of emerging data, projected utilization increases were applied to individual nutritional therapy services, procedure codes 97802 (initial assessment) and 97803 (re-assessment). Additionally, the reimbursement rates for these services increased to $26.50 and $23.05 per unit for 97802 and 97803, respectively. An adjustment is applied to the Other Professional category of service and is estimated at approximately $1.0 million based on SFY 2026 projected membership.

Cochlear Implant Coverage Expansion

Effective January 1, 2024, SCDHHS expanded coverage of cochlear implant services for all adult beneficiaries. We estimated the monthly costs of expanding cochlear implant services by reviewing emerging data after January 1, 2024 to develop a full year projection. As a portion of the total assumed costs for this service are already covered by the MCOs, the related costs in the SFY 2024 base data were subtracted from the total projected costs in development of the adjustment. An adjustment is applied to the Outpatient Hospital - Surgery, Ancillary - DME/Prosthetics, and Professional - Inpatient and Outpatient Surgery categories of service, with the majority of the impact in the Outpatient Hospital - Surgery category. The impact is estimated at approximately $0.3 million based on SFY 2026 projected membership.

Transplant Services Carve-In

Effective February 1, 2024, SCDHHS carved in the cost of transplant events[6] to managed care, in addition to the post-transplant event services the MCOs have been responsible for historically. To estimate the impact of this program change, we reviewed historical fee-for-service transplant experience for MCO members and applied an adjustment to reflect the portion of the base data period during which the transplant services carve-in was not yet effective. An adjustment is applied to the Inpatient Medical/Surgical/Non-Delivery category of service and is estimated at approximately $6.4 million based on SFY 2026 projected membership.

Development Evaluation Center (DEC) Carve-In and Reimbursement Update

Effective February 1, 2024, SCDHHS carved in coverage of DEC services to the managed care program. To estimate the impact of this program change, we summarized and reviewed historical fee-for-service DEC expenditures for the MCO population and applied an adjustment to reflect the portion of the base data period for which the DEC services carve-in was not yet effective.

Additionally, effective July 1, 2024, SCDHHS implemented a 17.5% reimbursement rate increase for all DEC services. To estimate the impact of this reimbursement change, SFY 2024 DEC expenditures were repriced to the July 1, 2024 fee schedule.

An adjustment is applied to the Other Professional category of service for the DEC carve-in and reimbursement rate increase and is estimated at approximately $3.9 million and $0.5 million, respectively based on SFY 2026 projected membership.

Genetic Testing Laboratory Services

Effective March 1, 2024, SCDHHS added coverage for Oncotype DX Breast Cancer Assay (procedure code 81519) and Neuropharmagen Genomic Testing (procedure code 81418) to state plan covered services.

[6] The following inpatient services outlined in the In-rate criteria provided by SCDHHS on 2/14/23 are anticipated to be carved into managed care effective February 1, 2024: DRGs 001, 002, 003, 006, 007, 008, 440

Based on guidance from SCDHHS related to anticipated utilization and reimbursement of these genetic testing laboratory services, adjustments were applied to the pathology/lab and other professional categories of service to reflect anticipated expenditures not yet reflected in the base data as a results of the March 1, 2024 effective date The estimated impact of this program change is approximately $0.3 million based on SFY 2026 projected membership.

Leap Year Adjustment

The SFY 2024 base period contains one additional day as a result of leap year. We developed a 0.9973 adjustment (365/366) to the utilization for each major category of service and rate cell to remove the additional day of services.

Prospective Program Change Review

Removal of Over-the-Counter COVID-19 Diagnostic Testing

Effective October 1, 2024, Over-the-Counter (OTC) COVID-19 tests are no longer a covered service. To estimate the impact of this program change, we summarized the estimated OTC COVID-19 testing utilization and associated cost in the SFY 2024 base data. An adjustment was applied to remove the OTC testing utilization and cost from the capitation rates in SFY 2026. The estimated impact of this program change is a decrease of approximately $0.5 million.

Crisis Stabilization Units

Effective January 1, 2024, SCDHHS added two new crisis stabilization state plan services, procedure codes S9484 (crisis intervention, hourly) and S9485 (crisis intervention, daily), for individuals in mental health crisis or suffering from substance use with or without co-occurring mental health disorders. These services are available to hospitals that have both constructed separate behavioral health emergency units (EmPATH units) and have enrolled in the EmPATH program for reimbursement. To develop the adjustment impact, we estimated SFY 2026 utilization based on facility-specific chair (S9484) and bed (S9485) capacity assumptions provided by SCDHHS, as well as effective dates for thirteen facilities that are anticipated to offer crisis stabilization services in SFY 2026 based on the anticipated program enrollment schedule by facility received from SCDHHS. The estimated utilization for each service was multiplied by the January 1, 2024 fee schedule[7] to determine the estimated impact, and is assumed to ramp up to each hospitals' expected Medicaid utilization rate within a year of enrolling in the program. The adjustment is applied to the Outpatient Non-Surgical – Emergency room category of service and is estimated at approximately $4.1 million.

Intensive In-Home Services

The following state plan services were added to the managed care program for intensive in-home services (IIHS):

- Effective January 1, 2024 SCDHHS carved in a new state plan service for multisystemic therapy (H2033, MST)
- Effective July 1, 2024, SCDHHS carved in a new state plan service for Homebuilders services (H2022, HB)

To develop the adjustment impact for IIHS, we estimated SFY 2026 utilization for MST and HB services based on observed emerging utilization through February 2025 and the following assumptions provided by SCDHHS: projected Medicaid beneficiaries served, average number of days in treatment per beneficiary, and anticipated per diem reimbursement of $309.56 (MST) and $386.80 (HB). An adjustment is applied to the professional MH/SA category of service and is estimated at approximately $1.0 million for MST services and $2.0 million for HB services based on SFY 2026 projected membership.

[7] Medicaid Bulletin (December 7, 2023) "Addition of hospital-based Crisis Stabilization Services": https://www.scdhhs.gov/sites/default/files/documents/(2023-12-7)%20Addition%20of%20Hospital-based%20Crisis%20Stabilization%20Services%20v7.pdf, Accessed May 1, 2024

Removal of Member Copays

Effective July 1, 2024, SCDHHS removed member copays for all services in the managed care program. To estimate the impact of this program change, we summarized the estimated copays paid by managed care members in the SFY 2024 base data and applied an adjustment to incorporate the estimated copay costs in the capitation rates in SFY 2026. The estimated impact of this program change for each major category of service is as follows: hospital inpatient = $0.5 million, hospital outpatient = $0.9 million, professional = $0.2 million, and pharmacy = $6.9 million.

Expansion of Continuous Glucose Monitoring (CGM) Devices

Effective July 1, 2024, SCDHHS expanded coverage of CGM devices to children and adults utilizing insulin therapy with Type 2 diabetes. To estimate the impact of this program change, we reviewed CGM utilization information from other state Medicaid programs that cover CGM devices for individuals with Type 2 diabetes, as well as SC managed care experience in the SFY 2024 base data. Based on this review, we assumed the following:

- CGM device utilization would increase to a 45% uptake rate for individuals with Type 2 diabetes who utilize insulin.
- An assumed cost per recipient of approximately $1,250 based on average observed CGM costs for Type 2 diabetes individuals in the SFY 2024 base data

Based on SFY 2026 projected membership and the assumptions described above, the expanded coverage of CGM devices reflects an increase to pharmacy expenditures of approximately $1.0 million.

Single Preferred Drug List (PDL)

- Effective July 1, 2024, SCDHHS implemented a single PDL for the managed care program, based on SCDHHS's formulary. Because the MCOs managed the pharmacy benefit with their own respective formularies in the base data period, a utilization shifting methodology was applied to estimate the pharmacy products that are expected to be utilized during the SFY 2026 contract period based on the PDL anticipated to be effective on July 1, 2025.

  The formulary file relied upon is the April 2025 SCDHHS PDL, with adjustments anticipated to go into effect on July 1, 2025, based on information received from SCDHHS.

  Our evaluation of the single PDL transition followed the methodology outlined below.

  (1) **Create PDL Groupings.** The PDL file provided by SCDHHS contains a field called Market Basket, which is a grouping of products intended to be used for similar indications. This is the base level we used to develop PDL Groupings, with further delineation of the Market Baskets as clinically appropriate. For example, we stratified the "Hypoglycemics, Insulin and Related Agents" Market Basket further to recognize the type of insulin (e.g., long-acting vs rapid-acting) and formulation (e.g., vials vs pens).

  (2) **Utilization Shifting.** Within each PDL grouping, the utilization shifting methodology can be viewed as a three-step process:

  1. *Brand preferred over generic*. The SCDHHS PDL includes brand drugs as preferred in many cases. The shift from generic products to brand generally results in a higher gross cost. For classes with brand products preferred over generic, we assumed a default 95% brand market share percentage that accounts for SCDHHS anticipated contractual requirements, such as PDL compliance.

  2. *General shifting*. This step reflects shifting other than brand preferred over generic that is anticipated to take place within PDL groupings. Generally, this step assumes shifting of non-preferred agents to preferred agents within the same PDL grouping based on the FFS distribution within the PDL grouping, unless the managed care distribution already had a greater percentage of preferred products. The cost impact of step 2 was materially less than step 1.

  3. *Clinical review*. The default shifting assumptions from steps 1 and 2 were overridden in some instances based on clinical review. This review included a review of the FFS distribution, market conditions, and other clinical considerations.

The assumed preferred market share considers whether the product is a specialty drug. We understand that most specialty drugs require prior authorization and, in many cases, members may have tried and failed other preferred first line therapy. Because of this, we assumed minimal shifting for specialty drugs.

In some instances, the clinical review validated the model shift from steps 1 and 2; in others, selections were made to reflect a more appropriate shifting assumption.

(3) **Cost per script assumption.** The total impact of the shifting is calculated by multiplying the shifted utilization by product by its cost per script.

1. Generally, the MCO composite cost per script included in the base data for a product is applied as the assumed cost per script for the shifted SFY 2024 utilization. In instances where the MCO composite cost per script is not credible, the wholesale acquisition cost (WAC) was used as appropriate.

2. The final cost per script assumptions reflect recent price reductions to a number of brand name drugs. The impacts of these price changes were material in some PDL groupings that have a preferred brand over generic strategy in place. The cost per script adjustment is estimated at approximately ($5.3) million based on the shifted utilization to the brand drug. The following products had the largest impacts due to the price reductions:

    - Hypoglycemics, insulin and related agents – Lantus, Humalog, Humulin, Levemir, Novolog, and Novolin
    - Glucocorticoids, inhaled – Advair, Symbicort, Asmanex
    - Hypoglycemics, incretin mimetics/enhancers – Victoza

- **Clinical Review: Key Drivers**

(1) **Cytokine And CAM Antagonists** – We assume that utilization will shift from the biosimilar Hadlima to brand Humira, resulting in 95% of utilization projected for the preferred brand Humira.

(2) **Opiate Dependence Treatments** – We assume that the brand over generic products Suboxone Film and Narcan Nasal Spray will each have 95% utilization from shifting from their generic equivalents.

(3) **Anticonvulsants - Carbamazepine Derivatives** – We assume that utilization will shift from the generic Oxcarbazepine to the brand Trileptal resulting in 95% brand drug utilization.

(4) **Insulin – Long Acting pen** – We assume that utilization will shift from Basaglar and generic insulin Glargine to brand Lantus utilization. The projected Lantus utilization is 97%, consistent with what we have observed in FFS.

An adjustment is applied to the prescription drug category of service and is estimated at approximately $18.9 million based on SFY 2026 projected membership, prior to trend. Figure 12 below shows the top 10 classes in terms of absolute impact. Note that the total ingredient cost impact of $23.7 million is based on SFY 2024 base data utilization.

FIGURE 12: SINGLE PDL UTILIZATION SHIFTING IMPACTS

PDL GROUPING	[A] ORIGINAL INGREDIENT COST	[B] SHIFTED INGREDIENT COST	[C] = [B] - [A] UTILIZATION SHIFTING IMPACT	[D] COST PER SCRIPT REDUCTION IMPACT	[E] = [C] + [D] TOTAL INGREDIENT COST IMPACT
CYTOKINE AND CAM ANTAGONISTS	$ 108.9	$ 122.8	$ 13.9	$ 0.0	$ 13.9
OPIATE DEPENDENCE TREATMENTS	6.4	11.9	5.6	0.0	5.6
ANTICONVULSANTS - CARBAMAZEPINE DERIVATIVES	1.7	5.3	3.6	0.0	3.6
INSULIN - LONG ACTING - PEN	6.9	4.3	(2.6)	(0.7)	(3.3)
GLUCOCORTICOIDS, INHALED -BETA AGONISTS COMBINATIONS	7.3	11.1	3.7	(0.6)	3.1
ADHD - AMPHETAMINES ER	13.5	16.6	3.1	0.0	3.1
INSULIN - RAPID ACTING - VIAL	2.5	2.5	(0.0)	(1.6)	(1.6)
ANTIDEPRESSANTS, OTHER	3.1	1.6	(1.4)	0.0	(1.4)
ANTICONVULSANTS - SECOND GENERATION	8.7	9.9	1.2	(0.1)	1.1
DIABETES - DPP-4 INHIBITORS	2.0	3.0	0.9	0.0	0.9
ALL OTHER PDL GROUPINGS	581.8	583.0	1.2	(2.3)	(1.2)
TOTAL	**$ 742.8**	**$ 771.9**	**$ 29.1**	**($ 5.3)**	**$ 23.7**

Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP)

Effective October 1, 2024, SCDHHS added two new services, intensive outpatient psychiatric services (S9480) and mental health partial hospitalization treatment (H0035). PHP and IOP provide a time-limited service to stabilize acute symptoms and can be used as either a step down from inpatient care, or a step up from professional behavioral health treatment.

To develop the adjustment impact, we estimated SFY 2026 utilization based on utilization and length of stay assumptions provided by SCDHHS. The estimated utilization for each service was multiplied by the per diem rates[8] to determine the estimated direct cost impact of PHP and IOP services. This direct cost impact is applied to the outpatient treatment/therapy/testing service category. It is anticipated that a portion of these newly-added services will be offset by a reduction in other services as a result of step down and step up treatments described above. The offsetting impacts resulting from replacement services were estimated by multiplying assumed utilization decreases by the cost of each avoided service. These offsets were applied to the inpatient MH/SA and professional MH/SA service categories. The net impact of this program change is estimated at approximately $6.3 million based on SFY 2026 projected membership.

Collaborative Care Management (CoCM) Services

Effective October 1, 2024, SCDHHS added collaborative care model services for treating behavioral health conditions in primary care through integration of care managers and psychiatric consultants. The following procedure codes are included in the COCM model.

- 99492: First 70 minutes in initial month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician
- 99493: First 60 minutes in subsequent month of collaborative care
- 99494: Additional 30 minutes of collaborative care
- G2214: First 30 minutes in a month of collaborative care, used when patient's total billable minutes are less than what is required for 99493

To develop the adjustment impact, we estimated SFY 2026 utilization based on participation rate assumptions of the target population provided by SCDHHS. The estimated utilization for each service was multiplied by reimbursement rates provided by SCDHHS to determine the estimated impact. Based on the methodology described above, an adjustment is applied to the professional MH/SA category of service and is estimated at approximately $6.8 million based on SFY 2026 projected membership.

GLP-1 Weight Management Agents

Effective November 1, 2024, SCDHHS implemented a policy to permit the use of GLP-1 pharmaceutical products as weight management agents. The majority of emerging utilization is for Wegovy, which is the preferred agent on the single PDL. Based on a review of emerging utilization, SCDHHS's clinical criteria for prior authorization, and historical patterns in other states that have implemented GLP-1 coverage for weight management, we have projected utilization for SFY 2026. An adjustment is applied to the prescription drug category of service and is estimated at approximately $20.6 million based on SFY 2026 projected membership.

Removal of Hospital Outpatient GME Multiplier

Effective October 1, 2025, SCDHHS anticipates transitioning hospital outpatient Graduate Medical Education (GME) payments from claims-based payments paid by the MCO through an outpatient GME multiplier to a per resident methodology paid by SCDHHS to the hospitals. For all impacted hospitals, SCDHHS provided the outpatient multiplier split between the base multiplier component and the GME component. To estimate the impact of this program change, we evaluated the impact of removing the GME portion of the multiplier by repricing hospital outpatient claims at the base outpatient multiplier and subtracting from hospital outpatient payments including both the base and GME component of the multiplier. To account for the October 1, 2025 anticipated effective date, the estimated decrease for the nine months of the SFY 2026 contract year is spread over the full 12 month period. The impact is estimated at approximately ($13.7) million based on SFY 2026 projected membership.

[8] https://www.scdhhs.gov/communications/addition-intensive-outpatient-and-partial-hospitalization-programs, Accessed May 5, 2025

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 $0.2 million, an increase of 0.2% to the 0-2 month rate cell, to include these expenditures that are expected to be covered by the MCOs during the SFY 2026 contract year.

Unwinding Acuity Adjustment

As part of the Consolidated Appropriations Act, 2023, continuous enrollment provisions were decoupled from the PHE on March 31, 2023, allowing eligibility reviews to begin prior to the expiration of the PHE. In South Carolina, the COVID-19 unwinding period began June 1, 2023. We have been in ongoing discussions with SCDHHS regarding their redetermination reinstatement process during the unwinding period. With reliance on SCDHHS direction, we have assumed the following related to eligibility changes throughout the unwinding process:

- Beginning April 1, 2023, individuals impacted by the disenrollment freeze were included in an eligibility review process, with the first disenrollments occurring June 1, 2023.
- We reviewed emerging eligibility data through March 2025 to assess members and the outcome of their eligibility redeterminations, as well as observed reenrollment patterns following termination, during the unwinding process.
    - Disenrollments for non-SSI populations related to the PHE unwinding are assumed to be complete as of August 2024.
    - Disenrollments for SSI populations related to the PHE unwinding are assumed to be complete as of March 2025.
    - Based on emerging data and SCDHHS guidance, a portion of members that have moved to FFS prior to April 2025 are expected to reenroll into managed care by October 2025. Therefore, reenrollments directly related to the PHE unwinding are expected to be complete by October 2025 with the member months for these reenrolled members anticipated to impact the remainder of the SFY 2026 contract period.

To estimate the acuity adjustment related to the unwinding activity, we allocated the enrollment into the following cohorts: categorically ineligible disenrolled members, other disenrolled members who do not return (“Other disenrolled”), other disenrolled members who return (“Returners”), and all other (i.e., stayers and “stable” churn).

To estimate the number of members and the relative acuity of each cohort, we reviewed emerging eligibility through March 2025 to assess members and the outcome of their eligibility redeterminations during the unwinding process. Using this information, and the unwinding assumptions described above, we estimated the number of members that would be included in each cohort and the average acuity for each cohort and rate cell combination based on the SFY 2024 experience for each member that has been reviewed during the unwinding process. These cohorts and their relative acuity are described in more detail below.

- **Categorically ineligible disenrolled members**. This cohort reflects members who have aged into the 19-44 rate cells during the PHE and have been disenrolled from the Healthy Connections Choices program during the unwinding process. We estimated the acuity for this cohort relative to the acuity of SFY 2024 members that were assumed to remain in the Medicaid managed care program during the unwinding process (the “All Other” cohort) for each rate cell. This group is not anticipated to return to Medicaid during SFY 2026.
- **Other disenrolled members who do not return (“Other disenrolled”).** This cohort reflects the group of members who have been disenrolled from the Healthy Connections Choices program during the unwinding process for reasons other than categorical ineligibility, and who are not anticipated to return to Medicaid during SFY 2026. This includes disenrolled members in the OCWI rate cell who are assumed to be more than twelve months postpartum. We estimated the acuity for this cohort relative to the acuity of SFY 2024 members that were assumed to remain in the Medicaid managed care program during the unwinding process (the “All Other” cohort) for each rate cell.

- **Other disenrolled members who return ("Returners").** This cohort reflects members that have been disenrolled during the unwinding process but are projected to reenroll into managed care by October 2025 and are assumed to represent "Returner" acuity for the remainder of SFY 2026. The SC Medicaid managed care program allows members to be retroactively assigned to an MCO for up to 60 days if they return to Medicaid within 60 days of losing Medicaid eligibility. If the member returns after 60 days, they are assumed to retroactively return to FFS and transition to managed care in the month following their return. We estimated the acuity for this cohort relative to the acuity of SFY 2024 members that were assumed to remain in the Medicaid managed care program during the unwinding process (the "All Other" cohort) for each rate cell.
- **All other eligible members.** This cohort reflects members who are reviewed during the unwinding process and deemed eligible for coverage (i.e., these members remain in the Medicaid managed care program during the unwinding process) and "stable" churn members (i.e., new members and those transitioning among rate cells). The acuity for this cohort is assumed to be a 1.0, with a relative PMPM developed from SFY 2024 claims experience.

Figure 13 illustrates the assumed relative acuity by rate cell for each cohort described above.

FIGURE 13: UNWINDING - RELATIVE ACUITY FACTORS

RATE CELL	ELIGIBLE POPULATION	CATEGORICALLY INELIGBLE DISENROLLED	OTHER DISENROLLED	RETURNERS
TANF - Age 1 - 6	1.000	-	0.700	0.900
TANF - Age 7 - 13	1.000	-	0.650	0.900
TANF - Age 14 - 18, Male	1.000	-	0.700	1.000
TANF - Age 14 - 18, Female	1.000	-	0.800	1.000
TANF - Age 19 - 44, Male	1.000	0.500	0.700	1.000
TANF - Age 19 - 44, Female	1.000	0.500	0.800	0.900
TANF - Age 45+, Male & Female	1.000	-	0.800	1.000
SSI - Children	1.000	-	1.000	1.000
SSI - Adult	1.000	-	1.000	1.000
SMI Children	1.000	-	0.600	0.900
SMI TANF Adults	1.000	-	0.800	0.900
SMI SSI Adults	1.000	-	1.000	1.000
OCWI	1.000	-	0.600	1.000

To estimate the adjustment factor to be applied to the SFY 2024 base data, we reviewed the projected SFY 2026 enrollment mix relative to the estimated enrollment mix in SFY 2024 and applied the relative acuity factors described above. To the extent the PHE unwinding differs from assumptions, associated impacts may be evaluated as the unwinding results become known.

The unwinding acuity factors used to develop the SFY 2026 managed care capitation rates are as follows:

FIGURE 14: UNWINDING - ACUITY ADJUSTMENT FACTOR

RATE CELL	ACUITY FACTOR
TANF - Age 1 - 6	1.047
TANF - Age 7 - 13	1.047
TANF - Age 14 - 18, Male	1.056
TANF - Age 14 - 18, Female	1.033
TANF - Age 19 - 44, Male	1.337
TANF - Age 19 - 44, Female	1.116
TANF - Age 45+, Male & Female	1.055
SSI - Children	1.000
SSI - Adult	1.000
SMI Children	1.084
SMI TANF Adults	1.071
SMI SSI Adults	1.000
OCWI	1.145

The detailed calculation by rate cell is provided in Appendix 8.

Out of State Members Adjustment

SCDHHS identified Medicaid membership assumed to be out of state during the SFY 2024 base period and subsequently disenrolled from the program as of May 2025. An adjustment was made to reflect the removal of the Medicaid managed care member months from the base data, along with associated expenditures. The composite impact of this adjustment is an increase of 0.7% to the SFY 2026 capitation rates.

Foster Care Member Determinations

Per SCDHHS guidance, experience for approximately 9,000 member months included in the Foster Care rate cell in the base data period was shifted to other rate cells to reflect the appropriate rate cell assignment. Figure 15 illustrates the PMPM experience shift to all impacted rate cells.

FIGURE 15: FOSTER CARE EXPERIENCE SHIFT

RATE CELL	BASE PMPM	ADJUSTED PMPM	PERCENT CHANGE
TANF - 0 - 2 Months, Male & Female	$ 2,010.82	$2,004.55	(0.3%)
TANF - 3 - 12 Months, Male & Female	224.74	224.71	(0.0%)
TANF - Age 1 - 6, Male & Female	136.85	137.01	0.1%
TANF - Age 7 - 13, Male & Female	111.75	111.85	0.1%
TANF - Age 14 - 18, Female	128.58	128.63	0.0%
TANF - Age 14 - 18, Male	115.92	115.78	(0.1%)
TANF - Age 19 - 44, Female	238.51	238.53	0.0%
TANF - Age 19 - 44, Male	140.05	140.02	(0.0%)
TANF - Age 45+, Male & Female	452.37	452.37	0.0%
SSI - Adults	1,114.43	1,114.17	(0.0%)
SSI - Children	596.63	596.85	0.0%
SMI Children	478.77	480.28	0.3%
SMI TANF Adults	620.89	620.68	(0.0%)
SMI SSI Adults	1,574.66	1,574.35	(0.0%)
Foster Care Children	675.36	767.82	13.7%
OCWI	200.08	200.10	0.0%

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 2026 that are not fully reflected in the base experience.

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

- **Nucleic Acid Amplification Testing (NAAT) for Bacterial Vaginosis.** Effective January 1, 2024, SCDHHS added a new state plan service (procedure code 81515) for a clinical lab used for the diagnosis of bacterial vaginosis.
- **Genetic Testing Policy, Codes and Fee Update.** Effective December 1, 2024, SCDHHS expanded the genetic testing procedure code list.
- **Pediatric HIV Clinics.** Effective July 1, 2025, SCDHHS anticipates updating the reimbursement methodology for services delivered in a Pediatric HIV Clinic (procedure codes T1015 and T1025).
- **Transcervical Fibroid Ablation.** Effective July 1, 2025, SCDHHS anticipates adding a new state plan service (procedure code 58580) for transcervical fibroid ablation.

(e) Exclusion of payments or services for the data

The following section documents exclusions and adjustments made to the base experience data: non-state plan services as identified by the in-rate criteria included in Appendix 5, IMD stays greater than 15 days for individuals aged 21 to 64, third-party liability recoveries, non-encounter claims payments, state plan services not covered by the capitation rate, pharmaceutical treatments covered by the anticipated SFY 2026 HCNE program, and claims attributed to the BabyNet program.

Services excluded from initial base data summaries

Non-State Plan Services

We excluded all services included in the encounter data that do not reflect approved state plan services (nor are an approved in lieu of service). All claims for non-state plan services, totaling approximately $0.7 million, were excluded from the base 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 $0.3 million, were excluded from the base experience data included in Appendix 6.

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

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

All claims and associated member months associated with IMD stays greater than 15 days for the age 21 to 64 population, totaling approximately $1.0 million and 122 member months, respectively, were excluded from the base experience data included in Appendix 6.

High Cost No Experience (HCNE) Exclusions

All expenditures included in the SFY 2024 encounter base data for pharmacy treatments that are anticipated to be included in the HCNE program during the SFY 2026 contract period, totaling approximately $44,000, were excluded from the base experience data in Appendix 6.

Exclusions for Members Past Date of Death

We excluded member months and associated claims incurred during the SFY 2024 experience period for all individuals in months following their date of death.

Adjustments made to base data

Third-Party Liability/Fraud and Abuse

In addition to actual cost avoidance reflected in the encounter data, we estimated additional third-party liability (TPL) and fraud recoveries based on an analysis of information submitted by the MCOs.

These data sources indicated that approximately 0.07% of total claims were recovered and not reflected in the baseline experience data. The estimated adjustment factor of 0.9993 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 $21.7 million in payments in the benefit cost component of the capitation rate development. This is reflected by an adjustment factor of 1.007, uniformly applied to each service category and rate cell, excluding Dual, in Appendix 6.

BabyNet Adjustment

Effective July 1, 2019, SCDHHS carved-in BabyNet services for infants and toddlers under age 3 to the Medicaid managed care program. Because the BabyNet program is funded through a federal grant, expenditures related to this program are not subject to the Federal Medical Assistance Percentage (FMAP). As such, all expenditures related to BabyNet are excluded from the SFY 2026 base capitation rate development and included as a separate BabyNet component to recognize the difference in funding sources.

To estimate the BabyNet claims to be removed from the base data, we utilized SFY 2019 historical experience from Bridges invoice data provided by SCDHHS to estimate the percentage of MCO members accessing BabyNet services through Bridges and the estimated cost per month for those services. Based on this review and identification of BabyNet recipients in the SFY 2024 base period, we removed approximately $1.6 million from the base data that is assumed to be related to BabyNet expenditures.

3. Projected benefit cost and trends

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

A. RATE DEVELOPMENT STANDARDS

i. Final capitation rate compliance

The final capitation rates are in compliance with 42 CFR 438.4(b)(6) and are only based on services outlined in 42 CFR 438.3(c)(1)(ii) and 438.3(e). Non-state plan services as identified by the in-rate criteria included in Appendix 5 have been excluded from the capitation rate development process. Effective July 1, 2019, SCDHHS expanded the use of IMDs as an in lieu of service for MH/SUD treatments for the 21 to 64-year old population for up to 15 days per month.

ii. 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.

iii. 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. The adjustment factor applied to the base data to account for the unit cost impact described above is further documented in Section I, item 2.B.iii.(d).

In addition, we reviewed benefit costs for enrollees aged 21 to 64 during the base experience period to identify costs associated with an IMD stay of more than 15 days in a month and any other MCO costs for services delivered in a month when an enrollee had an IMD stay of more than 15 days. These costs and associated enrollment were identified and removed from the encounter data.

iv. In lieu of service cost percentages

Not applicable. SCDHHS has indicated that there are no ILOSs anticipated for SFY 2026, except for short term stays in an IMD.

v. IMDs as an in lieu of service provider

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

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

We excluded all costs and associated enrollment for enrollees aged 21 to 64 associated with an IMD stay of more than 15 days in a calendar month. This exclusion included any other costs outside of the IMD for any services delivered during the time an enrollee was in the IMD for more than 15 days. All claims associated with IMD stays greater than 15 days for the age 21 to 64 population, approximately $1.0 million, were excluded from the base data experience included in Appendix 6.

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

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

B. APPROPRIATE DOCUMENTATION

i. Projected benefit costs

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

ii. Development of projected benefit costs

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

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

- **Step 1: Create unadjusted cost model summaries for the managed care population**

  The capitation rates were primarily developed from historical claims and enrollment data from the managed care enrolled populations. The data utilized to prepare the base period cost models consisted of SFY 2024 incurred encounter data that has been submitted by the MCOs. The information is summarized in Appendix 6 and is stratified by capitation rate cell and by major category of service. With the exception of removing the items outlined in the "Services excluded from initial base data summaries" section above, the exhibits in Appendix 6 reflect unadjusted summaries of the base period data. Note that the SFY 2024 base data in Appendix 6 is 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, TPL, and non-encounter claims payments.

- **Step 3: Adjust for prospective program and policy changes and trend to SFY 2026**

  We adjusted the SFY 2024 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 2026 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, 2024) to the midpoint of the rate period (January 1, 2026).

As described later in this section, further adjustments were applied to the base data experience to reflect targeted improvements in managed care efficiency for specific rate cells and service categories that are estimated to impact the projected SFY 2026 benefit expense. The PMPMs resulting from the application of these adjustments established the adjusted benefit expense by population rate cell for the rating period.

Material adjustments that were previously noted

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

- Claims completion
- Physician reimbursement, including the following fee schedule updates:
  - July 1, 2024, October 1, 2024, March 1, 2025 and July 1, 2025 FQHC PPS fee schedule
  - October 1, 2023 anesthesia fee schedule
  - July 1, 2024 RBHS licensed psychologists fee schedule
  - July 1, 2024 speech, physical, and occupational therapy services
  - July 1, 2024 physician fee schedule update
  - July 1, 2023 ASD fee schedule updates
  - October 1, 2025 Opioid Treatment Programs fee schedule update
- July 1, 2023 and July 1, 2024 expansion of ABA services
- January 1, 2024 crisis stabilization units added to Medicaid managed care program

- January 1, 2024 nutritional counseling reimbursement and coverage updates
- January 1, 2024 expansion of cochlear implants for all adult beneficiaries
- January 1, 2024 MST intensive in-home services added to Medicaid managed care program
- February 1, 2024 transplant services carve-in
- February 1, 2024 DEC carve-in and July 1, 2024 DEC reimbursement update
- March 1, 2024 added coverage for two genetic testing laboratory services
- July 1, 2024 removal of all member copays
- July 1, 2024 HB intensive in-home services added to Medicaid managed care program
- July 1, 2024 PRTF per diem rate changes
- July 1, 2024 implementation of single PDL
- July 1, 2024 free-standing psychiatric facility reimbursement updates
- July 1, 2024 expansion of CGM devices to beneficiaries with Type 2 diabetes November 1, 2024 added coverage of Wegovy and Saxenda as weight loss agents for the Medicaid managed care program
- COVID-19 diagnostic testing services and pharmaceutical treatments, including the additional MCO financial responsibility for Paxlovid as of October 1, 2023 and the removal of over-the-counter diagnostic testing as of October 1, 2024
- October 1, 2024 added coverage for IOP/PHP services
- October 1, 2024 added collaborative care management services
- October 1, 2025 hospital outpatient reimbursement updates to reflect removal of GME component of hospital outpatient multiplier
- IMD in lieu of unit cost adjustment
- Population adjustments as a result of the COVID-19 unwinding period
- Population adjustment as a result of out of state members assumed to be in the base period
- Population adjustment as a result of foster care member determinations

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

- Missing encounter data, including an adjustment related to truncated physician claims
- TPL/Fraud and Abuse
- Non-encounter claim payments
- Managed care in-rate claims paid FFS for managed care enrollees
- BabyNet adjustment
- Newborn enrollment
- Leap year adjustment in SFY 2024 base period

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 2024 base period utilization and contracting level achieved by each MCO
- Agency for Healthcare Research and Quality (AHRQ) prevention quality indicators (PQI) for inpatient admissions
- Mix of vaginal and cesarean section deliveries in the SFY 2024 base period utilization.

Inpatient Hospital Services – We applied managed care adjustments to reflect higher levels of care management relative to the SFY 2024 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. This resulted in a 0.9% managed care savings to the inpatient hospital category of service, or a reduction of approximately $5.6 million.

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 a review of MCO contracting of discounts for generic and brand drugs, as well as 340B drugs.

For non-340B pharmacy expenditures, we evaluated pharmacy contracting by repricing brand and generic drugs to average wholesale price (AWP). MCOs were ranked by their ratio of expenditures to AWP for both brand and generic drugs. For each drug type, the aggregate MCO AWP contract value for the lowest-performing MCO was targeted at the AWP contract value of the second lowest-performing MCO. This resulted in a 1.0% managed care savings to the prescription drug category of service, or a reduction of approximately $7.4 million.

For 340B expenditures, we evaluated pharmacy contracting by repricing all claims to FFS reimbursement methodology. Based on SCDHHS discussion with MCOs and 340B pharmacy providers, a contracting efficiency adjustment reflecting 50% of the difference between MCO and FFS reimbursement (approximately a 23% reduction to 340B expenditures in the base data) was applied. Based on SCDHHS guidance, the reduction was then dampened by 25% to allow MCOs approximately three months to incorporate contracting efficiency initiatives to achieve the targeted contracting savings. This resulted in a 2.8% managed care savings to the prescription drug category of service, or a reduction of approximately $21.0 million to the base data.

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 2026 expectations. This assumption was based on review and consideration of the following:

- SFY 2024 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 0.3%, or $0.4 million.

