Reference Based Pricing – A Hospital Perspective

Summary

Reference-based pricing (RBP) is an increasingly utilized strategy aimed at controlling healthcare costs by setting commercial reimbursement rates based on a percentage of Medicare, rather than traditional negotiated rates. While this model can help manage healthcare costs for patients and insurers, if not implemented carefully, it can have severe financial consequences for hospitals. Insufficient reimbursement rates may fail to cover the actual costs of care, leading to significant funding shortfalls, service reductions, and consequent financial instability. Without appropriate protections and collaboration between stakeholders, RBP can inadvertently compromise access to healthcare services, particularly for hospitals serving vulnerable populations or operating on weak margins.

The Key Elements of Reference Based Pricing: What It Is and What It Is Not

What is Reference Based Pricing (RBP)?

- RBP is a healthcare pricing strategy where a predetermined, price or benchmark for specific medical services is set, rather than covering a percentage of the price a hospital charges. This benchmark is typically based on industry standards, regional averages, or Medicare rates.
- The goal of RBP is to create more predictable and affordable pricing for patients, while also addressing the rising cost burden that is often shifted to insurers and, ultimately, consumers.

What are the limitations of RBP?

- RBP typically does not apply to every service or treatment. It usually targets specific procedures and services where there is significant variation in price.
- RBP is not a fix-all approach for managing all healthcare expenses. While it helps address high variability in prices for certain services, it does not eliminate the overall complexity of healthcare costs. There are still many costs that may not fall within the reference-based pricing framework.

Cost Coverage Considerations

Cost Considerations Must be Addressed:

- ***A fundamental issue with RBP is the starting point.*** Using Medicare (MCR) reimbursement as a basis for the commercial multiplier assumes that Medicare reimbursement is adequately covering the costs associated with providing the service.
- For Critical Access Hospitals (CAH) this is predominantly true due to their cost-based reimbursement; however, for Prospective Payment Hospitals (PPS) this is not true.

Example: RRMC's most recent cost filing with CMS indicated that the hospital's costs exceeded its Medicare reimbursement by $6.2M for inpatient services and $7.3M for outpatient services. Similarly, RRMC's inpatient and outpatient costs exceeded its Medicaid reimbursement by $22.1M.

Nationally, the Medicare IP reimbursement shortfall for non-profit hospitals is ≈13%. RRMC ≈16%.

IP Services			
	MCR Cost Per Day	MCR Reimbursement	MCR Cost Coverage
National	$3,167	$2,765	87%
PPS - RRMC	$3,096	$2,616	84%
CAH	$2,846	$2,818	99%

Why is RRMC's costs lower and cost coverage less than the national average?

Three factors are contributing to the result:

1. Vermont's aging population – VT ranks 2nd, tied with FL, for the highest population percentage aged 65 and over.
2. Vermont's infrastructure challenges, including homelessness, transportation, lack of long-term care resources, and substance use challenges, contribute to increased healthcare utilization. These factors lead to avoidable hospital visits and higher costs.
3. Opportunity for further operational efficiency.

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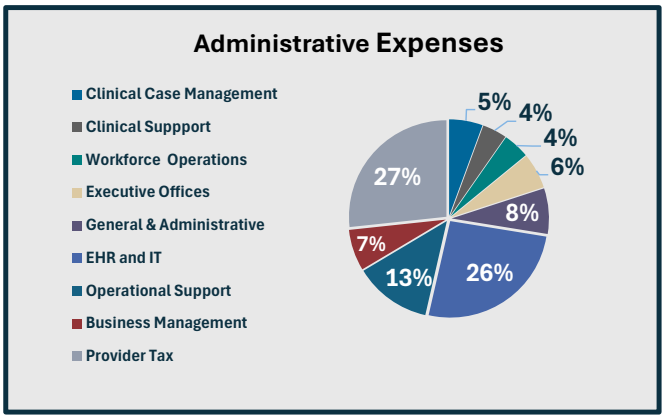
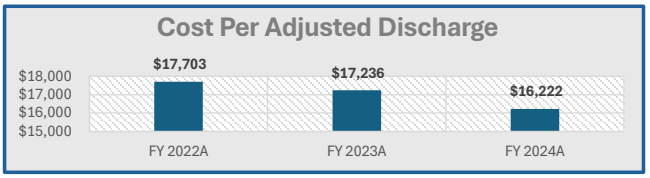
Operational Efficiency:

Commitment to Efficiency & Affordability for Vermonters!

Though RRMC's Medicare costs are below the national average, we remain committed to maintaining downward pressure and ensuring affordability for Vermonters. We recognize our shared responsibility in addressing healthcare costs. As a result of our cost-saving initiatives, we have been able to reduce our commercial rate request by nearly 6% over the last two years ($8.8M in savings).

Despite this achievement, there is still opportunity to improve operational efficiency. To ensure that hospital efficiency savings directly benefit Vermonters, we must establish a transparent tracking mechanism that links cost reductions to lower commercial insurance premiums. This accountability will help confirm that savings are realized by those we serve.





Commercial RBP Considerations:

Given the 16% shortfall, an efficiency adjustment should be balanced with a reasonable Medicare baseline. To mitigate this shortfall, potential solutions include securing additional Medicare funding, implementing programmatic adjustments, or increasing the commercial reference-based multiplier (RBM) to offset the Medicare deficit (cost shift).

- An additional potential solution is to advance state legislation for the 340B program and allocate a portion of the resulting funds to help offset the Medicare shortfall.

The shortfall is even greater within the Medicaid program. For total inpatient and outpatient services, the shortfall is 55%. However, there is an offsetting component that should be considered and would substantially bring the Medicaid shortfall closer in line with Medicare, allowing for the commercial RBM to remain at a more sustainable threshold:

- Consider allocating the state revenue generated from the provider tax, net of the disproportionate share payments made to hospitals, to subsidize the Medicaid shortfall. If implemented, this adjustment would reduce the Medicaid shortfall to 17%, aligning it closer with Medicare. Without this approach, the commercial RBM would need to increase to 445% for inpatient services and 360% for outpatient services.

Medicare Services				
	MCR Total Cost	MCR Reimbursement	MCR Cost Coverage	MCR Shortfall
MCR Total IP & OP	$ 86,736,021	$ 73,228,679	84%	16%
RRMC Adjusted @ 1.5%	$ 85,434,981	$ 73,228,679	86%	14%

Medicaid Services				
	MCD Total Cost	MCD Reimbursement	MCD Cost Coverage	MCD Shortfall
MCD Total IP & OP	$39,857,510	$17,796,808	45%	55%
Add Bed Tax, Offset w/DSH	$39,857,510	$33,176,294	83%	**17%**

Setting commercial RBP at 200% of Medicare rates would result in a financial shortfall exceeding $30M for RRMC. While we recognize our responsibility to contribute to cost-saving efforts, achieving this target would necessitate difficult decisions, including potential program closures, to maintain financial stability.

Initial Recommendations:

- Allocate the provider tax revenue to offset the Medicaid funding shortfall.
- Should state 340B legislation pass, leverage a portion of the funding to establish a reasonable Medicare baseline.
- Implement a pilot program for commercial RBP at a select number of hospitals and for select services.
  - Requires the Medicare baseline is appropriately established.
  - Includes a safeguard mechanism to allow for adjustments or discontinuation if financial instability arises
  - Ensures alignment with Act 167 and broader hospital sustainability objectives.