Fresh options fuel lab asset reshuffle

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May 2016—Father Guido Sarducci (Don Novello), of *Saturday Night Live* fame, boiled college business class down to one principle in his satirical "Five Minute University": You buy something; you sell it for more.

One can only dream of business being that simple in health care. But for laboratory, hospital, and health system executives who are weighing new business strategies for laboratory services, some would argue that the pressures of the economy, the regulatory environment, and hits to reimbursement boil down the choices to three: grow, outsource, or sell.

First of two parts. June 2016: All for one, one for all? Laboratory consolidation

There are many variations in how those choices are playing out, laboratory industry leaders say. But in CAP TODAY interviews, laboratory executives and consultants in mergers and acquisitions suggest that new business deals, whether in the form of outsourcing, mergers, management agreements, or joint ventures, are reshaping the landscape for independent and hospital-based laboratories.

"All the larger macroeconomic forces are driving change in health care—the transition from fee for service to fee for quality, bundled payments, the growth of networks, and the pressure on payers and providers to be as efficient as they can," says Patrick Allen, managing director with the mergers and acquisitions practice of Kaufman, Hall and Associates in Skokie, Ill.

"Five or 10 years ago, health care systems and providers wanted to do any and all services they could do reasonably well, and get paid for them. I think systems are transitioning now and trying to understand what their strengths are. There's really more of a competitive analysis."

Allen

Much of Allen's work involves strategizing with hospitals and hospital systems on whether, in providing laboratory services, they need to divest, or partner, or joint venture with some of the for-profit players. Some 100 health care organizations a year are now striking such deals, he says, compared with 40 or 50 a year in 2006. "We've seen a pretty good ramp up in the number of transactions," he says. As to the mergers of billion-dollar-plus hospital systems, or what the *Wall Street Journal* has referred to as "supersizing" of hospital networks, "we've had more in the past three or four years than in the previous 25."

For laboratories, a critical part of the trends is the changing role of outreach. For years, outreach has been a way of leveraging a hospital asset, says Robert DeCresce, MD, MBA, director of clinical laboratories at Chicago's Rush University Medical Center. "Laboratories would take advantage of their underused capacity and get new business from the surrounding area, and people still want to do that. But one of the things that often happened is that the outreach programs would use their hospital provider number for billing. So a lot of insurance companies might pay the hospital significantly more for lab tests than they would pay a commercial lab, just due to the nature of the contracts they have with hospitals."

That model has started to unravel, says Dr. DeCresce, who is the Harriet B. Borland professor and chair emeritus, Department of Pathology, Rush Medical College. "With accountable care organizations, the idea is that doctors, hospitals, and health plans are going to be responsible for the total cost of the patient encounter. So having high prices for laboratory tests doesn't necessarily help." (Dr. DeCresce serves on a health care roundtable at Madison Dearborn Partners, a Chicago firm that invested in Kaufman Hall last year.)

Outreach is still a profit center for many centers, Allen says, noting that for some academic medical centers, outpatient testing is done at a 100 to 125 percent markup. But patients saddled with higher-deductible plans are starting to ask how much their tests are costing. And so are insurers. "We saw this with some of our clients in Massachusetts, where insurers would say, 'You need to get your inpatient rates closer to outpatient rates, because if tests can be done outside the hospital, we're going to start reimbursing you at outpatient rates.'"

"Institutions committed to outreach can be successful, but the industry has changed," says David Nichols, MBA, president of Nichols Management Group in York Harbor, Me., which provides laboratory consulting, including strategic planning, operations optimization, mergers and acquisitions, and joint ventures.

"It is not like 10 or 15 years ago, when you could make minor investments to get in the business, such as hiring a sales rep or two, buying a few courier cars, and opening two or three draw stations. Now it requires strong management to be able to execute because the margins are tighter due to reimbursement decline and it's more difficult to thrive and compete with the national reference labs without larger investments in IT infrastructure and support functions."

So hospitals and health systems now have a question, Dr. DeCresce says. "Do they want to keep all their business from all their doctors and do it themselves? Or should they partner with someone who is better at doing it and can do it at a lot lower cost?"

Sometimes partnerships can indeed be the answer. "If I have a big outreach business, that's worth something to a commercial lab. They might actually buy it from me and I can have a joint venture with them," Dr. DeCresce says. Alternatively, because reimbursement is declining, some hospital and health system executives are considering whether a third party can run their inpatient laboratories better than they do. "People are starting to think, if Quest or LabCorp can buy supplies a lot cheaper than I can and I'm sending my reference work to them anyway, maybe I should get one of them to run my labs."

