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By Email

Mr. John Mendoza
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Re: Quest Diagnostics Incorporated's Stakeholder Comments on DHCS's December 28, 2012 Proposed Data Submission Requirements for Clinical Laboratories

Dear Mr. Mendoza:

As Quest Diagnostics' representatives stated during the stakeholder meeting in Sacramento on January 15, 2013, we would like to thank you, Mari Cantwell and your colleagues at DHCS for taking our prior comments into account in developing your revised proposal (dated December 28, 2012) for data submissions by clinical laboratories. Quest Diagnostics is generally supportive of the latest DHCS proposal, as we think it is a solid step in the right direction towards the collection by DHCS of appropriate payor data so that the agency has the information it will need to set a new Medi-Cal fee-for-service rate schedule for laboratory services, as contemplated by A.B. 1494. As we discussed at the last stakeholder meeting, however, we think your latest proposal raises a few relatively technical issues that would benefit from further DHCS clarification. Below is a list of these issues, together with Quest Diagnostics' recommendations concerning how they should be addressed.

1. Your written proposal is somewhat ambiguous about whether DHCS wants, from each reporting lab, (1) rates from *all* of the fee schedules for the top 5 (up to 10) largest third-party *payors* (based on the payor's total aggregate volume) for that lab in California -- which for Quest will likely amount to over 25 fee schedules per CPT code since most of its large payors have multiple fee schedules -- or (2) rates from just the top 5 (up to 10) *fee schedules* for each CPT code *based on the volume of units paid-for under each fee schedule for each individual CPT code*. During the January 15, 2013 stakeholder meeting, it appeared that DHCS may not have fully considered the fact that many large third-party payors have multiple fee schedules in

California, due to differing plan types, geography, etc., and that this would impact the number of submissions if the first scenario is adopted. Moreover, you stated at the outset of the recent stakeholder meeting that DHCS was seeking (from clinical labs like Quest Diagnostics) the fee-for-service fee schedule rates for laboratory services provided in California from at least 5 and *up to a maximum of 10* third-party payor fee schedules for each of the CPT codes contained on the recent DHCS CPT-code list. In other words, it appeared from your remarks to be DHCS's intention to receive between 5 and 10 fee schedule rates for each CPT code from each reporting lab. In light of your comments at the stakeholder meeting, we believe that DHCS favors approach #2 above, which is acceptable to Quest Diagnostics -- primarily because we think that if DHCS obtains 5-10 high-volume fee schedule rates (and associated volumes) for each of the 439 CPT codes on its list from Quest Diagnostics, as well as from the many other labs throughout the state that will be required to report, then DHCS will have more than enough representative benchmarking data for each CPT code to formulate an appropriate Medi-Cal reimbursement rate for each CPT code. At any rate, further written clarification from DHCS on this issue would be helpful.

2. Your proposal defines the "third-party payors" (whose California fee schedule rates should be reported if they fall within the top 5-10) as "insurers such as Anthem Blue Cross and Aetna, and other payors and programs comparable to Medi-Cal." At the recent stakeholder meeting, we asked whether the Medicare program falls within this definition so that Medicare's (California) fee-for-service CPT-code rates should be reported when Medicare is among the top 5-10 third-party payors for a particular CPT code. You stated that your preliminary view was that Medicare should be included, and we agree. Medicare is a "comparable" payor to Medi-Cal, as both are major third-party fee-for-service payors that make substantial reimbursements to California providers for clinical laboratory services. Moreover, because some private third-party payor fee schedules in California are expressed as a percentage of the Medicare fee schedule, it will benefit DHCS to have the Medicare CPT-code reimbursement rates. Written clarification that Medicare falls within the definition of "third party payors" would be helpful.

3. Your proposal seeks fee schedule rates (from a minimum of 5 fee schedules) that cover *80% of the lab's "business"* for each CPT code, up to a maximum of 10 fee schedule rates (or the fee schedule rates from 10 top payors, depending on the resolution of issue #1 above). However, the proposal does not specify what parts of the lab's "business" count as the "universe" for making the "80%" determination. During the January 15th stakeholder meeting, there seemed to be a consensus that the "universe" should be limited to the kinds of fee-for-service third party payors in California that are subject to the fee schedule reporting requirements of the proposal. That is, the business "universe" for the 80% calculation should be the business from all California fee-for-service third-party insurers, including Medicare (assuming you decide issue #2 above as recommended), plus other California fee-for service third-party payors that are "comparable" to Medi-Cal, if any -- but not Medi-Cal itself (since Medi-Cal's rates will not be reported). Again, written clarification on this issue would be helpful.

