# For labs, opportunity knocks as wallets close

## Karen Titus

August 2013—Robert L. Michel doesn't claim to have all the answers to all the problems laboratory medicine now faces. But as editor-in-chief of *The Dark Report*, the industry intelligence publication, he knows what those problems are chapter and verse. He also sees where future problems lie.

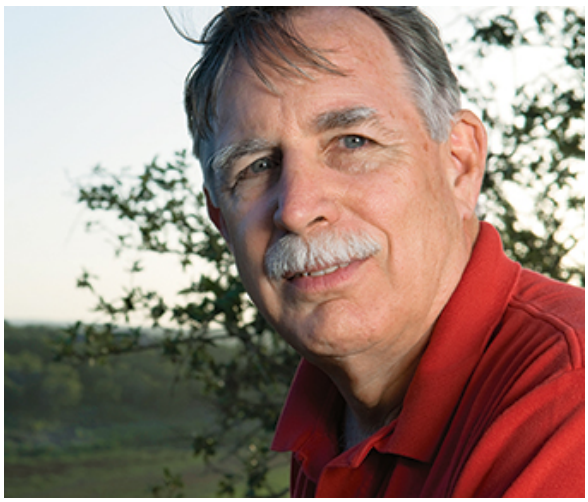
Michel shared his analysis at the opening session of *The Dark Report's* Executive War College, held in New Orleans in April. As it turns out, journalism's well-known axiom, Follow the money, works equally well in medicine. Michel walked his audience along the money stream, showing where it flows in health care—and where it dries up.

The government, of course, is one of the clinical laboratory industry's biggest customers, if not its wisest or most focused. The federal government pays for defense, education, and public works, among other things, as well as for health care. And it's done so at a fairly consistent clip. Federal spending as a percentage of gross domestic product, Michel reported, hovered slightly above 20 percent, on average, between 1960 and 2010. Unfortunately, federal income doesn't match outflows—it averaged about 18 percent in that same period.

With the most recent recession, the gap between revenue and spending widened. Federal revenues dropped to just under 15 percent of GDP, while spending bumped up to nearly 25 percent of GDP. That has since evened out a bit. But while federal revenues have returned to 18 percent, spending is still at 25 percent—and projected to rise to more than 26 percent by 2021 if current expected levels remain.

By now, that gap, and what the federal government should do about it, are familiar discussions to all but cave dwellers. Spend less! Tax more!

But the latter, said Michel, won't happen. The gap between federal receipts and spending has persisted at least as far back as 1929. Average spending over more than eight decades has been 18.3 percent (apart from an Alps-like spike during World War II), and average receipts have been 15.3 percent. Pathologists and other laboratory personnel need to understand, he said, "that no matter what they talk about in Congress, Congress cannot raise federal taxes enough to make up this gap. This truly is a spending gap," one that has remained consistent since the days when Herbert Hoover held office.



**Robert Michel:** "The marketplace that your lab served has reached a tipping point, and it's not going to be the same environment going forward that it's been over the last five or 10 years."

States face their own perpetual budget crises. Citing a *New York Times* article from June 21, 2011, Michel noted that states faced a collective $176 billion shortfall in meeting their public pensions obligations (although some states are operating in the black). “Illinois is the poster child for this. They’re $37 billion short of meeting an 80 percent goal for funding their public employee pension trusts,” he said. Ohio is $23.9 billion short; New Jersey, $18.8 billion.

That doesn’t mean states are failing to spend on health care. The variety here is striking, too. Among the states, said Michel, citing an April 8, 2013 *Wall Street Journal* article, Alaska leads the way, spending $9,128 per capita (2009 figures); Washington, DC, spends $10,349 per capita. Utah controls its purse strings more tightly, spending a low of $5,031 per capita.

The elections in 2010 failed to simplify matters. “The American people didn’t change anything,” Michel said, re-electing president Obama and leaving the Senate and House in the hands of, respectively, the Democrats and the Republicans. “The political commentators don’t want to acknowledge that, but the people voted the status quo, probably because they don’t trust anybody.”

But if the financial and political scenes are complex, Michel’s message was not: “My point about the money is that, particularly at the federal level, there’s not enough, and there’s not the political will to do what needs to be done to fix it.”

That means labs need to be savvy about the health care marketplace, mostly because of the upcoming end to pure fee-for-service reimbursement. The office-based physician sector of health care is undergoing transformation, for example. And the economies of scale created by Quest and LabCorp—the obvious way to grow and maximize profits in a fee-for-service environment—are no longer the reliable income generators they’ve been for decades. Or, as Michel put it: “There’s trouble in River City, because bundled reimbursement and value-based reimbursement [are] heading down the pike.” Unfortunately for labs, the danger isn’t a pool table.

