Overview of Medicaid Rate Setting

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Florida Medicaid Reimbursement

- The Florida Medicaid program makes payments to providers in two ways:
  - Capitated payments to health plans who in turn make payments for services rendered to providers in the plan network.
  - Fee-For-Service (FFS) payments made by the Florida Medicaid program directly to individual providers.

Florida Medicaid Reimbursement

- Although a majority of recipients in the Florida Medicaid program are enrolled in managed care, a population remains in the FFS program.
- The remaining FFS population is made up, for the most part, of those who have Medicaid coverage for a limited set of services, or for a limited amount of time AND of those who are newly eligible for the Medicaid program who have yet to enroll in a health plan.

Florida Medicaid Reimbursement

- The Florida Medicaid program must set rates for both managed care and FFS provider reimbursement.
- FFS rates are used in developing the Managed Care rates, along with data from the health plans.

Managed Care Plan Rate Setting

- Plans are paid a capitation rate for each recipient enrolled in their plan.
- Rates paid to the health plans must be actuarially sound.

Managed Care Plan Rate Setting

- Capitation rate is the *per-member-per-month amount (PMPM)*, including any adjustments, that is paid by the Agency to a health plan for *each* Medicaid recipient enrolled under a contract for the provision of Medicaid services during the payment *period*.
- The capitation rates reflect historical *utilization* and *spending* for covered services projected forward and are adjusted to reflect the level of care profile (*risk*) for enrollees in each health Plan.

Managed Care Rate Setting

- Rates must be approved by CMS.
- "Actuarial Soundness" required by 42 CFR 438.6(c).
- Rates must be certified; changes to rates must be accompanied by documentation from the actuary.
- Florida contracts with an actuarial firm for rate setting: Milliman.

Managed Care Plan Rate Setting

- Actuarial Soundness:
- Developed by a qualified actuary and provide for all reasonable, appropriate, and attainable costs of providing the required care and administering the contract.
  - Benefit costs
  - Administrative expenses
  - Fees and taxes
  - Cost of capital

Fee-For-Service Rate Setting

- Fee-For-Service payments made by the Florida Medicaid program directly to individual providers:
  - Cost Based Reimbursement
  - Prospective Payment Systems
  - All Inclusive Case Rates

LONG TERM CARE

Nursing Home Rate Setting

- Rates for FFS Nursing Home providers are set by the Agency as a per diem payment.
- Rate components are established in statute and through the Medicaid State Plan.
- Mechanisms for facilities to increase their rates have been established through statute and proviso in the GAA.

Nursing Home Rate Setting Elements

- Elements included in the Nursing Home Rate
  - Operating- administration, laundry and linen, plant operations, and housekeeping expenses.
  - Direct Patient Care- wage and benefit costs of direct care nursing staff and contracted direct care nursing staff.
  - Indirect Patient Care- non-direct care nursing, dietary, other patient care (e.g., social services and medical records) and ancillary services.
  - Property- property insurance, property taxes, home office property costs, and either: interest and depreciate or a fair rental value.
  - Return on Equity- rate of return based on the equity in the facility and is only paid to providers who receive interest and depreciation for property reimbursement.

Nursing Home Rate Setting Fact Sheet

Nursing Home FFS Rate Setting	
Type of Rate	Cost Based Per Diem Rate
Facility Specific Rate	Yes, each facility has an individual rate
Data Used	Cost Reports
Rate Period	Twice annually (1/1 and 7/1)- moving to once annually beginning 9/1/15 (Per statutory direction)
Current Rate Range	$161.82 - $294.34
Current Statewide Average Rate	$228.76
Rate Adjustments Allowed?	Yes, rates can be adjusted based on submission of modified cost reports or audit results