4. During the stakeholder meeting, it was pointed out that many third-party payor contracts contain confidentiality clauses that place restrictions on a lab's ability to disclose the payor's fee schedule or any particular CPT-code reimbursement rate. We then discussed whether the labs should be required to disclose to DHCS the payors whose data was being reported, and if so how. We all agreed that at a minimum, each lab should be required to keep

internal, confidential records that tie each disclosed rate to a specific payor's fee schedule. With respect to disclosure to DHCS, we discussed three possible alternatives: (1) masking the identity of all payors completely (and simply calling them "Payor 1," "Payor 2," etc.); (2) requiring each lab to disclose the required fee schedule rates for each CPT code and to identify the payor associated with each such rate; and (3) a "middle ground" that would require each lab to disclose in a footnote (for each CPT code) the names of *all* of the payors whose rates were being provided for that code, but without tying the name of a specific payor to a specific rate. Having considered this issue further since the stakeholder meeting, Quest Diagnostics understands that DHCS has a legitimate need to know which payors' rates are being provided. However, we see no reason for DHCS to need to know which specific rates come from which specific payors, by name. Therefore, Quest Diagnostics supports the "middle ground" discussed at the meeting (the third option above). Again, written clarification on this issue is requested.

In addition to the above issues, which were raised by Quest Diagnostics at the last stakeholder meeting, several other issues were raised by other stakeholders and/or by DHCS itself. Quest Diagnostics' positions on such other issues, to the extent it has a position, are as follows:

A. There was discussion at the meeting about whether hospitals with an "outpatient" or "outreach" lab business should be required to report third-party payor fee schedule information in the same way as independent labs. Quest Diagnostics has no position on this issue, but notes that unlike in the inpatient arena, hospital outpatient and outreach labs are often reimbursed by third-party payors on a CPT-code specific fee-for-service basis. Written clarification from DHCS concerning whether hospital outpatient and outreach third-party CPT-code based fee schedule rates should be reported in the same way as independent labs are required to report such rates would be helpful.

B. As previously discussed, third-party payor fee schedules sometimes change during the course of a calendar year. DHCS has now proposed (consistent with A.B. 1494) that labs report the third-party payor fee schedule rates that were in effect in 2011. We again recommend (as we did in our September 5, 2012 stakeholder letter) that December 31, 2011 be selected as the specific date within that year for which all fee schedule rate information should be reported.

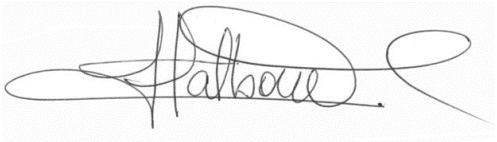
C. With respect to DHCS's first "Question for Stakeholders" in its recent proposal, Quest Diagnostics recommends that if a provider does not have or cannot locate a written "fee schedule" rate for a specific CPT code for a top payor, it should be required to report that payor's "allowed amount" for that CPT code (if that information is available). It is our understanding that a third-party payor's "allowed amount" is the same as its fee schedule rate for the vast majority of payors/CPT codes.

D. With respect to DHCS's second "Question for Stakeholders" in its recent proposal (concerning "de minimus" reporting thresholds), Quest Diagnostics has no position. However, we believe that DHCS should ultimately *apply the same reimbursement rate for each CPT code to all labs* in California -- and that all California entities that perform laboratory testing and receive CPT-code based reimbursement from third-party payors for that testing should therefore be encouraged take the opportunity to participate actively in the data submission process so that

DHCS has the benefit of fee schedule data from large and small labs alike when it later makes its rate-setting decisions.

Once again, Quest Diagnostics would like to thank DHCS for soliciting and considering its views as part of the important stakeholder process established by A.B. 1494.

Sincerely,



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