Emergency Room – For the outpatient hospital emergency room service category, multiple potentially avoidable diagnosis groups were clinically developed using the primary diagnosis of each claim. The potentially avoidable diagnosis groups were stratified by severity to target potentially avoidable emergency room visits in the three lowest severity groups.

Additionally, potentially avoidable outpatient hospital emergency room visits were summarized by rate cell. Target utilization levels were developed for each diagnosis grouping and rate cell. The following illustrates the adjustments by population group:

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

When applying the adjustments listed above, reductions were taken from level 1 emergency room claims first, followed by level 2 and level 3 claims if applicable. No adjustments were made to level 4 or level 5 emergency room claims. In coordination with determination of the managed care adjustments for hospital outpatient emergency room services, we assumed that 95% of emergency room visits reduced would be replaced with an office visit. Additionally, we reviewed historical data, along with data from other Medicaid states, to develop assumptions for additional services that may also be included with an office visit. Based on this review, additional services related to pathology/lab, office administered drugs, and radiology were included with the replacement office visit. The overall impact of the emergency room service efficiency adjustment is a decrease of $1.3 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://www.scdhhs.gov/sites/default/files/managedcare/MCO%20Contract%202024%20Amendment%20I%20%28updated%29.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, 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 2024) to the rating period of this certification (SFY 2026).

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 South Carolina Medicaid historical claims and encounter data from the covered populations. Our non-pharmacy trend analysis included a review of July 2021 through June 2024 experience. Our pharmacy trend analysis included a review of July 2021 through December 2024 experience, as well as emerging CY 2025 experience, as appropriate.

External data sources that were reviewed 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
- *Prime Therapeutics* – Medicaid Pharmacy Trend Report 2024 Ninth Edition found in the location listed below:

- https://issuu.com/primetherapeutics/docs/2024-medicaid-pharmacy-trend-report?fr=sYTI0Nzc5NDY1NDA
- *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.

While we reviewed the external data sources noted above, we primarily relied on South Carolina Medicaid historical experience because we were able to normalize for South Carolina specific acuity impacts related to the COVID-19 unwinding and continuous enrollment provisions to evaluate prospective trends.

(ii) Methodology

Non-pharmacy trends

Using internal SCDHHS data, historical utilization, and per member per month cost, data was stratified by month, population, and category of service. The data was adjusted for completion and normalized for historical program changes, reimbursement changes, and acuity. We developed trend rates to adjust the base experience data (midpoint of January 1, 2024) forward 24 months to the midpoint of the contract period, January 1, 2026. 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.

We analyzed historical and emerging experience by population and service category to gain an understanding of the impact of COVID-19 and subsequent utilization changes on the managed care program experience.

Based on our review, patterns did not indicate the need for an emerging experience adjustment in addition to trend. Consistent with the prior year, the TANF Children and TANF Infants populations were reviewed at the rate cell level of detail to apply appropriate trends based on differing emerging patterns within the populations. For example, the TANF - Age 1 - 6, Male & Female rate cell continues to exhibit higher trends than other rate cells within TANF Children, particularly for Outpatient services, and the selected trend factor for this rate cell reflects that. The annual non-pharmacy trend rates selected for each population and service category included a review of projected impacts on utilization related to changes in population acuity.

We applied our selected trend to each population and service category. 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.4.1 of this certification report.

Trend rates were developed by population (TANF Adult, TANF Newborn, TANF 3 - 12 Months, TANF Age 1 - 6, TANF Age 7 - 18, SSI Adult, SSI Children, SMI Children, SMI TANF Adults, SMI SSI Adults, OCWI, Foster, Dual and Kick) and by service category (Inpatient Excluding MH/SA, Inpatient MH/SA, Outpatient Excluding ER, Outpatient Non-Surgical ER, and Professional (including ancillary and office administered drugs)).

Due to the nature of the new SMI rate cells that emerged in July 2024, there are limitations to normalizing historical experience necessary for analyzing trend patterns of the SMI population. As such, on development of non-pharmacy trends for the new SMI populations, trend factors from the primary originating population were applied. Specifically, SSI Adult trend factors are applied to the SMI SSI Adult population, TANF Adult trend factors are applied to the SMI TANF Adult population, and TANF Age 7 - 18 trend factors are applied to the SMI Children population.

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, acuity, and the impact of reimbursement changes on utilization in each specific population.

Pharmacy trends

Using internal SCDHHS data, historical utilization and per member per month cost data was stratified by quarter and population. The data was normalized for historical pharmacy spread and acuity.

The data was also normalized for the cost per script reductions [AMP cap] described in the Single PDL adjustment description. We developed cost per unit and utilization trend rates to adjust the base experience data (midpoint of January 1, 2024) forward 24 months to the midpoint of the contract period, January 1, 2026.

The underlying data was further stratified by therapeutic class and drug type (brand/generic/specialty) as appropriate, which provided the level of granularity necessary to select appropriate trends in conjunction with the single PDL program adjustment. To account for changes in underlying trend patterns, we reviewed emerging data through February 2025 by population. To the extent any emerging utilization is not indicative of expected experience under the single PDL, it was not relied upon. Pharmacy trends were developed by population (TANF Adult, TANF Newborn, TANF 3 - 12 Months, TANF Age 1 - 6, TANF Age 7 - 18, SSI Adult, SSI Children, SMI Children, SMI TANF Adults, SMI SSI Adults, OCWI, and Foster). We analyzed emerging experience by population to gain an understanding of the impact of COVID-19 and subsequent utilization changes on the managed care program experience. Based on our review, patterns did not indicate the need for an emerging experience adjustment in addition to trend; however, the TANF Children and TANF Infants populations were reviewed at the rate cell level of detail to apply appropriate trends based on differing emerging patterns within the populations. The annual pharmacy trend rates selected for each population included a review of emerging utilization patterns and trend, as well as projected impacts on utilization related to changes in population acuity.

In development of pharmacy trends for the new SMI populations, differences in trends were reviewed at the rate cell and drug type level between SMI and non-SMI populations. In general, pharmacy trends in the SMI Children rate cell have historically been lower than the respective non-SMI rate cells, while pharmacy trends in the SMI Adult rate cells are emerging higher than the respective SMI rate cells.

As such, adjustments were applied to the pharmacy trends to account for anticipated differences between populations.

We did not make any adjustments for upcoming brand drug patent expirations through the rating period because the single PDL will not necessarily designate the new generic alternatives as preferred. Changes to the single PDL are evaluated separately and a program change adjustment is made, if warranted. Trend selections reflect the presumed mix of drugs by drug type under the single PDL.

Pharmacy high cost no experience program

Effective July 1, 2020, SCDHHS implemented a pharmacy HCNE program for newly-approved high cost pharmacy treatments that are not fully reflected in the base data. The program is anticipated to continue through the SFY 2026 contract year. Projected pharmacy trends reflect the impact of this 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 trends assumed in the SFY 2024 and SFY 2025 capitation rate development. The dual population medical non-pharmacy trends are anticipated to be consistent with trend assumptions developed for the calendar year (CY) 2025 Healthy Connections Prime Community population.

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

(iv) Chosen trend rates

Figure 17 illustrates the utilization component of the medical trend by rate cell and category of service grouping for the SFY 2026 capitation rate development. The utilization component includes both the trend in number of units as well as the mix or intensity of services provided for non-pharmacy trend. Pharmacy trend has been split between utilization and cost per script to better reflect anticipated script counts and corresponding costs by population.

FIGURE 17: ANNUAL TREND RATES

POPULATION	INPATIENT HOSPITAL (NON MH/SA)	INPATIENT HOSPITAL (MH/SA)	OUTPATIENT HOSPITAL (NON ER)	OUTPATIENT HOSPITAL (ER)	PROFESSIONAL & ANCILLARY	TOTAL MEDICAL	PHARMACY COST	PHARMACY UTILIZATION	COMPOSITE
TANF 0-2 Months	0.5%	0.0%	2.5%	3.8%	2.0%	**1.0%**	5.0%	0.0%	**1.0%**
TANF 3-12 Months	3.5%	0.0%	2.5%	4.0%	3.0%	**3.0%**	5.0%	0.0%	**3.3%**
TANF 1-6 Years	2.5%	0.0%	4.5%	5.0%	3.5%	**3.8%**	4.5%	9.0%	**4.8%**
TANF 7-13 Years	1.5%	2.0%	3.5%	4.0%	3.5%	**3.3%**	4.5%	9.0%	**6.0%**
TANF 14-18 Years	1.5%	2.0%	3.5%	4.0%	3.5%	**3.3%**	1.5%	5.5%	**4.3%**
TANF Adults	0.5%	0.8%	2.8%	2.8%	2.5%	**2.3%**	2.5%	7.5%	**4.8%**
SSI Children	0.0%	1.0%	1.5%	3.0%	2.0%	**1.8%**	2.0%	3.0%	**2.8%**
SSI Adults	0.0%	1.0%	2.0%	2.8%	1.0%	**1.0%**	2.5%	3.5%	**2.8%**
SMI Children	1.5%	2.0%	3.5%	4.0%	3.5%	**3.0%**	1.5%	3.5%	**3.3%**
SMI TANF Adults	0.5%	0.5%	2.5%	2.5%	2.5%	**2.0%**	2.5%	7.5%	**4.8%**
SMI SSI Adults	0.0%	1.0%	2.0%	2.5%	1.0%	**1.0%**	2.5%	3.5%	**3.0%**
OCWI	0.0%	1.0%	2.0%	2.5%	1.0%	**1.3%**	2.5%	1.5%	**1.8%**
Foster	1.3%	1.0%	2.5%	4.0%	0.5%	**0.8%**	9.0%	3.5%	**1.5%**
KICK	0.0%	0.0%	2.0%	0.0%	1.5%	**0.5%**	0.0%	0.0%	**0.5%**

Notes:
1. Pharmacy trend was selected for 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 for medical trend. For pharmacy trend, the mix and intensity component is captured in the cost trend assumption.

For the medical trend components, unit cost trends are not applied as a trend adjustment; instead each claim is repriced and adjusted based on reimbursement updates that have occurred or are anticipated to be implemented after the end of the base period. The repricing and reimbursement update analyses are described further in Section I, item 2.B.iii.4.

(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 service category, with exceptions noted above. 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 experience period. Additionally, all pharmacy therapies expected to be included in the pharmacy HCNE program have been excluded from this analysis.

The variation that occurs between these high-level prescription drug stratifications and further within each major population category contributes to the variation in the pharmacy trend assumptions applied across the managed care program in the SFY 2026 capitation rate development.

(i) Medicaid populations

Trends were developed by population category and category of service grouping. 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 0.25%.

(ii) Rate cells

Benefit cost trends are evaluated by population category and category of service grouping. For population categories comprised of multiple rate cells, the benefit cost trends are consistent across all rate cells, with the exception of TANF Children as described above and the pharmacy trend assumptions for the SMI population.

(iii) Subsets of benefits within a category of service

For the pharmacy trend assumption development, we considered experience and projected changes for specialty, brand, and generic drugs during the base period (SFY 2024) through the projection period (SFY 2026), particularly as it relates to the anticipated implementation of the single PDL effective July 1, 2024.

(d) Material adjustments

We made explicit adjustments to the historical data analyzed for trends in an effort to normalize the data for historical reimbursement adjustments, changing populations, and acuity, to 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 rate cells and categories of services where the raw model output was outside of a range of reasonable results, we relied on the sources identified to develop prospective trend.

Additionally, we considered the cost impact of recently released drugs on the pharmacy trend rates in coordination with the pharmacy HCNE program implemented on July 1, 2020 and anticipated to continue for SFY 2026.

(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

SCDHHS has implemented a Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) compliance review through the External Quality Review (EQR) process for all MCOs to demonstrate compliance with MHPAEA requirements in 42 CFR 438, subpart K and defined in Section 4.2.6.2 of the MCO Contract.

In addition, we reviewed MCO Survey results and MCO-submitted data to evaluate compliance with MHPAEA financial requirements. Based on the SCDHHS decision to remove all member cost-sharing (i.e., copays) in the Medicaid program effective July 1, 2024, there are no MHP financial requirements to evaluate for the SFY 2026 time period. Based on this, we believe the certified SFY 2026 capitation rates are adequate to allow MCOs to efficiently deliver covered services in compliance with MHPAEA and contractual requirements. Therefore, we have not made any explicit rating adjustments for MHPAEA

v. In Lieu Of Services

(a) Categories of covered service

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.

(b) ILOS cost percentage

IMD as an in lieu of service represents approximately $14.6 million of estimated annualized expenditures in the adjusted base data expenditures, or 20.5% of the “Inpatient MH/SA” service category and is not included in any other service categories.

SCDHHS has indicated that there are no other ILOSs anticipated for SFY 2026 apart from short term stays in an IMD; therefore, ILOS cost percentage is not applicable to this rate certification.

(c) Development of projected benefit costs

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.

(d) IMDs as an in lieu of service

The rate development complies with the requirements of 42 CFR 438.6(e). 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.

vi. Retrospective Eligibility Periods

At the time of this report, MCOs are not responsible for paying claims incurred during the retrospective eligibility period and, therefore, enrollment and claims for retrospective eligibility periods are not reflected in the base data. As such, no adjustment has been applied to the capitation rates to reflect the retroactive eligibility period.

vii. Impact of Material Changes

This section relates to material changes to covered benefits or services since the last rate certification. The last rate certification was for the January through June 2025 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.4.

(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.4.

(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 Section I, item 2.B.iii.4. 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.

The following incentive arrangements are included in the SFY 2026 managed care program in accordance with 42 CFR §438.6(b)(2), and excluded from the certified capitation rate:

- **Bonus pool distributions from quality withhold program.** An incentive pool is determined by the portion of the quality withhold that is not returned to the MCOs after a first pass review. Please see Section I, item 4.B.ii for additional discussion on the first pass review.
- **Incentive payments for Patient-Centered Medical Homes (PCMH).** 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 in Section 15.7 of the MCO Process and Procedure Guide. Approximate historical and anticipated incentive payments for the PCMH program are as follows:
    - SFY 2023: $11.0 million, approximately 0.2% of projected SFY 2026 capitation premium
    - SFY 2024: $11.0 million, approximately 0.2% of projected SFY 2026 capitation premium
    - SFY 2025 (anticipated): $8.8 million, approximately 0.1% of projected SFY 2026 capitation premium
    - SFY 2026 (anticipated): $9.0 million, approximately 0.1% of projected SFY 2026 capitation premium
- **Incentive payments for the South Carolina Quality Achievement Program (QAP).** These incentives are applicable to the SFY 2026 contract period. Based on information provided by SCDHHS, the QAP incentive will be paid by SCDHHS to the MCOs based on achievement of quality metrics that support program initiatives specified in the State's quality strategy. These QAP quality metrics will be evaluated on inpatient and outpatient hospital services performed at South Carolina's in-state acute care hospitals. Approximate historical and anticipated incentive payments for the QAP program are as follows:
    - SFY 2024: $275.3 million, approximately 4.3% of projected SFY 2026 capitation premium
    - SFY 2025 (anticipated): $200.0 million, approximately 3.1% of projected SFY 2026 capitation premium
    - SFY 2026 (anticipated): $200.0 million, approximately 3.1% of projected SFY 2026 capitation premium

SCDHHS will complete a reconciliation prior to finalizing SFY 2026 incentive arrangement payments to ensure total incentive payments for each MCO are below 105% of the certified rates paid under the contract. All incentive arrangements described above are excluded from the certified capitation rates and therefore have no effect on the certified capitation rate development.

B. WITHHOLD ARRANGEMENTS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of the Withhold Arrangement

(i) Time period

The withhold arrangement is measured on a calendar year basis.

(ii) Enrollees, services, and providers covered

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

(iii) Purpose

The withhold measure evaluates quality-based performance using a weighted average of all measures included in the composites of Patient Experience, Prevention, and Treatment as reported in each MCOs NCQA HEDIS data submission.

(iv) Description of total percentage withheld

SCDHHS has established a quality withhold of 1.5% of the capitation rate net of state-directed payments and will determine the first pass 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.

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

(v) Estimate of percent to be returned

SCDHHS evaluates the quality withhold results through a first pass withhold return and a bonus pool distribution. Withholds and incentives are treated separately for federal regulations; therefore, we reviewed the first pass and bonus pool distribution as separate components.

Following the reporting year 2021 (measurement year 2020) withhold program suspension, the MCO quality withhold and bonus program was reinstated by SCDHHS for reporting year 2022 (measurement year 2021). The MCOs in aggregate received 85.2% of available withhold funds from SCDHHS through first pass evaluation.

The MCO quality withhold and bonus program was updated for measurement year 2023 to incorporate the following three indices: Consumer Assessment of Healthcare Providers and Systems (CAHPS), Prevention HEDIS, and Treatment HEDIS. The MCOs in aggregate received 73.1% of available withhold funds from SCDHHS through first pass evaluation in the first year of updated quality withhold indices, with at least one MCO achieving 100% return of the withhold for each of the three individual indices.

Based on guidance from SCDHHS, the CY 2024, CY 2025, and CY 2026 MCO quality withhold and bonus program is assumed to be consistent with the measurement year 2023 program.

Based on our review, we believe it is reasonably achievable in the context of the SFY 2026 capitation rate development for the MCOs to meet the quality withhold targets for 100% return of the withhold for CY 2026.

(vi) Reasonableness of withhold arrangement

Our review of the total withhold percentage of 1.5% of capitation revenue, net of state-directed payments related to supplemental teaching physicians, the HAWQ program, private ambulance, public ambulance, and independent community pharmacy payments, 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 2024 NAIC annual statement.

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 2024 audited financial statements, RBC-levels for each MCO are at or greater than 410%.

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	843%	761%
BlueChoice	1284%	1258%
Humana	410%	371%
Molina	552%	500%
Select Health	641%	567%

Source: CY 2024 NAIC Annual Statement ('Five-Year Historical Data', Page 29)

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

A 1.5% withhold over the SFY is equivalent to approximately 5.5 days of revenue.

SCDHHS makes capitation payments to MCOs at the beginning of each month (which essentially "pre-pays" the expected claims for the month), contributing favorably to monthly cash flow needs.

(vii) Effect on the capitation rates

The SFY 2026 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable.

(b) Rate certification considerations of withhold

The SFY 2026 certified capitation rates reflect the expectation that 100% of the withhold is reasonably achievable, and the capitation rates are certified as actuarially sound.

C. RISK SHARING MECHANISMS

i. Rate Development Standards

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

ii. Appropriate Documentation

(a) Description of Risk-sharing Mechanism

(i) Rationale for use of risk-sharing arrangement

Pharmacy High Cost No Experience (HCNE) program

The pharmacy HCNE program has been established to address the financial risk associated with recent FDA approved high cost pharmaceutical treatments, as well as the potential for the prevalence of individuals utilizing the high cost pharmacy treatments to vary between MCOs given the relatively low volume of anticipated recipients.

PRTF Risk Pool

The PRTF risk pool will continue in SFY 2026 to address the higher costs associated with PRTF services and the potential for the prevalence of individuals utilizing PRTF services to vary between MCOs. The total PRTF risk pool is established and evaluated by rate cell and distributions across MCOs are calculated accordingly.

To the extent an MCO's proportion of PRTF expenditures is greater than the MCO's proportion of PRTF benefit received through capitation payments at the rate cell level, the MCO will receive additional reimbursement from the risk pool. Conversely, an MCO with a lower proportion of PRTF expenditures relative to the MCO's proportion of PRTF benefit received through capitation payments at the rate cell level will be required to pay into the risk pool.

(ii) **Description**

Pharmacy High Cost No Experience (HCNE) program

Effective July 1, 2020, SCDHHS implemented a pharmacy HCNE program as a risk mitigation mechanism to limit the MCO's exposure to new high-cost pharmacy therapies.

The HCNE program will continue in SFY 2026 and will include covered pharmacy therapies approved after the beginning of the base period (July 1, 2023) that are expected to exceed $500,000 per member per year, based on annual estimated cost from the WAC fee schedule.

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

SCDHHS is anticipated to reimburse the MCOs for the total cost of the pharmaceutical therapy that is equal to the lesser of MCO claim payment and the FFS fee schedule. All claims requested for reimbursement through the pharmacy HCNE program are subject to SCDHHS review and approval. The pharmacy therapies approved for inclusion in the risk mitigation program for SFY 2026 are included in Section 4.2.22.7 of the MCO Process and Procedure guide and are anticipated to be monitored on a quarterly basis throughout the contract year and updated as appropriate.

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

PRTF Risk Pool

The SFY 2026 PRTF risk pool aggregate amounts will be developed using the estimated SFY 2026 PRTF benefit expense PMPM by rate cell included in the SFY 2026 capitation rates, multiplied by the actual SFY 2026 membership by rate cell.

The estimated SFY 2026 PRTF PMPM is developed on a prospective basis and is based on a review of historical PRTF expenditures during the SFY 2024 base period. Program and policy changes developed for the SFY 2026 managed care capitation rates impacting PRTF expenditures were applied to the base experience.

Please note that the estimated SFY 2026 PRTF PMPM is based on the historical PRTF expenditures and applicable prospective adjustments, with no smoothing adjustment across rate cells.

Figures 19 and 20 illustrate a sample calculation of MCO payment/receipt of PRTF risk pool funds under two scenarios. The first scenario illustrates the payment/receipt of funds in the event total PRTF expenditures are greater than the risk pool funds, while the second scenario illustrates payment/receipt of funds in the event total PRTF expenditures are less than the risk pool funds. Additionally, it should be noted that when developing MCO payment/receipt amounts, the estimated PRTF PMPMs will be adjusted by rate cell for the relative risk scores applied to the SFY 2026 capitation rates.

FIGURE 19 TOTAL PRTF EXPERIENCE GREATER THAN POOL FUNDS

MCO	ACTUAL SFY 2026 MEMBER MONTHS	ESTIMATED SFY 2026 PRTF PMPM	MCO RISK-ADJUSTED SFY 2026 PRTF PMPM	ESTIMATED SFY 2026 PRTF EXPENDITURES	ACTUAL SFY 2026 PRTF EXPENDITURES	DISTRIBUTION OF ACTUAL PRTF COSTS	DISTRIBUTION APPLIED TO ESTIMATED COSTS	ADDITIONAL (PAYMENT)/ RECOUPMENT
Plan A	10,000	$ 5.00	$ 4.95	$ 49,500	$ 80,000	14.5%	$ 72,727	$ 23,227
Plan B	30,000	5.00	5.10	153,000	180,000	32.7%	163,636	10,636
Plan C	20,000	5.00	5.00	100,000	80,000	14.5%	72,727	(27,273)
Plan D	15,000	5.00	5.00	75,000	90,000	16.4%	81,818	6,818
Plan E	25,000	5.00	4.90	122,500	120,000	21.8%	109,091	(13,409)
All Plans	**100,000**	**$ 5.00**	**$ 5.00**	**$ 500,000**	**$ 550,000**	**100.0%**	**$ 500,000**	**$ 0**

FIGURE 20: TOTAL PRTF EXPERIENCE LESS THAN POOL FUNDS

MCO	ACTUAL SFY 2026 MEMBER MONTHS	ESTIMATED SFY 2026 PRTF PMPM	MCO RISK-ADJUSTED SFY 2026 PRTF PMPM	ESTIMATED SFY 2026 PRTF EXPENDITURES	ACTUAL SFY 2026 PRTF EXPENDITURES	DISTRIBUTION OF ACTUAL PRTF COSTS	DISTRIBUTION APPLIED TO ESTIMATED COSTS	ADDITIONAL (PAYMENT)/ RECOUPMENT
Plan A	10,000	$ 5.00	$ 4.95	$ 49,500	$ 60,000	12.5%	$ 62,500	$ 13,000
Plan B	30,000	5.00	5.10	153,000	145,000	30.2%	151,042	(1,958)
Plan C	20,000	5.00	5.00	100,000	90,000	18.8%	93,750	(6,250)
Plan D	15,000	5.00	5.00	75,000	80,000	16.7%	83,333	8,333
Plan E	25,000	5.00	4.90	122,500	105,000	21.9%	109,375	(13,125)
All Plans	**100,000**	**$ 5.00**	**$ 5.00**	**$ 500,000**	**$ 480,000**	**100.0%**	**$ 500,000**	**$ 0**

Figure 21 illustrates the estimated SFY 2026 member months, PRTF PMPM, and risk pool expenditures by rate cell.

FIGURE 21: PRTF RISK POOL - SFY 2026 PROJECTED PMPM

RATE CELL	ESTIMATED SFY 2026 MEMBER MONTHS	ESTIMATED SFY 2026 PRTF PMPM	ESTIMATED EXPENDITURES
TANF: 0-2 months old (AH3)	77,252	$ 0.00	$ 0
TANF: 3-12 months old (AI3)	338,280	-	-
TANF: Age 1-6 (AB3)	2,136,221	-	-
TANF: Age 7-13 (AC3)	2,594,528	0.36	936,314
TANF: Age 14-18, Male (AD1)	845,513	0.55	466,241
TANF: Age 14-18, Female (AD2)	817,358	0.18	150,246
TANF: Age 19-44, Male (AE1)	160,216	-	-
TANF: Age 19-44, Female (AE2)	1,112,937	-	-
TANF: Age 45+ (AF3)	201,585	-	-
SSI - Children (SO3)	149,431	2.63	393,062
SSI - Adults (SP3)	423,342	-	-
SMI Children (VV3)	158,287	85.27	13,497,241
SMI TANF Adults (TP3)	224,772	0.07	16,471
SMI SSI Adults (UP3)	156,170	0.76	118,866
OCWI (WG2)	288,631	-	-
DUAL	-	-	-
Foster Care - Children (FG3)	42,435	181.05	7,682,649
KICK (MG2/NG2)	22,356	-	-
Composite	**9,726,958**	**$ 2.39**	**$ 23,261,089**

Please note that the “Estimated expenditures” column in Figure 21 is a projection based on estimated SFY 2026 membership. The estimated SFY 2026 PRTF PMPMs by rate cell will not change as actual SFY 2026 PRTF experience emerges; however the aggregate PRTF risk pool amounts by rate cell may vary to the extent that actual SFY 2026 member months vary from the estimated membership.

Additionally, if capitation rates are amended during the SFY 2026 contract year related to PRTF program changes, the PRTF risk pool PMPMs will be reviewed and updated, as necessary.

(iii) **Effect on capitation rate development**

The development of the HCNE program and the PRTF risk pool do not impact the capitation rate development process.

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

The SFY 2026 pharmacy HCNE program and PRTF risk pool have been developed in accordance with generally accepted actuarial principles and practices.

(v) **Consistency with pricing assumptions used in capitation rate development**

The SFY 2026 pharmacy HCNE program and PRTF risk pool development are consistent with pricing assumptions used in capitation rate development. Note that the development of these arrangements do not impact the capitation rate development process.

(vi) **Demonstration of remittance/payment requirement**

The SFY 2026 pharmacy HCNE program is a non-risk arrangement with the State. As documented in Section 4.2.22.7 of the MCO Process and Procedure Guide, 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.

The SFY 2026 PRTF risk pool is a cost-neutral risk pool arrangement to redistribute assumed PRTF benefit costs between the MCOs and will not result in a remittance/payment between the MCOs and the State.

(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. STATE DIRECTED PAYMENTS

i. Rate Development Standards

(a) Description of Managed Care Plan Requirement

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

- **Supplemental Teaching Physician (STP) Program.** Physician state directed payment for all services performed by qualifying rendering teaching physicians billing through a qualified teaching academic facility (control name: SC_Fee_AMC_Renewal_20250701-20260630).
- **Health Access, Workforce, and Quality (HAWQ) Program**. Hospital inpatient and outpatient state directed payment program for all in-state contracted hospitals (control name: SC_Fee_IPH.OPH_Renewal_20250701-20260630).
- **Independent Community Pharmacy Program**. Pharmacy state directed payment initiative for all in-state independent contracted pharmacies (control name: SC_Fee_Oth_Renewal_20250701-20260630).
- **Public Ambulance State Directed Payment**. Emergency medical transport state directed payment program for all ground public and government owned or operated ambulance service providers enrolled as an active Medicaid provider with SCDHHS (control name: SC_Fee_Oth2_Renewal_20250701-20260630).

- **Private Ambulance State Directed Payment Program**. Emergency medical transport state directed payment program for ground non-governmental owned or operated ambulance service providers enrolled as an active Medicaid provider with SCDHHS (control name: SC_Fee_Oth3_Renewal_20250701-20260630).
- **Physician Directed Payment Program**. Physician state directed payment for in-network primary care and pediatric subspecialist providers (control name: SC_Fee_PC.Oth_New_20250701-20260630).
- **Rural Hospital Minimum Fee Schedule**. State directed minimum fee schedule for all in-network South Carolina rural hospitals defined under the Medicaid State plan at no less than the Medicaid fee-for-service approved rate for inpatient and outpatient services

(b) Prior written approval

All state-directed payments included in this rate certification are consistent with preprints currently under review by CMS. At the time of this report, SCDHHS has submitted, but not yet received approval for all of the state directed payments mentioned above.

The rural hospital minimum fee schedule is based on rates established in SC's approved state plan and does not require a preprint in accordance with 42 CFR §438.6(c).

(c) Generally accepted actuarial principles

The contract arrangements that direct MCO expenditures were developed in accordance with guidance in 42 CFR §438.4, the standards in §438.5, and generally accepted actuarial principles and practices.

(d) How Payment Arrangement is reflected in managed care rates

The rural hospital minimum fee schedule is reflected as an adjustment to the monthly capitation rates paid to the plans. STP, HAWQ, private and public ambulance, and the independent pharmacy program are reflected as separate payment terms**.**

(e) Documentation

In accordance with 42 CFR § 438.7(b)(6), all state directed payments anticipated to be effective as of July 1, 2025 are documented in this rate certification.

ii. Appropriate Documentation

(a) Description of State-Directed Payments

Figure 22 provides a description of each state directed payment included in the SFY 2026 Medicaid managed care program.

FIGURE 22 - DESCRIPTION OF STATE DIRECTED PAYMENTS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	TYPE OF PAYMENT	BRIEF DESCRIPTION	RATE ADJUSTMENT OR SEPARATE PAYMENT TERM
SC_Fee_AMC_Renewal_20250701-20260630 (Supplemental Teaching Physician Program)	Uniform percentage increase	Uniform increase to physician reimbursement for teaching physicians	Separate payment term
SC_Fee_IPH.OPH_Renewal_20250701-20260630 (Health, Access, Workforce, and Quality Program)	Uniform percentage increase	Uniform percentage increase to in-state inpatient and outpatient hospital payments	Separate payment term
SC_Fee_Oth_Renewal_20250701-20260630 (Independent Community Pharmacy Program)	Uniform per script increase	Uniform dollar increase to independent pharmacy scripts	Separate payment term
SC_Fee_PC.Oth_New_20250701-20260630 (Physician Directed Payment Program)	Minimum Fee Schedule	Minimum fee schedule for in-network primary care and pediatric subspecialist providers at 140% of Medicare	Separate payment term
SC_Fee_Oth2_Renewal_20250701-20260630 (Public Ambulance)	Uniform dollar amount	Uniform increase to public and government owned Emergency Medical Transport providers to cover increased cost	Separate payment term
SC_Fee_Oth3_Renewal_20250701-20260630 (Private Ambulance)	Uniform percentage increase	Uniform increase to non-governmental owned Emergency Medical Transport providers to help cover the difference between commercial reimbursement and Medicaid reimbursement	Separate payment term
Rural Hospital Minimum Fee Schedule	Minimum Fee Schedule	Minimum fee schedule as approved in the Medicaid State Plan for all rural hospitals	Rate adjustment

(i) Description of delivery system and provider payment Initiatives

Supplemental Teaching Physician Program

Effective July 1, 2025, the STP state directed payment program utilizes a uniform percentage increase methodology to increase provider reimbursement for Medicaid physicians performed by qualified rendering teaching physicians billing through a qualified teaching facility up to average commercial rate (ACR) payment. SCDHHS believes that by utilizing these dollars through a directed payment, the agency can impact Medicaid member access to pediatric subspecialty care and materially impact its quality strategy around access to care for all Medicaid participants.[9]

Provider Class Defined

Based on documentation provided in the SCDHHS-submitted preprint, the STP program establishes one provider class for all teaching physicians with faculty appointment or a teaching physician agreement with one of the following entities:

- The Medical University of South Carolina (MUSC);
- The University of South Carolina School of Medicine (USC); or,
- A SC Area Health Education Consortium (AHEC) Teaching Health System.

Only professional services billed by a SC academic medical center, its component units, or an SC AHEC Teaching Health System are eligible for state-directed payments. Teaching physicians must involve residents and/or medical students in the care of his or her patients or directly supervise residents in the care of patients.

[9] Supplemental Teaching Physician submitted preprint (SC_Fee_AMC_Renewal_20250701-20260630) Question 19d

Application of Uniform Methodology

The STP state directed payment applies a uniform methodology to the provider class, which brings qualified rendering teaching physician payments at a qualified academic teaching facility up to 100% of ACR.

Upon final reconciliation of the SFY 2026 contract year utilization and resulting state directed payments, the uniform payments may be adjusted as described further in the SCDHHS submitted preprint

Total SFY 2026 payments for the STP program are projected at approximately $155.0 million, consistent with the total dollar amount included in the preprint submitted to CMS and currently under review.

Health, Access, Workforce, and Quality Program

Effective July 1, 2025, the HAWQ program is developed to provide additional financial stability for hospitals across South Carolina to ensure access to care for MCO enrollees and promote investment in quality initiatives and the healthcare workforce.[10] SCDHHS believes that by utilizing these dollars through a directed payment, the agency can improve hospital quality and significantly impact its quality strategy for all Medicaid participants. These payments are anticipated to bring greater accountability to hospital quality across the provider class.

Provider Class Defined

Based on documentation provided in the SCDHHS-submitted preprint, all licensed South Carolina general acute care hospitals (including any that convert to a rural emergency hospital) that participate in the State's quality and workforce development programs are eligible for the uniform percentage increase.[11]

Application of Uniform Methodology

The HAWQ program will provide a uniform percentage increase for Medicaid managed care inpatient and outpatient hospital claims incurred by managed care enrollees covered under the Medicaid managed care program at in-network South Carolina hospitals during the SFY 2026 contract year.

The uniform percentage increase applied to each hospital inpatient claim during the SFY 2026 contract year is 206% and the uniform percentage increase applied to each hospital outpatient claim during the SFY 2026 contract year is 191%.[12] The uniform percentage increase applied in the state-directed payment brings eligible hospitals up to 100% of ACR for inpatient payments and 100% of ACR for outpatient payments during the SFY 2026 contract period.[13]

Upon final reconciliation of the SFY 2026 contract year utilization and resulting state directed payments, the uniform percentage increases may be adjusted as described further in the SCDHHS submitted preprint.

Total SFY 2026 payments for the HAWQ program are projected at approximately $2.57 billion, consistent with the total dollar amount currently under review by CMS.

Independent Community Pharmacy Program

Effective July 1, 2025, the independent pharmacy program directs a uniform dollar increase to all eligible prescriptions during the SFY 2026 contract year for SC in-network independent pharmacies. SCDHHS believes that by utilizing these dollars through a directed payment, the agency can improve Medicaid member access to care consistent with the Agency’s quality strategy.[14]

Provider Class Defined

Based on documentation provided in the SCDHHS-approved preprint, the independent pharmacy program establishes one provider class defined as Independent Community Pharmacies as determined by the permit application classification collected by the South Carolina Board of Pharmacy.