Along with changing reimbursements, labs are experiencing a change as office-based physicians move from being owners to employees. Hospitals and health systems are buying physician practices, and major health insurance companies are acquiring large medical group corporations. “Even employers have started opening up clinics and medical service facilities within their own offices and factories.”

If the physician is an employee, who decides which lab the medical practice will use? “It’s going to be the owner,” Michel said, answering his own question. If the owner is a hospital, it’s logical the work will go to that hospital’s lab. If the owner is an insurance company, the loss-leading rates that Quest and LabCorp offer might prove attractive. “The point is, it will not be the doctors themselves deciding which local laboratory or national laboratory they want to use.”

Relatively recent data from the Medical Group Management Association’s physician compensation and production survey helped Michel make his point. Physician-owned medical practices dropped from 70 percent in 2002 to less than 50 percent in 2008. Meanwhile, hospital-owned practices increased from 20 percent to more than 50 percent in that same period. By 2011, physician ownership of groups approached 30 percent, while hospital ownership was pushing 60 percent.

Furthermore, said Michel, data (based on an analysis by the Accenture consulting firm) from the MGMA and the American Medical Association show that even as the number of physicians was estimated to grow between 2000 and the present, from 683,000 to 793,000, the percentage of those who are independent was projected to drop, from about 57 percent in 2000 to 33 percent in 2013.

Something else has changed as well: greater emphasis on outpatient versus inpatient testing. By design, medical homes and accountable care organizations want to keep people out of the hospital. From 2004 to 2010, he noted, Medicare outpatient services grew at double-digit rates while hospital inpatient discharges per fee-for-service beneficiary declined.

While individual institutions may see modest growth—two percent, five percent—in inpatient admissions, Michel called that cold comfort. “At the same time you’re seeing growth in your inpatient count, you’re capturing a smaller proportion of all the health care services in your community.”

Michel’s argument was clear: “The marketplace that your lab served has reached a tipping point, and it’s not going to be the same environment going forward that it’s been over the last five or 10 years.”

Darwin might have had a field day poring over these evolutions in medicine, but for labs, the message allows scant room for intellectual enjoyment. Labs need to develop new strategies. Quickly.

A good starting place, Michel suggested, is to wrestle with the question he posed earlier: If people other than physicians are deciding where to have tests performed, how will they choose one lab provider over another? Michel said these nonphysician owners would be looking for the best value proposition.

“There’s going to be opportunity in all of this for innovative lab organizations,” Michel told his audience, “but it’s not going to come easily. It’s going to require initiative. It’s going to require you stimulating your lab team to be proactive—*What can we do? What can we try?*”

As an example, he talked about patients who now have annual deductibles of, say, $1,500 per individual or $5,000 per family. “Your labs are going to need to collect the entire bill, probably through June, July, August of a calendar year. Is your lab prepared to be collecting 100 percent of lab test claims? You may need to have a cash drawer in every phlebotomy station, because it’s smart to collect at time of service. That’s what the doctors and the radiologists and the ancillary care providers are doing.”

Labs will also need to sell the value of testing, rather than tout low prices.

At John T. Mather Memorial Hospital, in Port Jefferson, NY, the laboratory managed to do just that when it targeted *Clostridium difficile* and methicillin-resistant *Staphylococcus aureus*. The lab, which runs 2.3 million tests annually, added a PCR assay, which meant an additional $448,400 in screening costs of high-risk patients from 2008 to 2012. The number of MRSA infections, however, dropped from 74 in 2007 to 18 in 2012. That translated to $1.96 million in cost avoidance, or a net savings of $1,511,600.

The new testing algorithm, added at the same time, created a stratified protocol in which the lab continued to use its ELISA but triaged a certain percentage of patients to PCR. In four years of doing this, the number of *C. difficile* infections dropped from 70 to 26, Michel said. The increased lab costs came to $86,460, but the cost avoidance was $1.54 million, with the net savings an impressive $1,453,540.

“This is how you organize your lab to deliver value,” Michel said.

Labs should have plenty of incentive to make similar changes of their own, given that the government’s wallet is empty, he said.

Asking for a show of hands, he noted that only 10 percent (a figure he deemed generous) of audience members had been paid for certain molecular tests since Jan. 1. “You all should be very angry about this,” he said. And since private payers are waiting for Medicare to act, “You’re not getting paid by the private payers, either.”

Nor will matters improve. “It’s going to get worse before it gets better,” he predicted. Policymakers and claims administrators can’t keep up with technology changes or demand for services. The only change Michel sees ahead is even deeper cuts, from both public and private payers.

“Don’t be caught asleep at the switch,” he warned.

On the bright side, however, those who remain awake will find something worth cheering. “There will be 320 million Americans who continue to get lab testing,” Michel concluded. “That’s not going to change. *Some* lab is going to be performing these tests. Why shouldn’t that lab be your lab?”

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