§ 108A-147.5. Presumptive service cost component.

(a) For every State fiscal quarter prior to the fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the presumptive service cost component is zero.

(b) For the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the presumptive service cost component is the product of forty-eight million seven hundred fifty thousand dollars ($48,750,000) multiplied by the number of months in that State fiscal quarter in which G.S. 108A-54.3A(a)(24) is effective during any part of the month.

(c) For the first State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, the presumptive service cost component is one hundred forty-six million two hundred fifty thousand dollars ($146,250,000).

(d) For the second State fiscal quarter after the State fiscal quarter in which G.S. 108A-54.3A(a)(24) becomes effective, and for each State fiscal quarter thereafter, the presumptive service cost component is an amount of money that is the greatest of the following:

(1) The prior quarter's presumptive service cost component amount.

(2) The prior quarter's presumptive service cost component amount increased by a percentage that is the sum of each monthly percentage change in the Consumer Price Index: Medical Care for the most recent three months available on the first day of the current quarter.

(3) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for standard benefit plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for standard benefit plans.

(4) The prior quarter's presumptive service cost component amount increased by the percentage change in the weighted average of the base capitation rates for BH IDD tailored plans for all rating groups associated with newly eligible individuals compared to the prior quarter. The weight for each rating group shall be calculated using member months documented in the Medicaid managed care capitation rate certification for BH IDD tailored plans.

(5) The amount produced from multiplying 1.15 by the highest amount produced when calculating, for each quarter that is at least two and not more than five quarters prior to the current quarter, the actual nonfederal expenditures for the applicable quarter minus the HASP health advancement component calculated under G.S. 108A-147.6 for the applicable quarter. (2023-7, s. 1.6(b); 2023-134, s. 9E.23(c2).)