[10] HAWQ submitted preprint (SC_Fee_IPH.OPH_Renewal_20250701-20260630), Question 43

[11] HAWQ submitted preprint (SC_Fee_IPH.OPH_Renewal_20250701-20260630), Question 20b

[12] HAWQ CMS Round 1 question response, Question 4b

[13] HAWQ submitted preprint (SC_Fee_IPH.OPH_Renewal_20250701-20260630), Table 2

[14] Independent Pharmacy submitted preprint (SC_Fee_Oth_Renewal_20250701-20260630) Question 19d

Application of Uniform Methodology

The independent pharmacy directed payment applies a uniform dollar increase per script for all SC Medicaid-enrolled independent pharmacies.

Total SFY 2026 payments for the independent community pharmacy directed payment are projected at approximately $9.5 million, consistent with the total dollar amount included in the preprint and approved by CMS on 5/29/2025.

Physician Directed Payment Program

Effective July 1, 2025, the physician directed payment pharmacy program establishes a minimum fee schedule requirement at 140% of Medicare for all eligible services provided by qualified providers. SCDHHS believes that the increased payments would encourage qualified providers to treat Medicaid enrollees with competitive reimbursement rates and improve access for beneficiaries.[15]

Provider Class Defined

Based on documentation provided in the SCDHHS-submitted preprint, the physician directed payment program establishes two provider classes: primary care physicians and pediatric subspecialists. Providers who are eligible for the supplemental teaching physician payment are not eligible to receive a payment under the physician directed payment program.

Application of Minimum Fee Schedule

The physician directed payment establishes a minimum fee schedule requirement at 140% of Medicare for all services provided by qualified providers. Payments are not made for qualified providers who are already paid at 140% of Medicare-equivalent reimbursement from the plan outside of the physician directed payment program.[16]

Total SFY 2026 payments for the physician directed payment program are projected at approximately $113.0 million, consistent with the total dollar amount included in the preprint submitted to CMS and currently under review.

Public Ambulance State Directed Payment Program

Effective July 1, 2025, the public ambulance state directed payment program utilizes a uniform dollar increase methodology to increase reimbursement for public and government owned emergency transportation providers by applying a $325 add-on per trip[17]. The increase was developed to cover increased costs incurred related to emergency medical transport services for these providers.[18]

Provider Class Defined

Based on documentation provided in the SCDHHS-submitted preprint, the Public Ambulance State Directed Payment Program establishes one provider class for emergency medical transport services provided by public and government owned or operated ambulance service providers enrolled as an active Medicaid provider with SCDHHS and provided to eligible Medicaid Managed Care enrollees.

Application of Uniform Methodology

The state directed payment applies a uniform methodology to the provider class. The uniform increase is paid in five disbursements, four quarterly payments and a reconciliation payment. The first four payments will be made at the end of each quarter in equal amounts calculated as one fourth of the payment pool less a 10% reserve amount. The reconciliation will be based on actual utilization of services paid during the period (dates of service July 1, 2025 – June 30, 2026) and will be calculated six-months after the end of the rating period to allow for runout and ensure no overpayments are made.[19]

[15] Physician Directed Payment Program submitted preprint (SC_Fee_PC.Oth_new_20250701-20260630) Question 17b

[16] Physician Directed Payment Program submitted preprint (SC_Fee_PC.Oth_new_20250701-20260630) Question 21

[17] Public Ambulance State Directed Payment submitted preprint (SC_Fee_Oth2_Renewal_20250701-20260630) – Question 19b

[18] Public Ambulance State Directed Payment submitted preprint (SC_Fee_Oth2_Renewal_20250701-20260630) – Question 19d

[19] Public Ambulance State Directed Payment submitted preprint (SC_Fee_Oth2_Renewal_20250701-20260630) – Question 19c

Total SFY 2026 payments for the program are projected at approximately $13.0 million, consistent with the total dollar amount included in the preprint and approved by CMS on 5/29/2025.

Private Ambulance State Directed Payment Program

Effective July 1, 2025, the Private ambulance state directed payment program utilizes a uniform percentage increase methodology to increase reimbursement for non-governmentally owned ground emergency transportation providers by applying a percentage increase of 373.05% per claim[20]. "The percentage increase was developed through the determination of the average commercial reimbursement for ground non-governmental emergency ambulance services utilizing the top five commercial payers for each individual provider less the Medicaid base reimbursement for each individual provider to ensure payment does not exceed the average commercial reimbursement. The increase appropriately recognizes the shortfall in Medicaid reimbursement, the increase is equal to the difference between commercial reimbursement and Medicaid reimbursement paid for the same services. The State believes that by utilizing these dollars through a directed payment, the agency can impact Medicaid member access to ground non-governmental emergency ambulance services and materially impact its quality strategy around access to care for all Medicaid participants, improving equitable access to care for beneficiaries across the state."[21]

Provider Class Defined

Based on documentation provided in the SCDHHS-submitted preprint, the Private Ambulance State Directed Payment Program establishes one provider class for emergency medical transport provided by ground non-governmental ambulance service providers enrolled as an active Medicaid provider with SCDHHS and provided to eligible Medicaid Managed Care enrollees.

Application of Uniform Methodology

The state directed payment applies a uniform methodology to the provider class. The uniform increase is paid in five disbursements, four quarterly interim payments and a reconciliation payment. The first four interim payments will be made at the end of each quarter in equal amounts calculated as one fourth of the payment pool less a 10% reserve amount. The reconciliation will be based on actual utilization of services paid during the period (dates of service July 1, 2025 – June 30, 2026) and will be calculated six months after the end of the rating period to allow for runout and ensure no overpayments are made.[22]

Total SFY 2026 payments for the program are projected at approximately $16.2 million, consistent with the total dollar amount included in the preprint and approved by CMS on 5/29/2025.

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

The figure below illustrates the effect of each state directed payment incorporated as a rate adjustment on the SFY 2026 capitation rates.

FIGURE 23 - EFFECT OF STATE DIRECTED PAYMENTS AS RATE ADJUSTMENTS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	RATE CELLS AFFECTED	IMPACT	DESCRIPTION OF THE ADJUSTMENT	CONFIRMATION THE RATES ARE CONSISTENT WITH THE PREPRINT
Rural Hospital Minimum Fee Schedule	All	Approximately $2.6 million	Minimum fee schedule at no less than 100% of Medicaid fee-for-service reimbursement for all in-network SC rural hospitals defined under the Medicaid State Plan	N/A

(A) Affected rate cells

The rural hospital minimum fee schedule affects all rate cells in the managed care program.

(B) Impact on the capitation rates

The rural hospital minimum fee schedule was initially implemented on July 1, 2023.

[20] Private Ambulance State Directed Payment submitted preprint (SC_Fee_Oth3_Renewal_20250701-20260630) – Question 19b

[21] Private Ambulance State Directed Payment submitted preprint (SC_Fee_Oth3_Renewal_20250701-20260630) – Question 19d

[22] Private Ambulance State Directed Payment submitted preprint (SC_Fee_Oth3_Renewal_20250701-20260630) – Question 19c

As such, the SFY 2024 base data used in the development of the SFY 2026 capitation rates reflects the rural hospital minimum fee schedule. However, effective July 1, 2025, MUSC Black River became subject to the rural hospital minimum fee schedule. To account for this update, an adjustment of approximately $2.6 million was applied in the SFY 2026 capitation rate development. Figure 24 illustrates the projected benefit expense PMPM amounts by rate cell incorporated as a rate adjustment for the rural hospital minimum fee schedule reimbursement update.

FIGURE 24: RURAL HOSPITAL MINIMUM FEE SCHEDULE IMPACT BY RATE CELL

RATE CELL	PMPM
TANF: 0-2 months old (AH3)	$ 0.17
TANF: 3-12 months old (AI3)	0.18
TANF: Age 1-6 (AB3)	0.14
TANF: Age 7-13 (AC3)	0.10
TANF: Age 14-18, Male (AD1)	0.13
TANF: Age 14-18, Female (AD2)	0.17
TANF: Age 19-44, Male (AE1)	0.23
TANF: Age 19-44, Female (AE2)	0.37
TANF: Age 45+ (AF3)	0.78
SSI - Children (SO3)	0.16
SSI - Adults (SP3)	1.35
SMI Children (VV3)	0.31
SMI TANF Adults (TP3)	0.58
SMI SSI Adults (UP3)	1.28
OCWI (WG2)	0.24
DUAL	-
Foster Care - Children (FG3)	0.88
KICK (MG2/NG2)	0.05

(C) Reflection of payment arrangement in the certified capitation rates

Section 2.B.iii.(d) describes the adjustments made to the capitation rates related to the rural hospital minimum fee schedule effective July 1, 2025.

(D) Description of consistency with 438.6(c) preprint

Not applicable. It is our understanding that the rural hospital minimum fee schedule does not require a preprint since it is based on rates established in SC's approved state plan in accordance with guidance in 42 CFR §438.6(c).

(E) Maximum fee schedule

Not applicable. The SFY 2026 managed care capitation rates do not include state directed payment arrangements that have been implemented via a maximum fee schedule.

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

The figure below illustrates the effect on the capitation rates of payments incorporated as a separate payment term.

FIGURE 25 - EFFECT OF STATE DIRECTED PAYMENTS AS SEPARATE PAYMENT TERMS

CONTROL NAME OF THE STATE DIRECTED PAYMENT	AGGREGATE AMOUNT INCLUDED IN THE RATE CERTIFICATION	STATEMENT THAT THE ACTUARY IS CERTIFYING THE SEPARATE PAYMENT TERM	THE MAGNITUDE ON A PMPM BASIS	CONFIRMATION THE RATE DEVELOPMENT IS CONSISTENT WITH THE PREPRINT	CONFIRMATION THAT THE STATE ACTUARY WILL SUBMIT REQUIRED DOCUMENTATION AT THE END OF THE RATE PERIOD
SC_Fee_AMC_Renewal_20250701-20260630 (Supplemental Teaching Physician Program)	$ 155,000,000	The actuary certifies the amount of the separate payment term disclosed in this certification	Approx $15.94 PMPM	Consistent with submitted preprint	Confirmed
SC_Fee_IPH.OPH_Renewal_20250701-20260630 (Health, Access, Workforce, and Quality Program)	$ 2,575,731,483	The actuary certifies the amount of the separate payment term disclosed in this certification	Approx $264.80 PMPM	Consistent with submitted preprint	Confirmed
SC_Fee_Oth_Renewal_20250701-20260630 (Independent Pharmacy Dispensing Fee Payment)	$ 9,500,000	The actuary certifies the amount of the separate payment term disclosed in this certification	Approx $0.98 PMPM	Consistent with approved preprint	Confirmed
SC_Fee_PC.Oth_New_20250701-20260630 (Physician Directed Payment Program)	$ 113,000,000	The actuary certifies the amount of the separate payment term disclosed in this certification	Approx $11.62 PMPM	Consistent with submitted preprint	Confirmed
SC_Fee_Oth2_Renewal_20250701-20260630 (Public Ambulance)	$ 13,062,198	The actuary certifies the amount of the separate payment term disclosed in this certification	Approx $1.34 PMPM	Consistent with approved preprint	Confirmed
SC_Fee_Oth3_Renewal_20250701-20260630 (Private Ambulance)	$ 16,226,538	The actuary certifies the amount of the separate payment term disclosed in this certification	Approx $1.67 PMPM	Consistent with approved preprint	Confirmed

(A) Aggregate amount

The estimated aggregate amount attributable to the STP program, HAWQ program, independent community pharmacy program, physician directed payment program, public ambulance payment, and private ambulance payment is $155.0 million, $2.57 billion, $9.5 million, $113 million, $13.0 million, and $16.2 million, respectively.

(B) Statement from the actuary

The actuary certifies that the amounts of the separate payment term arrangements disclosed in this certification are consistent with those submitted in their respective preprints.

(C) Estimated PMPM by rate cell

The estimated PMPMs for each state directed payment program incorporated as a separate payment term during the SFY 2026 rating period are provided by rate cell in the figure below.

FIGURE 26: STATE DIRECTED PAYMENT PMPM BY RATE CELL

RATE CELL	STP	HAWQ	INDEPENDENT PHARMACY	PHYSICIAN DIRECTED PAYMENT	PUBLIC AMBULANCE	PRIVATE AMBULANCE
TANF: 0-2 months old (AH3)	$ 185.84	$ 3,579.58	$ 0.29	$ 93.62	$ 1.35	$ 1.67
TANF: 3-12 months old (AI3)	$ 32.42	$ 204.03	$ 0.50	$ 27.05	$ 0.64	$ 0.80
TANF: Age 1-6 (AB3)	$ 9.40	$ 97.46	$ 0.54	$ 11.43	$ 0.36	$ 0.45
TANF: Age 7-13 (AC3)	$ 6.17	$ 66.97	$ 0.62	$ 7.50	$ 0.26	$ 0.33
TANF: Age 14-18, Male (AD1)	$ 8.57	$ 92.31	$ 0.53	$ 5.06	$ 0.55	$ 0.68
TANF: Age 14-18, Female (AD2)	$ 10.11	$ 105.37	$ 0.73	$ 7.35	$ 0.63	$ 0.79
TANF: Age 19-44, Male (AE1)	$ 6.55	$ 182.93	$ 0.88	$ 4.95	$ 2.05	$ 2.55
TANF: Age 19-44, Female (AE2)	$ 17.08	$ 317.41	$ 1.08	$ 13.00	$ 1.68	$ 2.09
TANF: Age 45+ (AF3)	$ 21.99	$ 429.98	$ 2.48	$ 10.26	$ 1.88	$ 2.34
SSI - Children (SO3)	$ 30.65	$ 330.30	$ 1.49	$ 8.79	$ 1.12	$ 1.39
SSI - Adults (SP3)	$ 44.43	$ 1,197.11	$ 2.58	$ 10.62	$ 6.10	$ 7.57
SMI Children (VV3)	$ 17.81	$ 569.88	$ 2.41	$ 15.49	$ 3.63	$ 4.51
SMI TANF Adults (TP3)	$ 34.73	$ 613.23	$ 3.44	$ 20.55	$ 5.47	$ 6.80
SMI SSI Adults (UP3)	$ 59.58	$ 1,462.35	$ 4.66	$ 16.69	$ 16.31	$ 20.26
OCWI (WG2)	$ 33.28	$ 596.21	$ 1.33	$ 30.48	$ 1.66	$ 2.06
DUAL	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Foster Care - Children (FG3)	$ 15.70	$ 710.66	$ 1.98	$ 20.09	$ 3.46	$ 4.30
KICK (MG2/NG2)	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00

Actual final payments will be calculated and reconciled on a retrospective basis.

(D) Consistency with 438.6(c) preprint

We confirm that each state directed payment incorporated via separate payment term as described in this certification is consistent with the approved (or submitted and under review) 438.6(c) preprints.

(E) Statement that certification will be amended if rates vary

If the final state directed PMPM payments by rate cell for STP, HAWQ, Independent Pharmacy, Physician Directed Payment, Public Ambulance, or the Private Ambulance program vary from the initial estimates presented in this certification, an amendment will be completed to reflect the final payments.

(b) Additional Directed Payments Not Addressed in the Certification

There are no additional directed payments in the managed care program that are not addressed in this rate certification.

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

There are no additional requirements regarding the reimbursement rates the plans must pay to any providers unless specified in this certification as a directed payment or authorized under applicable law, regulation, or waiver.

E. PASS-THROUGH PAYMENTS

i. Rate Development Standards

There are no pass-through payments reflected in the SFY 2026 capitation rates.

ii. Appropriate Documentation

There are no pass-through payments reflected in the SFY 2026 capitation rates.

5. Projected non-benefit costs

A. RATE DEVELOPMENT STANDARDS

i. Overview

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

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

ii. PMPM versus percentage

The non-benefit cost assumption was developed as follows:

- The administrative expense was developed as a percentage of the benefit expense portion of the capitation rate;
- Intensive case management (ICM) was developed as a PMPM; and,
- The risk margin components 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.

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 2026 non-benefit costs are listed below:

- Calendar Year 2022, 2023, and 2024 administrative costs as reported in the Managed Care Survey completed by each MCO.
- Calendar Year 2024 administrative costs by category and function as reported in the MCO Administrative Cost template completed by each MCO
- 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 2023 report published in July 2024 (Medicaid managed care financial results for 2023) is provided here: Medicaid managed care financial results for 2023 (milliman.com)
- Estimated ICM member counts, caseload ratio requirements as outlined in the MCO contract, and Bureau of Labor and Statistics (BLS) wages for case managers and operational staff.

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.

In addition, SCDHHS added ICM requirements to the MCO contract effective January 1, 2025, requiring MCOs to apply specified criteria outlined in the MCO contract to members identified with a serious mental illness. To develop the ICM costs, we applied a case manager caseload ratio of 1:55 to the expected ICM recipients to estimate the number of case manager full time equivalents (FTEs) expected to administer the ICM activities.

Using 2023 BLS data to estimate salary and benefits for case managers, in addition to estimated indirect overhead costs associated with staff operations, the estimated impact of adding ICM services to the managed care program is estimated at approximately $14.8 million and is applied as a $25.44 PMPM to the SMI and Foster Care Children rate cells, which represents the populations primarily impacted by the ICM requirements.

Our review of the non-benefit cost component of the capitation rate (excluding risk margin) in comparison to Appendix 1 of the Medicaid managed care financial results for 2023 referenced above indicates that the allowance reflected in the South Carolina Medicaid managed care rates is reasonable in comparison to the national benchmark for states that have not expanded Medicaid to cover the new adult group defined by section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. The SFY 2026 administrative expense and risk margin percentages are consistent with the prior capitation rate setting analysis for all rate cells.

In addition, we reviewed the resulting composite non-benefit cost PMPMs for the SC Medicaid managed care program in the context of historical PMPMs included in the capitation rates, as well as MCO-reported non-benefit costs (care management and administrative expenses). We believe the non-benefit cost allowance continues to be a reasonable, appropriate and attainable assumption based on our review of historical financial results and administrative expenses reported by the MCOs, projected SFY 2026 enrollment, and continued review of the program contractual requirements.

(b) Material changes

The data, assumptions, and methodology used to develop the projected non-benefit costs are generally consistent with the SFY 2025 rate development. While there are no changes from the prior year to the administrative expense percentages illustrated in Figure 27; in SFY 2026, the percentages are applied as a percentage load to the benefit expense portion of the capitation rate to recognize the addition of the ICM PMPM component after application of the base administrative expense percentage load.

(c) Other material adjustments

There are no material adjustments applied to non-benefit costs for SFY 2026.

ii. Non-benefit costs, by cost category

With the exception of the ICM PMPM load, 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 for reasonableness.

The SFY 2026 non-benefit cost allowance is calculated as follows:

- The administrative expense component is applied as a percentage of the benefit expense portion of capitation rate, excluding ICM and state-directed payments
- ICM is applied as a PMPM add-on
- Risk margin is applied as a percentage of the capitation rate, excluding state-directed payments

The SFY 2026 non-benefit costs allowance assumptions by rate cell are illustrated in Figure 27 below.

FIGURE 27: NON-BENEFIT COST ALLOWANCE ASSUMPTIONS BY RATE CELL

RATE CELL	ADMINISTRATIVE EXPENSES	INTENSIVE CASE MANAGEMENT	RISK MARGIN
TANF: 0-2 months old (AH3)	6.35%	$ 0.00	1.00%
TANF: 3-12 months old (AI3)	11.60%	$ 0.00	1.00%
TANF: Age 1-6 (AB3)	11.85%	$ 0.00	1.00%
TANF: Age 7-13 (AC3)	12.35%	$ 0.00	1.00%
TANF: Age 14-18, Male (AD1)	12.35%	$ 0.00	1.00%
TANF: Age 14-18, Female (AD2)	12.35%	$ 0.00	1.00%
TANF: Age 19-44, Male (AE1)	10.10%	$ 0.00	1.00%
TANF: Age 19-44, Female (AE2)	10.10%	$ 0.00	1.00%
TANF: Age 45+ (AF3)	10.10%	$ 0.00	1.00%
SSI - Children (SO3)	7.85%	$ 0.00	1.00%
SSI - Adults (SP3)	7.85%	$ 0.00	1.00%
SMI Children (VV3)	12.10%	$ 25.44	1.00%
SMI TANF Adults (TP3)	10.35%	$ 25.44	1.00%
SMI SSI Adults (UP3)	7.35%	$ 25.44	1.00%
OCWI (WG2)	10.35%	$ 0.00	1.00%
DUAL[1]	N/A	N/A	N/A
Foster Care - Children (FG3)	10.35%	$ 25.44	1.00%
KICK (MG2/NG2)	2.35%	$ 0.00	1.00%

Notes:
1. The non-benefit cost allowance for the DUAL rate cell is 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 or regulatory fees attributed to the South Carolina Medicaid managed care program.

The benefit expense and non-benefit cost allowance components of the SFY 2026 capitation rates are illustrated by rate cell in Appendix 4.

iii. Historical non-benefit costs

Historical MCO-reported non-benefit cost data net of taxes for CY 2022, CY 2023, and CY 2024 are illustrated in Figure 28. In addition to the average non-benefit cost PMPM reported across all MCOs, we provided the minimum and maximum MCO non-benefit cost PMPM.

FIGURE 28: MCO REPORTED NON-BENEFIT COST PMPM

CALENDAR YEAR	AVERAGE REPORTED NON BENEFIT COSTS PMPM	MININUM REPORTED NON BENEFIT COSTS PMPM	MAXIMUM REPORTED NON BENEFIT COSTS PMPM
CY 2022	$ 31.42	$ 24.85	$ 42.92
CY 2023	$ 28.63	$ 25.92	$ 35.52
CY 2024	$ 31.79	$ 29.46	$ 37.32

Note: Due to low volume of Medicaid membership during the first three years of managed care activity, the new MCO entrant during 2021 has been excluded from the results.

Information related to the manner in which the historical non-benefit cost data was considered in the non-benefit cost assumptions used in the rate development is described in section I, item 5.B.i above. Appendix 4 includes administrative expense and ICM amounts on a PMPM basis, comparable to the values in Figure 27.

6. Risk adjustment

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

B. APPROPRIATE DOCUMENTATION

i. Prospective risk adjustment

(a) Data and adjustments

The risk adjustment analysis will use historical FFS and encounter data in the development of South Carolina-specific weights. The CDPS+Rx risk adjustment model and the South Carolina-specific weights will be applied to SFY 2024 FFS and encounter data for the population enrolled in managed care as of March 2025 as the underlying data source for the development of the July through December 2025 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 2025.

(b) Risk adjustment model

The July through December 2025 risk scores for the TANF Adult, TANF Children, SSI Adult, SSI Children, SMI TANF Adult, SMI SSI Adult, and SMI 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 2025.

(c) Risk adjustment methodology

The SCDHHS risk adjustment is designed to be cost neutral for each of the seven 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 7.0, including an additional MH/SA treatment prevalence variable, calibrated to South Carolina-specific weights for the last rating period. The most recent CDPS+Rx risk adjustment model, version 7.2, with MH/SA treatment prevalence variable calibrated to South Carolina-specific weights is anticipated to be used for the SFY 2026 rating period.

7. Acuity adjustment

This section provides information on the acuity adjustment incorporated into the SFY 2026 capitation rates.

A. RATE DEVELOPMENT STANDARDS

i. Overview

Assumptions related to anticipated changes in population acuity during SFY 2026 are applied as prospective acuity adjustments and are discussed in Section 2.B.iii.4.4, “Unwinding Acuity” adjustment.

B. APPROPRIATE DOCUMENTATION

ii. Description

Documentation of the prospective acuity adjustment included in the SFY 2026 capitation rate development is discussed in Section 2.B.iii.4.4, “Unwinding Acuity” adjustment.

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 disenrolled 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.

III. New adult group capitation rates

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

Limitations

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

The information contained in this letter, including the enclosures, has been prepared for SCDHHS and their consultants and advisors. . It is our understanding that the information contained in this letter will be distributed to CMS and each of the MCOs participating in the SC Medicaid managed care program. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

At the time of this report, we acknowledge there continues to be uncertainty regarding the resumption of Medicaid redeterminations that resulted in terminations of coverage and reenrollment prior to the SFY 2026 rating period. The assumptions documented in this certification report reflect information known to us at the time of this report and SCDHHS guidance related to the enrollment unwinding period.

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

Milliman has developed certain models to estimate the values included in this presentation. The intent of the models was to develop the SFY 2026 Medicaid managed care capitation rates. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by SCDHHS and the participating MCOs for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. Although the capitation rates have been certified as actuarially sound, the capitation rates may not be appropriate for any individual MCO. Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

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, 2025 through June 30, 2026

Actuarial Certification

I, Marlene T. Howard, 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 contracted 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, 2025 through June 30, 2026. 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.

I acknowledge the unique nature of the COVID-19 Public Health Emergency and the associated resumption of eligibility redeterminations that occurred between the base data period and rating period. The assumptions documented in this certification report reflect our best estimate based on information known to us at the time of this report.

Marlene T. Howard

Marlene T. Howard, FSA
Member, American Academy of Actuaries

June 18, 2025
Date

Appendix 2: Certified Capitation Rates

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Comparison to January - June 2025 Capitation Rates

Rate Cell Description	Rate Cell Code	SFY 2026 Projected Exposure	Excluding Add-Ons			Including Add-Ons		
			Jan-Jun 2025 Rates	SFY 2026 Rates	Total Rate Change	Jan-Jun 2025 Rates	SFY 2026 Rates	Total Rate Change
TANF Children								
TANF - 0 - 2 Months, Male & Female	**AH3**	77,252	$ 2,389.19	$ 2,307.65	(3.4%)	$ 5,753.86	$ 6,170.00	7.2%
TANF - 3 - 12 Months, Male & Female	**AI3**	338,280	291.70	287.54	(1.4%)	498.54	552.98	10.9%
TANF - Age 1 - 6, Male & Female	**AB3**	2,136,221	178.37	193.85	8.7%	266.67	313.49	17.6%
TANF - Age 7 - 13, Male & Female	**AC3**	2,594,528	146.45	160.31	9.5%	202.20	242.16	19.8%
TANF - Age 14 - 18, Male	**AD1**	845,513	168.43	162.28	(3.7%)	257.60	269.98	4.8%
TANF - Age 14 - 18, Female	**AD2**	817,358	177.71	176.99	(0.4%)	279.54	301.97	8.0%
Subtotal TANF Children		**6,809,152**	**$ 195.61**	**$ 203.76**	**4.2%**	**$ 316.30**	**$ 357.87**	**13.1%**
TANF Adult								
TANF - Age 19 - 44, Male	**AE1**	160,216	$ 210.39	$ 245.93	16.9%	$ 385.44	$ 445.84	15.7%
TANF - Age 19 - 44, Female	**AE2**	1,112,937	317.34	357.01	12.5%	648.16	709.35	9.4%
TANF - Age 45+, Male & Female	**AF3**	201,585	596.27	625.82	5.0%	1,045.55	1,094.75	4.7%
Subtotal TANF Adult		**1,474,738**	**$ 343.85**	**$ 381.69**	**11.0%**	**$ 673.94**	**$ 733.40**	**8.8%**
Disabled								
SSI - Children	**SO3**	149,431	$ 752.02	$ 756.31	0.6%	$ 1,004.38	$ 1,130.05	12.5%
SSI - Adults	**SP3**	423,342	1,374.48	1,360.91	(1.0%)	2,426.33	2,629.32	8.4%
Subtotal Disabled		**572,773**	**$ 1,212.09**	**$ 1,203.18**	**(0.7%)**	**$ 2,055.36**	**$ 2,238.17**	**8.9%**
SMI								
SMI Children	**VV3**	158,287	$ 706.18	$ 727.23	3.0%	$ 1,072.52	$ 1,340.96	25.0%
SMI TANF Adults	**TP3**	224,772	766.21	925.11	20.7%	1,250.29	1,609.33	28.7%
SMI SSI Adults	**UP3**	156,170	1,901.16	1,946.60	2.4%	3,051.51	3,526.45	15.6%
Subtotal SMI		**539,229**	**$ 1,077.29**	**$ 1,162.86**	**7.9%**	**$ 1,719.77**	**$ 2,085.78**	**21.3%**
OCWI	**WG2**	**288,631**	**$ 273.51**	**$ 281.67**	**3.0%**	**$ 866.45**	**$ 946.69**	**9.3%**
DUAL		**-**	**$ 178.57**	**$ 179.00**	**0.2%**	**$ 178.57**	**$ 179.00**	**0.2%**
Foster Care Children	**FG3**	**42,435**	**$ 935.94**	**$ 1,007.26**	**7.6%**	**$ 1,510.78**	**$ 1,763.45**	**16.7%**
KICK	**MG2/NG2**	**22,356**	**$ 7,091.34**	**$ 7,067.30**	**(0.3%)**	**$ 7,091.34**	**$ 7,067.30**	**(0.3%)**
Total		**9,726,958**	**$ 348.65**	**$ 364.82**	**4.6%**	**$ 588.56**	**$ 661.16**	**12.3%**

Note:
Jan-Jun 2025 and SFY 2026 composite rates reflect projected SFY 2026 enrollment by rate cell.

Appendix 3: Fiscal Impact Summary

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Fiscal Impact Summary ($ Millions)

Rate Cell	SFY 2026 Projected Exposure	Jan - Jun 2025 Capitation Rates			SFY 2026 Capitation Rates			Increase/(Decrease)	
		Capitation Rate	Projected Expenditures	FMAP (69.57%) Federal Expenditures	Capitation Rate	Projected Expenditures	FMAP (69.57%) Federal Expenditures	Projected Expenditures	FMAP (69.57%) Federal Expenditures
TANF Children									
TANF - 0 - 2 Months, Male & Female	77,252	$ 5,753.86	$ 444.5	$ 309.2	$ 6,170.00	$ 476.6	$ 331.6	$ 32.1	$ 22.4
TANF - 3 - 12 Months, Male & Female	338,280	498.54	168.6	117.3	552.98	187.1	130.1	18.4	12.8
TANF - Age 1 - 6, Male & Female	2,136,221	266.67	569.7	396.3	313.49	669.7	465.9	100.0	69.6
TANF - Age 7 - 13, Male & Female	2,594,528	202.20	524.6	364.9	242.16	628.3	437.1	103.7	72.1
TANF - Age 14 - 18, Male	845,513	257.60	217.8	151.5	269.98	228.3	158.8	10.5	7.3
TANF - Age 14 - 18, Female	817,358	279.54	228.5	158.9	301.97	246.8	171.7	18.3	12.8
Subtotal TANF Children	**6,809,152**	**$ 316.30**	**$ 2,153.7**	**$ 1,498.2**	**$ 357.87**	**$ 2,436.8**	**$ 1,695.1**	**$ 283.1**	**$ 196.9**
TANF Adult									
TANF - Age 19 - 44, Male	160,216	$ 385.44	$ 61.8	$ 43.0	$ 445.84	$ 71.4	$ 49.7	$ 9.7	$ 6.7
TANF - Age 19 - 44, Female	1,112,937	648.16	721.4	501.8	709.35	789.5	549.2	68.1	47.4
TANF - Age 45+, Male & Female	201,585	1,045.55	210.8	146.6	1,094.75	220.7	153.5	9.9	6.9
Subtotal TANF Adult	**1,474,738**	**$ 673.94**	**$ 993.9**	**$ 691.4**	**$ 733.40**	**$ 1,081.6**	**$ 752.4**	**$ 87.7**	**$ 61.0**
Disabled									
SSI - Children	149,431	$ 1,004.38	$ 150.1	$ 104.4	$ 1,130.05	$ 168.9	$ 117.5	$ 18.8	$ 13.1
SSI - Adults	423,342	2,426.33	1,027.2	714.5	2,629.32	1,113.1	774.3	85.9	59.8
Subtotal Disabled	**572,773**	**$ 2,055.36**	**$ 1,177.3**	**$ 819.0**	**$ 2,238.17**	**$ 1,282.0**	**$ 891.8**	**$ 104.7**	**$ 72.8**
SMI									
SMI Children	158,287	$ 1,072.52	$ 169.8	$ 118.1	$ 1,340.96	$ 212.3	$ 147.7	$ 42.5	$ 29.6
SMI TANF Adults	224,772	1,250.29	281.0	195.5	1,609.33	361.7	251.6	80.7	56.1
SMI SSI Adults	156,170	3,051.51	476.6	331.5	3,526.45	550.7	383.1	74.2	51.6
Subtotal SMI	**539,229**	**$ 1,719.77**	**$ 927.4**	**$ 645.1**	**$ 2,085.78**	**$ 1,124.7**	**$ 782.4**	**$ 197.4**	**$ 137.3**
OCWI	**288,631**	**$ 866.45**	**$ 250.1**	**$ 174.0**	**$ 946.69**	**$ 273.2**	**$ 190.1**	**$ 23.2**	**$ 16.1**
DUAL	**-**	**$ 178.57**	**-**	**-**	**$ 179.00**	**-**	**-**	**-**	**-**
Foster Care Children	**42,435**	**$ 1,510.78**	**$ 64.1**	**$ 44.6**	**$ 1,763.45**	**$ 74.8**	**$ 52.1**	**$ 10.7**	**$ 7.5**
KICK	**22,356**	**$ 7,091.34**	**$ 158.5**	**$ 110.3**	**$ 7,067.30**	**$ 158.0**	**$ 109.9**	**($ 0.5)**	**($ 0.4)**
Total	**9,726,958**	**$ 588.56**	**$ 5,724.9**	**$ 3,982.5**	**$ 661.16**	**$ 6,431.1**	**$ 4,473.8**	**$ 706.2**	**$ 491.3**

Note:
Jan-Jun 2025 and SFY 2026 composite rates reflect projected SFY 2026 enrollment by rate cell.