Nursing Home Rate Setting Fact Sheet

Nursing Home FFS Rate Setting	
Audit Process	Provider cost reports selected for audit based on several different criteria, including time period since last audited, initial cost report status, interim rate cost reports and discrepancies in cost reports discovered during preliminary review
	Cost reports and additional documentation are assigned to contracted CPA firms for audit review and analysis, which includes meeting with providers, site visits, exit conferences and preparation of work papers for each audit
	Audit findings and analysis are then sent to an AHCA analyst for compliance and acceptability review and analysis
	Once AHCA analyst finalizes audit report with CPA firm, the audit report is issued and is sent via certified mail to the facility. The audit report provides 21 day hearing rights
	Once audit is closed the audit is sent to Cost Reimbursement Unit for retroactive rate adjustment

Nursing Home Rate Setting Fact Sheet

Nursing Home FFS Rate Setting	
Local funding or Quality Assessments?	Yes, Nursing Home Quality Assessment
Buy- Back Option	Yes, Legislative proviso authorizes the buy-back of rate reductions effective on or after January 1, 2008, contingent on the nonfederal share being provided through nursing home quality assessments
Other Rate Enhancements	Yes, additional $285.50 per day paid for Medically Complex recipients under the age of 21 (January 1, 2015)
Statutory Parameters?	Yes, see sections 409.908 (2)(a)1 and 409.9082, F.S.

Nursing Home Rate Setting Fact Sheet

Nursing Home FFS Rate Setting	
Recurring Rate Cuts	Yes, 7 recurring cuts totaling $720,491,489
Targets?	Yes, Provider Specific Targets and New Provider Target Limitations
Rate Freeze?	Yes, Unit Cost at 6/30/11 of $160.83 prior to rate buy-backs through the nursing home quality assessment
Ceilings?	Yes, 6 classes based on Facility Size and Geographic Region
Exemptions?	No

Nursing Home Rate Setting Steps

- Establish rate based on most recent filed cost report with no recurring rate reductions or buy-backs.
- Apply recurring rate reductions as appropriate.
- Compare Unit Cost/ Rate freeze provisions.
- Apply buy-backs as appropriate.
- Establish final rate.

Hospice Rate Setting

- Rates for FFS Hospice providers are set by the Agency.
- Rate components are established in statute, through the Medicaid State Plan, and through the Medicare program.
- Mechanisms for facilities to increase their rates have been established through statute and proviso in the GAA.

Hospice Rate Setting

- The Medicaid program can make two different types of payment for hospice services:
  - Level of Care: Daily care in any setting.
  - Room and Board: Only when recipient is in the nursing home.
    - Passed through to Nursing Home.

Hospice Rate Setting Fact Sheet

Hospice FFS Rate Setting	
Type of Rate	Level of Care Rates; rates are established based on Medicare hospice national rates and adjusted for regional differences in wages Room and Board Rates; rates established based on 95 percent of the weighted average Nursing Home rates

Hospice Rate Setting Fact Sheet

Hospice FFS Rate Setting	
Facility Specific Rate	Room and Board rate: Yes Level of Care rate: Yes
Data Used	Medicare hospice national rates and 95 percent of the weighted average Nursing Home rates
Rate Period	Room and Board Rates are set twice annually, on January 1 and July 1 each year Level of Care Rates set once annually, effective October 1 each year

Hospice Rate Setting Fact Sheet

Hospice FFS Rate Setting			
Current Rate Range: Room and Board	$202.09 - $245.78		
Current Statewide Average Rate: Room and Board	$216.29		
Current Rate Range: Level of Care Rate	Routine	$135.66	$164.76
	Continuous	$32.93	$40.03
	Inpatient	$152.21	$177.94
	General	$608.55	$730.32
Current Statewide Average Rate: Level of Care Rate	Routine	$149.61	
	Continuous	$36.35	
	Inpatient	$164.93	
	General	$667.61	

Hospice Rate Setting Fact Sheet

Hospice FFS Rate Setting	
Rate Adjustments Allowed?	No, retroactive rate adjustments are not allowed; however, the rates may be adjusted prospectively
Audit Process	No
Local funding or Quality Assessments?	Yes, utilize Nursing Home Quality Assessment
Buy- Back Option?	Yes, Proviso authorizes buy-back of rate reductions effective on or after January 1, 2008. This is contingent on the nonfederal share being provided through nursing home quality assessments

