§ 108A-146.9. Fee-for-service component.

(a) The fee-for-service component is an amount of money that is a portion of all the Medicaid fee-for-service payments made to acute care hospitals during the previous data collection period for claims with a date of service on or after July 1, 2021. The fee-for-service component consists of a subcomponent pertaining to claims for which there is no third-party coverage and a subcomponent pertaining to claims for which there is third-party coverage.

(b) The subcomponent pertaining to claims for which there is no third-party coverage is the sum of the inpatient amount and the outpatient amount described in this subsection:

(1) The inpatient amount is the product of the total fee-for-service payments for claims for which there is no third-party coverage made to all acute care hospitals for inpatient hospital services multiplied by the inpatient hospital financing percentage and multiplied by the difference of one minus the FMAP.

(2) The outpatient amount is the product of the total fee-for-service payments for claims for which there is no third-party coverage made to all acute care hospitals for outpatient hospital services multiplied by the outpatient hospital financing percentage and multiplied by the difference of one minus the FMAP.

(c) The subcomponent pertaining to claims for which there is third-party coverage is the product of the total fee-for-service payments for claims for which there is third-party coverage made for inpatient hospital services and outpatient hospital services to (i) public acute care hospitals, (ii) private acute care hospitals, and (iii) critical access hospitals multiplied by the difference of one minus the FMAP.

(d) The fee-for-service component is calculated by adding together the subcomponent pertaining to claims for which there is no third-party coverage and the subcomponent pertaining to claims for which there is third-party coverage. (2021-61, s. 2.)