Appendix 4: Rate Change Summary

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Rate Change Summary

											State Directed Payments (separate payment terms)								
	Projected Exposure	Base Benefit Expense	Admin Expense	Care Management	Intensive Case Management	Risk Margin	Non-Benefit Expense	SFY 2026 Capitation Rate w/o Add-Ons	Jan-Jun 2025 Capitation Rate w/o Add-Ons	% Change	Health, Access, and Workforce Quality	Independent Community Pharmacy	Supplemental Teaching Physician	Private Ambulance Providers	Public Ambulance Providers	Physician Directed Payment	SFY 2026 Capitation Rate w/ Add-Ons	Jan-Jun 2025 Capitation Rate w/ Add-Ons	% Change
TANF Children																			
TANF - 0 - 2 Months, Male & Female	77,252	$ 2,139.50	$ 122.22	$ 22.85	$ 0.00	$ 23.08	$ 168.15	$ 2,307.65	$ 2,389.19	(3.4%)	$ 3,579.58	$ 0.29	$ 185.84	$ 1.67	$ 1.35	$ 93.62	$ 6,170.00	$ 5,753.86	7.2%
TANF - 3 - 12 Months, Male & Female	338,280	251.64	28.04	4.98	-	2.88	35.90	287.54	291.70	(1.4%)	204.03	0.50	32.42	0.80	0.64	27.05	552.98	498.54	10.9%
TANF - Age 1 - 6, Male & Female	2,136,221	169.17	19.38	3.36	-	1.94	24.68	193.85	178.37	8.7%	97.46	0.54	9.40	0.45	0.36	11.43	313.49	266.67	17.6%
TANF - Age 7 - 13, Male & Female	2,594,528	139.11	17.22	2.38	-	1.60	21.20	160.31	146.45	9.5%	66.97	0.62	6.17	0.33	0.26	7.50	242.16	202.20	19.8%
TANF - Age 14 - 18, Male	845,513	140.82	17.43	2.41	-	1.62	21.46	162.28	168.43	(3.7%)	92.31	0.53	8.57	0.68	0.55	5.06	269.98	257.60	4.8%
TANF - Age 14 - 18, Female	817,358	153.58	19.01	2.63	-	1.77	23.41	176.99	177.71	(0.4%)	105.37	0.73	10.11	0.79	0.63	7.35	301.97	279.54	8.0%
Subtotal TANF Children	**6,809,152**	**$ 178.78**	**$ 19.87**	**$ 3.08**	**$ 0.00**	**$ 2.04**	**$ 24.99**	**$ 203.76**	**$ 195.61**	**4.2%**	**$ 130.95**	**$ 0.59**	**$ 11.30**	**$ 0.50**	**$ 0.40**	**$ 10.36**	**$ 357.87**	**$ 316.30**	**13.1%**
TANF Adult																			
TANF - Age 19 - 44, Male	160,216	$ 218.88	$ 21.55	$ 3.04	$ 0.00	$ 2.46	$ 27.05	$ 245.93	$ 210.39	16.9%	$ 182.93	$ 0.88	$ 6.55	$ 2.55	$ 2.05	$ 4.95	$ 445.84	$ 385.44	15.7%
TANF - Age 19 - 44, Female	1,112,937	317.74	31.28	4.42	-	3.57	39.27	357.01	317.34	12.5%	317.41	1.08	17.08	2.09	1.68	13.00	709.35	648.16	9.4%
TANF - Age 45+, Male & Female	201,585	556.99	54.83	7.74	-	6.26	68.83	625.82	596.27	5.0%	429.98	2.48	21.99	2.34	1.88	10.26	1,094.75	1,045.55	4.7%
Subtotal TANF Adult	**1,474,738**	**$ 339.70**	**$ 33.44**	**$ 4.72**	**$ 0.00**	**$ 3.82**	**$ 41.98**	**$ 381.69**	**$ 343.85**	**11.0%**	**$ 318.19**	**$ 1.25**	**$ 16.61**	**$ 2.17**	**$ 1.75**	**$ 11.75**	**$ 733.40**	**$ 673.94**	**8.8%**
Disabled																			
SSI - Children	149,431	$ 689.97	$ 49.42	$ 9.36	$ 0.00	$ 7.56	$ 66.34	$ 756.31	$ 752.02	0.6%	$ 330.30	$ 1.49	$ 30.65	$ 1.39	$ 1.12	$ 8.79	$ 1,130.05	$ 1,004.38	12.5%
SSI - Adults	423,342	1,241.54	88.92	16.84	-	13.61	119.37	1,360.91	1,374.48	(1.0%)	1,197.11	2.58	44.43	7.57	6.10	10.62	2,629.32	2,426.33	8.4%
Subtotal Disabled	**572,773**	**$ 1,097.64**	**$ 78.61**	**$ 14.89**	**$ 0.00**	**$ 12.03**	**$ 105.53**	**$ 1,203.18**	**$ 1,212.09**	**(0.7%)**	**$ 970.97**	**$ 2.30**	**$ 40.83**	**$ 5.96**	**$ 4.80**	**$ 10.14**	**$ 2,238.17**	**$ 2,055.36**	**8.9%**
SMI																			
SMI Children	158,287	$ 610.47	$ 59.73	$ 24.31	$ 25.45	$ 7.27	$ 116.76	$ 727.23	$ 706.18	3.0%	$ 569.88	$ 2.41	$ 17.81	$ 4.51	$ 3.63	$ 15.49	$ 1,340.96	$ 1,072.52	25.0%
SMI TANF Adults	224,772	798.25	60.99	31.16	25.45	9.26	126.86	925.11	766.21	20.7%	613.23	3.44	34.73	6.80	5.47	20.55	1,609.33	1,250.29	28.7%
SMI SSI Adults	156,170	1,761.91	106.49	33.28	25.45	19.47	184.69	1,946.60	1,901.16	2.4%	1,462.35	4.66	59.58	20.26	16.31	16.69	3,526.45	3,051.51	15.6%
Subtotal SMI	**539,229**	**$ 1,022.22**	**$ 73.80**	**$ 29.76**	**$ 25.45**	**$ 11.63**	**$ 140.64**	**$ 1,162.86**	**$ 1,077.29**	**7.9%**	**$ 846.42**	**$ 3.49**	**$ 36.96**	**$ 10.03**	**$ 8.07**	**$ 17.95**	**$ 2,085.78**	**$ 1,719.77**	**21.3%**
OCWI	**288,631**	**$ 249.99**	**$ 24.68**	**$ 4.18**	**$ 0.00**	**$ 2.82**	**$ 31.68**	**$ 281.67**	**$ 273.51**	**3.0%**	**$ 596.21**	**$ 1.33**	**$ 33.28**	**$ 2.06**	**$ 1.66**	**$ 30.48**	**$ 946.69**	**$ 866.45**	**9.3%**
DUAL	**-**	**$ 73.47**	**$ 78.61**	**$ 14.89**	**$ 0.00**	**$ 12.03**	**$ 105.53**	**$ 179.00**	**$ 178.57**	**0.2%**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 179.00**	**$ 178.57**	**0.2%**
Foster Care Children	**42,435**	**$ 871.16**	**$ 64.13**	**$ 36.44**	**$ 25.45**	**$ 10.08**	**$ 136.10**	**$ 1,007.26**	**$ 935.94**	**7.6%**	**$ 710.66**	**$ 1.98**	**$ 15.70**	**$ 4.30**	**$ 3.46**	**$ 20.09**	**$ 1,763.45**	**$ 1,510.78**	**16.7%**
KICK	**22,356**	**$ 6,832.21**	**$ 146.93**	**$ 17.49**	**$ 0.00**	**$ 70.67**	**$ 235.09**	**$ 7,067.30**	**$ 7,091.34**	**(0.3%)**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 0.00**	**$ 7,067.30**	**$ 7,091.34**	**(0.3%)**
Total	**9,726,958**	**$ 324.88**	**$ 29.05**	**$ 5.72**	**$ 1.52**	**$ 3.65**	**$ 39.94**	**$ 364.82**	**$ 348.65**	**4.6%**	**$ 264.80**	**$ 0.98**	**$ 15.94**	**$ 1.67**	**$ 1.34**	**$ 11.62**	**$ 661.16**	**$ 588.56**	**12.3%**

Note:
Jan-Jun 2025 and SFY 2026 composite rates reflect projected SFY 2026 enrollment by rate cell.

Appendix 5: In-Rate Criteria

South Carolina Department of Health and Human Services SFY 2026 Medicaid Managed Care Capitation Rate Development In-Rate Criteria for Services Covered Under Managed Care Capitation Rate		
Eligibility Criteria		
Eligibility File Type	**Criteria**	**Notes**
Recipient	Exclude Recipient Payment Categories:10,14,15,33,48,50,52, 54,55,70,89,90	
Recipient	Exclude Recipient Limited Benefit Indicators: E, I, C, D, J, P, A, B, G	
Recipient	Exclude if age >= 65 on date of service	
Recipient	Exclude Dual eligible members	
Recipient	Retroactive Eligibility	
Recipient	Long Term Care Exclusion	
RSP	Exclude where RSP Program Indicator is: 3,5,A,C,D,F,J,K,L,M, O, R,S,T,V,W	

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

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

UB-04 Claims Criteria			
Claim Type	**Provider Type**	**Provider Specialty**	**Notes**
Y	01	Any	Exclude if Ownership Code = 11
Y	02	Any	Exclude if Ownership Code = 11
Y	01,02	Any	Exclude all COVID Vaccine procedure codes for any one under the age of 19

Pharmacy Claims Criteria			
Claim Type	**Provider Type**	**Provider Specialty**	**Notes**
D	70	Any	Exclude all COVID Vaccine procedure codes for anyone under the age of 19
D	70	Any	Exclude the following HCNE Pharmaceuticals ("SOHONOS","VEOPOZ","POMBILITI","FABHALTA","CASGEVY","LYFGENIA","BEQVEZ","OJEMDA","LENMELDY","TECELRA","MIPLYFFA","AQNEURSA","HYMPAVZI","AUCATZYL", "KEBILIDI","BIZENGRI")

South Carolina Department of Health and Human Services SFY 2026 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 all COVID Vaccine procedure codes for any one under the age of 19
A	All	Any	Exclude hearing aid and hearing aid accessories for any one over the age of 21 (Procedure Code V5030-V5299)
A	All	Any	Exclude all vaccine codes for any one under the age of 19 (90476-90749 except 90460 and 90461) Providers must provide vaccinations through the VFC program for Medicaid eligible children
A	10	20	Exclude Procedure Codes (G9004 THROUGH G9011, T1016, T1017, T1023, T1024)
A	10	28	Exclude Procedure Codes (T1016, T1017)
A	10	90	Exclude Procedure Codes (T1016, T1017)
A	10	91	Exclude Provider Type and Specialty
A	10	92	Exclude Procedure Code (H2021, H2022, S9482, T1007, T1015, T1016, T1017, T2023, X2300)
A	19	Any	Exclude Procedure Codes (G9004 THROUGH G9011, T1016, T1017, T1023, T1024)
A	20	27	Exclude if Procedure Code in (H1001, T1001)
A	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 Ownership code = 017 AND Primary Diagnosis in COMDHEC table OR procedure code is S3870

South Carolina Department of Health and Human Services SFY 2026 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
A94	A94
A950	A959
A980	A988
A99	A99
B000	B019
B050	B059
B0600	B079

South Carolina Department of Health and Human Services SFY 2026 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**
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
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

South Carolina Department of Health and Human Services SFY 2026 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**
Z717	Z717
Z7189	Z7189
Z7251	Z7253