Hospice Rate Setting Fact Sheet

Hospice FFS Rate Setting	
Other Rate Enhancements?	No
Statutory Parameters?	Yes, see section 409.908 (10), F.S.
Recurring Rate Cuts?	Yes, utilizing Nursing Home rate setting rates
Targets?	No
Rate Freeze	No
Ceilings?	No
Exemptions?	No

Hospice Rate Setting Steps

- Level of Care – based on Medicare levels, adjusted for wage differences
- Room and Board – set as 95% of the weighted average Nursing Home rates

Long-term Care Program Rate Setting

- The Statewide Medicaid Managed Care program has two components: the Long-Term Care (LTC) program and the Managed Medical Assistance (MMA) program.
  - The LTC program covers most recipients 18 years of age or older who need nursing facility level of care.
  - The LTC program provides institutional long-term care and home and community based waiver services.

Long-term Care Program Rate Setting

- Competitive procurement required
- "Best value" to the state included negotiated capitation rates for the period of August 1, 2013 through August 31, 2014.
  - Detailed Data Book & sample methodology in ITN.
  - Bidders submitted cost proposals and methodology.
  - Actuarially sound rate range was published in the ITN.
  - Agency negotiated at the bottom of the range.
  - Negotiations resulting in a rate schedule of common base rates for all awarded capitated health plans in each region.

Long-term Care Program Rate Setting

- State established (remaining contract years):
  - Developed by Agency's contracted actuary.
  - Uses historical data and incorporates actual LTC program experience as sufficient validated data becomes available.
  - Transparent process:
    - Base data summaries provided to plans.
    - Meetings with plans to review data and issues, draft rates.
    - Full actuarial reports provided to plans.

Long-term Care Program Rate Setting

- Recipient enrolled in the LTC component of the SMMC program can reside either in a Nursing Home or in a home and community based setting.
- A distinct base rate is set for each setting and geographic region.
- The actual capitation rate paid to each plan is a blended capitation rate based on the plan's own case mix with transition percentage applied
- Statutory transition targets at s. 409.983 (3) & (5).

Long-term Care Program Rate Setting

- Blended capitation rate is a payment model where two rates are blended, one for the nursing home population and one for the community-based population.
- FFS rates are critical, particularly for nursing facilities and hospices.

Reflecting Plan Enrollment Risk Differences

- Base rates are regional averages for the rate cell.
- When there are multiple plans, there may be risk differences among plans, even in a single rate group.
- Mechanism to better match payment to enrolled risk when there are multiple plans.
- "Re-sizes" the slices of the pie, but does not change the size of the pie
- LTC –
  - Blend based on plan's own casemix
  - Community High Risk Pool further adjusts for very high cost community residents

Rate Setting and Adjustment Schedule

- LTC base rates are updated annually, with new rates effective on September 1 of each year.
- Plan-specific blended rates are updated monthly based on most recent enrollment.

Long-term Care Program Rate Setting Components

- Long-term Care Plans are required to:
  - Pay nursing facilities an amount equal to the nursing home-specific payment rates set by the Agency.
  - Pay hospice providers through a prospective system for each enrollee an amount equal to the per diem rate set by the Agency.
- All Medicaid enrolled nursing homes and hospices are required to **participate** with every long-term care plan in their region.

Long-term Care Program Rate Setting Components

- Incentives Shift to Home & Community Based Care Services:
  - The law requires that managed care plan rates be adjusted to provide an incentive to shift services from nursing facilities to community based care.
  - Transition percentages apply until no more than 35% of the plan's enrollees are in nursing facilities.
- An enrollee who starts the year in a nursing home is continued to be treated as nursing home for rate blended for the entire year, even after transition.
- Plans "win" financially if they beat the target, "lose" if they do not meet the target.

