

3 Giralda Farms
Madison, New Jersey 07940
QuestDiagnostics.com



August 20, 2012

By Email

Mr. John Mendoza
Acting Chief of Fee for Service and Rates Development Division
Post Office Box 997413 M.S. 4612
Sacramento, CA 95899-7413
john.mendoza@dhcs.ca.gov.

Re: Quest Diagnostics Incorporated Comments in Connection with Clinical Laboratory Rate Setting Stakeholder Meeting on August 24, 2012

Dear Mr. Mendoza:

Quest Diagnostics Incorporated, the largest clinical laboratory in California, is grateful for the opportunity to participate in the stakeholder input process recently mandated by AB1494, and would like to set forth its views concerning (a) the data that DHCS should require labs to submit under the statute and (b) how DHCS should use that data in the new rate setting methodology that it is required to develop under the statute.

Guiding Principles

We believe that there is fundamental agreement on several key points which should guide this process. We agree that: (1) The now-suspended 51501 regime needed reform, due to its ambiguity and the heavy burden it placed on both labs and DHCS; (2) Medi-Cal should set industry-wide rates for its fee-for-service program that are competitive for such a significant third party payor while still complying with the federal access to care requirement, and (3) a new fee for service rate setting system should be developed that is fair to everyone involved and that can be implemented and administered efficiently.

We think the legislature's recent suspension of 51501 and commitment to a more simplified reporting and rate-setting process are steps in the right direction, provided the statute is interpreted and administered with these points in mind. The legislature established a stakeholder process, directed DHCS to be sensitive to the access to care requirement and other variables, and gave DHCS considerable discretion concerning what data each lab must report going forward and how that data should be used in the rate-setting process. Thus, an outcome should be possible that accomplishes our mutual goals, if we work together. Further regulatory guidance clearly is needed on the two key issues you have invited us to address: (a) precisely

what data the labs should report, and (b) how DHCS will use that data in setting new reimbursement rates. We have specific recommendations on each of these issues.

Proposed Data Reporting

With respect to what data should be reported, the bill requires reporting of “the lowest amounts other payors are paying, including other state Medicaid programs and private insurance,” subject to DHCS’s discretion and consideration of the access to care requirement. Given that Medi-Cal is a major third-party payor, we think the legislature clearly intended this language to mean other *third party* payors (that is, insurers such as Anthem Blue Cross and Aetna) and comparable Medicaid programs that negotiate CPT-code based fee-for-service fee schedules. It should not be read to include “clients” (which are customers, not “payors”) or entities that have capitated per-member-per month arrangements. Such arrangements offer no meaningful guidance on how a fee-for-service program should set its reimbursement rates.

A significant goal of AB1494 was to get away from the kind of broad and complex reporting obligations and uncertainty that beset the 51501 regime, not to re-impose them. We believe that the goal of the legislature was to make sure that DHCS gets meaningful market data, without getting bogged down in technical issues and minutiae. Moreover, even with respect to fee-for-service third party payors of the sort clearly contemplated by the statute’s reporting requirement, there are issues relating to the “lowest amount they are paying” that need further clarification from DHCS. For example, we do not think DHCS should conclude that the “lowest amount” determination should be made solely on a CPT code-by CPT code basis, without reference to the overall reimbursement contemplated under the “other payor’s” entire fee schedule. We also think that DHCS should determine that the complex disallowance and denial rules of each payor should be irrelevant to what fee-for-service reimbursement *rates* should be established for Medi-Cal (especially given that Medi-Cal’s disallowance and denial rules result in greater disallowances and denials than virtually any other third party payor in the state).

We also believe that it is critical that DHCS require the reporting of a data set that is clearly and objectively defined -- while still staying faithful to the statutory directive that it collect data that will capture the lowest rates set by other “payors” -- so that it can set industry-wide rates that are competitive yet fair. As already noted, the amounts labs charge their clients (such as hospitals, clinics and physician groups) should not be part of the reported data set because clients are “customers” and not “payors.” Similarly, per-member-per month capitated arrangements should not be part of the reported data set because those arrangements do not provide any kind of benchmark for Medi-Cal’s fee-for-service fee schedule.

Our principle recommendation is that DHCS should make the reasonable determination that large commercial insurers (with negotiating power) that have negotiated market-based, contractual fee-for-service arrangements with each lab will provide both the most meaningful benchmark data for Medi-Cal *and* the lowest rates set by other “payors.”

Moreover, as further discussed below, we think DHCS will be in a much better position to determine the appropriate Medi-Cal reimbursement rate if it does not *limit* each lab's submission to some sort of "lowest amount" reimbursed by a single payor. Determining the "lowest amount" would not only be difficult for the reasons discussed above, but limiting reporting to that amount would also deprive DHCS of important benchmark data that it could and should capture by requiring the reporting of the *entire fee schedule* of the most competitive payors. Moreover, this broader set of data from such major payors would also likely still satisfy the statutory requirement that "lowest amounts" from other payors be included in the reports.