Appendix 6: Adjusted SFY 2024 Base Data

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - 0 - 2 Months, Male & Female Base Year Member Months: 75,856 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	8,958.7	$ 1,560.40	$ 1,164.93	$ 50.67	$ 0.00	$ (0.74)	$ 0.06	$ (6.01)	$ 7.69	$ 0.00	$ 0.00	$ 0.00	$ 0.00	9,296.5	$ 1,570.40	$ 1,216.60
Inpatient Well Newborn	5,921.4	656.32	323.86	14.09	-	(0.21)	0.04	(1.30)	2.14	-	-	-	-	6,151.4	660.57	338.62
Inpatient MH/SA	2.7	178.48	0.04	-	-	-	-	-	-	-	-	-	-	2.7	178.48	0.04
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 1,488.83**													**$ 1,555.26**
Outpatient Hospital																
Surgery	72.9	$ 1,239.04	$ 7.53	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	73.7	$ 1,247.18	$ 7.66
Non-Surg - Emergency Room	812.8	352.85	23.90	0.38	-	(0.35)	0.17	(0.12)	0.15	-	-	-	-	809.7	357.60	24.13
Non-Surg - Other	1,202.3	123.07	12.33	0.20	-	-	-	(0.07)	0.08	-	-	-	-	1,215.0	123.86	12.54
Observation Room	55.4	875.59	4.04	0.07	-	-	-	(0.03)	0.03	-	-	-	-	55.9	882.03	4.11
Treatment/Therapy/Testing	767.1	99.81	6.38	0.10	-	-	-	(0.03)	0.04	-	-	-	-	775.5	100.43	6.49
Other Outpatient	63.8	116.70	0.62	0.01	-	-	-	-	-	-	-	-	-	64.8	116.70	0.63
Subtotal Outpatient Hospital			**$ 54.80**													**$ 55.56**
Retail Pharmacy																
Prescription Drugs	2,280.8	$ 22.62	$ 4.30	$ 0.00	$ 0.00	$ 0.00	$ (0.08)	$ (0.02)	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,270.2	$ 22.31	$ 4.22
Subtotal Retail Pharmacy			**$ 4.30**													**$ 4.22**
Ancillary																
Transportation	197.4	$ 247.38	$ 4.07	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ (0.02)	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	199.9	$ 249.18	$ 4.15
DME/Prosthetics	1,485.9	18.09	2.24	0.04	-	-	-	-	0.01	-	-	-	-	1,512.5	18.17	2.29
Dental	0.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	95.2	90.72	0.72	0.01	-	-	-	0.08	0.01	-	-	-	-	107.1	91.84	0.82
Subtotal Ancillary			**$ 7.03**													**$ 7.26**
Professional																
Inpatient and Outpatient Surgery	1,965.2	$ 112.11	$ 18.36	$ 0.20	$ 0.00	$ 0.00	$ 0.00	$ (0.08)	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ 0.00	1,978.1	$ 112.84	$ 18.60
Anesthesia	97.6	201.63	1.64	0.02	-	-	-	(0.01)	0.01	-	-	-	-	98.2	202.85	1.66
Inpatient Visits	13,796.5	184.35	211.95	2.27	-	-	-	(0.85)	1.36	-	-	-	-	13,888.9	185.53	214.73
MH/SA	26.4	27.25	0.06	-	-	-	-	-	-	-	-	-	-	26.4	27.25	0.06
Emergency Room	895.5	75.71	5.65	0.06	-	(0.08)	-	(0.02)	0.04	-	-	-	-	889.2	76.25	5.65
Office/Home Visits/Consults	7,767.2	90.43	58.53	0.63	-	0.08	-	(0.20)	0.38	-	-	-	-	7,834.9	91.01	59.42
Pathology/Lab	2,594.9	37.92	8.20	0.09	-	-	-	0.49	0.06	-	-	-	-	2,778.4	38.18	8.84
Radiology	2,932.0	14.78	3.61	0.04	-	0.01	-	(0.02)	0.02	-	-	-	-	2,956.3	14.86	3.66
Office Administered Drugs	35.4	3.39	0.01	-	-	-	-	-	36.16	-	-	-	-	35.4	12,248.71	36.17
Physical Exams	24,986.3	59.18	123.23	1.32	-	-	-	(0.47)	0.79	-	-	-	-	25,158.7	59.56	124.87
Therapy	159.8	27.04	0.36	-	-	-	-	0.01	-	-	-	-	-	164.2	27.04	0.37
Vision	17.7	60.96	0.09	-	-	-	-	-	-	-	-	-	-	17.7	60.96	0.09
Other Professional	4,626.1	62.70	24.17	0.26	-	-	-	0.76	(2.99)	-	0.02	-	-	4,821.3	55.30	22.22
Subtotal Professional			**$ 455.86**													**$ 496.34**
Total Medical Costs			**$ 2,010.82**													**$ 2,118.64**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - 3 - 12 Months, Male & Female Base Year Member Months: 335,843 Category of Service	MCO Encounter Data Base Year Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustments Utilization Adjustment	 Cost Adjustment	Managed Care Adjustments Utilization Adjustment	 Cost Adjustment	Other Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	226.2	$ 2,117.65	$ 39.92	$ 1.74	$ 0.00	$ (0.23)	$ 0.07	$ (0.08)	$ 0.26	$ 0.00	$ 0.75	$ 0.00	$ 0.00	234.3	$ 2,172.96	$ 42.43
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 39.92**													**$ 42.43**
Outpatient Hospital																
Surgery	70.6	$ 1,526.25	$ 8.98	$ 0.14	$ 0.00	$ 0.00	$ 0.00	$ (0.02)	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ 0.00	71.5	$ 1,536.31	$ 9.16
Non-Surg - Emergency Room	899.1	280.14	20.99	0.34	-	(0.53)	0.17	(0.06)	0.14	-	-	-	-	888.4	284.32	21.05
Non-Surg - Other	724.3	131.88	7.96	0.13	-	-	-	(0.02)	0.05	-	-	-	-	734.3	132.70	8.12
Observation Room	11.6	1,157.37	1.12	0.02	-	-	-	(0.01)	0.01	-	-	-	-	11.7	1,167.61	1.14
Treatment/Therapy/Testing	273.6	270.62	6.17	0.10	-	-	-	(0.02)	0.04	-	-	-	-	277.1	272.35	6.29
Other Outpatient	67.7	162.96	0.92	0.01	-	-	-	-	0.01	-	-	-	-	68.5	164.71	0.94
Subtotal Outpatient Hospital			**$ 46.14**													**$ 46.70**
Retail Pharmacy																
Prescription Drugs	3,944.2	$ 32.13	$ 10.56	$ 0.00	$ 0.00	$ 0.00	$ (0.20)	$ (0.02)	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.00	3,936.8	$ 31.73	$ 10.41
Subtotal Retail Pharmacy			**$ 10.56**													**$ 10.41**
Ancillary																
Transportation	91.5	$ 136.44	$ 1.04	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	93.2	$ 136.44	$ 1.06
DME/Prosthetics	3,548.8	12.17	3.60	0.06	-	-	-	(0.01)	0.03	-	-	-	-	3,598.1	12.27	3.68
Dental	252.2	17.13	0.36	0.01	-	-	-	-	-	-	-	-	-	259.2	17.13	0.37
Other Ancillary	22.8	78.96	0.15	-	-	-	-	-	-	-	-	-	-	22.8	78.96	0.15
Subtotal Ancillary			**$ 5.15**													**$ 5.26**
Professional																
Inpatient and Outpatient Surgery	262.8	$ 203.17	$ 4.45	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	265.2	$ 204.53	$ 4.52
Anesthesia	137.0	118.29	1.35	0.01	-	-	-	-	0.01	-	-	-	-	138.0	119.16	1.37
Inpatient Visits	686.3	183.59	10.50	0.11	-	-	-	(0.01)	0.07	-	-	-	-	692.9	184.80	10.67
MH/SA	134.7	12.47	0.14	-	-	-	-	-	-	-	-	-	-	134.7	12.47	0.14
Emergency Room	912.0	70.53	5.36	0.06	-	(0.14)	-	-	0.03	-	-	-	-	898.4	70.93	5.31
Office/Home Visits/Consults	4,695.6	91.29	35.72	0.38	-	0.17	-	(0.04)	0.23	-	-	-	-	4,762.6	91.87	36.46
Pathology/Lab	3,045.4	27.27	6.92	0.07	-	0.01	-	(0.01)	0.05	-	-	-	-	3,076.2	27.46	7.04
Radiology	571.7	17.63	0.84	0.01	-	-	-	-	0.01	-	-	-	-	578.5	17.84	0.86
Office Administered Drugs	288.2	8.33	0.20	-	-	-	-	-	6.85	-	-	-	-	288.2	293.58	7.05
Physical Exams	12,872.2	45.20	48.48	0.52	-	-	-	(0.05)	0.31	-	-	-	-	12,997.0	45.48	49.26
Therapy	1,402.9	22.92	2.68	0.03	-	-	-	(0.20)	0.02	-	-	-	-	1,313.9	23.11	2.53
Vision	166.1	11.56	0.16	-	-	-	-	-	-	-	-	-	-	166.1	11.56	0.16
Other Professional	2,341.2	31.68	6.18	0.07	-	-	-	(0.02)	(0.02)	0.06	0.16	-	-	2,382.9	32.38	6.43
Subtotal Professional			**$ 122.98**													**$ 131.80**
Total Medical Costs			**$ 224.75**													**$ 236.60**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 1 - 6, Male & Female Base Year Member Months: 2,300,548 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	43.4	$ 2,374.35	$ 8.59	$ 0.37	$ 0.00	$ (0.04)	$ 0.01	$ 0.01	$ 0.06	$ 0.00	$ 0.89	$ 0.00	$ 0.00	45.1	$ 2,629.60	$ 9.89
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	0.6	829.03	0.04	-	-	-	-	-	-	-	-	-	-	0.6	829.03	0.04
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 8.63**													**$ 9.93**
Outpatient Hospital																
Surgery	66.7	$ 1,467.09	$ 8.15	$ 0.13	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	67.7	$ 1,475.95	$ 8.33
Non-Surg - Emergency Room	487.3	300.16	12.19	0.20	-	(0.31)	0.11	-	0.07	-	-	-	-	482.9	304.63	12.26
Non-Surg - Other	298.7	133.39	3.32	0.05	-	-	-	-	0.03	-	-	-	-	303.2	134.58	3.40
Observation Room	4.6	1,500.36	0.57	0.01	-	-	-	-	-	-	-	-	-	4.6	1,500.36	0.58
Treatment/Therapy/Testing	230.7	213.24	4.10	0.07	-	-	-	-	0.02	-	-	-	-	234.7	214.26	4.19
Other Outpatient	49.4	356.73	1.47	0.02	-	-	-	-	0.01	-	-	-	-	50.1	359.12	1.50
Subtotal Outpatient Hospital			**$ 29.80**													**$ 30.26**
Retail Pharmacy																
Prescription Drugs	3,883.8	$ 50.36	$ 16.30	$ 0.00	$ 0.00	$ 0.00	$ (0.47)	$ (0.01)	$ 0.11	$ 0.00	$ 0.00	$ 0.00	$ 0.00	3,881.5	$ 49.25	$ 15.93
Subtotal Retail Pharmacy			**$ 16.30**													**$ 15.93**
Ancillary																
Transportation	47.4	$ 119.11	$ 0.47	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	48.4	$ 119.11	$ 0.48
DME/Prosthetics	4,087.3	6.31	2.15	0.04	-	-	-	-	0.01	-	-	-	-	4,163.4	6.34	2.20
Dental	248.1	81.25	1.68	0.03	-	-	-	-	0.01	-	-	-	-	252.6	81.72	1.72
Other Ancillary	18.6	58.03	0.09	-	-	-	-	-	-	-	-	-	-	18.6	58.03	0.09
Subtotal Ancillary			**$ 4.39**													**$ 4.49**
Professional																
Inpatient and Outpatient Surgery	203.9	$ 151.87	$ 2.58	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	206.2	$ 153.03	$ 2.63
Anesthesia	138.2	99.85	1.15	0.01	-	-	-	-	0.01	-	-	-	-	139.4	100.71	1.17
Inpatient Visits	96.4	136.93	1.10	0.01	-	-	-	-	0.01	-	-	-	-	97.3	138.16	1.12
MH/SA	5,274.3	20.29	8.92	0.10	-	-	-	0.01	0.06	-	-	-	-	5,339.4	20.43	9.09
Emergency Room	503.4	70.56	2.96	0.03	-	(0.07)	-	-	0.02	-	-	-	-	496.6	71.04	2.94
Office/Home Visits/Consults	3,215.3	89.91	24.09	0.26	-	0.08	-	0.04	0.15	-	-	-	-	3,266.0	90.46	24.62
Pathology/Lab	2,479.0	25.75	5.32	0.06	-	-	-	0.01	0.03	-	-	-	-	2,511.6	25.90	5.42
Radiology	309.6	19.38	0.50	0.01	-	-	-	-	-	-	-	-	-	315.8	19.38	0.51
Office Administered Drugs	341.5	7.03	0.20	-	-	-	-	-	1.44	-	-	-	-	341.5	57.63	1.64
Physical Exams	2,153.1	59.69	10.71	0.11	-	-	-	0.02	0.07	-	-	-	-	2,179.2	60.08	10.91
Therapy	8,293.0	22.92	15.84	0.17	-	-	-	(0.52)	0.10	-	-	-	-	8,109.7	23.07	15.59
Vision	323.0	26.01	0.70	0.01	-	-	-	-	-	-	-	-	-	327.6	26.01	0.71
Other Professional	2,076.2	21.27	3.68	0.04	-	-	-	(0.01)	0.01	0.32	0.71	-	-	2,273.6	25.07	4.75
Subtotal Professional			**$ 77.75**													**$ 81.10**
Total Medical Costs			**$ 136.87**													**$ 141.71**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 7 - 13, Male & Female Base Year Member Months: 2,827,634 Category of Service	MCO Encounter Data Base Year Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustments Utilization Adjustment	 Cost Adjustment	Managed Care Adjustments Utilization Adjustment	 Cost Adjustment	Other Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	25.8	$ 2,831.83	$ 6.08	$ 0.26	$ 0.00	$ (0.03)	$ 0.00	$ 0.07	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	27.0	$ 2,849.58	$ 6.42
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	25.6	614.70	1.31	0.06	-	-	-	0.01	0.01	-	-	-	-	26.9	619.16	1.39
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.39**													**$ 7.81**
Outpatient Hospital																
Surgery	35.3	$ 1,566.94	$ 4.61	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	36.0	$ 1,576.94	$ 4.73
Non-Surg - Emergency Room	295.8	316.84	7.81	0.13	-	(0.16)	0.05	0.02	0.05	-	-	-	-	295.4	320.90	7.90
Non-Surg - Other	182.7	133.34	2.03	0.03	-	-	-	0.01	0.01	-	-	-	-	186.3	133.98	2.08
Observation Room	2.2	1,473.86	0.27	-	-	-	-	0.01	-	-	-	-	-	2.3	1,473.86	0.28
Treatment/Therapy/Testing	168.7	247.59	3.48	0.06	-	-	-	0.01	0.02	-	-	-	-	172.1	248.98	3.57
Other Outpatient	27.9	206.30	0.48	0.01	-	-	-	-	-	-	-	-	-	28.5	206.30	0.49
Subtotal Outpatient Hospital			**$ 18.68**													**$ 19.05**
Retail Pharmacy																
Prescription Drugs	4,405.0	$ 75.92	$ 27.87	$ 0.00	$ 0.00	$ 0.00	$ (1.04)	$ 0.09	$ 0.19	$ 0.00	$ 0.02	$ 0.00	$ 0.00	4,419.2	$ 73.67	$ 27.13
Subtotal Retail Pharmacy			**$ 27.87**													**$ 27.13**
Ancillary																
Transportation	33.6	$ 117.71	$ 0.33	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	34.7	$ 117.71	$ 0.34
DME/Prosthetics	2,749.5	5.02	1.15	0.02	-	-	-	-	0.01	-	-	-	-	2,797.3	5.06	1.18
Dental	34.0	84.74	0.24	-	-	-	-	0.01	-	-	-	-	-	35.4	84.74	0.25
Other Ancillary	38.2	40.87	0.13	-	-	-	-	-	-	-	-	-	-	38.2	40.87	0.13
Subtotal Ancillary			**$ 1.85**													**$ 1.90**
Professional																
Inpatient and Outpatient Surgery	135.7	$ 142.35	$ 1.61	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	137.4	$ 143.23	$ 1.64
Anesthesia	55.7	107.73	0.50	0.01	-	-	-	-	-	-	-	-	-	56.8	107.73	0.51
Inpatient Visits	71.2	104.53	0.62	0.01	-	-	-	-	-	-	-	-	-	72.3	104.53	0.63
MH/SA	2,783.9	63.97	14.84	0.16	-	-	-	0.06	0.11	-	-	-	-	2,825.2	64.43	15.17
Emergency Room	308.2	71.65	1.84	0.02	-	(0.03)	-	-	0.01	-	-	-	-	306.5	72.04	1.84
Office/Home Visits/Consults	2,466.9	92.72	19.06	0.20	-	0.05	-	0.09	0.12	-	-	-	-	2,510.9	93.29	19.52
Pathology/Lab	2,064.8	23.30	4.01	0.04	-	0.01	-	0.02	0.02	-	-	-	-	2,100.9	23.42	4.10
Radiology	375.3	19.50	0.61	0.01	-	-	-	-	-	-	-	-	-	381.5	19.50	0.62
Office Administered Drugs	566.9	16.30	0.77	0.01	-	-	-	-	0.01	-	-	-	-	574.3	16.51	0.79
Physical Exams	927.1	73.52	5.68	0.06	-	-	-	0.02	0.04	-	-	-	-	940.2	74.03	5.80
Therapy	1,194.6	22.30	2.22	0.02	-	-	-	0.02	0.01	-	-	-	-	1,216.1	22.40	2.27
Vision	634.6	34.04	1.80	0.02	-	-	-	0.01	0.01	-	-	-	-	645.1	34.22	1.84
Other Professional	2,204.9	12.90	2.37	0.03	-	-	-	0.01	0.01	0.18	0.32	-	-	2,409.6	14.54	2.92
Subtotal Professional			**$ 55.93**													**$ 57.65**
Total Medical Costs			**$ 111.72**													**$ 113.54**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Male Base Year Member Months: 939,280 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	45.6	$ 3,251.86	$ 12.37	$ 0.54	$ 0.00	$ (0.10)	$ 0.01	$ 0.06	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	47.5	$ 3,274.60	$ 12.96
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	55.1	581.87	2.67	0.12	-	-	-	0.01	0.01	-	-	-	-	57.7	583.95	2.81
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 15.04**													**$ 15.77**
Outpatient Hospital																
Surgery	45.2	$ 1,599.11	$ 6.02	$ 0.10	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	46.0	$ 1,609.55	$ 6.17
Non-Surg - Emergency Room	279.4	319.11	7.43	0.12	-	(0.10)	0.03	0.01	0.05	-	-	-	-	280.5	322.53	7.54
Non-Surg - Other	123.2	141.27	1.45	0.02	-	-	-	0.01	0.01	-	-	-	-	125.7	142.22	1.49
Observation Room	2.4	1,099.16	0.22	-	-	-	-	-	0.01	-	-	-	-	2.4	1,149.12	0.23
Treatment/Therapy/Testing	186.3	345.88	5.37	0.09	-	-	-	-	0.04	-	-	-	-	189.4	348.41	5.50
Other Outpatient	22.6	132.89	0.25	-	-	-	-	-	0.01	-	-	-	-	22.6	138.21	0.26
Subtotal Outpatient Hospital			**$ 20.74**													**$ 21.19**
Retail Pharmacy																
Prescription Drugs	3,684.2	$ 112.89	$ 34.66	$ 0.00	$ 0.00	$ 0.00	$ (1.86)	$ 0.02	$ 0.24	$ 0.00	$ 0.10	$ 0.00	$ 0.00	3,686.4	$ 107.94	$ 33.16
Subtotal Retail Pharmacy			**$ 34.66**													**$ 33.16**
Ancillary																
Transportation	69.5	$ 131.27	$ 0.76	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	70.4	$ 132.98	$ 0.78
DME/Prosthetics	1,393.9	13.17	1.53	0.03	-	-	-	-	0.01	-	-	-	-	1,421.2	13.26	1.57
Dental	9.6	37.42	0.03	-	-	-	-	-	-	-	-	-	-	9.6	37.42	0.03
Other Ancillary	32.8	47.51	0.13	-	-	-	-	-	-	-	-	-	-	32.8	47.51	0.13
Subtotal Ancillary			**$ 2.45**													**$ 2.51**
Professional																
Inpatient and Outpatient Surgery	177.1	$ 153.16	$ 2.26	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	179.4	$ 154.50	$ 2.31
Anesthesia	57.9	128.55	0.62	0.01	-	-	-	-	-	-	-	-	-	58.8	128.55	0.63
Inpatient Visits	113.4	96.28	0.91	0.01	-	-	-	-	0.01	-	-	-	-	114.7	97.32	0.93
MH/SA	1,343.4	76.55	8.57	0.09	-	-	-	0.04	0.06	0.54	-	-	-	1,448.5	77.05	9.30
Emergency Room	300.5	76.66	1.92	0.02	-	(0.02)	-	-	0.02	-	-	-	-	300.5	77.46	1.94
Office/Home Visits/Consults	1,777.7	91.67	13.58	0.15	-	0.02	-	0.05	0.09	-	-	-	-	1,806.5	92.27	13.89
Pathology/Lab	1,732.8	22.16	3.20	0.03	-	0.01	-	0.01	0.02	-	-	-	-	1,759.9	22.30	3.27
Radiology	538.7	24.28	1.09	0.01	-	-	-	0.01	-	-	-	-	-	548.5	24.28	1.11
Office Administered Drugs	975.9	22.38	1.82	0.02	-	-	-	0.01	0.01	-	-	-	-	991.9	22.50	1.86
Physical Exams	641.7	79.85	4.27	0.05	-	-	-	0.01	0.03	-	-	-	-	650.7	80.41	4.36
Therapy	653.9	21.65	1.18	0.01	-	-	-	0.01	-	-	-	-	-	665.0	21.65	1.20
Vision	522.3	35.15	1.53	0.02	-	-	-	-	0.01	-	-	-	-	529.1	35.38	1.56
Other Professional	1,623.0	15.30	2.07	0.02	-	-	-	0.01	0.01	0.12	0.10	-	-	1,740.7	16.06	2.33
Subtotal Professional			**$ 43.02**													**$ 44.69**
Total Medical Costs			**$ 115.91**													**$ 117.32**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Female Base Year Member Months: 886,202 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	34.0	$ 2,931.66	$ 8.31	$ 0.36	$ 0.00	$ (0.03)	$ 0.00	$ 0.01	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.00	35.4	$ 2,955.39	$ 8.72
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	52.8	632.35	2.78	0.12	-	-	-	0.01	0.02	-	-	-	-	55.2	636.70	2.93
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 11.09**													**$ 11.65**
Outpatient Hospital																
Surgery	44.7	$ 1,479.24	$ 5.51	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	45.5	$ 1,489.79	$ 5.65
Non-Surg - Emergency Room	410.8	335.64	11.49	0.18	-	(0.15)	0.06	0.03	0.07	-	-	-	-	412.9	339.42	11.68
Non-Surg - Other	187.6	149.66	2.34	0.04	-	-	-	0.01	0.01	-	-	-	-	191.6	150.29	2.40
Observation Room	4.7	939.53	0.37	0.01	-	-	-	-	-	-	-	-	-	4.9	939.53	0.38
Treatment/Therapy/Testing	305.3	218.95	5.57	0.09	-	-	-	0.02	0.04	-	-	-	-	311.3	220.49	5.72
Other Outpatient	29.3	135.27	0.33	0.01	-	-	-	-	-	-	-	-	-	30.2	135.27	0.34
Subtotal Outpatient Hospital			**$ 25.61**													**$ 26.17**
Retail Pharmacy																
Prescription Drugs	5,237.3	$ 75.73	$ 33.05	$ 0.00	$ 0.00	$ 0.00	$ (1.76)	$ 0.09	$ 0.13	$ (0.01)	$ 0.18	$ 0.00	$ 0.00	5,249.9	$ 72.41	$ 31.68
Subtotal Retail Pharmacy			**$ 33.05**													**$ 31.68**
Ancillary																
Transportation	81.9	$ 102.50	$ 0.70	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	83.1	$ 103.95	$ 0.72
DME/Prosthetics	1,104.6	11.41	1.05	0.02	-	-	-	-	0.01	-	-	-	-	1,125.6	11.51	1.08
Dental	9.6	37.50	0.03	-	-	-	-	-	-	-	-	-	-	9.6	37.50	0.03
Other Ancillary	28.4	63.42	0.15	-	-	-	-	-	-	-	-	-	-	28.4	63.42	0.15
Subtotal Ancillary			**$ 1.93**													**$ 1.98**
Professional																
Inpatient and Outpatient Surgery	147.6	$ 139.00	$ 1.71	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	150.2	$ 139.80	$ 1.75
Anesthesia	49.8	120.51	0.50	0.01	-	-	-	-	-	-	-	-	-	50.8	120.51	0.51
Inpatient Visits	119.5	91.38	0.91	0.01	-	-	-	-	0.01	-	-	-	-	120.8	92.38	0.93
MH/SA	1,480.2	95.58	11.79	0.13	-	-	-	0.06	0.07	0.15	-	-	-	1,522.9	96.13	12.20
Emergency Room	424.9	78.23	2.77	0.03	-	(0.04)	-	0.01	0.02	-	-	-	-	424.9	78.79	2.79
Office/Home Visits/Consults	2,421.9	92.90	18.75	0.20	-	0.04	-	0.09	0.12	-	-	-	-	2,464.5	93.49	19.20
Pathology/Lab	3,432.3	19.61	5.61	0.06	-	-	-	0.03	0.04	-	-	-	-	3,487.4	19.75	5.74
Radiology	515.9	29.31	1.26	0.01	-	0.01	-	-	0.01	-	-	-	-	524.1	29.53	1.29
Office Administered Drugs	14,001.2	1.58	1.84	0.02	-	0.01	-	0.01	0.01	-	-	-	-	14,305.6	1.59	1.89
Physical Exams	704.0	79.09	4.64	0.05	-	-	-	0.02	0.03	-	-	-	-	714.6	79.59	4.74
Therapy	588.8	22.22	1.09	0.01	-	-	-	0.01	-	-	-	-	-	599.6	22.22	1.11
Vision	783.0	34.18	2.23	0.02	-	-	-	0.01	0.02	-	-	-	-	793.5	34.48	2.28
Other Professional	2,304.1	19.74	3.79	0.04	-	-	-	0.02	0.02	0.11	0.05	-	-	2,407.4	20.09	4.03
Subtotal Professional			**$ 56.89**													**$ 58.46**
Total Medical Costs			**$ 128.57**													**$ 129.94**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Male Base Year Member Months: 397,195 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	114.9	$ 2,919.17	$ 27.95	$ 1.22	$ 0.00	$ (0.42)	$ 0.07	$ 0.06	$ 0.19	$ 0.00	$ 0.28	$ 0.00	$ 0.00	118.4	$ 2,973.88	$ 29.35
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	26.6	657.49	1.46	0.06	-	-	-	0.01	0.01	-	0.18	-	-	27.9	739.14	1.72
Other Inpatient	0.5	441.33	0.02	-	-	-	-	-	-	-	-	-	-	0.5	441.33	0.02
Subtotal Inpatient Hospital			**$ 29.43**													**$ 31.09**
Outpatient Hospital																
Surgery	56.7	$ 1,481.28	$ 7.00	$ 0.11	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	57.4	$ 1,491.74	$ 7.13
Non-Surg - Emergency Room	382.8	322.30	10.28	0.17	-	(0.21)	0.08	(0.01)	0.06	-	-	-	-	380.9	326.71	10.37
Non-Surg - Other	58.2	189.63	0.92	0.01	-	-	-	-	0.01	-	-	-	-	58.9	191.67	0.94
Observation Room	3.4	1,019.35	0.29	-	-	-	-	-	0.01	-	-	-	-	3.4	1,054.50	0.30
Treatment/Therapy/Testing	208.0	477.03	8.27	0.13	-	-	-	-	0.06	-	-	-	-	211.3	480.43	8.46
Other Outpatient	22.6	621.28	1.17	0.02	-	-	-	-	0.01	-	-	-	-	23.0	626.50	1.20
Subtotal Outpatient Hospital			**$ 27.93**													**$ 28.40**
Retail Pharmacy																
Prescription Drugs	2,769.7	$ 191.55	$ 44.21	$ 0.00	$ 0.00	$ 0.00	$ (1.47)	$ (0.04)	$ 0.29	$ (0.02)	$ 0.23	$ 0.00	$ 0.00	2,765.9	$ 187.42	$ 43.20
Subtotal Retail Pharmacy			**$ 44.21**													**$ 43.20**
Ancillary																
Transportation	117.7	$ 120.30	$ 1.18	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	119.7	$ 121.30	$ 1.21
DME/Prosthetics	1,518.5	14.15	1.79	0.03	-	-	-	-	0.01	-	-	-	-	1,544.0	14.22	1.83
Dental	0.3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	35.7	67.26	0.20	-	-	-	-	-	-	-	-	-	-	35.7	67.26	0.20
Subtotal Ancillary			**$ 3.17**													**$ 3.24**
Professional																
Inpatient and Outpatient Surgery	235.6	$ 142.62	$ 2.80	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	239.0	$ 143.12	$ 2.85
Anesthesia	76.4	120.98	0.77	0.01	-	-	-	-	0.01	-	-	-	-	77.4	122.53	0.79
Inpatient Visits	235.6	92.19	1.81	0.02	-	-	-	0.01	0.01	-	-	-	-	239.5	92.69	1.85
MH/SA	706.4	86.80	5.11	0.05	-	-	-	0.08	0.05	-	-	-	-	724.4	87.63	5.29
Emergency Room	412.8	82.57	2.84	0.03	-	(0.05)	-	0.01	0.01	-	-	-	-	411.3	82.86	2.84
Office/Home Visits/Consults	1,308.3	92.09	10.04	0.11	-	0.05	-	0.03	0.07	-	-	-	-	1,333.1	92.72	10.30
Pathology/Lab	1,678.3	16.37	2.29	0.02	-	0.01	-	-	0.02	-	-	-	-	1,700.3	16.52	2.34
Radiology	652.0	29.81	1.62	0.02	-	-	-	0.01	0.01	-	-	-	-	664.1	30.00	1.66
Office Administered Drugs	2,670.2	18.61	4.14	0.04	-	0.01	-	0.02	0.02	-	-	-	-	2,715.3	18.69	4.23
Physical Exams	110.1	77.41	0.71	0.01	-	-	-	-	-	-	-	-	-	111.6	77.41	0.72
Therapy	371.6	22.60	0.70	0.01	-	-	-	-	-	-	-	-	-	376.9	22.60	0.71
Vision	145.2	43.80	0.53	0.01	-	-	-	-	-	-	-	-	-	147.9	43.80	0.54
Other Professional	1,044.7	22.40	1.95	0.02	-	-	-	-	0.02	0.01	0.01	-	-	1,060.7	22.74	2.01
Subtotal Professional			**$ 35.31**													**$ 36.13**
Total Medical Costs			**$ 140.05**													**$ 142.06**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Female Base Year Member Months: 1,507,591 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	139.5	$ 2,521.40	$ 29.31	$ 1.27	$ 0.00	$ (0.43)	$ 0.09	$ 0.19	$ 0.18	$ 0.00	$ 0.50	$ 0.00	$ 0.00	144.4	$ 2,585.39	$ 31.11
Inpatient Well Newborn	0.1	886.82	0.01	-	-	-	-	-	-	-	-	-	-	0.1	886.82	0.01
Inpatient MH/SA	23.2	733.90	1.42	0.06	-	-	-	0.02	0.01	-	0.12	-	-	24.5	797.50	1.63
Other Inpatient	4.3	387.27	0.14	0.01	-	(0.01)	0.01	-	-	-	-	-	-	4.3	414.93	0.15
Subtotal Inpatient Hospital			**$ 30.88**													**$ 32.90**
Outpatient Hospital																
Surgery	135.6	$ 1,324.45	$ 14.97	$ 0.24	$ 0.00	$ 0.00	$ 0.00	$ 0.11	$ 0.11	$ 0.04	$ 0.00	$ 0.00	$ 0.00	139.2	$ 1,333.94	$ 15.47
Non-Surg - Emergency Room	776.8	350.98	22.72	0.37	-	(0.47)	0.19	0.14	0.15	-	-	-	-	778.2	356.22	23.10
Non-Surg - Other	213.7	165.07	2.94	0.05	-	-	-	0.02	0.02	-	-	-	-	218.8	166.17	3.03
Observation Room	19.9	627.16	1.04	0.02	-	-	-	-	0.01	-	-	-	-	20.3	633.07	1.07
Treatment/Therapy/Testing	680.7	283.11	16.06	0.26	-	-	-	0.14	0.12	-	-	-	-	697.7	285.17	16.58
Other Outpatient	101.0	181.79	1.53	0.02	-	-	-	0.02	0.01	-	-	-	-	103.6	182.95	1.58
Subtotal Outpatient Hospital			**$ 59.26**													**$ 60.83**
Retail Pharmacy																
Prescription Drugs	6,193.8	$ 123.96	$ 63.98	$ 0.01	$ 0.00	$ 0.00	$ (2.50)	$ 0.50	$ 0.45	$ (0.02)	$ 0.61	$ 0.00	$ 0.00	6,241.2	$ 121.19	$ 63.03
Subtotal Retail Pharmacy			**$ 63.98**													**$ 63.03**
Ancillary																
Transportation	174.0	$ 99.29	$ 1.44	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	177.7	$ 99.97	$ 1.48
DME/Prosthetics	1,740.9	13.92	2.02	0.03	-	-	-	0.03	0.01	-	-	-	-	1,792.7	13.99	2.09
Dental	0.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	91.8	117.62	0.90	0.02	-	-	-	0.01	-	-	-	-	-	94.9	117.62	0.93
Subtotal Ancillary			**$ 4.36**													**$ 4.50**
Professional																
Inpatient and Outpatient Surgery	352.9	$ 185.34	$ 5.45	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ 0.06	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	360.6	$ 186.67	$ 5.61
Anesthesia	153.4	118.92	1.52	0.02	-	-	-	0.01	0.01	-	-	-	-	156.4	119.68	1.56
Inpatient Visits	322.9	89.56	2.41	0.03	-	-	-	0.02	0.01	-	-	-	-	329.6	89.92	2.47
MH/SA	1,019.7	95.79	8.14	0.09	-	-	-	0.19	0.06	-	-	-	-	1,054.8	96.47	8.48
Emergency Room	813.9	83.16	5.64	0.06	-	(0.11)	-	0.05	0.04	-	-	-	-	813.9	83.75	5.68
Office/Home Visits/Consults	3,054.0	92.57	23.56	0.25	-	0.12	-	0.28	0.16	-	-	-	-	3,138.3	93.18	24.37
Pathology/Lab	6,521.5	18.57	10.09	0.11	-	0.01	-	0.11	0.07	-	0.07	-	-	6,670.2	18.82	10.46
Radiology	1,270.6	40.51	4.29	0.05	-	-	-	0.05	0.03	-	-	-	-	1,300.3	40.79	4.42
Office Administered Drugs	23,405.4	4.53	8.84	0.09	-	0.05	-	0.11	0.07	-	-	-	-	24,067.3	4.57	9.16
Physical Exams	331.2	81.89	2.26	0.02	-	-	-	0.03	0.02	-	-	-	-	338.5	82.60	2.33
Therapy	514.8	23.31	1.00	0.01	-	-	-	0.01	0.01	-	-	-	-	525.1	23.54	1.03
Vision	170.7	54.14	0.77	0.01	-	-	-	0.01	-	-	-	-	-	175.1	54.14	0.79
Other Professional	4,383.5	16.56	6.05	0.06	-	-	-	0.08	0.03	0.03	0.01	-	-	4,506.6	16.67	6.26
Subtotal Professional			**$ 80.02**													**$ 82.62**
Total Medical Costs			**$ 238.50**													**$ 243.88**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: TANF - Age 45+, Male & Female Base Year Member Months: 288,799 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	329.7	$ 2,796.27	$ 76.83	$ 3.34	$ 0.00	$ (1.25)	$ 0.17	$ 0.45	$ 0.47	$ 0.00	$ 0.76	$ 0.00	$ 0.00	340.6	$ 2,845.60	$ 80.77
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	19.4	737.49	1.19	0.05	-	-	-	0.01	0.01	-	0.13	-	-	20.3	820.09	1.39
Other Inpatient	26.0	304.48	0.66	0.03	-	(0.01)	0.01	0.01	-	-	-	-	-	27.2	308.90	0.70
Subtotal Inpatient Hospital			**$ 78.68**													**$ 82.86**
Outpatient Hospital																
Surgery	158.0	$ 1,865.84	$ 24.57	$ 0.40	$ 0.00	$ 0.00	$ 0.00	$ 0.08	$ 0.15	$ 0.00	$ 0.00	$ 0.00	$ 0.00	161.1	$ 1,877.01	$ 25.20
Non-Surg - Emergency Room	555.7	364.94	16.90	0.27	-	(0.29)	0.13	0.03	0.11	-	-	-	-	556.0	370.12	17.15
Non-Surg - Other	229.7	159.83	3.06	0.05	-	-	-	0.01	0.02	-	-	-	-	234.2	160.86	3.14
Observation Room	14.3	1,113.34	1.33	0.02	-	-	-	0.01	0.01	-	-	-	-	14.7	1,121.53	1.37
Treatment/Therapy/Testing	927.7	540.45	41.78	0.67	-	-	-	0.16	0.29	-	-	-	-	946.1	544.13	42.90
Other Outpatient	252.4	192.53	4.05	0.07	-	-	-	0.01	0.03	-	-	-	-	257.4	193.93	4.16
Subtotal Outpatient Hospital			**$ 91.69**													**$ 93.92**
Retail Pharmacy																
Prescription Drugs	13,451.8	$ 140.25	$ 157.22	$ 0.02	$ 0.00	$ 0.00	$ (5.81)	$ 0.18	$ 0.99	$ (0.03)	$ 0.96	$ 0.00	$ 0.00	13,466.3	$ 136.81	$ 153.53
Subtotal Retail Pharmacy			**$ 157.22**													**$ 153.53**
Ancillary																
Transportation	183.1	$ 107.47	$ 1.64	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	186.5	$ 108.12	$ 1.68
DME/Prosthetics	8,667.7	7.70	5.56	0.10	-	-	-	(0.02)	0.06	0.01	-	-	-	8,808.0	7.78	5.71
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	200.9	79.46	1.33	0.02	-	-	-	0.01	-	-	-	-	-	205.4	79.46	1.36
Subtotal Ancillary			**$ 8.53**													**$ 8.75**
Professional																
Inpatient and Outpatient Surgery	850.4	$ 161.42	$ 11.44	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ 0.06	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.00	863.8	$ 162.40	$ 11.69
Anesthesia	324.1	112.19	3.03	0.03	-	-	-	0.02	0.02	-	-	-	-	329.4	112.92	3.10
Inpatient Visits	636.3	90.33	4.79	0.05	-	-	-	0.02	0.04	-	-	-	-	645.6	91.08	4.90
MH/SA	808.5	97.66	6.58	0.07	-	-	-	0.11	0.05	-	-	-	-	830.7	98.38	6.81
Emergency Room	591.5	90.07	4.44	0.05	-	(0.07)	-	0.01	0.03	-	-	-	-	590.2	90.68	4.46
Office/Home Visits/Consults	4,303.7	95.55	34.27	0.37	-	0.07	-	0.16	0.22	-	-	-	-	4,379.1	96.16	35.09
Pathology/Lab	6,243.6	15.30	7.96	0.09	-	-	-	0.04	0.05	-	0.03	-	-	6,345.6	15.45	8.17
Radiology	2,205.3	40.54	7.45	0.08	-	0.02	-	0.03	0.05	-	-	-	-	2,243.8	40.81	7.63
Office Administered Drugs	21,118.4	12.30	21.64	0.23	-	0.06	-	0.13	0.14	-	-	-	-	21,528.2	12.37	22.20
Physical Exams	311.8	75.04	1.95	0.02	-	-	-	0.01	0.01	-	-	-	-	316.6	75.42	1.99
Therapy	1,396.7	22.42	2.61	0.03	-	-	-	0.01	0.02	-	-	-	-	1,418.1	22.59	2.67
Vision	191.5	67.05	1.07	0.01	-	-	-	0.01	-	-	-	-	-	195.1	67.05	1.09
Other Professional	4,027.2	26.85	9.01	0.10	-	-	-	0.04	0.06	0.02	0.01	-	-	4,098.7	27.05	9.24
Subtotal Professional			**$ 116.24**													**$ 119.04**
Total Medical Costs			**$ 452.36**													**$ 458.10**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SSI - Children Base Year Member Months: 141,476 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	331.3	$ 2,392.34	$ 66.05	$ 3.33	$ 0.00	$ (0.97)	$ (0.31)	$ 0.65	$ 0.49	$ 0.00	$ 2.94	$ 0.00	$ 0.00	346.4	$ 2,500.42	$ 72.18
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	113.4	644.42	6.09	0.31	-	-	-	0.08	0.04	-	-	-	-	120.7	648.40	6.52
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 72.14**													**$ 78.70**
Outpatient Hospital																
Surgery	99.5	$ 1,985.25	$ 16.46	$ 0.40	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.20	$ 0.00	$ 0.00	$ 0.00	$ 0.00	102.0	$ 2,008.78	$ 17.07
Non-Surg - Emergency Room	504.3	353.10	14.84	0.36	-	(0.23)	0.10	0.08	0.08	-	-	-	-	511.5	357.32	15.23
Non-Surg - Other	602.1	152.66	7.66	0.19	-	-	-	0.07	0.05	-	-	-	-	622.6	153.62	7.97
Observation Room	10.3	1,565.51	1.35	0.03	-	-	-	0.02	0.01	-	-	-	-	10.7	1,576.70	1.41
Treatment/Therapy/Testing	648.0	418.13	22.58	0.55	-	-	-	0.23	0.17	-	-	-	-	670.4	421.17	23.53
Other Outpatient	74.0	259.59	1.60	0.04	-	-	-	0.02	0.01	-	-	-	-	76.7	261.15	1.67
Subtotal Outpatient Hospital			**$ 64.49**													**$ 66.88**
Retail Pharmacy																
Prescription Drugs	12,253.5	$ 217.17	$ 221.76	$ 0.13	$ 0.00	$ 0.00	$ (9.69)	$ 3.40	$ 1.70	$ (0.01)	$ 0.11	$ 0.00	$ 0.00	12,448.0	$ 209.58	$ 217.40
Subtotal Retail Pharmacy			**$ 221.76**													**$ 217.40**
Ancillary																
Transportation	166.4	$ 116.09	$ 1.61	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	169.5	$ 117.51	$ 1.66
DME/Prosthetics	89,487.2	2.95	22.03	0.32	-	-	-	0.12	0.25	-	-	-	-	91,274.5	2.99	22.72
Dental	79.6	114.51	0.76	0.01	-	-	-	0.01	0.01	-	-	-	-	81.7	115.97	0.79
Other Ancillary	216.3	40.50	0.73	0.01	-	-	-	0.01	-	-	-	-	-	222.2	40.50	0.75
Subtotal Ancillary			**$ 25.13**													**$ 25.92**
Professional																
Inpatient and Outpatient Surgery	270.2	$ 191.83	$ 4.32	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.06	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	277.1	$ 193.13	$ 4.46
Anesthesia	182.4	128.97	1.96	0.02	-	-	-	0.03	0.02	-	-	-	-	187.0	130.26	2.03
Inpatient Visits	611.2	122.12	6.22	0.07	-	-	-	0.11	0.04	-	-	-	-	628.9	122.88	6.44
MH/SA	47,513.6	19.48	77.15	0.87	-	-	-	1.58	0.38	-	-	-	-	49,022.4	19.58	79.98
Emergency Room	544.7	82.61	3.75	0.04	-	(0.05)	-	0.04	0.02	-	-	-	-	549.1	83.05	3.80
Office/Home Visits/Consults	4,020.0	98.12	32.87	0.37	-	0.06	-	0.53	0.23	-	-	-	-	4,137.5	98.79	34.06
Pathology/Lab	2,809.4	21.27	4.98	0.06	-	-	-	0.08	0.03	-	-	-	-	2,888.4	21.40	5.15
Radiology	743.9	23.71	1.47	0.02	-	-	-	0.02	0.01	-	-	-	-	764.1	23.87	1.52
Office Administered Drugs	13,352.8	24.41	27.16	0.31	-	0.15	-	0.52	0.18	-	-	-	-	13,834.6	24.56	28.32
Physical Exams	1,071.9	71.54	6.39	0.07	-	-	-	0.09	0.05	-	-	-	-	1,098.7	72.08	6.60
Therapy	19,743.2	22.06	36.30	0.41	-	-	-	(0.77)	0.22	-	-	-	-	19,547.4	22.20	36.16
Vision	667.0	35.26	1.96	0.02	-	-	-	0.03	0.01	-	-	-	-	684.0	35.44	2.02
Other Professional	4,000.1	25.74	8.58	0.10	-	-	-	0.11	0.05	0.90	2.02	-	-	4,517.6	31.24	11.76
Subtotal Professional			**$ 213.11**													**$ 222.30**
Total Medical Costs			**$ 596.63**													**$ 611.20**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SSI - Adults Base Year Member Months: 447,808 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	1,408.6	$ 2,415.82	$ 283.57	$ 14.29	$ 0.00	$ (5.41)	$ (0.15)	$ 5.01	$ 2.15	$ 0.00	$ 4.79	$ 0.00	$ 0.00	1,477.6	$ 2,470.96	$ 304.25
Inpatient Well Newborn	0.7	3,224.22	0.18	0.01	-	-	-	-	-	-	-	-	-	0.7	3,224.22	0.19
Inpatient MH/SA	60.4	784.76	3.95	0.20	-	-	-	(0.02)	0.06	-	0.45	-	-	63.2	881.66	4.64
Other Inpatient	424.0	279.07	9.86	0.50	-	(0.19)	(0.05)	0.16	0.08	-	-	-	-	444.2	279.88	10.36
Subtotal Inpatient Hospital			**$ 297.56**													**$ 319.44**
Outpatient Hospital																
Surgery	230.8	$ 1,937.45	$ 37.26	$ 0.91	$ 0.00	$ 0.00	$ 0.00	$ 0.61	$ 0.29	$ 0.43	$ 0.00	$ 0.00	$ 0.00	242.9	$ 1,951.78	$ 39.50
Non-Surg - Emergency Room	949.3	444.60	35.17	0.86	-	(0.23)	0.12	0.35	0.31	-	-	-	-	975.7	449.89	36.58
Non-Surg - Other	510.5	202.14	8.60	0.21	-	-	-	0.15	0.05	-	-	-	-	531.9	203.27	9.01
Observation Room	33.3	1,133.05	3.14	0.08	-	-	-	0.05	0.01	-	-	-	-	34.6	1,136.52	3.28
Treatment/Therapy/Testing	1,282.4	1,016.44	108.62	2.65	-	-	-	1.95	0.86	-	-	-	-	1,336.7	1,024.16	114.08
Other Outpatient	220.1	343.00	6.29	0.15	-	-	-	0.12	0.04	-	-	-	-	229.5	345.09	6.60
Subtotal Outpatient Hospital			**$ 199.08**													**$ 209.05**
Retail Pharmacy																
Prescription Drugs	18,987.4	$ 240.92	$ 381.20	$ 0.23	$ 0.00	$ 0.00	$ (16.00)	$ 6.02	$ 1.12	$ (0.04)	$ 0.62	$ 0.00	$ 0.00	19,296.7	$ 232.05	$ 373.15
Subtotal Retail Pharmacy			**$ 381.20**													**$ 373.15**
Ancillary																
Transportation	797.6	$ 103.52	$ 6.88	$ 0.10	$ 0.00	$ 0.00	$ 0.00	$ 0.06	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	816.1	$ 104.25	$ 7.09
DME/Prosthetics	38,550.3	7.04	22.61	0.33	-	-	-	0.38	0.18	0.06	-	-	-	39,863.2	7.09	23.56
Dental	0.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	784.2	77.59	5.07	0.07	-	-	-	0.09	0.03	-	-	-	-	808.9	78.03	5.26
Subtotal Ancillary			**$ 34.56**													**$ 35.91**
Professional																
Inpatient and Outpatient Surgery	1,171.7	$ 155.36	$ 15.17	$ 0.17	$ 0.00	$ 0.00	$ 0.00	$ 0.30	$ 0.10	$ 0.00	$ 0.00	$ 0.00	$ 0.00	1,208.0	$ 156.36	$ 15.74
Anesthesia	423.7	115.28	4.07	0.05	-	-	-	0.07	0.03	-	-	-	-	436.2	116.11	4.22
Inpatient Visits	2,701.8	89.98	20.26	0.23	-	-	-	0.34	0.14	-	-	-	-	2,777.8	90.59	20.97
MH/SA	956.4	89.96	7.17	0.08	-	-	-	0.18	0.05	-	-	-	-	991.1	90.56	7.48
Emergency Room	1,101.6	95.64	8.78	0.10	-	(0.05)	-	0.11	0.06	-	-	-	-	1,121.7	96.28	9.00
Office/Home Visits/Consults	5,052.6	100.70	42.40	0.48	-	0.05	-	0.81	0.26	-	-	-	-	5,212.2	101.30	44.00
Pathology/Lab	6,758.2	14.15	7.97	0.09	-	0.01	-	0.14	0.05	-	0.07	-	-	6,961.7	14.36	8.33
Radiology	3,175.5	41.15	10.89	0.12	-	0.03	-	0.19	0.06	-	-	-	-	3,274.6	41.37	11.29
Office Administered Drugs	51,167.3	13.44	57.32	0.65	-	0.22	-	0.91	0.57	-	-	-	-	52,756.3	13.57	59.67
Physical Exams	321.8	60.05	1.61	0.02	-	-	-	0.03	0.01	-	-	-	-	331.7	60.41	1.67
Therapy	1,278.5	22.43	2.39	0.03	-	-	-	0.04	0.02	-	-	-	-	1,315.9	22.62	2.48
Vision	180.4	65.84	0.99	0.01	-	-	-	0.02	0.01	-	-	-	-	185.9	66.49	1.03
Other Professional	6,113.1	45.15	23.00	0.26	-	-	-	0.43	0.17	0.03	0.02	-	-	6,304.5	45.51	23.91
Subtotal Professional			**$ 202.02**													**$ 209.79**
Total Medical Costs			**$ 1,114.42**													**$ 1,147.34**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: OCWI Base Year Member Months: 394,090 Category of Service	MCO Encounter Data Base Year Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustments Utilization Adjustment	 Cost Adjustment	Managed Care Adjustments Utilization Adjustment	 Cost Adjustment	Other Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	135.1	$ 2,013.96	$ 22.68	$ 0.73	$ 0.00	$ (0.20)	$ 0.03	$ (0.07)	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ 0.00	137.9	$ 2,021.79	$ 23.23
Inpatient Well Newborn	1.3	641.54	0.07	-	-	-	-	-	-	-	-	-	-	1.3	641.54	0.07
Inpatient MH/SA	38.5	720.21	2.31	0.07	-	-	-	0.01	0.01	-	0.25	-	-	39.8	798.56	2.65
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 25.06**													**$ 25.95**
Outpatient Hospital																
Surgery	252.1	$ 727.82	$ 15.29	$ 0.25	$ 0.00	$ 0.00	$ 0.00	$ (0.02)	$ 0.10	$ 0.00	$ 0.00	$ 0.00	$ 0.00	255.9	$ 732.51	$ 15.62
Non-Surg - Emergency Room	713.4	381.00	22.65	0.37	-	(0.13)	0.06	(0.06)	0.15	-	-	-	-	719.0	384.51	23.04
Non-Surg - Other	339.6	162.56	4.60	0.08	-	-	-	(0.01)	0.03	-	-	-	-	344.7	163.60	4.70
Observation Room	50.2	387.39	1.62	0.03	-	-	-	-	0.01	-	-	-	-	51.1	389.74	1.66
Treatment/Therapy/Testing	840.7	181.29	12.70	0.21	-	-	-	(0.02)	0.09	-	-	-	-	853.2	182.55	12.98
Other Outpatient	80.5	141.65	0.95	0.02	-	-	-	(0.01)	0.01	-	-	-	-	81.3	143.13	0.97
Subtotal Outpatient Hospital			**$ 57.81**													**$ 58.97**
Retail Pharmacy																
Prescription Drugs	7,571.2	$ 58.64	$ 37.00	$ 0.00	$ 0.00	$ 0.00	$ (1.46)	$ (0.05)	$ 0.27	$ (0.01)	$ 0.41	$ 0.00	$ 0.00	7,558.9	$ 57.41	$ 36.16
Subtotal Retail Pharmacy			**$ 37.00**													**$ 36.16**
Ancillary																
Transportation	169.2	$ 99.28	$ 1.40	$ 0.01	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	170.4	$ 99.28	$ 1.41
DME/Prosthetics	1,101.2	23.43	2.15	0.02	-	-	-	-	0.01	-	-	-	-	1,111.4	23.54	2.18
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	163.8	142.13	1.94	0.02	-	-	-	(0.01)	0.02	-	-	-	-	164.6	143.59	1.97
Subtotal Ancillary			**$ 5.49**													**$ 5.56**
Professional																
Inpatient and Outpatient Surgery	270.2	$ 174.95	$ 3.94	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	274.4	$ 175.83	$ 4.02
Anesthesia	119.6	118.39	1.18	0.02	-	-	-	-	-	-	-	-	-	121.6	118.39	1.20
Inpatient Visits	448.6	82.39	3.08	0.04	-	-	-	-	0.02	-	-	-	-	454.4	82.92	3.14
MH/SA	1,042.9	105.74	9.19	0.12	-	-	-	0.10	0.06	-	-	-	-	1,067.9	106.42	9.47
Emergency Room	792.3	80.88	5.34	0.07	-	(0.03)	-	-	0.03	-	-	-	-	798.2	81.33	5.41
Office/Home Visits/Consults	2,572.4	87.89	18.84	0.24	-	0.03	-	0.03	0.12	-	-	-	-	2,613.4	88.44	19.26
Pathology/Lab	7,593.0	18.52	11.72	0.15	-	0.01	-	0.01	0.08	-	0.22	-	-	7,703.1	18.99	12.19
Radiology	1,075.2	51.01	4.57	0.06	-	0.01	-	-	0.04	-	-	-	-	1,091.7	51.44	4.68
Office Administered Drugs	19,864.0	2.37	3.93	0.05	-	0.02	-	-	0.04	-	-	-	-	20,217.8	2.40	4.04
Physical Exams	449.5	52.60	1.97	0.03	-	-	-	-	0.01	-	-	-	-	456.3	52.86	2.01
Therapy	392.4	24.46	0.80	0.01	-	-	-	-	0.01	-	-	-	-	397.3	24.77	0.82
Vision	117.2	56.31	0.55	0.01	-	-	-	-	-	-	-	-	-	119.3	56.31	0.56
Other Professional	8,634.6	13.38	9.63	0.12	-	-	-	0.01	0.07	0.01	0.01	-	-	8,760.1	13.49	9.85
Subtotal Professional			**$ 74.74**													**$ 76.65**
Total Medical Costs			**$ 200.10**													**$ 203.29**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SMI Children Base Year Member Months: 200,243 Category of Service	MCO Encounter Data Base Year Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustments Utilization Adjustment	 Cost Adjustment	Managed Care Adjustments Utilization Adjustment	 Cost Adjustment	Other Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	124.6	$ 2,459.94	$ 25.54	$ 0.69	$ 0.00	$ (0.38)	$ 0.08	$ 0.13	$ 0.17	$ 0.00	$ 0.00	$ 0.00	$ 0.00	126.7	$ 2,483.61	$ 26.23
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	2,553.4	557.94	118.72	3.22	-	-	-	0.26	0.92	-	0.07	-	-	2,628.2	562.46	123.19
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 144.26**													**$ 149.42**
Outpatient Hospital																
Surgery	79.6	$ 1,494.67	$ 9.92	$ 0.17	$ 0.00	$ 0.00	$ 0.00	$ 0.05	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ 0.00	81.4	$ 1,503.51	$ 10.20
Non-Surg - Emergency Room	820.6	380.36	26.01	0.45	-	(0.25)	0.11	0.06	0.17	-	-	-	-	828.8	384.42	26.55
Non-Surg - Other	359.9	148.70	4.46	0.08	-	-	-	0.01	0.03	-	-	-	-	367.2	149.68	4.58
Observation Room	8.4	1,079.32	0.76	0.01	-	-	-	-	-	-	-	-	-	8.6	1,079.32	0.77
Treatment/Therapy/Testing	474.6	241.99	9.57	0.17	-	-	-	0.03	0.06	-	-	-	-	484.5	243.48	9.83
Other Outpatient	58.0	293.74	1.42	0.02	-	-	-	0.01	0.01	-	-	-	-	59.2	295.77	1.46
Subtotal Outpatient Hospital			**$ 52.14**													**$ 53.39**
Retail Pharmacy																
Prescription Drugs	14,824.2	$ 59.41	$ 73.39	$ 0.00	$ 0.00	$ 0.00	$ (3.16)	$ 0.22	$ 0.49	$ 0.00	$ 0.25	$ 0.00	$ 0.00	14,868.6	$ 57.46	$ 71.19
Subtotal Retail Pharmacy			**$ 73.39**													**$ 71.19**
Ancillary																
Transportation	392.2	$ 113.22	$ 3.70	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	396.4	$ 113.82	$ 3.76
DME/Prosthetics	5,522.5	4.80	2.21	0.02	-	-	-	0.01	0.01	-	-	-	-	5,597.5	4.82	2.25
Dental	13.7	87.44	0.10	-	-	-	-	-	-	-	-	-	-	13.7	87.44	0.10
Other Ancillary	389.6	45.58	1.48	0.01	-	-	-	-	0.01	-	-	-	-	392.3	45.89	1.50
Subtotal Ancillary			**$ 7.49**													**$ 7.61**
Professional																
Inpatient and Outpatient Surgery	248.5	$ 147.27	$ 3.05	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	251.8	$ 148.23	$ 3.11
Anesthesia	99.0	118.79	0.98	0.01	-	-	-	-	0.01	-	-	-	-	100.0	119.99	1.00
Inpatient Visits	1,216.3	74.49	7.55	0.07	-	-	-	0.03	0.06	-	-	-	-	1,232.5	75.07	7.71
MH/SA	16,663.9	74.08	102.87	0.89	-	-	-	0.55	0.59	1.71	-	-	-	17,174.1	74.49	106.61
Emergency Room	878.8	86.84	6.36	0.06	-	(0.06)	-	0.02	0.04	-	-	-	-	881.6	87.39	6.42
Office/Home Visits/Consults	5,090.9	105.95	44.95	0.39	-	0.07	-	0.20	0.28	-	-	-	-	5,165.7	106.60	45.89
Pathology/Lab	4,932.8	19.61	8.06	0.07	-	0.01	-	0.03	0.05	-	-	-	-	5,000.2	19.73	8.22
Radiology	906.5	27.53	2.08	0.02	-	-	-	0.01	0.02	-	-	-	-	919.6	27.79	2.13
Office Administered Drugs	18,810.3	6.17	9.67	0.08	-	0.07	-	0.06	0.06	-	-	-	-	19,218.8	6.21	9.94
Physical Exams	860.1	74.78	5.36	0.05	-	-	-	0.02	0.03	-	-	-	-	871.3	75.20	5.46
Therapy	1,065.0	22.87	2.03	0.02	-	-	-	0.01	0.01	-	-	-	-	1,080.8	22.98	2.07
Vision	931.5	35.81	2.78	0.02	-	-	-	0.02	0.01	-	-	-	-	944.9	35.94	2.83
Other Professional	3,268.6	21.11	5.75	0.05	-	-	-	0.01	0.05	0.24	0.33	-	-	3,439.1	22.44	6.43
Subtotal Professional			**$ 201.49**													**$ 207.82**
Total Medical Costs			**$ 478.77**													**$ 489.43**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SMI TANF Adults Base Year Member Months: 329,727 Category of Service	MCO Encounter Data Base Year Experience Utilization per 1,000	 Cost per Service	 PMPM	Completion Adjustments Utilization Adjustment	 Cost Adjustment	Managed Care Adjustments Utilization Adjustment	 Cost Adjustment	Other Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	386.6	$ 2,532.16	$ 81.58	$ 2.21	$ 0.00	$ (1.06)	$ 0.05	$ 0.19	$ 0.52	$ 0.00	$ 1.33	$ 0.00	$ 0.00	393.0	$ 2,590.18	$ 84.82
Inpatient Well Newborn	0.1	1,648.64	0.01	-	-	-	-	-	-	-	-	-	-	0.1	1,648.64	0.01
Inpatient MH/SA	390.8	600.01	19.54	0.53	-	-	-	0.01	0.14	-	3.20	-	-	401.6	699.81	23.42
Other Inpatient	35.7	323.00	0.96	0.03	-	(0.02)	0.01	-	0.01	-	-	-	-	36.0	329.66	0.99
Subtotal Inpatient Hospital			**$ 102.09**													**$ 109.24**
Outpatient Hospital																
Surgery	233.8	$ 1,629.64	$ 31.75	$ 0.55	$ 0.00	$ 0.00	$ 0.00	$ 0.02	$ 0.23	$ 0.19	$ 0.00	$ 0.00	$ 0.00	239.4	$ 1,641.17	$ 32.74
Non-Surg - Emergency Room	1,305.4	372.57	40.53	0.70	-	(0.64)	0.29	-	0.26	-	-	-	-	1,307.3	377.62	41.14
Non-Surg - Other	368.2	159.36	4.89	0.08	-	-	-	0.01	0.03	-	-	-	-	375.0	160.32	5.01
Observation Room	26.2	875.91	1.91	0.03	-	-	-	-	0.02	-	-	-	-	26.6	884.94	1.96
Treatment/Therapy/Testing	1,166.0	321.61	31.25	0.54	-	-	-	0.02	0.24	-	-	-	-	1,186.9	324.03	32.05
Other Outpatient	206.5	183.05	3.15	0.05	-	-	-	0.01	0.02	-	-	-	-	210.4	184.19	3.23
Subtotal Outpatient Hospital			**$ 113.48**													**$ 116.13**
Retail Pharmacy																
Prescription Drugs	18,238.0	$ 130.89	$ 198.93	$ 0.00	$ 0.00	$ 0.00	$ (6.48)	$ 0.07	$ 1.22	$ (0.04)	$ 0.99	$ 0.00	$ 0.00	18,240.7	$ 128.08	$ 194.69
Subtotal Retail Pharmacy			**$ 198.93**													**$ 194.69**
Ancillary																
Transportation	517.9	$ 97.09	$ 4.19	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	521.6	$ 97.78	$ 4.25
DME/Prosthetics	8,271.0	8.60	5.93	0.05	-	-	-	-	0.04	-	-	-	-	8,340.7	8.66	6.02
Dental	0.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	439.1	66.42	2.43	0.02	-	-	-	-	0.02	-	-	-	-	442.7	66.96	2.47
Subtotal Ancillary			**$ 12.55**													**$ 12.74**
Professional																
Inpatient and Outpatient Surgery	827.1	$ 176.43	$ 12.16	$ 0.11	$ 0.00	$ 0.00	$ 0.00	$ 0.04	$ 0.07	$ 0.01	$ 0.00	$ 0.00	$ 0.00	838.0	$ 177.43	$ 12.39
Anesthesia	364.8	114.47	3.48	0.03	-	-	-	0.01	0.03	-	-	-	-	369.0	115.45	3.55
Inpatient Visits	1,186.0	82.87	8.19	0.07	-	-	-	0.04	0.05	-	-	-	-	1,201.9	83.37	8.35
MH/SA	5,847.6	96.47	47.01	0.41	-	-	-	0.39	0.31	-	-	-	-	5,947.1	97.10	48.12
Emergency Room	1,388.3	87.73	10.15	0.09	-	(0.15)	-	0.03	0.06	-	-	-	-	1,384.2	88.25	10.18
Office/Home Visits/Consults	6,885.0	97.27	55.81	0.49	-	0.15	-	0.24	0.37	-	-	-	-	6,993.6	97.91	57.06
Pathology/Lab	9,334.4	17.48	13.60	0.12	-	0.01	-	0.05	0.09	-	0.05	-	-	9,458.0	17.66	13.92
Radiology	2,538.8	37.34	7.90	0.07	-	0.02	-	0.03	0.05	-	-	-	-	2,577.3	37.57	8.07
Office Administered Drugs	33,161.8	6.57	18.16	0.16	-	0.06	-	0.07	0.14	-	-	-	-	33,691.4	6.62	18.59
Physical Exams	413.7	76.28	2.63	0.02	-	-	-	0.01	0.02	-	-	-	-	418.4	76.86	2.68
Therapy	1,286.6	23.60	2.53	0.02	-	-	-	0.01	0.02	-	-	-	-	1,301.9	23.78	2.58
Vision	233.7	58.03	1.13	0.01	-	-	-	-	0.01	-	-	-	-	235.8	58.54	1.15
Other Professional	6,301.9	21.14	11.10	0.10	-	-	-	0.03	0.09	0.04	0.01	-	-	6,398.4	21.32	11.37
Subtotal Professional			**$ 193.85**													**$ 198.01**
Total Medical Costs			**$ 620.90**													**$ 630.81**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: SMI SSI Adults Base Year Member Months: 172,875 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	1,706.5	$ 2,177.32	$ 309.63	$ 8.39	$ 0.00	$ (4.79)	$ (0.27)	$ 3.13	$ 2.33	$ 0.00	$ 0.00	$ 0.00	$ 0.00	1,743.6	$ 2,191.50	$ 318.42
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	1,419.7	556.10	65.79	1.78	-	-	-	(0.35)	0.43	-	16.87	-	-	1,450.5	699.23	84.52
Other Inpatient	758.9	285.88	18.08	0.49	-	(0.28)	(0.12)	0.21	0.12	-	-	-	-	776.5	285.88	18.50
Subtotal Inpatient Hospital			**$ 393.50**													**$ 421.44**
Outpatient Hospital																
Surgery	272.1	$ 1,991.15	$ 45.15	$ 0.78	$ 0.00	$ 0.00	$ 0.00	$ 0.41	$ 0.36	$ 0.00	$ 0.00	$ 0.00	$ 0.00	279.3	$ 2,006.62	$ 46.70
Non-Surg - Emergency Room	1,897.3	420.91	66.55	1.15	-	(0.45)	0.25	0.29	0.47	-	-	-	-	1,925.5	425.40	68.26
Non-Surg - Other	566.6	180.03	8.50	0.15	-	-	-	0.09	0.05	-	-	-	-	582.6	181.06	8.79
Observation Room	43.9	2,560.30	9.36	0.16	-	-	-	0.13	0.06	-	-	-	-	45.2	2,576.22	9.71
Treatment/Therapy/Testing	1,460.8	650.18	79.15	1.37	-	-	-	0.87	0.60	-	-	-	-	1,502.2	654.97	81.99
Other Outpatient	292.1	241.56	5.88	0.10	-	-	-	0.07	0.04	-	-	-	-	300.5	243.16	6.09
Subtotal Outpatient Hospital			**$ 214.59**													**$ 221.54**
Retail Pharmacy																
Prescription Drugs	32,737.3	$ 223.60	$ 610.00	$ 0.00	$ 0.00	$ 0.00	$ (17.88)	$ 5.44	$ 4.06	$ (0.04)	$ 0.79	$ 0.00	$ 0.00	33,027.1	$ 218.86	$ 602.37
Subtotal Retail Pharmacy			**$ 610.00**													**$ 602.37**
Ancillary																
Transportation	2,021.9	$ 94.07	$ 15.85	$ 0.12	$ 0.00	$ 0.00	$ 0.00	$ 0.06	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,044.9	$ 94.54	$ 16.11
DME/Prosthetics	50,757.9	5.36	22.67	0.17	-	-	-	0.28	(0.01)	-	-	-	-	51,765.4	5.36	23.11
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	2,228.5	59.56	11.06	0.09	-	-	-	0.10	0.08	-	-	-	-	2,266.8	59.98	11.33
Subtotal Ancillary			**$ 49.58**													**$ 50.55**
Professional																
Inpatient and Outpatient Surgery	1,658.1	$ 139.82	$ 19.32	$ 0.17	$ 0.00	$ 0.00	$ 0.00	$ 0.22	$ 0.14	$ 0.00	$ 0.00	$ 0.00	$ 0.00	1,691.6	$ 140.82	$ 19.85
Anesthesia	550.2	114.94	5.27	0.05	-	-	-	0.05	0.03	-	-	-	-	560.6	115.59	5.40
Inpatient Visits	4,680.7	81.24	31.69	0.28	-	-	-	0.28	0.19	-	-	-	-	4,763.5	81.72	32.44
MH/SA	18,523.7	37.39	57.71	0.50	-	-	-	0.79	0.30	-	-	-	-	18,937.8	37.58	59.30
Emergency Room	2,138.7	92.52	16.49	0.14	-	(0.09)	-	0.10	0.11	-	-	-	-	2,158.2	93.13	16.75
Office/Home Visits/Consults	8,522.5	107.84	76.59	0.67	-	0.11	-	0.82	0.48	-	-	-	-	8,700.5	108.50	78.67
Pathology/Lab	9,049.3	14.67	11.06	0.10	-	-	-	0.12	0.07	-	0.10	-	-	9,229.3	14.89	11.45
Radiology	4,304.2	36.10	12.95	0.11	-	0.03	-	0.14	0.09	-	-	-	-	4,397.3	36.35	13.32
Office Administered Drugs	120,881.1	4.80	48.39	0.42	-	0.21	-	0.64	0.26	-	-	-	-	124,053.7	4.83	49.92
Physical Exams	420.8	56.75	1.99	0.02	-	-	-	0.02	0.01	-	-	-	-	429.2	57.03	2.04
Therapy	1,533.3	23.17	2.96	0.03	-	-	-	0.04	0.01	-	-	-	-	1,569.6	23.24	3.04
Vision	219.6	67.23	1.23	0.01	-	-	-	0.02	-	-	-	-	-	224.9	67.23	1.26
Other Professional	6,885.3	37.19	21.34	0.19	-	-	-	0.19	(0.03)	0.05	0.02	-	-	7,024.1	37.17	21.76
Subtotal Professional			**$ 306.99**													**$ 315.20**
Total Medical Costs			**$ 1,574.66**													**$ 1,611.10**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: DUAL Base Year Member Months: 622,837 Category of Service	FFS Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	544.2	$ 282.68	$ 12.82	$ 0.23	$ 0.00	$ 0.00	$ 0.00	$ (0.04)	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	552.3	$ 282.68	$ 13.01
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	39.9	231.68	0.77	0.01	-	-	-	-	-	-	-	-	-	40.4	231.68	0.78
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 13.59**													**$ 13.79**
Outpatient Hospital																
Surgery	135.8	$ 190.88	$ 2.16	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	138.3	$ 190.88	$ 2.20
Non-Surg - Emergency Room	283.3	83.88	1.98	0.04	-	-	-	(0.01)	-	-	-	-	-	287.6	83.88	2.01
Non-Surg - Other	313.5	31.77	0.83	0.02	-	-	-	(0.01)	-	-	-	-	-	317.3	31.77	0.84
Observation Room	7.0	120.77	0.07	-	-	-	-	-	-	-	-	-	-	7.0	120.77	0.07
Treatment/Therapy/Testing	695.9	124.67	7.23	0.14	-	-	-	(0.02)	-	-	-	-	-	707.5	124.67	7.35
Other Outpatient	58.8	79.59	0.39	0.01	-	-	-	-	-	-	-	-	-	60.3	79.59	0.40
Subtotal Outpatient Hospital			**$ 12.66**													**$ 12.87**
Retail Pharmacy																
Prescription Drugs	268.1	$ 88.16	$ 1.97	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	268.1	$ 88.16	$ 1.97
Subtotal Retail Pharmacy			**$ 1.97**													**$ 1.97**
Ancillary																
Transportation	32.9	$ 32.86	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	32.9	$ 32.86	$ 0.09
DME/Prosthetics	9,741.8	4.26	3.46	0.13	-	-	-	(0.01)	-	-	-	-	-	10,079.7	4.26	3.58
Dental	0.4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	66.3	27.16	0.15	0.01	-	-	-	-	-	-	-	-	-	70.7	27.16	0.16
Subtotal Ancillary			**$ 3.70**													**$ 3.83**
Professional																
Inpatient and Outpatient Surgery	328.7	$ 29.21	$ 0.80	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	336.9	$ 29.21	$ 0.82
Anesthesia	220.4	17.97	0.33	0.01	-	-	-	-	-	-	-	-	-	227.0	17.97	0.34
Inpatient Visits	616.5	18.88	0.97	0.03	-	-	-	-	-	-	-	-	-	635.6	18.88	1.00
MH/SA	7,389.6	15.59	9.60	0.31	-	-	-	(0.02)	-	-	-	-	-	7,612.8	15.59	9.89
Emergency Room	62.4	36.54	0.19	0.01	-	-	-	-	-	-	-	-	-	65.7	36.54	0.20
Office/Home Visits/Consults	2,618.2	57.70	12.59	0.41	-	-	-	(0.03)	-	-	-	-	-	2,697.3	57.70	12.97
Pathology/Lab	767.1	6.41	0.41	0.01	-	-	-	-	-	-	-	-	-	785.8	6.41	0.42
Radiology	778.3	13.57	0.88	0.03	-	-	-	-	-	-	-	-	-	804.9	13.57	0.91
Office Administered Drugs	26,343.0	3.11	6.82	0.22	-	-	-	(0.02)	-	-	-	-	-	27,115.5	3.11	7.02
Physical Exams	36.8	19.55	0.06	-	-	-	-	-	-	-	-	-	-	36.8	19.55	0.06
Therapy	673.5	4.81	0.27	0.01	-	-	-	-	-	-	-	-	-	698.4	4.81	0.28
Vision	33.0	54.60	0.15	-	-	-	-	-	-	-	-	-	-	33.0	54.60	0.15
Other Professional	2,746.8	6.47	1.48	0.05	-	-	-	(0.01)	-	-	-	-	-	2,821.0	6.47	1.52
Subtotal Professional			**$ 34.55**													**$ 35.58**
Total Medical Costs			**$ 66.47**													**$ 68.04**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: Foster Care Children Base Year Member Months: 53,436 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital																
Inpatient Medical/Surgical/Non-Delivery	192.2	$ 2,088.12	$ 33.45	$ 1.46	$ 0.00	$ (0.74)	$ 0.31	$ 4.72	$ 0.25	$ 0.00	$ 0.00	$ 0.00	$ 0.00	223.5	$ 2,118.19	$ 39.45
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	3,634.2	590.82	178.93	7.78	-	-	-	25.09	1.42	-	-	-	-	4,301.8	594.79	213.22
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 212.38**													**$ 252.67**
Outpatient Hospital																
Surgery	92.3	$ 1,417.16	$ 10.90	$ 0.18	$ 0.00	$ 0.00	$ 0.00	$ 1.51	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	106.6	$ 1,426.16	$ 12.67
Non-Surg - Emergency Room	638.9	340.53	18.13	0.29	-	(0.12)	0.04	2.49	0.13	-	-	-	-	732.6	343.31	20.96
Non-Surg - Other	463.5	138.51	5.35	0.09	-	-	-	0.73	0.04	-	-	-	-	534.6	139.41	6.21
Observation Room	7.0	1,172.14	0.68	0.01	-	-	-	0.10	-	-	-	-	-	8.1	1,172.14	0.79
Treatment/Therapy/Testing	389.2	229.41	7.44	0.12	-	-	-	1.03	0.06	-	-	-	-	449.3	231.01	8.65
Other Outpatient	55.7	206.85	0.96	0.02	-	-	-	0.12	0.01	-	-	-	-	63.8	208.73	1.11
Subtotal Outpatient Hospital			**$ 43.46**													**$ 50.39**
Retail Pharmacy																
Prescription Drugs	12,208.8	$ 41.04	$ 41.75	$ 0.00	$ 0.00	$ 0.00	$ (1.14)	$ 5.47	$ 0.36	$ 0.00	$ 0.03	$ 0.00	$ 0.00	13,808.4	$ 40.38	$ 46.47
Subtotal Retail Pharmacy			**$ 41.75**													**$ 46.47**
Ancillary																
Transportation	377.0	$ 122.85	$ 3.86	$ 0.07	$ 0.00	$ 0.00	$ 0.00	$ 0.53	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	435.7	$ 123.68	$ 4.49
DME/Prosthetics	23,537.6	2.05	4.03	0.07	-	-	-	0.56	0.03	-	-	-	-	27,217.2	2.07	4.69
Dental	135.6	52.20	0.59	0.01	-	-	-	0.08	0.01	-	-	-	-	156.3	52.97	0.69
Other Ancillary	259.2	45.38	0.98	0.02	-	-	-	0.13	0.01	-	-	-	-	298.8	45.78	1.14
Subtotal Ancillary			**$ 9.46**													**$ 11.01**
Professional																
Inpatient and Outpatient Surgery	299.1	$ 156.86	$ 3.91	$ 0.04	$ 0.00	$ 0.00	$ 0.00	$ 0.55	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	344.3	$ 157.90	$ 4.53
Anesthesia	152.7	110.80	1.41	0.02	-	-	-	0.19	0.01	-	-	-	-	175.4	111.49	1.63
Inpatient Visits	877.8	77.51	5.67	0.06	-	-	-	0.81	0.04	-	-	-	-	1,012.5	77.98	6.58
MH/SA	87,021.8	35.38	256.59	2.75	-	-	-	36.06	1.93	-	-	-	-	100,184.1	35.61	297.33
Emergency Room	684.0	80.52	4.59	0.05	-	(0.03)	-	0.64	0.03	-	-	-	-	782.4	80.98	5.28
Office/Home Visits/Consults	4,644.3	102.24	39.57	0.42	-	0.04	-	5.55	0.30	-	-	-	-	5,349.7	102.91	45.88
Pathology/Lab	3,879.0	21.59	6.98	0.07	-	0.01	-	0.97	0.06	-	-	-	-	4,462.5	21.75	8.09
Radiology	671.9	23.75	1.33	0.01	-	0.01	-	0.18	0.01	-	-	-	-	772.9	23.91	1.54
Office Administered Drugs	5,491.8	1.88	0.86	0.01	-	-	-	0.11	0.02	-	-	-	-	6,258.1	1.92	1.00
Physical Exams	2,694.8	64.30	14.44	0.15	-	-	-	2.02	0.09	-	-	-	-	3,099.8	64.65	16.70
Therapy	13,226.4	21.34	23.52	0.25	-	-	-	1.55	0.17	-	-	-	-	14,238.6	21.48	25.49
Vision	1,060.4	44.93	3.97	0.04	-	-	-	0.55	0.03	-	-	-	-	1,218.0	45.22	4.59
Other Professional	3,429.4	19.14	5.47	0.06	-	-	-	0.74	0.02	0.51	1.18	-	-	4,250.7	22.53	7.98
Subtotal Professional			**$ 368.31**													**$ 426.62**
Total Medical Costs			**$ 675.36**													**$ 787.16**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Retrospective Adjustments

