

Retrospective Cost-Based vs. Prospective Reimbursement Systems – Some Terms and Issues

While there are many types of retrospective cost-based reimbursement systems and there are many types of prospective reimbursement systems, there are some general distinguishing factors:

- Retrospective Cost-Based Reimbursement Systems require a cost reporting process, the establishment of interim rates, and a settlement process. Typically, the settlement does not occur until an audit is completed. Neither the state nor the providers know how much they spent or received until settlement is completed. Retrospective cost-based systems are very labor intensive for the state and providers and as a result are not used much any more. (Only New Jersey claims it is completely cost settled. However, the cost settlement is actually between the Medicaid agency and the DDD agency which in turn does settlement with providers with limitations.)
- Prospective Reimbursement Systems establish the payment for a service before the service is rendered. The established payment is made regardless of the cost of the service and there is no cost settlement. Both the state and the provider know what was spent and what revenue was received on a current basis. Prospective Systems may require cost reporting but audit typically occurs rarely if ever. Prospective Reimbursement Systems may be called a “fee schedule” but this is not completely accurate. A fee schedule typically pays providers the less of the charge for the service or the established fee. This is not the case under “pure” prospective rate-setting systems.

Rate Strategies (Recycled)

Determining the appropriate payment for medically fragile and behaviorally challenged individuals is difficult for several reasons. First, costs for medically fragile and behaviorally challenged can not be separately identified from the current reporting structure. Second, the current budget adjustment process accounts for some of the same underlying costs of high needs clients that bucket address. Third, there is an inherent disconnect between tying payment to assessed needs in a cost settlement environment. Finally, North Dakota pays the same for all residents regardless of need for residential placements. Any strategy developed must ensure that North Dakota does not pay twice for the same underlying cost.

Most rate strategies that tie payment to needs address acuity in general rather than specific conditions and most are prospective where rates are set in advance and there is not cost settlement. Strategies adopted by states include:

- Case mix adjusted rates. These systems measure acuity for all individuals served by a provider and adjusts the rate based on total case mix. Typically case mix reimbursement systems adjusts all direct care costs but not other components of the rate.
- Individualized funding levels based on needs that predict resource use based on historical examination of utilization. This method does build in past practices that may reflect policies that are undesirable and the state does not want to continue
- Time and motion studies which measure resource differences – this methodology is used frequently for nursing and medical treatments but is very expensive and time consuming.
- Rate modifiers designed to enhance provider acceptance of higher acuity clients and retention of those providers. Ohio, for example, uses this approach for in-home supports. Two modifiers, one for behavior and another for nursing delegated activities are added to the base rate developed using independent models. Ohio does not have cost settlement.
- Rate adjustments tied specifically to wage differentials for providers of service. Again these adjustments are straightforward when a cost settlement process is not involved.
- Development of independent rate models which allow states to describe and quantify the nature of the services the state wants to purchase for high acuity clients versus what the state wants to purchase for average and lower acuity clients. These models include wage differentials, staffing ratios, and provider training and credentialing. Here again, independent models operate well without cost settlement processes
- Development of tiered rates reflecting different acuities for each service or as a percentage differential applied to all services

Retrospective Cost-Based Versus Prospective Rate Systems – Rate Reductions

One issue raised by providers in North Dakota and elsewhere is the concern that rate reductions are “easier” under prospective systems. The reality is that rate freezes and/or reductions are easy under either type of rate system unless it is a pure retrospective cost-based reimbursement system (requiring a settlement and audit) without budget limits and/or limits on various cost categories.

Even in the olden days when Medicare payments were based on “reasonable cost based” there were always many, many limitations summarized in a massive document called now Provider Reimbursement Manual CMS 15.

Unfortunately there is no official “literature” on this topic (someone should write something). As a result, we provide experience of providers in other states experiencing extreme budget pressure under both cost-based and prospective systems.

Retrospective Cost-Based Systems

In the DD and Mental Health arena, cost-based systems are generally both budget-based and cost-based. This means that the available budget is limited by appropriations and that the actual revenue received by a provider is limited to the lesser of the available budget or cost whichever is less. Cost-based systems that are not budget based are quite different than budget based, cost based systems.

North Dakota’s system is both budget-based and cost-based. The budget is used to implement available appropriations and appropriation increases and could pass along appropriation decreases in the same manner should the economy require such a reduction. And, at the end of the day, providers in North Dakota receive the lesser of the budget target or cost. North Dakota has not experienced the budget pressure that other states have experienced.

Illinois mental health providers (many of whom also serve the developmentally disabled) who were paid under a budget-based/cost-based system found that their reported costs cycled down as the budget amounts went down. This caused a downward spiral with provider attempts to lower their cost resulting in reductions in their budgets in subsequent years. In addition, the “budget” of the Division of Mental Health did not accommodate or recognize the entitlement of Medicaid clients to services. Providers found that they could not meet increased demand for Medicaid services within contracted budgets. Even when the economy rebounded budgeted rates were set on the artificially deflated costs. States in this position often move to “independent rates” which depend on the wage rates in competitive industries. While its membership was originally mental health centers, many of its members are now DD providers.

In other states with other providers when we have rebased rates after this downward spiral, rates have gone down making independent data sources very important to keep the system and wage rates under the system competitive. Further, these systems (unless they are cost-based and not budget-based) do not adjust for case mix as it increases.

Prospective Rates

To begin with there are many different types of prospective rate systems as described in the previous section, some of which are based initially on cost data and others that use independent data sources or resource consumption data to establish rates. Even where a prospective rate system is cost-based originally, some states tightly control inflation and/or rebase to more current cost very infrequently (never, 10 years, 7 years).

The real issue for a prospective system is the data on which it is based. If assessments are a requirement and funding is by level of client, the system naturally increases as case mix increases. If the system is informed by cost but based on independent measures, then costs that were deflated as a result of economic conditions have less of an effect. If the system is cost-based but rates are not inflated and the system is rebased to current cost very infrequently, providers will face hardships. States can also have an across the board percentage and/or rate reduction. Remember this is also true of a retrospective system.

Under a fee-for service prospective rate system, however, you never get into the situation where you don't get paid for a Medicaid eligible member when clients grow because the budget is insufficient. The payment may be inadequate but a payment is made for every service rendered.

To the extent that a prospective system was measured (not necessarily based on cost) against costs, some providers will make money while others will not to a greater extent than a cost based/budget based system.

Conclusion

Either a cost-based retrospective system or a prospective system can reduce payments. Both systems depend on clarity of assumptions which are generally more articulated in prospective systems in a way that all parties understand the parameters. Cost based/budget based systems are much more resource intensive than prospective systems.