For a complete Reference Based Pricing (RBP) solution we partner with Payer Compass and their VisMed pricing module. Reimbursements are based on a percentage of Medicare, determined by the Plan. They utilize the following Medicare pricing methods:

Inpatient PPS (DRG)
Sole Community Hospitals (SCHs)
Medicare Dependent Hospitals (MDHs)
Critical Access Hospitals (CASs)
Cancer and Children's Hospitals
DRG Grouping
Outpatient PPS (APC)
Ambulatory Surgical Centers (ASC)
Physician RBRVS repricing schedules
NCCI Edits (part of IOCE)
National Clinical Lab
Durable Medical Equipment (DME)
DME Prosthetics, Orthotics & Supplies (DMEPOS)
Federally Qualified Health Centers (FQHCs)
End Stage Renal Disease (ESRD)
Home Health
Inpatient Rehabilitation Facilities (IRFs)
Inpatient Psychiatric Facilities (IPFs)
Skilled Nursing Facilities (SNFs)
Hospice
Long Term Acute Care (LTCH)
Ambulance (air and ground)
Outpatient Rehabilitation Facilities (ORF)
Comprehensive Outpatient Rehabilitation Facilities (CORFs)
Rural Health Clinics (RHCs)
Parental and Enteral Nutrition (PEN)
High-Cost Drugs
Clinical Lab

For items that Medicare does not cover, for services that Medicare covers only in certain settings or non-Medicare providers involved in the coverage area, they provide a suite of tools that provide a close approximation of Medicare rates for these situations.

Under the VisGuide, Patient Advocacy Program, in regards to Balance Billing, Payer Compass provides:

- Initial contact with providers for acceptance of the plan reimbursement
- Routine follow up with providers for management's decision on acceptance
- Sending letters to providers
- Keeping the member informed on balance bill status
- Negotiating with providers when requested by the Plan, through the TPA
- A detailed tracking of contacts and results are documented in the medical management system and a shared FTP site.

There is no way to prevent balance billing entirely, but the VisDefense strategies are applied to limit and combat it, such as pre-negotiation and using assignment-of-benefits as a bargaining chip.

Fear of setting precedent by paying more (to settle balance billing) is justified, but can be softened by pointing to unique factors applicable to the particular instance, as well as listing multiple parameters that the Plan can used in deciding what the payable amount is. The preferred definition of Usual & Customary (U&C) in a plan document doesn't rely on a "black and white" firm definition – using a "Medicare + XYZ& or nothing" approach. Instead, Medicare should be one of many things the fiduciary (Plan Sponsor) considers in calculating the U&C amount.

The solution in a RBP scenario relies on preparation, not reaction. If you:

- negotiate with providers before they treat patients;
- add language to your plan document and ID card before claims are incurred; and
- educate employees,

your results will be much better.

All providers can be reimbursed by reference based pricing. In a full "network replacement / no PPO" strategy, you would replace the costs for the PPO access fees and pre-certification services with the payment of a $15.25 PEPM (per employee per month) fee for Payer Compass. One of the reasons that we chose this solution was their pricing model, which is a fixed cost and **not** related to a percentage of savings of percentage of billed charges.