Region: Statewide Rate Cell: KICK Base Year Deliveries: 23,613 Category of Service	MCO Encounter Data Base Year Experience			Completion Adjustments		Managed Care Adjustments		Other Adjustments		Program and Policy Adjustments		Reimbursement Adjustments		Base Year Adjusted Base Experience		
	Utilization per 1,000	Cost per Service	Cost per Delivery	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization per 1,000	Cost per Service	Cost per Delivery
Inpatient Hospital																
Inpatient Maternity Delivery	2,296.3	$ 1,834.41	$ 4,212.31	$ 144.48	$ 0.00	$ 0.00	$ (16.70)	$ (13.56)	$ 28.46	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,367.6	$ 1,839.38	$ 4,354.99
Subtotal Inpatient Hospital			**$ 4,212.31**													**$ 4,354.99**
Outpatient Hospital																
Outpatient Hospital - Maternity	49.3	$ 473.88	$ 23.36	$ 0.44	$ 0.00	$ 0.00	$ 0.00	$ (0.09)	$ 0.16	$ 0.00	$ 0.00	$ 0.00	$ 0.00	50.0	$ 477.08	$ 23.87
Subtotal Outpatient Hospital			**$ 23.36**													**$ 23.87**
Professional																
Maternity Delivery	881.3	$ 1,050.22	$ 925.60	$ 9.90	$ 0.00	$ 0.00	$ 0.25	$ (1.39)	$ 5.94	$ 0.00	$ 0.00	$ 0.00	$ 0.00	889.4	$ 1,057.18	$ 940.30
Maternity Anesthesia	1,109.8	303.95	337.33	3.61	-	-	-	(0.51)	2.12	-	-	-	-	1,120.0	305.85	342.55
Maternity Office Visits	7,977.0	75.77	604.44	6.47	-	-	-	(0.62)	3.96	-	-	-	-	8,054.2	76.26	614.25
Maternity Radiology	5,136.1	77.85	399.84	4.28	-	-	-	(0.45)	2.69	-	-	-	-	5,185.3	78.37	406.36
Maternity Non-Delivery	3.0	93.12	0.28	-	-	-	-	-	0.01	-	-	-	-	3.0	96.45	0.29
Subtotal Professional			**$ 2,267.49**													**$ 2,303.75**
Total Medical Costs			**$ 6,503.16**													**$ 6,682.61**