Long-term Care Program
Rate Setting Components

Rate Blend Example -- Numbers are Illustrative Only					
	Nursing Home	Community	Total		
Regional Casemix	47.3%	52.7%	100.0%		
Base Capitation Rate	$5,433.60	$1,361.34	$3,288.45		
Transition Target (2%) Applied	45.3%	54.7%	100.0%		
Regional Blended Rate	$5,433.60	$1,361.34	$3,207.01		
	Actual Enrollment		***With transition***		Blended
	Nursing Home	Community	Nursing Home	Community	Rate
Plan 1	55.9%	44.1%	53.9%	46.1%	$3,557.30
Plan 2	43.5%	56.5%	41.5%	58.5%	$3,051.77
Plan 3	37.3%	62.7%	35.3%	64.7%	$2,799.03
Plan 4	47.3%	52.7%	45.3%	54.7%	$3,205.07
Region Total	47.3%	52.7%	45.3%	54.7%	$3,207.01

Long-term Care Program
Rate Setting Steps

Steps in LTC Capitation Rate Development:

1. Start with best available validated historical utilization and cost data.
2. Adjust for any changes to the program (e.g., benefit change, nursing home and hospice fee schedule change).
3. Trend to rate period.
4. Add allowance for capitated plan administrative costs and margin.

ACUTE CARE/ PREVENTIVE CARE

Hospital Inpatient Rate Setting

- Rates are set by the Agency as a single base rate which is adjusted based on patient acuity and procedures required.
- Rate components are established in statute, proviso, and through the Medicaid State Plan.

Hospital Inpatient Rate Setting Fact Sheet

Hospital Inpatient FFS Rate Setting	
Type of Rate	Prospective Payment System; Diagnosis Related Groups
Facility Specific Rate	No
Data Used	FFS Claims data/ Discharge data
Rate Period	Annual, rates set once a year effective July 1 of each year

Hospital Inpatient Rate Setting Fact Sheet

Hospital Inpatient FFS Rate Setting	
Current Rate Range	Standard Base Rate of $3,078.93
Current Statewide Average Rate	Standard Base Rate of $3,078.93
Rate Adjustments Allowed?	No
Audit Process?	No
Local funding or Quality Assessments?	Yes, IGTs are used
Buy- Back Option?	No, effective 7/1/2014 historical buy-backs funded through LIP

Hospital Inpatient Rate Setting Fact Sheet

Hospital Inpatient FFS Rate Setting		
2014-15 DRG Parameters	Neonate service adjustor	1.30
	Pediatric service/age adjustor	1.30
	Free-standing rehab provider adjustor	2.701
	Rural provider adjustor	2.119
	LTAC provider adjustor	2.125
	High Medicaid and high outlier provider adjustor	2.526
	Outlier threshold	$60,000
	Marginal cost percentage	60%
	Documentation and Coding Adjustment	5%

Hospital Inpatient Rate Setting Fact Sheet

Hospital Inpatient FFS Rate Setting	
Statutory Parameters?	Yes, see 409.905 (5)(c), F.S.
Recurring Rate Cuts?	“Baked in” to DRG base
Targets?	No
Rate Freeze?	No
Ceilings?	No
Exemptions?	No

Hospital Inpatient Rate Setting Steps

- Legislature determines DRG parameters based on simulation modeling performed by the Agency.
  - Simulations based on historical FFS claims data.
- Very streamlined as compared to cost-based reimbursement.

Hospital Outpatient Rate Setting

- Rates for hospital outpatient service providers are set by the Agency as a per diem payment.
- Rate components are established in statute and through the Medicaid State Plan.

Hospital Outpatient Rate Setting Elements

- The reimbursement methodologies outline allowable costs for the purposes of outpatient cost reporting and rate setting. General Cost Factors include:
  - Ancillary – Support services such as room and board, surgery, laboratory, radiology, pharmacy, and therapy.
  - Routine – Services including the regular room, dietary and nursery services, and minor medical and surgical supplies.
  - Malpractice – Malpractice insurance costs.
  - Total Costs – Total expenses.
  - Charges – Revenues.

