§ 108A-146.7. Managed care component.

(a) The managed care component is an amount of money that is a portion of the total paid capitation for all rating groups not associated with newly eligible individuals in all capitated contracted plan types for the previous data collection period. The managed care component is calculated by adding the aggregate inpatient subcomponents for all the rating groups calculated under subsection (b) of this section and the aggregate outpatient subcomponents for all the rating groups calculated under subsection (c) of this section.

(b) The inpatient subcomponent is an amount calculated for each rating group not associated with newly eligible individuals by multiplying the paid capitation for the applicable rating group in the previous data collection period by the percentage that is calculated by (i) multiplying the inpatient portion of the statewide capitation rate for the applicable rating group by the inpatient hospital financing percentage, (ii) multiplying that product by the nonfederal share for not newly eligible individuals, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

(c) The outpatient subcomponent is an amount calculated for each rating group not associated with newly eligible individuals by multiplying the paid capitation for the applicable rating group in the previous data collection period by the percentage that is calculated by (i) multiplying the outpatient portion of the statewide capitation rate for the applicable rating group by the outpatient hospital financing percentage, (ii) multiplying that product by the nonfederal share for not newly eligible individuals, and (iii) dividing that product by the statewide capitation rate for the applicable rating group.

(d) Repealed by Session Laws 2023-7, s. 1.7(d), effective April 1, 2023, and applicable to assessments imposed on or after that date. (2021-61, s. 2; 2023-7, s. 1.7(d).)