Appendix 7: SFY 2026 Capitation Rate Development

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - 0 - 2 Months, Male & Female SFY 2026 Member Months: 77,252 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	9,296.5	$ 1,570.40	$ 1,216.60	$ 12.20	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	9,389.7	$ 1,570.40	$ 1,228.80
Inpatient Well Newborn	6,151.4	660.57	338.62	3.39	-	-	-	-	-	-	6,213.0	660.57	342.01
Inpatient MH/SA	2.7	178.48	0.04	-	-	-	-	-	-	-	2.7	178.48	0.04
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 1,555.26**										**$ 1,570.85**
Outpatient Hospital													
Surgery	73.7	$ 1,247.18	$ 7.66	$ 0.36	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.49)	$ 0.00	77.2	$ 1,170.98	$ 7.53
Non-Surg - Emergency Room	809.7	357.60	24.13	1.67	-	-	0.16	-	(0.86)	-	865.8	347.89	25.10
Non-Surg - Other	1,215.0	123.86	12.54	0.59	-	-	-	-	(0.81)	-	1,272.1	116.22	12.32
Observation Room	55.9	882.03	4.11	0.20	-	-	-	-	(0.17)	-	58.6	847.24	4.14
Treatment/Therapy/Testing	775.5	100.43	6.49	0.31	-	-	0.01	-	(0.35)	-	812.5	95.40	6.46
Other Outpatient	64.8	116.70	0.63	0.03	-	-	-	-	(0.02)	-	67.9	113.17	0.64
Subtotal Outpatient Hospital			**$ 55.56**										**$ 56.19**
Retail Pharmacy													
Prescription Drugs	2,270.2	$ 22.31	$ 4.22	$ 0.00	$ 0.44	$ 0.00	$ 0.00	$ 0.00	$ 0.05	$ 0.00	2,270.2	$ 24.90	$ 4.71
Subtotal Retail Pharmacy			**$ 4.22**										**$ 4.71**
Ancillary													
Transportation	199.9	$ 249.18	$ 4.15	$ 0.17	$ 0.00	$ 0.00	$ (0.02)	$ 0.00	$ 0.00	$ 0.00	208.0	$ 248.03	$ 4.30
DME/Prosthetics	1,512.5	18.17	2.29	0.10	-	-	0.28	-	-	-	1,578.5	20.30	2.67
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	107.1	91.84	0.82	0.03	-	-	-	-	-	-	111.1	91.84	0.85
Subtotal Ancillary			**$ 7.26**										**$ 7.82**
Professional													
Inpatient and Outpatient Surgery	1,978.1	$ 112.84	$ 18.60	$ 0.73	$ 0.00	$ (0.01)	$ (0.47)	$ 0.00	$ 0.00	$ 0.00	2,054.7	$ 110.09	$ 18.85
Anesthesia	98.2	202.85	1.66	0.06	-	-	(0.03)	-	-	-	101.8	199.31	1.69
Inpatient Visits	13,888.9	185.53	214.73	8.29	-	-	(9.61)	-	-	-	14,425.1	177.53	213.41
MH/SA	26.4	27.25	0.06	-	-	-	-	-	-	-	26.4	27.25	0.06
Emergency Room	889.2	76.25	5.65	0.24	-	-	0.13	-	-	-	927.0	77.93	6.02
Office/Home Visits/Consults	7,834.9	91.01	59.42	2.63	-	(0.21)	5.84	-	-	-	8,154.0	99.60	67.68
Pathology/Lab	2,778.4	38.18	8.84	0.34	-	(0.15)	(0.36)	-	-	-	2,838.1	36.66	8.67
Radiology	2,956.3	14.86	3.66	0.14	-	-	(0.39)	-	-	-	3,069.4	13.33	3.41
Office Administered Drugs	35.4	12,248.71	36.17	1.41	-	(0.08)	(1.08)	-	-	-	36.7	11,895.95	36.42
Physical Exams	25,158.7	59.56	124.87	4.93	-	(0.46)	(2.39)	-	-	-	26,059.3	58.46	126.95
Therapy	164.2	27.04	0.37	0.02	-	-	0.08	-	-	-	173.1	32.58	0.47
Vision	17.7	60.96	0.09	-	-	-	-	-	-	-	17.7	60.96	0.09
Other Professional	4,821.3	55.30	22.22	0.63	-	(0.31)	(6.33)	-	-	-	4,890.7	39.77	16.21
Subtotal Professional			**$ 496.34**										**$ 499.93**
Total Medical Costs			**$ 2,118.64**										**$ 2,139.50**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - 3 - 12 Months, Male & Female SFY 2026 Member Months: 338,280 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	234.3	$ 2,172.96	$ 42.43	$ 3.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	251.0	$ 2,172.96	$ 45.45
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 42.43**										**$ 45.45**
Outpatient Hospital													
Surgery	71.5	$ 1,536.31	$ 9.16	$ 0.43	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.60)	$ 0.00	74.9	$ 1,440.19	$ 8.99
Non-Surg - Emergency Room	888.4	284.32	21.05	1.47	-	-	0.18	-	(0.66)	-	950.5	278.26	22.04
Non-Surg - Other	734.3	132.70	8.12	0.38	-	-	-	-	(0.56)	-	768.7	123.95	7.94
Observation Room	11.7	1,167.61	1.14	0.05	-	-	-	-	(0.07)	-	12.2	1,098.93	1.12
Treatment/Therapy/Testing	277.1	272.35	6.29	0.30	-	-	-	-	(0.35)	-	290.4	257.89	6.24
Other Outpatient	68.5	164.71	0.94	0.05	-	-	-	-	(0.03)	-	72.1	159.72	0.96
Subtotal Outpatient Hospital			**$ 46.70**										**$ 47.29**
Retail Pharmacy													
Prescription Drugs	3,936.8	$ 31.73	$ 10.41	$ 0.00	$ 1.06	$ 0.00	$ 0.00	$ (0.01)	$ (0.15)	$ 0.00	3,933.0	$ 34.51	$ 11.31
Subtotal Retail Pharmacy			**$ 10.41**										**$ 11.31**
Ancillary													
Transportation	93.2	$ 136.44	$ 1.06	$ 0.07	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ 0.00	99.4	$ 135.23	$ 1.12
DME/Prosthetics	3,598.1	12.27	3.68	0.24	-	-	0.35	-	-	-	3,832.7	13.37	4.27
Dental	259.2	17.13	0.37	0.02	-	(0.01)	(0.03)	-	-	-	266.2	15.78	0.35
Other Ancillary	22.8	78.96	0.15	0.01	-	-	-	-	-	-	24.3	78.96	0.16
Subtotal Ancillary			**$ 5.26**										**$ 5.90**
Professional													
Inpatient and Outpatient Surgery	265.2	$ 204.53	$ 4.52	$ 0.27	$ 0.00	$ 0.00	$ (0.13)	$ 0.00	$ 0.00	$ 0.00	281.0	$ 198.97	$ 4.66
Anesthesia	138.0	119.16	1.37	0.08	-	-	(0.04)	-	-	-	146.0	115.87	1.41
Inpatient Visits	692.9	184.80	10.67	0.62	-	-	(0.42)	-	-	-	733.1	177.93	10.87
MH/SA	134.7	12.47	0.14	0.01	-	-	-	-	-	-	144.3	12.47	0.15
Emergency Room	898.4	70.93	5.31	0.33	-	-	0.17	-	-	-	954.2	73.07	5.81
Office/Home Visits/Consults	4,762.6	91.87	36.46	2.41	-	(0.44)	3.61	-	-	-	5,020.0	100.49	42.04
Pathology/Lab	3,076.2	27.46	7.04	0.39	-	(0.19)	(0.35)	-	-	-	3,163.5	26.14	6.89
Radiology	578.5	17.84	0.86	0.04	-	-	(0.08)	-	-	-	605.4	16.25	0.82
Office Administered Drugs	288.2	293.58	7.05	0.43	-	(0.07)	0.01	-	-	-	302.9	293.97	7.42
Physical Exams	12,997.0	45.48	49.26	2.96	-	(0.19)	(0.38)	-	-	-	13,727.8	45.15	51.65
Therapy	1,313.9	23.11	2.53	0.17	-	-	0.40	-	-	-	1,402.2	26.53	3.10
Vision	166.1	11.56	0.16	0.01	-	-	(0.01)	-	-	-	176.5	10.88	0.16
Other Professional	2,382.9	32.38	6.43	0.39	-	(0.11)	-	-	-	-	2,486.6	32.38	6.71
Subtotal Professional			**$ 131.80**										**$ 141.69**
Total Medical Costs			**$ 236.60**										**$ 251.64**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 1 - 6, Male & Female SFY 2026 Member Months: 2,136,221 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	45.1	$ 2,629.60	$ 9.89	$ 0.50	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.49	49.7	$ 2,629.60	$ 10.88
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	0.6	829.03	0.04	-	-	-	-	-	-	0.01	0.7	829.03	0.05
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 9.93**										**$ 10.93**
Outpatient Hospital													
Surgery	67.7	$ 1,475.95	$ 8.33	$ 0.73	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ (0.41)	$ 0.41	77.0	$ 1,413.61	$ 9.07
Non-Surg - Emergency Room	482.9	304.63	12.26	1.11	-	-	0.13	-	(0.31)	0.62	551.1	300.71	13.81
Non-Surg - Other	303.2	134.58	3.40	0.30	-	-	-	-	(0.21)	0.16	344.2	127.25	3.65
Observation Room	4.6	1,500.36	0.58	0.05	-	-	-	-	(0.04)	0.03	5.3	1,409.43	0.62
Treatment/Therapy/Testing	234.7	214.26	4.19	0.37	-	-	-	-	(0.19)	0.20	266.6	205.71	4.57
Other Outpatient	50.1	359.12	1.50	0.13	-	-	-	-	(0.05)	0.07	56.8	348.56	1.65
Subtotal Outpatient Hospital			**$ 30.26**										**$ 33.37**
Retail Pharmacy													
Prescription Drugs	3,881.5	$ 49.25	$ 15.93	$ 3.04	$ 1.76	$ 0.00	$ 0.00	$ (0.03)	$ 0.27	$ 0.98	4,853.6	$ 54.27	$ 21.95
Subtotal Retail Pharmacy			**$ 15.93**										**$ 21.95**
Ancillary													
Transportation	48.4	$ 119.11	$ 0.48	$ 0.03	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.03	54.4	$ 119.11	$ 0.54
DME/Prosthetics	4,163.4	6.34	2.20	0.17	-	-	0.18	-	-	0.12	4,712.2	6.80	2.67
Dental	252.6	81.72	1.72	0.12	-	(0.01)	(0.02)	-	-	0.09	281.9	80.87	1.90
Other Ancillary	18.6	58.03	0.09	0.01	-	-	-	-	-	-	20.7	58.03	0.10
Subtotal Ancillary			**$ 4.49**										**$ 5.21**
Professional													
Inpatient and Outpatient Surgery	206.2	$ 153.03	$ 2.63	$ 0.18	$ 0.00	$ 0.00	$ (0.09)	$ 0.00	$ 0.00	$ 0.13	230.5	$ 148.35	$ 2.85
Anesthesia	139.4	100.71	1.17	0.08	-	-	(0.03)	-	-	0.06	156.1	98.41	1.28
Inpatient Visits	97.3	138.16	1.12	0.07	-	-	(0.05)	-	-	0.06	108.6	132.64	1.20
MH/SA	5,339.4	20.43	9.09	0.82	-	2.15	(0.12)	0.16	0.25	0.58	7,518.6	20.64	12.93
Emergency Room	496.6	71.04	2.94	0.21	-	-	0.08	-	-	0.15	557.4	72.77	3.38
Office/Home Visits/Consults	3,266.0	90.46	24.62	1.91	-	(0.27)	2.53	-	-	1.34	3,661.4	98.75	30.13
Pathology/Lab	2,511.6	25.90	5.42	0.36	-	(0.11)	(0.26)	-	-	0.26	2,748.0	24.76	5.67
Radiology	315.8	19.38	0.51	0.03	-	-	(0.03)	-	-	0.03	353.0	18.36	0.54
Office Administered Drugs	341.5	57.63	1.64	0.12	-	(0.01)	0.07	-	-	0.09	383.1	59.82	1.91
Physical Exams	2,179.2	60.08	10.91	0.77	-	(0.08)	(0.02)	-	-	0.55	2,426.9	59.98	12.13
Therapy	8,109.7	23.07	15.59	1.20	-	-	1.35	-	-	0.85	9,176.1	24.83	18.99
Vision	327.6	26.01	0.71	0.06	-	-	0.07	-	-	0.03	369.1	28.28	0.87
Other Professional	2,273.6	25.07	4.75	0.37	-	(0.03)	0.48	-	-	0.26	2,560.8	27.32	5.83
Subtotal Professional			**$ 81.10**										**$ 97.71**
Total Medical Costs			**$ 141.71**										**$ 169.17**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 7 - 13, Male & Female SFY 2026 Member Months: 2,594,528 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	27.0	$ 2,849.58	$ 6.42	$ 0.19	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.32	29.2	$ 2,849.58	$ 6.93
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	26.9	619.16	1.39	0.06	-	-	0.18	(0.21)	-	0.06	25.2	704.89	1.48
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 7.81**										**$ 8.41**
Outpatient Hospital													
Surgery	36.0	$ 1,576.94	$ 4.73	$ 0.32	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ (0.22)	$ 0.23	40.2	$ 1,514.22	$ 5.07
Non-Surg - Emergency Room	295.4	320.90	7.90	0.56	-	-	0.09	-	(0.15)	0.40	331.3	318.73	8.80
Non-Surg - Other	186.3	133.98	2.08	0.14	-	-	-	-	(0.12)	0.10	207.8	127.05	2.20
Observation Room	2.3	1,473.86	0.28	0.02	-	-	-	-	(0.02)	0.01	2.5	1,378.78	0.29
Treatment/Therapy/Testing	172.1	248.98	3.57	0.29	-	-	-	0.77	(0.28)	0.21	233.3	234.58	4.56
Other Outpatient	28.5	206.30	0.49	0.07	-	-	-	0.14	0.36	0.05	43.6	305.33	1.11
Subtotal Outpatient Hospital			**$ 19.05**										**$ 22.03**
Retail Pharmacy													
Prescription Drugs	4,419.2	$ 73.67	$ 27.13	$ 5.35	$ 3.11	$ 0.00	$ 0.00	$ (0.05)	$ 1.36	$ 1.75	5,567.5	$ 83.30	$ 38.65
Subtotal Retail Pharmacy			**$ 27.13**										**$ 38.65**
Ancillary													
Transportation	34.7	$ 117.71	$ 0.34	$ 0.02	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.02	38.7	$ 117.71	$ 0.38
DME/Prosthetics	2,797.3	5.06	1.18	0.09	-	-	0.11	-	-	0.07	3,176.6	5.48	1.45
Dental	35.4	84.74	0.25	0.01	-	-	-	-	-	0.02	39.6	84.74	0.28
Other Ancillary	38.2	40.87	0.13	0.01	-	-	-	-	-	0.01	44.0	40.87	0.15
Subtotal Ancillary			**$ 1.90**										**$ 2.26**
Professional													
Inpatient and Outpatient Surgery	137.4	$ 143.23	$ 1.64	$ 0.11	$ 0.00	$ 0.00	$ (0.05)	$ 0.00	$ 0.00	$ 0.08	153.3	$ 139.31	$ 1.78
Anesthesia	56.8	107.73	0.51	0.03	-	-	(0.01)	-	-	0.03	63.5	105.84	0.56
Inpatient Visits	72.3	104.53	0.63	0.04	-	-	(0.01)	-	-	0.04	81.5	103.06	0.70
MH/SA	2,825.2	64.43	15.17	1.14	-	1.04	(0.49)	0.06	0.20	0.81	3,393.2	63.41	17.93
Emergency Room	306.5	72.04	1.84	0.14	-	-	0.04	-	-	0.09	344.8	73.44	2.11
Office/Home Visits/Consults	2,510.9	93.29	19.52	1.52	-	(0.18)	1.99	-	-	1.08	2,822.1	101.75	23.93
Pathology/Lab	2,100.9	23.42	4.10	0.28	-	(0.06)	(0.18)	-	-	0.19	2,311.0	22.48	4.33
Radiology	381.5	19.50	0.62	0.04	-	-	(0.03)	-	-	0.03	424.5	18.66	0.66
Office Administered Drugs	574.3	16.51	0.79	0.05	-	-	(0.03)	-	-	0.04	639.7	15.95	0.85
Physical Exams	940.2	74.03	5.80	0.41	-	(0.05)	0.05	-	-	0.29	1,045.6	74.60	6.50
Therapy	1,216.1	22.40	2.27	0.18	-	-	0.25	-	-	0.12	1,376.9	24.58	2.82
Vision	645.1	34.22	1.84	0.15	-	-	0.27	-	-	0.11	736.3	38.63	2.37
Other Professional	2,409.6	14.54	2.92	0.21	-	(0.01)	(0.04)	-	-	0.14	2,690.2	14.36	3.22
Subtotal Professional			**$ 57.65**										**$ 67.76**
Total Medical Costs			**$ 113.54**										**$ 139.11**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Male SFY 2026 Member Months: 845,513 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	47.5	$ 3,274.60	$ 12.96	$ 0.39	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.75	51.7	$ 3,274.60	$ 14.10
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	57.7	583.95	2.81	0.13	-	-	0.68	(0.17)	-	0.20	61.0	717.65	3.65
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 15.77**										**$ 17.75**
Outpatient Hospital													
Surgery	46.0	$ 1,609.55	$ 6.17	$ 0.43	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ (0.24)	$ 0.35	51.8	$ 1,556.28	$ 6.72
Non-Surg - Emergency Room	280.5	322.53	7.54	0.53	-	-	0.10	-	(0.12)	0.45	317.0	321.77	8.50
Non-Surg - Other	125.7	142.22	1.49	0.10	-	-	-	-	(0.09)	0.09	141.8	134.60	1.59
Observation Room	2.4	1,149.12	0.23	0.02	-	-	-	-	(0.02)	0.01	2.7	1,060.73	0.24
Treatment/Therapy/Testing	189.4	348.41	5.50	0.41	-	-	0.01	0.65	(0.35)	0.35	238.0	331.27	6.57
Other Outpatient	22.6	138.21	0.26	0.03	-	-	0.01	0.05	0.21	0.03	32.1	220.39	0.59
Subtotal Outpatient Hospital			**$ 21.19**										**$ 24.21**
Retail Pharmacy													
Prescription Drugs	3,686.4	$ 107.94	$ 33.16	$ 4.04	$ 1.21	$ 0.00	$ 0.00	$ 0.03	$ 2.57	$ 2.29	4,393.4	$ 118.27	$ 43.30
Subtotal Retail Pharmacy			**$ 33.16**										**$ 43.30**
Ancillary													
Transportation	70.4	$ 132.98	$ 0.78	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.05	79.4	$ 132.98	$ 0.88
DME/Prosthetics	1,421.2	13.26	1.57	0.12	-	-	0.13	-	-	0.10	1,620.3	14.22	1.92
Dental	9.6	37.42	0.03	-	-	-	-	-	-	-	9.6	37.42	0.03
Other Ancillary	32.8	47.51	0.13	0.01	-	-	-	-	-	0.01	37.9	47.51	0.15
Subtotal Ancillary			**$ 2.51**										**$ 2.98**
Professional													
Inpatient and Outpatient Surgery	179.4	$ 154.50	$ 2.31	$ 0.16	$ 0.00	$ 0.00	$ (0.06)	$ 0.00	$ 0.00	$ 0.14	202.7	$ 150.94	$ 2.55
Anesthesia	58.8	128.55	0.63	0.05	-	-	(0.01)	-	-	0.03	66.3	126.74	0.70
Inpatient Visits	114.7	97.32	0.93	0.07	-	-	-	-	-	0.05	129.5	97.32	1.05
MH/SA	1,448.5	77.05	9.30	0.68	-	-	0.22	0.06	0.09	0.58	1,654.1	79.30	10.93
Emergency Room	300.5	77.46	1.94	0.14	-	-	0.02	-	-	0.12	340.8	78.16	2.22
Office/Home Visits/Consults	1,806.5	92.27	13.89	1.09	-	(0.12)	1.43	-	-	0.91	2,051.0	100.63	17.20
Pathology/Lab	1,759.9	22.30	3.27	0.22	-	(0.04)	(0.07)	-	-	0.19	1,959.0	21.87	3.57
Radiology	548.5	24.28	1.11	0.07	-	-	(0.07)	-	-	0.07	617.7	22.92	1.18
Office Administered Drugs	991.9	22.50	1.86	0.13	-	-	(0.02)	-	-	0.11	1,119.9	22.29	2.08
Physical Exams	650.7	80.41	4.36	0.31	-	(0.05)	0.06	-	-	0.26	728.3	81.40	4.94
Therapy	665.0	21.65	1.20	0.10	-	-	0.18	-	-	0.08	764.7	24.48	1.56
Vision	529.1	35.38	1.56	0.13	-	-	0.22	-	-	0.11	610.5	39.70	2.02
Other Professional	1,740.7	16.06	2.33	0.17	-	(0.01)	(0.04)	-	-	0.13	1,957.3	15.82	2.58
Subtotal Professional			**$ 44.69**										**$ 52.58**
Total Medical Costs			**$ 117.32**										**$ 140.82**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 14 - 18, Female SFY 2026 Member Months: 817,358	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	35.4	$ 2,955.39	$ 8.72	$ 0.26	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.30	37.7	$ 2,955.39	$ 9.28
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	55.2	636.70	2.93	0.13	-	-	0.65	(0.21)	-	0.12	56.0	776.04	3.62
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 11.65**										**$ 12.90**
Outpatient Hospital													
Surgery	45.5	$ 1,489.79	$ 5.65	$ 0.38	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ (0.22)	$ 0.20	50.2	$ 1,439.57	$ 6.02
Non-Surg - Emergency Room	412.9	339.42	11.68	0.83	-	-	0.14	-	(0.17)	0.42	457.1	338.64	12.90
Non-Surg - Other	191.6	150.29	2.40	0.16	-	-	-	-	(0.14)	0.09	211.6	142.35	2.51
Observation Room	4.9	939.53	0.38	0.02	-	-	-	-	(0.02)	0.02	5.4	894.79	0.40
Treatment/Therapy/Testing	311.3	220.49	5.72	0.44	-	-	0.02	0.79	(0.24)	0.23	390.8	213.73	6.96
Other Outpatient	30.2	135.27	0.34	0.05	-	-	-	0.06	0.29	0.02	41.7	218.73	0.76
Subtotal Outpatient Hospital			**$ 26.17**										**$ 29.55**
Retail Pharmacy													
Prescription Drugs	5,249.9	$ 72.41	$ 31.68	$ 3.93	$ 1.17	$ 0.00	$ 0.00	$ 0.08	$ 3.00	$ 1.33	6,134.9	$ 80.57	$ 41.19
Subtotal Retail Pharmacy			**$ 31.68**										**$ 41.19**
Ancillary													
Transportation	83.1	$ 103.95	$ 0.72	$ 0.05	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.02	91.2	$ 103.95	$ 0.79
DME/Prosthetics	1,125.6	11.51	1.08	0.08	-	-	0.10	-	-	0.04	1,250.7	12.47	1.30
Dental	9.6	37.50	0.03	-	-	-	-	-	-	-	9.6	37.50	0.03
Other Ancillary	28.4	63.42	0.15	0.01	-	-	-	-	-	0.01	32.2	63.42	0.17
Subtotal Ancillary			**$ 1.98**										**$ 2.29**
Professional													
Inpatient and Outpatient Surgery	150.2	$ 139.80	$ 1.75	$ 0.12	$ 0.00	$ 0.00	$ (0.08)	$ 0.00	$ 0.00	$ 0.06	165.7	$ 134.01	$ 1.85
Anesthesia	50.8	120.51	0.51	0.03	-	-	(0.01)	-	-	0.02	55.8	118.35	0.55
Inpatient Visits	120.8	92.38	0.93	0.07	-	-	0.01	-	-	0.03	133.8	93.27	1.04
MH/SA	1,522.9	96.13	12.20	0.91	-	-	0.33	0.27	0.04	0.46	1,727.6	98.70	14.21
Emergency Room	424.9	78.79	2.79	0.20	-	-	0.02	-	-	0.10	470.6	79.30	3.11
Office/Home Visits/Consults	2,464.5	93.49	19.20	1.50	-	(0.18)	1.94	-	-	0.75	2,730.3	102.01	23.21
Pathology/Lab	3,487.4	19.75	5.74	0.41	-	(0.05)	0.07	-	-	0.20	3,827.6	19.97	6.37
Radiology	524.1	29.53	1.29	0.08	-	-	(0.08)	-	-	0.05	576.9	27.87	1.34
Office Administered Drugs	14,305.6	1.59	1.89	0.12	-	-	(0.17)	-	-	0.07	15,743.7	1.46	1.91
Physical Exams	714.6	79.59	4.74	0.34	-	(0.06)	0.06	-	-	0.17	782.5	80.51	5.25
Therapy	599.6	22.22	1.11	0.09	-	-	0.17	-	-	0.05	675.2	25.24	1.42
Vision	793.5	34.48	2.28	0.18	-	-	0.34	-	-	0.10	891.0	39.06	2.90
Other Professional	2,407.4	20.09	4.03	0.29	-	(0.02)	0.04	-	-	0.15	2,658.3	20.27	4.49
Subtotal Professional			**$ 58.46**										**$ 67.65**
Total Medical Costs			**$ 129.94**										**$ 153.58**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Male SFY 2026 Member Months: 160,216 Category of Service	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trend Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Acuity Adjustments Utilization Adjustment	SFY 2026 Projected Benefit Expense Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	118.4	$ 2,973.88	$ 29.35	$ 0.29	$ 0.00	$ 0.00	$ 0.07	$ 0.00	$ 0.05	$ 10.05	160.2	$ 2,982.88	$ 39.81
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	27.9	739.14	1.72	0.01	-	-	0.11	(0.20)	0.01	0.56	33.9	781.58	2.21
Other Inpatient	0.5	441.33	0.02	-	-	-	-	-	-	0.01	0.8	441.33	0.03
Subtotal Inpatient Hospital			**$ 31.09**										**$ 42.05**
Outpatient Hospital													
Surgery	57.4	$ 1,491.74	$ 7.13	$ 0.35	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ (0.13)	$ 2.49	80.2	$ 1,475.28	$ 9.86
Non-Surg - Emergency Room	380.9	326.71	10.37	0.42	-	-	0.12	-	(0.10)	3.65	530.4	327.16	14.46
Non-Surg - Other	58.9	191.67	0.94	0.04	-	-	-	-	(0.04)	0.32	81.4	185.77	1.26
Observation Room	3.4	1,054.50	0.30	0.02	-	-	-	-	(0.01)	0.10	4.8	1,029.39	0.41
Treatment/Therapy/Testing	211.3	480.43	8.46	0.47	-	-	0.02	0.90	(0.06)	3.30	328.0	478.97	13.09
Other Outpatient	23.0	626.50	1.20	0.07	-	-	-	0.20	0.04	0.51	37.9	639.16	2.02
Subtotal Outpatient Hospital			**$ 28.40**										**$ 41.10**
Retail Pharmacy													
Prescription Drugs	2,765.9	$ 187.42	$ 43.20	$ 7.26	$ 2.73	$ 0.00	$ 0.00	$ 0.04	$ 3.40	$ 19.10	4,456.2	$ 203.93	$ 75.73
Subtotal Retail Pharmacy			**$ 43.20**										**$ 75.73**
Ancillary													
Transportation	119.7	$ 121.30	$ 1.21	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.42	167.2	$ 121.30	$ 1.69
DME/Prosthetics	1,544.0	14.22	1.83	0.10	-	-	0.15	-	0.01	0.71	2,227.3	15.09	2.80
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	35.7	67.26	0.20	0.01	-	-	-	-	-	0.07	50.0	67.26	0.28
Subtotal Ancillary			**$ 3.24**										**$ 4.77**
Professional													
Inpatient and Outpatient Surgery	239.0	$ 143.12	$ 2.85	$ 0.14	$ 0.00	$ 0.00	$ (0.10)	$ 0.00	$ 0.00	$ 0.98	332.9	$ 139.52	$ 3.87
Anesthesia	77.4	122.53	0.79	0.04	-	-	(0.02)	-	-	0.28	108.7	120.32	1.09
Inpatient Visits	239.5	92.69	1.85	0.10	-	-	(0.01)	-	-	0.65	336.6	92.34	2.59
MH/SA	724.4	87.63	5.29	0.39	-	0.22	2.02	0.12	0.07	2.73	1,198.2	108.56	10.84
Emergency Room	411.3	82.86	2.84	0.15	-	-	(0.02)	-	-	1.00	577.8	82.44	3.97
Office/Home Visits/Consults	1,333.1	92.72	10.30	0.57	-	(0.08)	1.09	-	-	4.01	1,915.5	99.55	15.89
Pathology/Lab	1,700.3	16.52	2.34	0.12	-	(0.01)	0.04	-	-	0.84	2,390.5	16.72	3.33
Radiology	664.1	30.00	1.66	0.07	-	-	(0.14)	-	-	0.54	908.1	28.15	2.13
Office Administered Drugs	2,715.3	18.69	4.23	0.21	-	-	(0.16)	-	-	1.44	3,774.5	18.19	5.72
Physical Exams	111.6	77.41	0.72	0.03	-	-	-	-	-	0.26	156.6	77.41	1.01
Therapy	376.9	22.60	0.71	0.04	-	-	0.10	-	-	0.29	552.1	24.78	1.14
Vision	147.9	43.80	0.54	0.03	-	-	0.07	-	0.01	0.22	216.4	48.24	0.87
Other Professional	1,060.7	22.74	2.01	0.10	-	(0.02)	(0.01)	-	-	0.70	1,472.4	22.66	2.78
Subtotal Professional			**$ 36.13**										**$ 55.23**
Total Medical Costs			**$ 142.06**										**$ 218.88**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 19 - 44, Female SFY 2026 Member Months: 1,112,937 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	144.4	$ 2,585.39	$ 31.11	$ 0.31	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ 0.05	$ 3.66	162.8	$ 2,590.55	$ 35.15
Inpatient Well Newborn	0.1	886.82	0.01	-	-	-	-	-	-	-	0.1	886.82	0.01
Inpatient MH/SA	24.5	797.50	1.63	0.02	-	-	0.02	(0.34)	-	0.15	22.0	808.43	1.48
Other Inpatient	4.3	414.93	0.15	-	-	-	-	-	-	0.02	4.9	414.93	0.17
Subtotal Inpatient Hospital			**$ 32.90**										**$ 36.81**
Outpatient Hospital													
Surgery	139.2	$ 1,333.94	$ 15.47	$ 0.77	$ 0.00	$ 0.00	$ 0.03	$ 0.00	$ (0.36)	$ 1.85	162.7	$ 1,309.60	$ 17.76
Non-Surg - Emergency Room	778.2	356.22	23.10	0.94	-	-	0.26	-	(0.24)	2.79	903.8	356.49	26.85
Non-Surg - Other	218.8	166.17	3.03	0.15	-	-	-	-	(0.11)	0.35	254.9	160.99	3.42
Observation Room	20.3	633.07	1.07	0.06	-	-	-	-	(0.02)	0.12	23.7	622.95	1.23
Treatment/Therapy/Testing	697.7	285.17	16.58	0.91	-	-	0.05	1.57	(0.18)	2.20	894.6	283.43	21.13
Other Outpatient	103.6	182.95	1.58	0.09	-	-	0.01	0.08	0.26	0.24	130.5	207.78	2.26
Subtotal Outpatient Hospital			**$ 60.83**										**$ 72.65**
Retail Pharmacy													
Prescription Drugs	6,241.2	$ 121.19	$ 63.03	$ 11.47	$ 4.32	$ 0.00	$ 0.00	$ 0.54	$ 10.15	$ 10.40	8,460.2	$ 141.71	$ 99.91
Subtotal Retail Pharmacy			**$ 63.03**										**$ 99.91**
Ancillary													
Transportation	177.7	$ 99.97	$ 1.48	$ 0.08	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ 0.18	208.9	$ 99.39	$ 1.73
DME/Prosthetics	1,792.7	13.99	2.09	0.11	-	-	0.20	-	0.01	0.28	2,127.2	15.18	2.69
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	94.9	117.62	0.93	0.05	-	-	-	-	-	0.11	111.2	117.62	1.09
Subtotal Ancillary			**$ 4.50**										**$ 5.51**
Professional													
Inpatient and Outpatient Surgery	360.6	$ 186.67	$ 5.61	$ 0.27	$ 0.00	$ 0.00	$ (0.20)	$ 0.00	$ 0.00	$ 0.66	420.4	$ 180.96	$ 6.34
Anesthesia	156.4	119.68	1.56	0.08	-	-	(0.03)	-	-	0.18	182.5	117.71	1.79
Inpatient Visits	329.6	89.92	2.47	0.13	-	-	(0.01)	-	-	0.30	387.0	89.61	2.89
MH/SA	1,054.8	96.47	8.48	0.56	-	0.23	2.20	0.21	0.07	1.37	1,349.6	116.66	13.12
Emergency Room	813.9	83.75	5.68	0.29	-	-	(0.03)	-	-	0.69	954.3	83.37	6.63
Office/Home Visits/Consults	3,138.3	93.18	24.37	1.35	-	(0.23)	2.69	-	-	3.28	3,704.9	101.90	31.46
Pathology/Lab	6,670.2	18.82	10.46	0.55	-	(0.05)	0.43	-	-	1.32	7,830.7	19.48	12.71
Radiology	1,300.3	40.79	4.42	0.21	-	-	(0.28)	-	-	0.50	1,509.1	38.57	4.85
Office Administered Drugs	24,067.3	4.57	9.16	0.45	-	-	(0.30)	-	-	1.08	28,087.3	4.44	10.39
Physical Exams	338.5	82.60	2.33	0.12	-	(0.01)	-	-	-	0.28	395.1	82.60	2.72
Therapy	525.1	23.54	1.03	0.06	-	-	0.15	-	-	0.14	627.1	26.41	1.38
Vision	175.1	54.14	0.79	0.04	-	-	0.10	-	0.01	0.11	208.3	60.48	1.05
Other Professional	4,506.6	16.67	6.26	0.33	-	(0.04)	0.20	-	-	0.78	5,276.9	17.12	7.53
Subtotal Professional			**$ 82.62**										**$ 102.86**
Total Medical Costs			**$ 243.88**										**$ 317.74**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: TANF - Age 45+, Male & Female SFY 2026 Member Months: 201,585 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	340.6	$ 2,845.60	$ 80.77	$ 0.81	$ 0.00	$ 0.00	$ 0.20	$ 0.00	$ 0.14	$ 4.51	363.0	$ 2,856.83	$ 86.43
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	20.3	820.09	1.39	-	-	-	-	(0.68)	0.01	0.04	11.0	831.02	0.76
Other Inpatient	27.2	308.90	0.70	0.01	-	-	-	-	-	0.04	29.1	308.90	0.75
Subtotal Inpatient Hospital			**$ 82.86**										**$ 87.94**
Outpatient Hospital													
Surgery	161.1	$ 1,877.01	$ 25.20	$ 1.26	$ 0.00	$ 0.00	$ 0.09	$ 0.00	$ (0.54)	$ 1.43	178.3	$ 1,846.73	$ 27.44
Non-Surg - Emergency Room	556.0	370.12	17.15	0.70	-	-	0.31	-	(0.16)	0.99	610.8	373.07	18.99
Non-Surg - Other	234.2	160.86	3.14	0.15	-	-	-	-	(0.09)	0.18	258.9	156.69	3.38
Observation Room	14.7	1,121.53	1.37	0.07	-	-	-	-	(0.02)	0.08	16.3	1,106.77	1.50
Treatment/Therapy/Testing	946.1	544.13	42.90	2.31	-	-	0.14	3.01	(0.46)	2.64	1,121.7	540.70	50.54
Other Outpatient	257.4	193.93	4.16	0.26	-	-	0.04	0.22	0.68	0.29	305.1	222.25	5.65
Subtotal Outpatient Hospital			**$ 93.92**										**$ 107.50**
Retail Pharmacy													
Prescription Drugs	13,466.3	$ 136.81	$ 153.53	$ 26.08	$ 9.80	$ 0.00	$ 0.00	$ 0.75	$ 13.27	$ 11.21	16,802.8	$ 153.29	$ 214.64
Subtotal Retail Pharmacy			**$ 153.53**										**$ 214.64**
Ancillary													
Transportation	186.5	$ 108.12	$ 1.68	$ 0.08	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.10	206.4	$ 108.12	$ 1.86
DME/Prosthetics	8,808.0	7.78	5.71	0.32	-	-	0.55	-	0.05	0.36	9,857.0	8.51	6.99
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	205.4	79.46	1.36	0.07	-	-	-	-	-	0.08	228.0	79.46	1.51
Subtotal Ancillary			**$ 8.75**										**$ 10.36**
Professional													
Inpatient and Outpatient Surgery	863.8	$ 162.40	$ 11.69	$ 0.57	$ 0.00	$ (0.01)	$ (0.42)	$ 0.00	$ 0.01	$ 0.65	953.2	$ 157.23	$ 12.49
Anesthesia	329.4	112.92	3.10	0.16	-	-	(0.08)	-	-	0.17	364.5	110.28	3.35
Inpatient Visits	645.6	91.08	4.90	0.25	-	-	0.04	-	-	0.29	716.8	91.75	5.48
MH/SA	830.7	98.38	6.81	0.47	-	0.26	2.28	(0.26)	0.04	0.52	951.4	127.64	10.12
Emergency Room	590.2	90.68	4.46	0.23	-	-	(0.05)	-	-	0.25	653.7	89.76	4.89
Office/Home Visits/Consults	4,379.1	96.16	35.09	1.96	-	(0.47)	4.17	-	-	2.24	4,844.6	106.49	42.99
Pathology/Lab	6,345.6	15.45	8.17	0.42	-	(0.06)	0.21	-	-	0.48	6,998.0	15.81	9.22
Radiology	2,243.8	40.81	7.63	0.35	-	-	(0.61)	-	-	0.41	2,467.3	37.84	7.78
Office Administered Drugs	21,528.2	12.37	22.20	1.08	-	(0.02)	(0.89)	-	-	1.23	23,749.0	11.92	23.60
Physical Exams	316.6	75.42	1.99	0.09	-	(0.01)	(0.05)	-	-	0.11	346.9	73.69	2.13
Therapy	1,418.1	22.59	2.67	0.15	-	-	0.41	-	-	0.18	1,593.4	25.68	3.41
Vision	195.1	67.05	1.09	0.06	-	-	0.09	-	0.03	0.07	218.4	73.64	1.34
Other Professional	4,098.7	27.05	9.24	0.45	-	(0.11)	(0.34)	-	-	0.51	4,475.7	26.14	9.75
Subtotal Professional			**$ 119.04**										**$ 136.55**
Total Medical Costs			**$ 458.10**										**$ 556.99**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SSI - Children SFY 2026 Member Months: 149,431 Category of Service	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trend Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Acuity Adjustments Utilization Adjustment	SFY 2026 Projected Benefit Expense Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	346.4	$ 2,500.42	$ 72.18	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	346.4	$ 2,500.42	$ 72.18
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	120.7	648.40	6.52	0.13	-	-	0.74	(1.13)	-	-	102.2	735.32	6.26
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 78.70**										**$ 78.44**
Outpatient Hospital													
Surgery	102.0	$ 2,008.78	$ 17.07	$ 0.48	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ (1.27)	$ 0.00	104.8	$ 1,864.56	$ 16.29
Non-Surg - Emergency Room	511.5	357.32	15.23	0.76	-	-	0.13	-	(0.44)	-	537.0	350.39	15.68
Non-Surg - Other	622.6	153.62	7.97	0.22	-	-	-	-	(0.54)	-	639.8	143.49	7.65
Observation Room	10.7	1,576.70	1.41	0.04	-	-	-	-	(0.11)	-	11.0	1,457.08	1.34
Treatment/Therapy/Testing	670.4	421.17	23.53	0.79	-	-	0.02	4.20	(1.73)	-	812.6	395.92	26.81
Other Outpatient	76.7	261.15	1.67	0.10	-	-	-	0.58	1.06	-	108.0	378.95	3.41
Subtotal Outpatient Hospital			**$ 66.88**										**$ 71.18**
Retail Pharmacy													
Prescription Drugs	12,448.0	$ 209.58	$ 217.40	$ 13.67	$ 9.63	$ 0.00	$ 0.00	$ (0.37)	$ 7.53	$ 0.00	13,209.6	$ 225.16	$ 247.86
Subtotal Retail Pharmacy			**$ 217.40**										**$ 247.86**
Ancillary													
Transportation	169.5	$ 117.51	$ 1.66	$ 0.06	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	175.6	$ 117.51	$ 1.72
DME/Prosthetics	91,274.5	2.99	22.72	1.01	-	-	2.37	-	-	-	95,332.0	3.29	26.10
Dental	81.7	115.97	0.79	0.03	-	-	(0.01)	-	-	-	84.8	114.56	0.81
Other Ancillary	222.2	40.50	0.75	0.03	-	-	-	-	-	-	231.1	40.50	0.78
Subtotal Ancillary			**$ 25.92**										**$ 29.41**
Professional													
Inpatient and Outpatient Surgery	277.1	$ 193.13	$ 4.46	$ 0.17	$ 0.00	$ 0.00	$ (0.18)	$ 0.00	$ 0.00	$ 0.00	287.7	$ 185.62	$ 4.45
Anesthesia	187.0	130.26	2.03	0.08	-	-	(0.04)	-	-	-	194.4	127.79	2.07
Inpatient Visits	628.9	122.88	6.44	0.26	-	-	(0.04)	-	-	-	654.3	122.15	6.66
MH/SA	49,022.4	19.58	79.98	4.16	-	23.17	(0.79)	(1.48)	2.15	-	64,866.7	19.83	107.19
Emergency Room	549.1	83.05	3.80	0.16	-	-	0.04	-	-	-	572.2	83.89	4.00
Office/Home Visits/Consults	4,137.5	98.79	34.06	1.52	-	(0.24)	3.67	-	-	-	4,292.9	109.04	39.01
Pathology/Lab	2,888.4	21.40	5.15	0.20	-	(0.07)	(0.13)	-	-	-	2,961.3	20.87	5.15
Radiology	764.1	23.87	1.52	0.06	-	-	(0.13)	-	-	-	794.3	21.91	1.45
Office Administered Drugs	13,834.6	24.56	28.32	1.11	-	(0.01)	(0.62)	-	-	-	14,372.0	24.05	28.80
Physical Exams	1,098.7	72.08	6.60	0.27	-	(0.06)	0.05	-	-	-	1,133.7	72.61	6.86
Therapy	19,547.4	22.20	36.16	1.61	-	-	3.55	-	-	-	20,417.8	24.28	41.32
Vision	684.0	35.44	2.02	0.09	-	-	0.27	-	-	-	714.5	39.97	2.38
Other Professional	4,517.6	31.24	11.76	0.53	-	(0.03)	1.48	-	-	-	4,709.7	35.01	13.74
Subtotal Professional			**$ 222.30**										**$ 263.08**
Total Medical Costs			**$ 611.20**										**$ 689.97**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SSI - Adults SFY 2026 Member Months: 423,342 Category of Service	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trend Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Acuity Adjustments Utilization Adjustment	SFY 2026 Projected Benefit Expense Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	1,477.6	$ 2,470.96	$ 304.25	$ 0.00	$ 0.00	$ 0.00	$ 0.48	$ 0.00	$ 0.46	$ 0.00	1,477.6	$ 2,478.59	$ 305.19
Inpatient Well Newborn	0.7	3,224.22	0.19	-	-	-	-	-	-	-	0.7	3,224.22	0.19
Inpatient MH/SA	63.2	881.66	4.64	0.06	-	-	-	(1.65)	0.02	-	41.5	887.45	3.07
Other Inpatient	444.2	279.88	10.36	-	-	-	-	-	0.04	-	444.2	280.96	10.40
Subtotal Inpatient Hospital			**$ 319.44**										**$ 318.85**
Outpatient Hospital													
Surgery	242.9	$ 1,951.78	$ 39.50	$ 1.56	$ 0.00	$ 0.00	$ 0.08	$ 0.00	$ (1.01)	$ 0.00	252.4	$ 1,907.57	$ 40.13
Non-Surg - Emergency Room	975.7	449.89	36.58	1.48	-	-	0.54	-	(0.51)	-	1,015.2	450.24	38.09
Non-Surg - Other	531.9	203.27	9.01	0.35	-	-	-	-	(0.33)	-	552.6	196.10	9.03
Observation Room	34.6	1,136.52	3.28	0.13	-	-	0.02	-	(0.07)	-	36.0	1,119.85	3.36
Treatment/Therapy/Testing	1,336.7	1,024.16	114.08	4.83	-	-	0.19	7.44	(1.97)	-	1,480.4	1,009.74	124.57
Other Outpatient	229.5	345.09	6.60	0.32	-	-	0.04	0.62	0.66	-	262.2	377.13	8.24
Subtotal Outpatient Hospital			**$ 209.05**										**$ 223.42**
Retail Pharmacy													
Prescription Drugs	19,296.7	$ 232.05	$ 373.15	$ 28.02	$ 21.33	$ 0.00	$ 0.00	$ 1.56	$ 18.72	$ 0.00	20,826.4	$ 255.13	$ 442.78
Subtotal Retail Pharmacy			**$ 373.15**										**$ 442.78**
Ancillary													
Transportation	816.1	$ 104.25	$ 7.09	$ 0.14	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	$ 0.00	$ 0.00	832.2	$ 103.82	$ 7.20
DME/Prosthetics	39,863.2	7.09	23.56	0.52	-	-	2.43	-	0.11	-	40,743.0	7.84	26.62
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	808.9	78.03	5.26	0.11	-	-	-	-	0.01	-	825.8	78.18	5.38
Subtotal Ancillary			**$ 35.91**										**$ 39.20**
Professional													
Inpatient and Outpatient Surgery	1,208.0	$ 156.36	$ 15.74	$ 0.30	$ 0.00	$ (0.01)	$ (0.65)	$ 0.00	$ 0.01	$ 0.00	1,230.3	$ 150.11	$ 15.39
Anesthesia	436.2	116.11	4.22	0.08	-	-	(0.11)	-	-	-	444.4	113.14	4.19
Inpatient Visits	2,777.8	90.59	20.97	0.43	-	-	0.15	-	-	-	2,834.8	91.22	21.55
MH/SA	991.1	90.56	7.48	0.17	-	0.20	1.76	(1.34)	0.07	-	862.6	116.02	8.34
Emergency Room	1,121.7	96.28	9.00	0.17	-	-	(0.16)	-	-	-	1,142.9	94.60	9.01
Office/Home Visits/Consults	5,212.2	101.30	44.00	0.98	-	(0.65)	5.23	-	-	-	5,251.3	113.25	49.56
Pathology/Lab	6,961.7	14.36	8.33	0.17	-	(0.08)	0.30	-	-	-	7,037.0	14.87	8.72
Radiology	3,274.6	41.37	11.29	0.21	-	-	(0.94)	-	-	-	3,335.5	37.99	10.56
Office Administered Drugs	52,756.3	13.57	59.67	1.18	-	(0.04)	(0.68)	-	-	-	53,764.2	13.42	60.13
Physical Exams	331.7	60.41	1.67	0.03	-	(0.01)	(0.01)	-	-	-	335.7	60.05	1.68
Therapy	1,315.9	22.62	2.48	0.06	-	-	0.36	-	-	-	1,347.8	25.82	2.90
Vision	185.9	66.49	1.03	0.02	-	-	0.06	-	0.03	-	189.5	72.19	1.14
Other Professional	6,304.5	45.51	23.91	0.48	-	(0.32)	0.05	-	-	-	6,346.6	45.61	24.12
Subtotal Professional			**$ 209.79**										**$ 217.29**
Total Medical Costs			**$ 1,147.34**										**$ 1,241.54**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: OCWI SFY 2026 Member Months: 288,631 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	137.9	$ 2,021.79	$ 23.23	$ 0.00	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ 0.00	$ 3.38	157.9	$ 2,022.55	$ 26.62
Inpatient Well Newborn	1.3	641.54	0.07	-	-	-	-	-	-	0.01	1.5	641.54	0.08
Inpatient MH/SA	39.8	798.56	2.65	0.05	-	-	0.01	(0.33)	-	0.35	40.9	801.50	2.73
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 25.95**										**$ 29.43**
Outpatient Hospital													
Surgery	255.9	$ 732.51	$ 15.62	$ 0.61	$ 0.00	$ 0.00	$ 0.02	$ 0.00	$ (0.43)	$ 2.30	303.6	$ 716.30	$ 18.12
Non-Surg - Emergency Room	719.0	384.51	23.04	0.92	-	-	0.19	-	(0.32)	3.46	855.7	382.68	27.29
Non-Surg - Other	344.7	163.60	4.70	0.18	-	-	-	-	(0.24)	0.68	407.8	156.54	5.32
Observation Room	51.1	389.74	1.66	0.06	-	-	-	-	(0.03)	0.25	60.7	383.81	1.94
Treatment/Therapy/Testing	853.2	182.55	12.98	0.58	-	-	0.02	1.46	(0.27)	2.14	1,128.0	179.89	16.91
Other Outpatient	81.3	143.13	0.97	0.05	-	-	-	0.04	0.15	0.18	104.0	160.44	1.39
Subtotal Outpatient Hospital			**$ 58.97**										**$ 70.97**
Retail Pharmacy													
Prescription Drugs	7,558.9	$ 57.41	$ 36.16	$ 1.18	$ 2.03	$ 0.00	$ 0.00	$ 0.11	$ 2.64	$ 6.11	9,105.8	$ 63.56	$ 48.23
Subtotal Retail Pharmacy			**$ 36.16**										**$ 48.23**
Ancillary													
Transportation	170.4	$ 99.28	$ 1.41	$ 0.03	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ 0.21	199.4	$ 98.68	$ 1.64
DME/Prosthetics	1,111.4	23.54	2.18	0.05	-	-	0.17	-	-	0.35	1,315.3	25.09	2.75
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	164.6	143.59	1.97	0.04	-	-	-	-	-	0.29	192.2	143.59	2.30
Subtotal Ancillary			**$ 5.56**										**$ 6.69**
Professional													
Inpatient and Outpatient Surgery	274.4	$ 175.83	$ 4.02	$ 0.08	$ 0.00	$ 0.00	$ (0.14)	$ 0.00	$ 0.00	$ 0.57	318.7	$ 170.56	$ 4.53
Anesthesia	121.6	118.39	1.20	0.02	-	-	(0.01)	-	-	0.18	141.9	117.54	1.39
Inpatient Visits	454.4	82.92	3.14	0.06	-	-	-	-	-	0.46	529.7	82.92	3.66
MH/SA	1,067.9	106.42	9.47	0.22	-	0.09	1.01	0.38	(0.01)	1.62	1,328.4	115.45	12.78
Emergency Room	798.2	81.33	5.41	0.11	-	-	0.02	-	-	0.81	934.0	81.59	6.35
Office/Home Visits/Consults	2,613.4	88.44	19.26	0.43	-	(0.10)	2.00	-	-	3.13	3,082.9	96.22	24.72
Pathology/Lab	7,703.1	18.99	12.19	0.25	-	(0.03)	0.54	-	-	1.88	9,030.1	19.71	14.83
Radiology	1,091.7	51.44	4.68	0.09	-	-	(0.18)	-	-	0.67	1,268.9	49.74	5.26
Office Administered Drugs	20,217.8	2.40	4.04	0.08	-	-	(0.09)	-	-	0.59	23,570.7	2.35	4.62
Physical Exams	456.3	52.86	2.01	0.04	-	-	(0.03)	-	-	0.30	533.5	52.18	2.32
Therapy	397.3	24.77	0.82	0.02	-	-	0.12	-	-	0.14	474.8	27.80	1.10
Vision	119.3	56.31	0.56	0.01	-	-	0.07	-	-	0.10	142.8	62.20	0.74
Other Professional	8,760.1	13.49	9.85	0.21	-	(0.02)	0.76	-	-	1.57	10,325.4	14.38	12.37
Subtotal Professional			**$ 76.65**										**$ 94.67**
Total Medical Costs			**$ 203.29**										**$ 249.99**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SMI Children SFY 2026 Member Months: 158,287 Category of Service	Base Year Adjusted Base Experience Utilization per 1,000	 Cost per Service	 PMPM	Trend Adjustments Utilization Adjustment	 Cost Adjustment	Reimbursement Adjustments Utilization Adjustment	 Cost Adjustment	Program and Policy Adjustments Utilization Adjustment	 Cost Adjustment	Acuity Adjustments Utilization Adjustment	SFY 2026 Projected Benefit Expense Utilization per 1,000	 Cost per Service	 PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	126.7	$ 2,483.61	$ 26.23	$ 0.79	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 2.28	141.6	$ 2,483.61	$ 29.30
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	2,628.2	562.46	123.19	5.45	-	-	14.18	(2.39)	-	11.81	2,945.5	620.23	152.24
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 149.42**										**$ 181.54**
Outpatient Hospital													
Surgery	81.4	$ 1,503.51	$ 10.20	$ 0.69	$ 0.00	$ 0.00	$ 0.01	$ 0.00	$ (0.45)	$ 0.88	93.9	$ 1,447.30	$ 11.33
Non-Surg - Emergency Room	828.8	384.42	26.55	1.87	-	-	0.24	-	(0.52)	2.37	961.1	380.92	30.51
Non-Surg - Other	367.2	149.68	4.58	0.31	-	-	-	-	(0.26)	0.38	422.5	142.29	5.01
Observation Room	8.6	1,079.32	0.77	0.05	-	-	0.01	-	(0.03)	0.07	9.9	1,055.07	0.87
Treatment/Therapy/Testing	484.5	243.48	9.83	1.30	-	-	0.04	9.05	(0.69)	1.64	1,075.4	236.22	21.17
Other Outpatient	59.2	295.77	1.46	0.21	-	-	0.01	0.58	0.96	0.28	102.6	409.17	3.50
Subtotal Outpatient Hospital			**$ 53.39**										**$ 72.39**
Retail Pharmacy													
Prescription Drugs	14,868.6	$ 57.46	$ 71.19	$ 5.61	$ 2.56	$ 0.00	$ 0.00	$ 0.16	$ 7.53	$ 7.32	17,602.6	$ 64.33	$ 94.37
Subtotal Retail Pharmacy			**$ 71.19**										**$ 94.37**
Ancillary													
Transportation	396.4	$ 113.82	$ 3.76	$ 0.27	$ 0.00	$ 0.00	$ (0.01)	$ 0.00	$ 0.00	$ 0.34	460.7	$ 113.56	$ 4.36
DME/Prosthetics	5,597.5	4.82	2.25	0.18	-	-	0.22	-	-	0.22	6,592.6	5.22	2.87
Dental	13.7	87.44	0.10	-	-	-	-	-	-	0.01	15.1	87.44	0.11
Other Ancillary	392.3	45.89	1.50	0.11	-	-	-	-	-	0.13	455.0	45.89	1.74
Subtotal Ancillary			**$ 7.61**										**$ 9.08**
Professional													
Inpatient and Outpatient Surgery	251.8	$ 148.23	$ 3.11	$ 0.22	$ 0.00	$ 0.00	$ (0.12)	$ 0.00	$ 0.00	$ 0.26	290.6	$ 143.27	$ 3.47
Anesthesia	100.0	119.99	1.00	0.07	-	-	(0.03)	-	-	0.09	116.0	116.88	1.13
Inpatient Visits	1,232.5	75.07	7.71	0.61	-	-	0.84	-	-	0.77	1,453.0	82.01	9.93
MH/SA	17,174.1	74.49	106.61	7.95	-	1.45	1.66	0.81	1.04	10.05	20,437.9	76.08	129.57
Emergency Room	881.6	87.39	6.42	0.46	-	-	0.02	-	-	0.58	1,024.4	87.62	7.48
Office/Home Visits/Consults	5,165.7	106.60	45.89	3.56	-	(0.23)	4.36	-	-	4.50	6,047.1	115.26	58.08
Pathology/Lab	5,000.2	19.73	8.22	0.58	-	(0.07)	(0.02)	-	-	0.73	5,754.5	19.69	9.44
Radiology	919.6	27.79	2.13	0.14	-	-	(0.14)	-	-	0.18	1,057.7	26.21	2.31
Office Administered Drugs	19,218.8	6.21	9.94	0.70	-	(0.01)	(0.12)	-	-	0.89	22,273.7	6.14	11.40
Physical Exams	871.3	75.20	5.46	0.39	-	(0.06)	0.07	-	-	0.49	1,002.2	76.04	6.35
Therapy	1,080.8	22.98	2.07	0.17	-	-	0.27	-	-	0.21	1,279.2	25.52	2.72
Vision	944.9	35.94	2.83	0.23	-	-	0.41	-	-	0.29	1,118.5	40.34	3.76
Other Professional	3,439.1	22.44	6.43	0.45	-	(0.03)	0.02	-	-	0.58	3,974.0	22.50	7.45
Subtotal Professional			**$ 207.82**										**$ 253.09**
Total Medical Costs			**$ 489.43**										**$ 610.47**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SMI TANF Adults	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
SFY 2026 Member Months: 224,772 Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	393.0	$ 2,590.18	$ 84.82	$ 0.85	$ 0.00	$ 0.00	$ 0.10	$ 0.00	$ 0.14	$ 6.11	425.2	$ 2,596.95	$ 92.02
Inpatient Well Newborn	0.1	1,648.64	0.01	-	-	-	-	-	-	-	0.1	1,648.64	0.01
Inpatient MH/SA	401.6	699.81	23.42	0.23	-	-	0.79	(1.37)	0.11	1.65	410.3	726.13	24.83
Other Inpatient	36.0	329.66	0.99	0.01	-	-	-	-	-	0.08	39.3	329.66	1.08
Subtotal Inpatient Hospital			**$ 109.24**										**$ 117.94**
Outpatient Hospital													
Surgery	239.4	$ 1,641.17	$ 32.74	$ 1.61	$ 0.00	$ 0.00	$ 0.03	$ 0.00	$ (0.86)	$ 2.39	268.6	$ 1,604.10	$ 35.91
Non-Surg - Emergency Room	1,307.3	377.62	41.14	1.66	-	-	0.32	-	(0.50)	3.03	1,456.4	376.14	45.65
Non-Surg - Other	375.0	160.32	5.01	0.24	-	-	-	-	(0.19)	0.36	419.9	154.89	5.42
Observation Room	26.6	884.94	1.96	0.09	-	-	-	-	(0.05)	0.15	29.8	864.83	2.15
Treatment/Therapy/Testing	1,186.9	324.03	32.05	1.90	-	-	0.11	5.93	(0.39)	2.82	1,581.3	321.91	42.42
Other Outpatient	210.4	184.19	3.23	0.20	-	-	0.02	0.16	0.54	0.30	253.4	210.71	4.45
Subtotal Outpatient Hospital			**$ 116.13**										**$ 136.00**
Retail Pharmacy													
Prescription Drugs	18,240.7	$ 128.08	$ 194.69	$ 34.78	$ 13.07	$ 0.00	$ 0.00	$ 1.58	$ 27.20	$ 19.29	23,454.6	$ 148.68	$ 290.61
Subtotal Retail Pharmacy			**$ 194.69**										**$ 290.61**
Ancillary													
Transportation	521.6	$ 97.78	$ 4.25	$ 0.22	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	$ 0.00	$ 0.31	586.6	$ 97.16	$ 4.75
DME/Prosthetics	8,340.7	8.66	6.02	0.33	-	-	0.53	-	0.05	0.49	9,476.8	9.40	7.42
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	442.7	66.96	2.47	0.13	-	-	-	-	-	0.18	498.2	66.96	2.78
Subtotal Ancillary			**$ 12.74**										**$ 14.95**
Professional													
Inpatient and Outpatient Surgery	838.0	$ 177.43	$ 12.39	$ 0.61	$ 0.00	$ (0.01)	$ (0.38)	$ 0.00	$ 0.01	$ 0.89	938.7	$ 172.70	$ 13.51
Anesthesia	369.0	115.45	3.55	0.17	-	-	(0.09)	-	-	0.26	413.7	112.84	3.89
Inpatient Visits	1,201.9	83.37	8.35	0.43	-	-	0.26	-	-	0.65	1,357.3	85.67	9.69
MH/SA	5,947.1	97.10	48.12	2.88	-	0.48	5.83	1.98	0.35	4.24	7,131.1	107.50	63.88
Emergency Room	1,384.2	88.25	10.18	0.51	-	-	(0.14)	-	-	0.75	1,555.5	87.17	11.30
Office/Home Visits/Consults	6,993.6	97.91	57.06	3.19	-	(0.41)	6.31	-	-	4.70	7,910.4	107.48	70.85
Pathology/Lab	9,458.0	17.66	13.92	0.72	-	(0.07)	0.39	-	-	1.06	10,619.9	18.10	16.02
Radiology	2,577.3	37.57	8.07	0.38	-	-	(0.64)	-	-	0.55	2,874.3	34.90	8.36
Office Administered Drugs	33,691.4	6.62	18.59	0.92	-	(0.02)	(0.33)	-	-	1.36	37,787.3	6.52	20.52
Physical Exams	418.4	76.86	2.68	0.13	-	(0.01)	-	-	-	0.20	468.4	76.86	3.00
Therapy	1,301.9	23.78	2.58	0.15	-	-	0.39	-	-	0.23	1,493.6	26.91	3.35
Vision	235.8	58.54	1.15	0.06	-	-	0.13	-	0.02	0.10	268.6	65.24	1.46
Other Professional	6,398.4	21.32	11.37	0.58	-	(0.09)	0.20	-	-	0.86	7,158.1	21.66	12.92
Subtotal Professional			**$ 198.01**										**$ 238.75**
Total Medical Costs			**$ 630.81**										**$ 798.25**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: SMI SSI Adults SFY 2026 Member Months: 156,170 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	1,743.6	$ 2,191.50	$ 318.42	$ 0.00	$ 0.00	$ 0.00	$ 0.34	$ 0.00	$ 0.52	$ 0.00	1,743.6	$ 2,197.42	$ 319.28
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	1,450.5	699.23	84.52	1.66	-	-	0.51	(3.01)	0.37	-	1,427.4	706.62	84.05
Other Inpatient	776.5	285.88	18.50	-	-	-	-	-	0.08	-	776.5	287.12	18.58
Subtotal Inpatient Hospital			**$ 421.44**										**$ 421.91**
Outpatient Hospital													
Surgery	279.3	$ 2,006.62	$ 46.70	$ 1.84	$ 0.00	$ 0.00	$ 0.06	$ 0.00	$ (1.34)	$ 0.00	290.3	$ 1,953.70	$ 47.26
Non-Surg - Emergency Room	1,925.5	425.40	68.26	2.74	-	-	0.64	-	(1.12)	-	2,002.8	422.52	70.52
Non-Surg - Other	582.6	181.06	8.79	0.34	-	-	-	-	(0.38)	-	605.1	173.53	8.75
Observation Room	45.2	2,576.22	9.71	0.39	-	-	0.01	-	(0.11)	-	47.0	2,550.71	10.00
Treatment/Therapy/Testing	1,502.2	654.97	81.99	3.75	-	-	0.20	12.24	(1.76)	-	1,795.1	644.55	96.42
Other Outpatient	300.5	243.16	6.09	0.30	-	-	0.03	0.40	0.83	-	335.1	273.96	7.65
Subtotal Outpatient Hospital			**$ 221.54**										**$ 240.60**
Retail Pharmacy													
Prescription Drugs	33,027.1	$ 218.86	$ 602.37	$ 45.13	$ 34.36	$ 0.00	$ 0.00	$ 2.53	$ 28.74	$ 0.00	35,640.3	$ 240.11	$ 713.13
Subtotal Retail Pharmacy			**$ 602.37**										**$ 713.13**
Ancillary													
Transportation	2,044.9	$ 94.54	$ 16.11	$ 0.32	$ 0.00	$ 0.00	$ (0.07)	$ 0.00	$ 0.00	$ 0.00	2,085.5	$ 94.14	$ 16.36
DME/Prosthetics	51,765.4	5.36	23.11	0.51	-	-	2.24	-	0.15	-	52,907.8	5.90	26.01
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	2,266.8	59.98	11.33	0.23	-	-	-	-	0.01	-	2,312.8	60.03	11.57
Subtotal Ancillary			**$ 50.55**										**$ 53.94**
Professional													
Inpatient and Outpatient Surgery	1,691.6	$ 140.82	$ 19.85	$ 0.39	$ 0.00	$ (0.02)	$ (0.65)	$ 0.00	$ 0.01	$ 0.00	1,723.1	$ 136.36	$ 19.58
Anesthesia	560.6	115.59	5.40	0.10	-	-	(0.17)	-	-	-	571.0	112.01	5.33
Inpatient Visits	4,763.5	81.72	32.44	0.67	-	-	0.94	-	-	-	4,861.8	84.04	34.05
MH/SA	18,937.8	37.58	59.30	1.31	-	0.23	4.23	(1.26)	2.90	-	19,027.2	42.07	66.71
Emergency Room	2,158.2	93.13	16.75	0.33	-	-	(0.35)	-	-	-	2,200.7	91.23	16.73
Office/Home Visits/Consults	8,700.5	108.50	78.67	1.71	-	(0.85)	7.29	-	-	-	8,795.6	118.45	86.82
Pathology/Lab	9,229.3	14.89	11.45	0.24	-	(0.09)	0.38	-	-	-	9,350.2	15.38	11.98
Radiology	4,397.3	36.35	13.32	0.25	-	-	(1.18)	-	-	-	4,479.8	33.19	12.39
Office Administered Drugs	124,053.7	4.83	49.92	0.97	-	(0.02)	(1.37)	-	-	-	126,414.5	4.70	49.50
Physical Exams	429.2	57.03	2.04	0.04	-	(0.01)	(0.03)	-	-	-	435.6	56.20	2.04
Therapy	1,569.6	23.24	3.04	0.07	-	-	0.42	-	-	-	1,605.7	26.38	3.53
Vision	224.9	67.23	1.26	0.02	-	-	0.09	-	0.03	-	228.5	73.53	1.40
Other Professional	7,024.1	37.17	21.76	0.44	-	(0.38)	0.45	-	-	-	7,043.5	37.94	22.27
Subtotal Professional			**$ 315.20**										**$ 332.33**
Total Medical Costs			**$ 1,611.10**										**$ 1,761.91**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: DUAL	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
Category of Service	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	552.3	$ 282.68	$ 13.01	$ 0.54	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.23	$ 0.00	575.2	$ 287.47	$ 13.78
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	40.4	231.68	0.78	0.04	-	-	0.24	-	-	-	42.5	299.49	1.06
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 13.79**										**$ 14.84**
Outpatient Hospital													
Surgery	138.3	$ 190.88	$ 2.20	$ 0.13	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	146.5	$ 188.42	$ 2.30
Non-Surg - Emergency Room	287.6	83.88	2.01	0.12	-	-	0.03	-	-	-	304.7	85.06	2.16
Non-Surg - Other	317.3	31.77	0.84	0.05	-	-	-	-	(0.03)	-	336.1	30.70	0.86
Observation Room	7.0	120.77	0.07	-	-	-	-	-	-	-	7.0	120.77	0.07
Treatment/Therapy/Testing	707.5	124.67	7.35	0.45	-	-	0.01	-	(0.05)	-	750.8	124.03	7.76
Other Outpatient	60.3	79.59	0.40	0.02	-	-	0.01	-	(0.01)	-	63.3	79.59	0.42
Subtotal Outpatient Hospital			**$ 12.87**										**$ 13.57**
Retail Pharmacy													
Prescription Drugs	268.1	$ 88.16	$ 1.97	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	268.1	$ 88.16	$ 1.97
Subtotal Retail Pharmacy			**$ 1.97**										**$ 1.97**
Ancillary													
Transportation	32.9	$ 32.86	$ 0.09	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	32.9	$ 32.86	$ 0.09
DME/Prosthetics	10,079.7	4.26	3.58	0.15	-	-	(0.01)	-	0.05	-	10,502.0	4.31	3.77
Dental	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Ancillary	70.7	27.16	0.16	0.01	-	-	-	-	-	-	75.1	27.16	0.17
Subtotal Ancillary			**$ 3.83**										**$ 4.03**
Professional													
Inpatient and Outpatient Surgery	336.9	$ 29.21	$ 0.82	$ 0.03	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	$ 0.01	$ 0.00	349.2	$ 28.52	$ 0.83
Anesthesia	227.0	17.97	0.34	0.02	-	-	-	-	-	-	240.4	17.97	0.36
Inpatient Visits	635.6	18.88	1.00	0.04	-	-	(0.01)	-	0.01	-	661.0	18.88	1.04
MH/SA	7,612.8	15.59	9.89	0.41	-	-	0.16	-	0.13	-	7,928.4	16.03	10.59
Emergency Room	65.7	36.54	0.20	0.01	-	-	-	-	-	-	69.0	36.54	0.21
Office/Home Visits/Consults	2,697.3	57.70	12.97	0.59	-	-	1.37	-	0.17	-	2,819.9	64.26	15.10
Pathology/Lab	785.8	6.41	0.42	0.02	-	-	(0.03)	-	0.01	-	823.2	6.12	0.42
Radiology	804.9	13.57	0.91	0.03	-	-	(0.06)	-	0.01	-	831.4	12.85	0.89
Office Administered Drugs	27,115.5	3.11	7.02	0.29	-	-	0.09	-	0.09	-	28,235.7	3.18	7.49
Physical Exams	36.8	19.55	0.06	-	-	-	-	-	-	-	36.8	19.55	0.06
Therapy	698.4	4.81	0.28	0.01	-	-	0.04	-	-	-	723.4	5.47	0.33
Vision	33.0	54.60	0.15	-	-	-	-	-	-	-	33.0	54.60	0.15
Other Professional	2,821.0	6.47	1.52	0.06	-	-	(0.01)	-	0.02	-	2,932.3	6.51	1.59
Subtotal Professional			**$ 35.58**										**$ 39.06**
Total Medical Costs			**$ 68.04**										**$ 73.47**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: Foster Care Children SFY 2026 Member Months: 42,435 Category of Service	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
	Utilization per 1,000	Cost per Service	PMPM	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	PMPM
Inpatient Hospital													
Inpatient Medical/Surgical/Non-Delivery	223.5	$ 2,118.19	$ 39.45	$ 0.80	$ 0.00	$ 0.00	$ 0.17	$ 0.00	$ 0.00	$ 0.00	228.0	$ 2,127.14	$ 40.42
Inpatient Well Newborn	-	-	-	-	-	-	-	-	-	-	-	-	-
Inpatient MH/SA	4,301.8	594.79	213.22	4.50	-	-	10.98	(0.46)	-	-	4,383.3	624.84	228.24
Other Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-
Subtotal Inpatient Hospital			**$ 252.67**										**$ 268.66**
Outpatient Hospital													
Surgery	106.6	$ 1,426.16	$ 12.67	$ 0.61	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ (0.65)	$ 0.00	111.7	$ 1,356.36	$ 12.63
Non-Surg - Emergency Room	732.6	343.31	20.96	1.06	-	-	0.65	-	(0.60)	-	769.7	344.09	22.07
Non-Surg - Other	534.6	139.41	6.21	0.29	-	-	-	-	(0.41)	-	559.5	130.61	6.09
Observation Room	8.1	1,172.14	0.79	0.04	-	-	-	-	(0.04)	-	8.5	1,115.66	0.79
Treatment/Therapy/Testing	449.3	231.01	8.65	0.50	-	-	0.05	1.71	(0.45)	-	564.1	222.50	10.46
Other Outpatient	63.8	208.73	1.11	0.11	-	-	0.01	0.31	0.78	-	88.0	316.50	2.32
Subtotal Outpatient Hospital			**$ 50.39**										**$ 54.36**
Retail Pharmacy													
Prescription Drugs	13,808.4	$ 40.38	$ 46.47	$ 3.46	$ 9.78	$ 0.00	$ 0.00	$ (0.09)	$ 2.15	$ 0.00	14,809.8	$ 50.05	$ 61.77
Subtotal Retail Pharmacy			**$ 46.47**										**$ 61.77**
Ancillary													
Transportation	435.7	$ 123.68	$ 4.49	$ 0.04	$ 0.00	$ 0.00	$ (0.03)	$ 0.00	$ 0.00	$ 0.00	439.5	$ 122.86	$ 4.50
DME/Prosthetics	27,217.2	2.07	4.69	0.06	-	-	0.77	-	-	-	27,565.4	2.40	5.52
Dental	156.3	52.97	0.69	0.01	-	-	(0.01)	-	-	-	158.6	52.21	0.69
Other Ancillary	298.8	45.78	1.14	0.01	-	-	-	-	-	-	301.4	45.78	1.15
Subtotal Ancillary			**$ 11.01**										**$ 11.86**
Professional													
Inpatient and Outpatient Surgery	344.3	$ 157.90	$ 4.53	$ 0.04	$ 0.00	$ 0.00	$ (0.22)	$ 0.00	$ 0.00	$ 0.00	347.3	$ 150.30	$ 4.35
Anesthesia	175.4	111.49	1.63	0.02	-	-	(0.03)	-	-	-	177.6	109.46	1.62
Inpatient Visits	1,012.5	77.98	6.58	0.07	-	-	1.05	-	-	-	1,023.3	90.30	7.70
MH/SA	100,184.1	35.61	297.33	3.29	-	3.85	2.66	17.59	6.96	-	108,516.8	36.68	331.68
Emergency Room	782.4	80.98	5.28	0.06	-	-	0.09	-	-	-	791.3	82.35	5.43
Office/Home Visits/Consults	5,349.7	102.91	45.88	0.50	-	(0.19)	4.61	-	-	-	5,385.8	113.19	50.80
Pathology/Lab	4,462.5	21.75	8.09	0.08	-	(0.06)	(0.06)	-	-	-	4,473.5	21.59	8.05
Radiology	772.9	23.91	1.54	0.02	-	-	(0.09)	-	-	-	783.0	22.53	1.47
Office Administered Drugs	6,258.1	1.92	1.00	0.01	-	-	(0.16)	-	-	-	6,320.7	1.61	0.85
Physical Exams	3,099.8	64.65	16.70	0.17	-	0.01	0.43	-	-	-	3,133.2	66.30	17.31
Therapy	14,238.6	21.48	25.49	0.31	-	-	4.71	-	-	-	14,411.8	25.40	30.51
Vision	1,218.0	45.22	4.59	0.05	-	-	0.87	-	-	-	1,231.3	53.70	5.51
Other Professional	4,250.7	22.53	7.98	0.09	-	-	1.16	-	-	-	4,298.6	25.77	9.23
Subtotal Professional			**$ 426.62**										**$ 474.51**
Total Medical Costs			**$ 787.16**										**$ 871.16**

