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November 14, 2012

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Re: Medi-Cal Rate Methodology – Proposed Data Elements and Format for Data Reporting
Pursuant to AB 1494

Dear Mr. Mendoza:

Laboratory Corporation of America ("LabCorp") appreciates the opportunity to comment on the proposed data elements and format for data reporting pursuant to AB 1494 which were recently posted on the website of the California Department of Health Care Services ("DHCS" or the "Department"). In the comments below, we will identify those proposed data elements that LabCorp would be incapable of reporting as of January 31, 2013; those proposed data elements that would be inappropriate to report for purposes of establishing a new Medi-Cal rate methodology for laboratory services; those proposed data elements that should be reported but were omitted from the Department's proposal; and questions raised by the proposal. We urge the Department to address these items in a prompt and appropriate manner, including a written explanation for any decisions made.

At the outset, we would like to clarify our position with respect to the proposals previously offered by Quest Diagnostics, Inc. While we did not agree with all of the specifics of its proposals, we did generally support the concept of reporting fee schedule data from comparable fee-for-service third party payers for the reporting laboratory in California. We agree that this approach would enable Medi-Cal to establish a new rate methodology that most closely approximates market reimbursement for laboratory services by payers comparable to Medi-Cal, while minimizing the reporting burden on laboratories and without endangering patient access to services. We urge DHCS to reconsider such an approach. However, since the Department's initial proposal takes a different approach, we are offering the following comments in a good faith effort to improve it in the event that the approach we favor is not adopted.

The approach reflected in the Department's proposed data elements and format suggests that the Department would seek to "cherry pick" the lowest reimbursement amount by CPT code from among virtually all sources of laboratory reimbursement around the United States, regardless of the comparability of those reimbursement sources to Medi-Cal. At the very least, significant adjustment of the raw reported data pursuant to consensus, established, objective formulas related to geography and volume would be necessary to achieve comparability to the Medi-Cal setting and to avoid massive disruptions to patient access to laboratory services in California. While we stand ready to work with the Department through the rate methodology development process to develop or adopt such adjustment mechanisms if necessary, we firmly believe it would be more appropriate and more efficient to begin with a data set that is as comparable as possible to the Medi-Cal setting, which would require significant changes to the data elements that the Department has proposed.

Data Elements That Cannot Be Reported as of January 31, 2012

As of January 31, 2013, LabCorp would be incapable of reporting certain proposed data elements to the Department. These data elements include:

- Any data element for which calendar year 2012 financial or volume data is required
- Cost to Lab
- Location where specimen was taken

We urge the Department to clarify in writing that the applicable reporting year is calendar year 2011, not calendar year 2012. AB 1494 requires reporting by December 27, 2012 for the previous calendar year. We interpret this provision to require reporting data for calendar year 2011. The Department's decision to delay reporting to January 31, 2013 has raised the issue of whether it has also moved the applicable reporting year from 2011 to 2012. It is our understanding from the Department's verbal comments on the November 5, 2012 stakeholder call that the Department did not intend to change the applicable reporting year by delaying the reporting deadline, but written confirmation would be appreciated. Our systems would be incapable of reporting calendar year 2012 financial or volume data as of January 31, 2013.

We would also be incapable of reporting cost data at the CPT code level, which our internal accounting systems are not designed to address, as well as the location where the specimen was taken. For any given CPT code reimbursed by a particular payer, specimens may be taken from hundreds or even thousands of different locations, and our systems are not designed to capture that information.

Data Elements That Would Be Inappropriate To Report

Several of the data elements proposed by the Department would be inappropriate to report for purposes of establishing a new Medi-Cal rate methodology, even if we have the capability to report such data. These data elements include:

- "Client" payment information: Amounts paid by physician and hospital clients are inappropriate because they are not comparable to Medi-Cal as payers.
- "Client" address and identifier information: Since amounts paid by physician and hospital clients are inappropriate and should not be reported, client address and other identifying information (such as NPI and where the specimen was collected) should not be needed to make geographical adjustment of client payment data.
- Payer/Client Indicator: Since client data should not be included, there should be no need for a payer/client indicator to differentiate the two.
- Capitated Payer Data: Capitated payer data is inappropriate because it is not comparable to Medi-Cal fee for service reimbursement. There is no appropriate way to convert a per-member-per-month reimbursement arrangement for all tests performed for a capitated payer's members to a fee-for-service rate by CPT code.
- Fee Schedule Rate or Contracted Rate: The Department should only collect data on either: 1) the fee schedule rate or contracted rate, 2) the billed amount, or 3) the paid amount, but not all three for any given CPT code. Of these three data elements, the fee schedule rate or contracted rate, if available, is the most relevant to the purposes for which this data is being collected – establishment of a new Medi-Cal fee schedule.
- Billed Amount: The Department should only collect data on either: 1) the fee schedule rate or contracted rate, 2) the billed amount, or 3) the paid amount, but not all three for any given CPT code. Of these three data elements, the fee schedule rate or contracted rate, if available, is the most relevant to the purposes for which this data is being collected – establishment of a new Medi-Cal fee schedule.
- Paid Amount: The Department should only collect data on either: 1) the fee schedule rate or contracted rate, 2) the billed amount, or 3) the paid amount, but not all three for any given CPT code. Of these three data elements, the fee schedule rate or contracted rate, if available, is the most relevant to the purposes for which this data is being collected – establishment of a new Medi-Cal fee schedule.

