



September 5, 2012

By Email

labcomments@dhcs.ca.gov

Re: Foundation Laboratory's comments for Clinical Laboratory and Laboratory Services Rate Methodology Change.

Dear DHCS Representative,

Foundation Laboratory, Inc. is pleased to participate as a stakeholder during DHCS recent initiative, mandated by AB1494, to establish its revised Fee-For-Service reimbursement schedule. In this document, you will find Foundation Laboratory's views on the following:

1. What data set should be required by DHCS to be submitted by all stakeholders
2. How the submitted data set should be used by DHCS to determine the revised reimbursement schedule.

General Comments

Foundation Laboratory understands the concepts behind AB1494 and agrees with DHCS that 51501 needs to be reformed in order to create a more transparent and problem free relationship between clinical laboratories and DHCS. Furthermore, we agree with DHCS that a revised reimbursement schedule needs to be competitive with other major third-party payors while still maintaining compliance with federal guidelines associated with patient access and care. Finally, we ask that DHCS conduct this entire process transparently and fairly to every stakeholder involved since the clinical laboratory sector is heavily lopsided with great majority of market size currently captured by two national laboratories, Quest Diagnostics and LabCorp.

To elaborate further on the final point of the last paragraph regarding transparency and complete involvement of all stakeholders, Foundation Laboratory was notified about this latest initiative through word of mouth and not through a formal notice. Although the pertinent announcement could be found on DHCS webpage, Foundation Laboratory and many smaller laboratories, incidentally not members of CCLA, were unaware of the steps involved in this process, were unaware that our comments were due by September 5th, were unaware of the general timelines involved, etc. DHCS has an excellent record of communicating with its stakeholders regularly and efficiently through formal notices via mail on significant issues such as the subject initiative and we would like to recommend that all stakeholders are provided notification about upcoming events connected with this recent initiative.



Data Reporting

Foundation Laboratory believes that before DHCS establishes what data set will be required to be provided to DHCS by all stakeholders, we believe that significant effort must be spent in identifying the parameters of the data set which depicts exactly the same or similar payor profile as compared to Medi-Cal. When reading the Statute 14105.22 (b), “It is the intent of the Legislature that the department develop reimbursement rates for clinical laboratory or laboratory services that are comparable to the payment amounts received from other payers for clinical laboratory or laboratory services....”, we interpret “other payers” to mean other third-party payors similar in nature to Medi-Cal. Accordingly, we believe that the payor group exactly or similarly depicting Medi-Cal payor profile is composed of large, third-party payors such as HealthNet, Anthem Blue Cross, Cigna, Aetna, etc. This group of payors matches well with Medi-Cal for several reasons including:

1. These insurers have Fee-For-Service reimbursement structures based on CPT-Codes.
2. These insurers have complex denial and/or disallowance methodologies similar to Medi-Cal, based on standardized Diagnosis Codes.
3. These insurers have negotiating power similar to Medi-Cal.
4. These insurers provide coverage to patients under diverse demographic and geographic considerations.

Incidentally, a standard clinical laboratory will have revenue stream composed of diverse lines of businesses, associated with diverse group of customers. We believe that there are lines of businesses in a standard revenue stream which will not compare accurately with Medi-Cal. These lines of businesses may be comprised of private and commercial customers, IPAs, Hospitals, etc., all of which have significantly dissimilar nature compared to Medi-Cal. These entities may have reimbursement schedules not based on CPT codes, these entities typically don’t have denial/disallowance methodologies, and these entities typically don’t have comparable negotiating power nor provide services under diverse demographic and/or geographic considerations.

Although we are recommending stakeholders to submit reimbursement schedules with large insurance companies, to be used in this exercise as the most comparable data set, there are some considerations to be discussed. The rate schedules submitted must be complete and not limited to certain CPT codes and not calculated by the individual stakeholder as payment against a particular CPT code after factoring denials/disallowances/deductibles. To factor in denials/disallowances/deductibles during the data submission process would skew the data set unpredictably and would require significant IT related resources in the event a particular stakeholder does not possess the software related capacity or capability to conduct this process accurately and efficiently. Therefore, we recommend that the reimbursement schedules submitted to DHCS in this process be submitted simply as fee schedules based on CPT codes.



Data analysis by DHCS

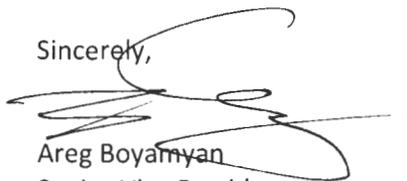
In analyzing and ultimately deciding on a revised reimbursement schedule, we encourage DHCS to create a process which is transparent, well-engineered, and fair to all parties involved. Here again, there are some considerations which must be reviewed and properly understood before an industry-wide fee schedule is created by DHCS.

First, we encourage DHCS to analyze the data entirely and not by individual CPT codes. Various submitted fee schedules may create advantageous or disadvantageous price considerations regarding a particular CPT code. DHCS must devise a methodology in analyzing this information objectively and fairly, without creating affinity toward the most advantageous price considerations. Favoring the most advantageous price considerations submitted in the entire data set would create an unreasonable reimbursement schedule, which may result in unfavorable consequences to all stakeholders in addition to creating unpredictable lapses of service and severe patient access issues. These consequences must be avoided entirely, as they were never implied to be the resulting outcome or casual effects of AB1494.

Secondly, we encourage DHCS to analyze the data submitted by the national clinical laboratories with some algorithm which will somehow mediate the differences in laboratory size. The national laboratories may have negotiated different reimbursement schedules or volume based discounts with large insurance carriers based on the entirety of their relationship nationwide. These reimbursement schedules may be readily supported by the national laboratories' size and the resulting economies of scale in their operations, however would create an unfair competitive advantage for most stakeholders. By adopting a reimbursement schedule below the operating cost of most stakeholders in a single State would create a significant disruption in stakeholder population. These disruptions would further amplify the monopolistic overtones currently experienced by the clinical laboratory sector in this great State, in addition to creating significant patient access issues. The ultimate effect of such disruption and depletion of the stakeholder population would result in DHCS being completely exposed or vulnerable to the will of a few.

In conclusion, we sincerely hope that the material presented here will assist DHCS in this process. We would like to offer any further assistance and look forward to working with DHCS in accomplishing its goals for the future.

Sincerely,



Areg Boyamyan
Senior Vice President