



## Competitive Bidding Demonstration Project Potential Impacts to Health Care

### *Background*

In 2003, Congress passed the Medicare Modernization Act of 2003 (MMA). This bill is primarily known for the prescription drug benefit for America's seniors. Hidden within this bill are other initiatives, which primarily are there to provide funding sources to pay for the prescription drug benefit. Some of those impact the laboratory. One is the 5-year freeze on the Medicare fee schedule. Another initiative, and much more ominous, is the mandate for the development of a Laboratory Competitive Bidding demonstration project.

Basically the Congress has mandated that the Center for Medicare and Medicaid Services (CMS), which oversees Medicare, develop a pilot project to put outreach (or non-patient) clinical laboratory services out on bid, rather than rely on the current Medicare clinical laboratory fee schedule. The government believes that it pays too much for laboratory testing and that by putting it out to bid, it will be able to demonstrate that it can obtain a lower price which could then be applied across the nation. CMS is required to come up with a demonstration project, in 2 geographical areas of the country. The first one will start in 2007 and go for 3 years and the other will start in 2008 and go for three years. After this "demonstration" is complete, the information will be evaluated, the cost savings realized will be analyzed, and the plan is to implement competitive bidding nationwide.

### **The Impact of the Proposed Medicare Competitive Bidding Demonstration Project**

#### **References: Washington G2 Report; Legislative Days documents**

Medicare's competitive bidding demonstration for independent clinical laboratory services payable under Part B is scheduled for launch in its first site on April 1, 2007. A second demo is to begin in another site on April 1, 2008. In both areas, the demo will run for three years. The clinical laboratory industry has unanimously opposed the lab competitive bidding concept, saying it treats lab services as a commodity, rather than a complex medical service that is documented as providing 70-75% of medical decision-making in health care.

### **CMS Policy on Competitive Lab Bidding Demo**

#### ***Q Which lab tests are included, excluded?***

**A** "Demo tests" include all codes on the current Part B lab fee schedule for services that do not involve a face-to-face encounter with the beneficiary. Pap smears and colorectal cancer screening are excluded by law. CMS also is excluding new codes added to the lab fee schedule during the duration of the demo.

#### ***Q Where will the demo run?***

**A** In two sites handled by the same local Medicare carrier. Sites are expected to be within a single state and will be based on Metropolitan Statistical Areas.

***Q Which providers are covered?***

**A** Clinical labs that provide demo tests to beneficiaries living in the demo site. This includes independent clinical labs as well as outreach testing by hospital and physician office labs.

***Q Which labs must bid?***

**A** "Required bidders" are those with \$100,000 or more in annual Part B fee-for-service payments as of calendar 2005 for demo tests provided to beneficiaries in the demo site.

***Q Which labs don't have to bid?***

**A** Small labs with less than the \$100,000 threshold, defined as "passive labs." But they may bid if they choose.

***Q Which labs will be paid by Medicare?***

**A** Both required and non-required bid winners will be paid the competitively bid price for demo tests in the demo site (regardless of where the lab is located). Price will be set based on a composite of bids received and other calculations. To win, labs must bid at or below the composite rate. Multiple winners are expected in each demo site. Demo-excluded tests will continue to be paid via the Part B lab fee schedule.

***Q Which labs will not be paid by Medicare?***

**A** Both required and non-required bidders that bid and lose. Medicare will pay them \$0 for demo tests (regardless of where the lab is located) for the duration of the demo. Similarly, Medicare will not pay for demo tests performed by required bidders that do not bid.

***Q How will passive labs be paid?***

**A** They will get the competitively bid rate for demo tests up to an annual ceiling of \$100,000. If they exceed this ceiling by \$25,000 or more, they will get \$0 for the duration of the demo.

***Q Who can bill for demo tests?***

**A** Only the lab that performs the test and only winning and passive labs are eligible for the demo payment rate. Non-winning labs cannot bill Medicare or the beneficiary, but may refer demo tests to a winning or passive lab. Strong opposition to this demonstration and the concept of competitive bidding must be voiced to our Congressional leaders and CMS. Should the demo occur and the concept implemented in every metropolitan statistical area across the nation the following would be evident:

- Beneficiary access to laboratory services will be more limited since services could only be obtained from winning laboratories.
- Hospital and clinic outreach laboratory services may close, impacting profitability, jeopardizing jobs, and limiting beneficiary access close to home.
- More, if not all, Medicare non-patient testing will be sent to large national reference laboratories, which may be located outside our state and may delay testing results.
- Since incentives exist for labs to decrease cost in order to submit low bids to win, the quality of laboratory services will be jeopardized, at a time when healthcare's focus is on improving quality and patient safety.

## ***Projected Impact for Hospitals and Our Rural Health Communities – Devastating!***

### ***Impact on our Rural Communities:***

- Access to full range of clinical laboratory services would be affected adversely. Local and/or regional laboratory services may not be winning bidders
- Courier transport & service levels may decrease due to increased cost to provide in rural settings – fewer pickups; unacceptable times (pickup times set by bid winner based on cost of service not facility need)
- Increased TAT for laboratory results equals increased time to disease diagnosis or clinical intervention; STAT or urgent testing may not be immediately available
- Potential loss of quality support/service for rural laboratories (outreach consultation support not available)
- Fragmentation of total service at local level – Medicare B handled differently from IPs, OPs, other 3<sup>rd</sup> party payers; increased error potential; increased direct cost due to duplication in process
- Cost/test for hospital laboratory services performing outreach testing would increase for inpatients and outpatients (24-7 service coverage and minimum staffing still required; critical test offerings would still need to be available)
- Decreased reimbursement for passive laboratories, hospital outpatients, POLs – competitively bid fee schedule is predicted to be at a minimum 5% less (% predicted to be considerably higher for routine automated testing which is the majority volume of testing within our local and regional laboratories).
- Large national reference lab may win the bid – Glucose winning bid = \$2.50; current fee schedule = \$6.64

### ***Impact for Providers & Medicare Beneficiaries:***

- Physicians would lose the ability to choose the laboratory service they believe best serves the needs of their patients. Laboratory service choices related to patient convenience, quality of service, testing accuracy and timeliness of results would be replaced by government (CMS) allocation of service based on price and service coverage area.
- Patients may have to travel considerable distances, at great inconvenience, in order to obtain services from a bid winning laboratory. This may result in patients not receiving services in a timely manner or even at all.

### ***Financial & Testing Volume Impacts:***

- Even though competitive bidding as proposed, only affects the Medicare testing and revenue stream, it has the potential to completely shut down outreach services if the current Medicare testing percent is high.
- If originating hospitals and clinics must send Medicare non-patient testing to bid winners, they may choose to send 100% to that laboratory to avoid service fragmentation and the cost of performing duplicated processes.