- Cost to Lab: The actual total cost of performing a service represented by a single CPT code is not only infeasible in most cases, but is an inappropriate data element on which to base reimbursement rates because it is variable and would fail to account for the value of the service to the recipient.

Data Elements That Should Be Reported But Were Omitted From The Department's Proposal

There are several data elements that should be reported, but were omitted from the Department's proposal. These data elements include:

- Volume data, per CPT and per payer: The statute provides that the determination of reimbursement rates should exclude significant deviations of volume factors. This exclusion can only be made if the Department has utilization data from which it can identify significant volume deviations that may affect pricing. For each CPT code reported, there should be two volume-related data elements. One should provide the total volume of that CPT billed to the identified payer. Another should provide the total volume of all CPTs billed to the identified payer. This utilization data would help determine how comparable the volumes of the identified CPT and payer are to Medi-Cal utilization at both the CPT and payer levels, so that significant deviations could be excluded when establishing new rates.
- Amount of volume discount: The spreadsheet asks if the payer was eligible for a volume discount or a rebate as a result of performing the service, but only asks for the amount of the rebate associated with the service. While provision of fee schedule amounts should make both discounts and rebates irrelevant in most if not all cases, if the amount of rebates is requested, the amount of any volume discount associated with the service, if any, should be reported as well.
- Third Party Payer Address: The spreadsheets do not appear to request the address of a third party payer for possible geographic consideration; they should.
- Maximum Number of Units of Service Paid When There Are Units of Service Edits: Bad debt and administrative costs vary widely among payers, and are not accounted for in the data elements proposed by the Department. One objective data element that would help capture these variable revenue offsets for consideration in the new rate methodology is the maximum number of units of service paid when there are units of service edits.

Questions Raised By The Department's Proposal

The Department's proposal raises a number of questions, including the following:

- What is the calendar year for which reporting is required? If reporting is required for calendar year 2012, under what authority is the Department permitted to change the applicable calendar year established by statute (2011) by postponing the reporting deadline to the next calendar year after enactment of the Act?
- Why does the Department neglect to mention in the overview document the need to consider significant volume deviations and fail to include utilization data elements in the fee for service spreadsheet, when the statute directs the Department to exclude significant deviations in volume factors when setting rates?
- How is the location where the sample was taken relevant to geographical considerations in rate setting, when the laboratory performing the test is typically located elsewhere and it is the test being billed for rather than collection of the specimen?
- Why does the Department request address information for the location where the sample was taken to identify, for geographical consideration, the location of a third party payer that will always be located elsewhere?
- Why does the Department not request the amount of any applicable volume discount associated with the service when it asks whether any rebate or volume discount is applicable and asks for the amount of the rebate?
- Why does the Department use "Lab Address" as the heading for the data element requesting the address where the sample was taken, when another "Lab Address" data element requests where the lab test was performed? Shouldn't the second "Lab Address" data element heading be replaced with the heading, "Payer Address", and request the payer address for possible geographical consideration?
- When reporting the NPI of the lab performing the service, should the lab report the organizational NPI for the laboratory, or the subpart NPIs of all laboratory facilities performing the identified CPT code for the identified payer, which could be in the hundreds all across the United States?
- Which spreadsheet should be used to report fee-for-service data for fee-for-service third party payers – the "fee for service" spreadsheet, or the "capitated rates and managed care" spreadsheet?

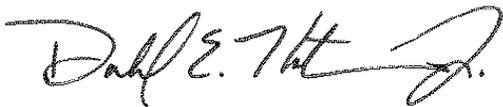
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- How can the Department justify going on a "fishing expedition" for data when it has no idea how it might use that data in establishing new payment rates? Shouldn't the Department first establish a new rate methodology, and then determine the minimum data necessary to establish the rates using that methodology?
- How will the Department utilize data on CPT codes that were in effect during the applicable reporting period but will not be in effect in 2013 and beyond, such as the "stacking codes" for molecular pathology which are being replaced with 101 new CPT codes?
- Instead of identifying the fee-for-service third party payer paying the lowest amount per CPT code, which the Department would then presumably average across the amounts reported for that CPT code by all providers, would the Department accept, for each CPT code, the average fee schedule amount for that CPT code from comparable contracted fee-for-service third party payers in California and, separately, the average amount paid by comparable non-contracted fee-for-service third party payers in California? Wouldn't this approach accomplish the same goal with less work for the Department?
- How will the Department ensure the confidentiality of the reported data? Under what circumstances, if any, will the Department release the data to other persons or entities? Who are the other permissible recipients, if any?

LabCorp looks forward to working with the Department to ensure that the new Medi-Cal rate methodology results in appropriate reimbursement for, and the preservation of patient access to, laboratory services in California.

Very truly yours,

A handwritten signature in black ink, appearing to read "Donald E. Horton, Jr.", written in a cursive style.

Donald E. Horton, Jr.
Vice President, Public Policy & Advocacy