Hospital Outpatient Rate Setting Fact Sheet

Hospital Outpatient FFS Rate Setting	
Type of Rate	Cost Based Per Diem Rate
Facility Specific Rate	Yes, each facility has an individual rate
Data Used	Cost Reports
Rate Period	Annual, effective July 1 of each year
Current Rate Range	$9.15 - $366.92
Current Statewide Average Rate	$87.53
Rate Adjustments Allowed?	Yes, rates can be adjusted based on submission of modified cost reports or audit results

Hospital Outpatient Rate Setting Fact Sheet

Hospital Outpatient FFS Rate Setting	
Audit Process	100 percent of provider cost reports used for rate setting are selected for audit.
	Cost reports and additional documentation are submitted by provider to the contracted CPA firm for audit review and analysis, which includes meeting with providers, site visits, exit conferences and preparation of work papers for each audit.
	Once audit report is finalized by the CPA firm, the audit report is issued and is sent via certified mail to the facility.
	Once audit is closed the audit is sent to Cost Reimbursement Unit by CPA firm for retroactive rate adjustment.

Hospital Outpatient Rate Setting Fact Sheet

Hospital Outpatient FFS Rate Setting	
Local funding or Quality Assessments?	Yes, IGTs are used
Buy- Back Option?	No, effective 7/1/2014 historical buy-backs funded through LIP
Other Rate Enhancements?	No
Statutory Parameters?	Yes, see section 409.905 (6), F.S.

Hospital Outpatient Rate Setting Fact Sheet

Hospital Outpatient FFS Rate Setting	
Recurring Rate Cuts?	Yes
Targets?	Yes
Rate Freeze?	Yes
Ceilings?	Yes
Exemptions?	Yes

Hospital Outpatient Rate Setting Steps

- Establish rate based on most recent filed cost report with no recurring rate reductions or buy-backs.
- Apply recurring rate reductions as appropriate.
- Compare Unit Cost/ Rate freeze provisions.
- Apply buy-backs as appropriate.
- Establish final rate.

County Health Department Rate Setting

- Rates for county health departments are set by the Agency as an all inclusive rate based on submitted cost reports.
  - CHDs receive this one rate for each visit by a recipient, regardless of which of an approved array of services is provided.
- Rates components are established in statute and through the Medicaid State Plan.

County Health Department Rate Setting Elements

- The reimbursement methodologies outline allowable costs for the purposes of county health department reporting and rate setting. General Cost Factors include:
  - Allowable Services – Medical, laboratory, X-Ray, Nutrition Program, dental, Psychology, Physical Therapy, Mobile Satellite Clinic, School-Based Medical Clinic.
  - Administrative & Facility Overhead Costs – Administration, Building Maintenance and Repairs, security, General Insurance, Rent, Depreciation, Transportation, Interest.

County Health Department Rate Setting Fact Sheet

County Healthy Department FFS Rate Setting	
Type of Rate	Cost Base/ All Inclusive Rate
Facility Specific Rate	Yes, each facility has an individual rate
Data Used	Cost Reports
Rate Period	Annual, effective July 1 of each year
Current Rate Range	$90.00 - $180.00
Current Statewide Average Rate	$149.10
Rate Adjustments Allowed?	Yes, rates can be adjusted based on submission of modified cost reports or audit results

County Health Department Rate Setting Fact Sheet

County Health Department FFS Rate Setting	
Audit Process	The Department of Health submits provider cost reports to the Agency to be used for setting rates
	100 percent of provider cost reports are selected for Desk Audit Review performed by Agency staff
	If the Desk Audit Review identifies changes that need to be made the Agency sends the provider cost report back to DOH for Correction and/or Agency staff make the necessary change
	Once the desk audit is complete the provider cost report will then be used for rate setting

County Health Department Rate Setting Fact Sheet

County Health Department FFS Rate Setting	
Local funding or Quality Assessments?	Yes, IGTs are used
Buy- Back Option?	Yes, contingent on non-federal share being provided through IGTs
Other Rate Enhancements?	No
Statutory Parameters?	Yes, see section 409.908 (19), F.S.