So, our proposal is that DHCS should require each lab to submit the largest five contractual fee schedules (on a CPT code basis) that it has negotiated with fee-for-service insurance carriers in California (in which the lab is contracted as a participating lab provider) that are in effect on a specified date during the reporting period. It should be possible to develop a spreadsheet for such reporting so that DHCS can analyze it any way it wishes, and Quest Diagnostics would be willing to work with DHCS on the development of such a spreadsheet.¹ In addition, because Quest Diagnostics and most other labs should be able to report not only the selected insurer's negotiated CPT-code specific fee schedule but also the volume of tests reimbursed by that insurer, on a CPT code basis, we recommend that such volume utilization reporting for the top fee schedules should also be required. That way, if DHCS wishes to do weighting or averaging as part of its rate setting analysis (which we also recommend), it will have the data needed to do so.²

As far as AB1494's requirement that labs also report the amounts that other state Medicaid programs are paying, we frankly think this data is not very useful. Different economic conditions in other states can make their Medicaid rates inapplicable to California. States with a lower cost of living are likely to have lower reimbursement rates, and vice versa. Nevertheless, because the trailer bill requires some (undefined) reporting of other Medicaid rates, we

¹ Please note that we think that requiring the reporting of the insurer's entire published fee schedule is most appropriate, as opposed to requiring labs to attempt to calculate and report the carrier's "net" payment amount per CPT code after disallowances. This is because (a) disallowances are usually made on a CPT code specific basis, so that a single denial would make "zero" the lowest net payment amount for most CPT codes (not a useful benchmark), and (b) because it would be very difficult to allocate such CPT code specific disallowances over the typical group of tests involving multiple CPT codes that patients often have performed simultaneously. If a contractual arrangement subject to reporting includes across-the-board or volume discounts from a published fee schedule, however, then the reported fee schedule for that carrier should either include the across the board discount or otherwise disclose the discount arrangement.

² Of course, all data reported by any lab should be kept confidential from other labs and from the public, as it is competitively sensitive information. AB1494 suggests that DHCS use an auditor to collect and assist in analyzing the data, and reporting the data to a reputable auditor under a strict confidentiality agreement should also help to insure that it is kept confidential.

recommend that DHCS select a small group of other states that it believes are most comparable to California and then develop a way to obtain their reimbursement rates, either directly or through some cooperative arrangement with the California labs that also do business outside of California.

Finally, we recommend that following the stakeholder process and the submission by each lab of its first set of data on December 27, 2012 as described above, DHCS require that each lab submit a second set of updated data before the new Medi-Cal rates are set. The new statute requires that the first set of data be for the year 2011, but contemplates that the new Medi-Cal reimbursement rates will not be set until 2013. We think that DHCS should ask each lab to submit 2012 data on or about April 1, 2013, so that DHCS can base its new Medi-Cal fee schedule on its examination of both 2011 and 2012 data.

Use of Reported Data in the New Rate Setting Process

With respect to how the reported data described above should ultimately be used by DHCS in setting its industry-wide fee-for-service reimbursement rates under the new regime contemplated by AB 1494, we urge DHCS to view the reported fee schedules in their entirety, rather than using what we refer to as the “cherry-pick” approach. Under the “cherry-pick” approach, DHCS would set its published Medi-Cal reimbursement rate for each CPT code by picking the lowest rate for that CPT code set by any other payor. This would inevitably result in an overall Medi-Cal fee schedule that is far lower than any other payor’s, which would be entirely inconsistent with the law.

The following hypothetical illustrates the unacceptable results that would come from adopting a “cherry-pick” approach. Assume that a lab’s largest three negotiated third-party payor fee schedules are with Insurer 1, Insurer 2 and Insurer 3, and that (for simplicity) each payor reimburses for three CPT codes (A, B and C) once, at the rates reflected in the table. The last column is the fee schedule that would result for Medi-Cal if it used a “cherry-pick” approach (which we believe would be entirely unsupported).

Insurer 1	Insurer 2	Insurer 3	Medi-Cal
A: \$5	A: \$10	A: \$10	A: \$5
B: \$10	B: \$5	B: \$10	B: \$5
C: \$10	C: \$10	C: \$5	C: \$5
Total: \$25	Total: \$25	Total: \$25	Total: \$15

Under the hypothetical, Medi-Cal’s total reimbursement for all three tests would be \$15, whereas each of the other payors would reimburse \$25 for the exact same three tests. Such significantly under-market Medi-Cal rates would cause labs to disfavor treatment of Medi-Cal patients, severely limit access to care by those patients, and would be inconsistent with the directive in AB1494 that DHCS ensure a rate methodology that complies with the federal Medicaid access to care requirement. Moreover, as a practical matter, such a fee schedule would be opposed by Quest Diagnostics and the rest of the California lab industry, as well as by patient advocacy groups, and would not be approved by CMS or the courts. A key reason why we think

DHCS should require each lab to report its 5 largest negotiated insurer fee schedules **in their entirety** is that DHCS will then have the data needed to make informed and intelligent decisions about what rates are fair and competitive for Medi-Cal. If it has such comprehensive rate data on a CPT-code basis from many labs, especially if it also includes CPT-code specific utilization data, then DHCS will be able to analyze and weight the data appropriately, discard outliers, and develop a rate schedule that will be consistent as an overall matter with other large insurers with market power, and consistent with the law.

We hope that this letter provides some helpful input to DHCS at the outset of the stakeholder process. Quest Diagnostics stands ready to continue to participate in the process as it moves forward over the coming months.

Sincerely,

A handwritten signature in black ink, appearing to read "Halbout", with a large, sweeping flourish extending to the right.

Jean-Marc Halbout
Quest Diagnostics
West Region Vice President