South Carolina Department of Health and Human Services
Medicaid Managed Care Program
State Fiscal Year 2026 Capitation Rate Development
Prospective Adjustments

Region: Statewide Rate Cell: KICK	Base Year Adjusted Base Experience			Trend Adjustments		Reimbursement Adjustments		Program and Policy Adjustments		Acuity Adjustments	SFY 2026 Projected Benefit Expense		
SFY 2026 Deliveries: 22,356 Category of Service	Utilization per 1,000	Cost per Service	Cost per Delivery	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Cost Adjustment	Utilization Adjustment	Utilization per 1,000	Cost per Service	Cost per Delivery
Inpatient Hospital													
Inpatient Maternity Delivery	2,367.6	$ 1,839.38	$ 4,354.99	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00	2,367.6	$ 1,839.38	$ 4,354.99
Subtotal Inpatient Hospital			**$ 4,354.99**										**$ 4,354.99**
Outpatient Hospital													
Outpatient Hospital - Maternity	50.0	$ 477.08	$ 23.87	$ 0.95	$ 0.00	$ 0.00	$ 0.05	$ 0.00	$ (0.50)	$ 0.00	52.0	$ 468.43	$ 24.37
Subtotal Outpatient Hospital			**$ 23.87**										**$ 24.37**
Professional													
Maternity Delivery	889.4	$ 1,057.18	$ 940.30	$ 27.40	$ 0.00	$ (0.29)	$ (33.52)	$ 0.00	$ 0.00	$ 0.00	915.1	$ 1,020.55	$ 933.89
Maternity Anesthesia	1,120.0	305.85	342.55	10.30	-	-	(1.77)	-	-	-	1,153.7	304.31	351.08
Maternity Office Visits	8,054.2	76.26	614.25	22.11	-	(2.01)	119.41	-	-	-	8,317.8	90.62	753.76
Maternity Radiology	5,185.3	78.37	406.36	12.14	-	(0.07)	(4.61)	-	-	-	5,339.3	77.50	413.82
Maternity Non-Delivery	3.0	96.45	0.29	0.01	-	-	-	-	-	-	3.1	96.45	0.30
Subtotal Professional			**$ 2,303.75**										**$ 2,452.85**
Total Medical Costs			**$ 6,682.61**										**$ 6,832.21**

Appendix 8: Development of Relative Acuity by Rate Cell

South Carolina Department of Health and Human Services
SFY 2026 Capitation Rate Development
SFY 2024 Member Months and Morbidity

		SFY 2024									
		All Other		Disenrolled Members		Categorically Ineligible		Returning Members		Total	
Population	Rate Cell	MMs	Morbidity	MMs	Morbidity	MMs	Morbidity	MMs	Morbidity	MMs	Morbidity
TANF Children	TANF - 0 - 2 Months, Male & Female	75,863	1.00	-	1.00	-	-	-	1.00	75,863	1.00
TANF Children	TANF - 3 - 12 Months, Male & Female	335,880	1.00	-	1.00	-	-	-	1.00	335,880	1.00
TANF Children	TANF - Age 1 - 6, Male & Female	1,612,862	1.00	193,750	0.70	-	-	491,979	0.90	2,298,591	0.95
TANF Children	TANF - Age 7 - 13, Male & Female	2,115,216	1.00	255,559	0.65	-	-	446,980	0.90	2,817,755	0.95
TANF Children	TANF - Age 14 - 18, Male	636,246	1.00	165,291	0.70	-	-	135,586	1.00	937,123	0.95
TANF Children	TANF - Age 14 - 18, Female	600,173	1.00	143,221	0.80	-	-	141,992	1.00	885,386	0.97
TANF Children	**Subtotal**	**5,376,240**	**1.00**	**757,821**	**0.70**	**-**	**-**	**1,216,537**	**0.92**	**7,350,598**	**0.96**
TANF Adult	TANF - Age 19 - 44, Male	110,737	1.00	83,013	0.70	150,666	0.50	52,930	1.00	397,346	0.75
TANF Adult	TANF - Age 19 - 44, Female	709,716	1.00	318,673	0.80	134,226	0.50	340,311	0.90	1,502,926	0.89
TANF Adult	TANF - Age 45+, Male & Female	163,493	1.00	75,492	0.80	-	-	50,097	1.00	289,082	0.95
TANF Adult	**Subtotal**	**983,946**	**1.00**	**477,178**	**0.79**	**-**	**-**	**443,338**	**0.93**	**2,189,354**	**0.89**
Disabled	SSI - Children	123,674	1.00	4,248	1.00	-	-	12,397	1.00	140,319	1.00
Disabled	SSI - Adults	389,032	1.00	16,200	1.00	-	-	39,783	1.00	445,015	1.00
Disabled	**Subtotal**	**512,706**	**1.00**	**20,448**	**1.00**	**-**	**-**	**52,180**	**1.00**	**585,334**	**1.00**
SMI	SMI Children	133,437	1.00	31,169	0.60	-	-	28,999	0.90	193,605	0.92
SMI	SMI TANF Adults	169,851	1.00	76,573	0.80	-	-	71,656	0.90	318,080	0.93
SMI	SMI SSI Adults	147,326	1.00	4,752	1.00	-	-	16,040	1.00	168,118	1.00
SMI	**Subtotal**	**450,614**	**1.00**	**112,494**	**0.78**	**-**	**-**	**116,695**	**0.93**	**679,803**	**0.96**
Pregnant Women	OCWI	169,601	1.00	124,562	0.60	-	-	98,854	1.00	393,017	0.87
Foster	Foster Care Children	53,347	1.00	-	1.00	-	-	-	1.00	53,347	1.00
Composite		**7,546,454**	**1.00**	**1,492,503**	**0.76**	**-**	**-**	**1,927,604**	**0.94**	**11,251,453**	**0.95**
Composite (Normalized for SFY 2026 Membership)											**0.96**

South Carolina Department of Health and Human Services
SFY 2026 Capitation Rate Development
SFY 2026 Member Months and Morbidity

		SFY 2026									
		All Other		Disenrolled Members		Categorically Ineligible		Returning Members		Total	
Population	Rate Cell	MMs	Morbidity	MMs	Morbidity	MMs	Morbidity	MMs	Morbidity	MMs	Morbidity
TANF Children	TANF - 0 - 2 Months, Male & Female	77,252	1.00	-	1.00	-	-	-	1.00	77,252	1.00
TANF Children	TANF - 3 - 12 Months, Male & Female	338,280	1.00	-	1.00	-	-	-	1.00	338,280	1.00
TANF Children	TANF - Age 1 - 6, Male & Female	2,088,312	1.00	-	0.70	-	-	47,909	0.90	2,136,221	1.00
TANF Children	TANF - Age 7 - 13, Male & Female	2,526,526	1.00	-	0.65	-	-	68,002	0.90	2,594,528	1.00
TANF Children	TANF - Age 14 - 18, Male	821,335	1.00	-	0.70	-	-	24,178	1.00	845,513	1.00
TANF Children	TANF - Age 14 - 18, Female	792,444	1.00	-	0.80	-	-	24,914	1.00	817,358	1.00
TANF Children	**Subtotal**	**6,644,149**	**1.00**	**-**	**-**	**-**	**-**	**165,003**	**0.93**	**6,809,152**	**1.00**
TANF Adult	TANF - Age 19 - 44, Male	151,171	1.00	-	0.70	-	0.50	9,045	1.00	160,216	1.00
TANF Adult	TANF - Age 19 - 44, Female	1,043,820	1.00	-	0.80	-	0.50	69,118	0.90	1,112,937	0.99
TANF Adult	TANF - Age 45+, Male & Female	191,043	1.00	-	0.80	-	-	10,542	1.00	201,585	1.00
TANF Adult	**Subtotal**	**1,386,034**	**1.00**	**-**	**-**	**-**	**-**	**88,705**	**0.93**	**1,474,738**	**1.00**
Disabled	SSI - Children	139,577	1.00	-	1.00	-	-	9,854	1.00	149,431	1.00
Disabled	SSI - Adults	406,515	1.00	-	1.00	-	-	16,827	1.00	423,342	1.00
Disabled	**Subtotal**	**546,092**	**1.00**	**-**	**-**	**-**	**-**	**26,681**	**1.00**	**572,773**	**1.00**
SMI	SMI Children	155,206	1.00	-	0.60	-	-	3,081	0.90	158,287	1.00
SMI	SMI TANF Adults	214,414	1.00	-	0.80	-	-	10,358	0.90	224,772	1.00
SMI	SMI SSI Adults	152,193	1.00	-	1.00	-	-	3,977	1.00	156,170	1.00
SMI	**Subtotal**	**521,813**	**1.00**	**-**	**-**	**-**	**-**	**17,416**	**0.94**	**539,229**	**1.00**
Pregnant Women	OCWI	264,211	1.00	-	0.60	-	-	24,421	1.00	288,631	1.00
Foster	Foster Care Children	42,435	1.00	-	1.00	-	-	-	1.00	42,435	1.00
Composite		**9,404,734**	**1.00**	**-**	**-**	**-**	**-**	**322,226**	**0.95**	**9,726,958**	**1.00**

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Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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