County Health Department Rate Setting Fact Sheet

County Health Department FFS Rate Setting	
Recurring Rate Cuts?	Yes
Targets?	No
Rate Freeze	Yes
Ceilings?	No
Exemptions?	No

County Health Department Rate Setting Steps

- Establish rate based on most recent filed cost report with no recurring rate reductions or buy-backs.
- Apply recurring rate reductions as appropriate.
- Compare Unit Cost/ Rate freeze provisions.
- Apply buy-backs as appropriate.
- Establish final rate.

Managed Medical Assistance Program Rate Setting

- The Managed Medical Assistance (MMA) program is the second component of the Statewide Medicaid Managed Care program.
  - The MMA program covers most recipients of any age who are eligible to receive full Medicaid benefits.
  - The MMA program covers acute care and preventive medical services.

Managed Medical Assistance Program Rate Setting

- Competitive procurement required .
- "Best value" to the state included negotiated capitation rates for the period of May 1, 2014 – Aug 31, 2015 for MMA.
  - Detailed Data Book & sample methodology in ITN
  - Bidders submitted cost proposals, methodology, and actuarial certification.
  - Negotiations resulting in a rate schedule of common rates for all awarded standard plans in each region .

Managed Medical Assistance Program Rate Setting

- Rate-related negotiation goals:
  - Actuarially sound.
  - Take advantage of competitive process; listen to industry.
  - Achieve savings target established in statute.
  - Establish common base rates for all selected standard plans in each region.

Managed Medical Assistance Program Rate Setting

- State established (remaining contract years).
- Developed by Agency's contracted actuary.
  - Uses historical data and incorporates actual MMA program experience as sufficient validated data becomes available.
  - Transparent process:
    - Base data summaries provided to plans.
    - Meetings with plans to review data and issues, adjustments and draft rates.
    - Full actuarial reports provided to plans.

Managed Medical Assistance Program Rate Setting

- Under the MMA program rate cells are developed for various eligibility groups.
- For TANF and SSI groups, rates are risk adjusted based on historical claims/ encounter data.
- Separate rates developed for special populations:
  - HIV/AIDS
  - Child Welfare
  - MMA enrollees also enrolled in the LTC program

Managed Medical Assistance Program Rate Setting

Summary of Rate Cells by Primary Rate Group		
TANF	SSI No Medicare	Dual Eligible
Age 0-2 months	Age 0-2 months	Age < 65
Age 3-11 months	Age 3-11 months	Age 65+
Age 1-13	Age 1-13	
Age 14-54 male	Age 14+	
Age 14-54 female		
Age 55+		

Highlighted cells indicate rates that will be risk adjusted

Managed Medical Assistance Program Risk Adjustment

- Mechanism to better match payment to enrolled risk when there are multiple plans.
- Uses claim data to assess relative risk of enrollees and assign "scores".
- Aggregates by plan to see how each plan's enrollees compare to the average.
- More sophisticated than age/gender alone; explains more variation.
- "Re-sizes" the slices of the pie, but does not change the size of the pie.

Managed Medical Assistance Program Risk Adjustment

- CDPS+Rx version 5.4 (Chronic Illness and Disability Payment System):
  - Diagnostic and Pharmacy based risk adjustment model.
  - Widespread use in Medicaid managed care around the country.
- Prospective approach:
  - Data from a recent historical time period is used to identify chronic conditions and estimate acuity-related cost differences for a future time period.
- Custom risk weights for Florida Medicaid:
  - Custom risk weights will reflect Florida's specific covered benefits, eligibility rules, provider reimbursement, and practice patterns.

Managed Medical Assistance Program Rate Setting Steps

Steps in MMA Capitation Rate Development:

1. Start with best available validated historical utilization and cost data.
2. Adjust for any changes to the program (e.g., benefit change, significant fee schedule change for hospitals).
3. Adjust for the effect of improved medical management (e.g., if starting with FFS data).
4. Trend to rate period.
5. Add allowance for capitated plan administrative costs and margin.

INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

ICF/IID Rate Setting

- Rates for ICF/IID service providers are set by the Agency as a per diem payment.
- Rates components are established in statute and through the Medicaid State Plan.
- Mechanisms for facilities to increase their rates have been established through statute and proviso in the GAA.

ICF/IID Rate Setting Elements

- The reimbursement methodologies outline allowable costs for the purposes of reporting and rate setting. The cost report must include all items of expense. General items and services include:
  1. Room
  2. Private Room
  3. Clothing
  4. Behavior Services
  5. Dental Services
  6. Preventative Health Care
  7. Nutritional Services
  8. Personal Care Services
  9. Medication Services
  10. Psychotropic Medications
  11. Rehabilitative and Restorative Care Services
  12. Therapy Services
  13. Assistance with Activities of Daily Living
  14. Recreational and Leisure Services
  15. Rehabilitative and Restorative Care Service Requirement
  16. Incontinence Supplies
  17. Medical Equipment
  18. Adaptive Equipment
  19. Stock Medical Supplies
  20. Transportation

ICF/IID Rate Setting Fact Sheet

ICF/IID FFS Rate Setting				
Type of Rate	Cost Based Per Diem Rate			
Facility Specific Rate	Yes, each facility has an individual rate			
Data Used	Cost Reports			
Rate Period	One yearly, effective July 1 of each year			
Current Rate Range	Public/Residential & Institutional Rate Non-Ambulatory & Medical Rate	$240.63 – $391.79 $345.57 – $589.68	Private/ Residential & Institutional Rate Non-Ambulatory & Medical Rate	$200.14 – $458.69 $217.78 - $571.85
Current Statewide Average Rate	Public/Residential & Institutional Rate Non-Ambulatory & Medical Rate	$293.01 $428.96	Private/ Residential & Institutional Rate Non-Ambulatory & Medical Rate	$267.17 $266.24
Rate Adjustments Allowed?	Yes, rates can be adjusted based on submission of amended cost reports or audit results			

ICF/IID Rate Setting Fact Sheet

ICF/IID FFS Rate Setting	
Audit Process	Provider cost reports are selected for audit based on several different criteria, including time period since last audited, initial cost report status, cost reports receiving an interim rate and discrepancies in cost reports discovered during preliminary review.
	Cost reports and additional documentation are assigned to contracted CPA firms for audit review and analysis, which includes meeting with providers, site visits, exit conferences and preparation of work papers for each audit.
	Audit findings and analysis are then sent to an AHCA analyst for compliance and acceptability review and analysis.
	Once AHCA analyst finalizes audit report with CPA firm, the audit report is issued and is sent via certified mail to the facility. The audit report provides 21 day hearing rights.
	Once audit is closed the audit is sent to the Cost Reimbursement Unit for retroactive rate adjustment.

ICF/IID Rate Setting Fact Sheet

ICF/IID FFS Rate Setting	
Local funding or Quality Assessments?	Yes, ICF/IID Quality Assessment
Buy-Back Option?	Yes, contingent on the non-federal share being provided through the ICF/IID Quality Assessment
Other Rate Enhancements?	No
Statutory Parameters?	Yes, see sections 409.906 (15) 409.908(2)(a)1., 409.9083, F.S.

ICF/IID Rate Setting Fact Sheet

ICF/IID FFS Rate Setting	
Recurring Rate Cuts?	Yes
Targets?	Yes
Rate Freeze?	Yes
Ceilings?	Yes
Exemptions?	No

ICF/IID Rate Setting

ICF/IID FFS Rate Setting	
Recurring Rate Cuts	Yes, legislative proviso takes into consideration reductions from 10/1/08 forward - July 2014 rate reduction taken was $20,615,932, prior to rate buy-backs through the ICF quality assessment
Targets?	Yes, Provider Specific Targets and New Provider Ceiling Limitations
Rate Freeze?	Yes, Unit cost at 6/30/11 of $293.51 prior to rate buy-backs through the ICF quality assessment - July 2014 was a 1.6149% cut, totaling $4,144,015
Ceilings?	Yes, applies only to new provider budgeted rates
Exemptions?	No

Questions?