At Seattle's Swedish Hospital, for example, LabCorp has run the laboratory on site for several years. That arrangement is a relic of LabCorp's 2002 purchase of Dynacare Laboratories, which bought the pathology lab that serviced Swedish more than 20 years ago, says CAP TODAY publisher Robert McGonnagle. "It's widely regarded as LabCorp's most successful venture in this direction. And, again,

many assume LabCorp would love to duplicate that in 20 metropolitan cities."

Dr.
DeCresce

That model is gaining more traction now, as hospitals feel more pressure on the cost side, Dr. DeCresce says. Information technology problems used to pose an obstacle to such arrangements, because it was always hard to trade data between different systems, but that problem has been largely solved, he adds. For example, "It's not as big a problem now for Quest to send results to my Epic system."

These factors are easing the way for increasing numbers of deals between hospitals and the national laboratories, including outright sales and joint ventures, Dr. DeCresce says. "Some people are just buying the outreach. The hospitals have an asset, and Quest and LabCorp need to grow to keep their stockholders happy. It's becoming more and more difficult for these labs to grow, so acquiring hospital outreach business and even the entire lab business from a hospital may make some sense."

Many similar acquisitions are in the offing. "Both LabCorp and Quest are challenged to get bigger, and what's the biggest market in the entire U.S.? Hospital labs." With about 67 percent of the market, the hospital laboratory business dwarfs that of all the physician offices. It's an area, too, in which the big commercial labs have little penetration, so there's a lot of room for them to grow there, Dr. DeCresce says.

Confronted with the make-or-buy question when it comes to laboratory services, hospitals can find infrastructure a stumbling block. At Rush, he says, "We used to have a very big outreach business, and we folded it back 15 years ago because we lost one of our biggest clients. And we really didn't have the infrastructure in place to expand. That can include a client service, automobiles—a whole series of things that have nothing to do with running tests. And infrastructure is typically lacking at big hospitals."

The hospitals also often have to decide: Is it better to spend $400,000 on cardiologists to bring more patients to the hospital or to spend $400,000 to fix the laboratory? "I think hospitals will focus capital on what brings patients to the hospital," Dr. DeCresce says. "Labs are important. But the hospitals don't necessarily have to own all of the lab to be successful." Hospitals can avoid capital expenditure by having someone else take on their lab testing, he notes, just as other services might be outsourced.

Having acquired physician practices, "a hospital may find itself all of a sudden with such a flood of new tests, along with new technology demands and the basic organic growth of testing, that they're faced with having to make a substantial investment in their lab operation," McGonnagle says. "That often takes the form of building a large, expensive off-site lab with capital outlays of $15 to $40 million."

Geisinger Health System in Pennsylvania was faced with this situation recently and opted to invest in Geisinger Medical Laboratories (see "New lab, new efficiencies: doors open at Geisinger," CAP TODAY, July 2015, page 80). But hospitals that are thinking about such large outlays might talk with a mergers and acquisitions consultant about selling the entire lab operation. "Certainly, Quest and LabCorp are

interested in purchasing the whole shebang, or they may want to operate it under a management contract," McGonnagle says.

Both large companies have a business model that depends on growth, but a new wrinkle has surfaced. McGonnagle notes that, like all independent labs, "they've lost certain customers that have been acquired by systems." The physician customers who used to make a decision in their favor may no longer be the decision-makers.

In the face of such challenges, Patrick Allen sees the large national labs as motivated to make deals on outreach business—and as creative in devising deals. "It's really running the gamut of saying, if you want to sell it, we'll buy it, or if you want to venture or joint partner with us in some responsible way, we're willing to work with you on that front."

The size of a facility or hospital network plays a key role in the decision to sell, partner, or outsource laboratory services, says David Nichols. "There are certainly economies of scale that exist. If a system is very large and they have penetrated their entire physician staff and there's no more room to grow, it may be an opportune time to sell."

Nichols

If a system is small and lacks a large physician staff to internalize, it may also wish to sell to an outside reference lab. Midsize systems that still have growth, and large successful systems that are continuing to acquire other hospitals, such as Northwell Health (formerly North Shore-LIJ Health System) in New York, are in better shape to stand alone, Nichols believes.

Declining reimbursement has long been part of the laboratory world. "It's like a slow, steady drumbeat that just won't go away," Nichols says. "Historically, there has always been declining reimbursement but new tests offset the decline," such as HDL, hepatitis, PSA, HIV, and vitamin D testing and monolayer Pap technology. However, reimbursement reductions are now broad-based, there is far greater visibility and transparency of laboratory pricing, and, most important, he notes, almost all insurance policies have gone to a higher deductible or copayment, making patients more aware of pricing. In time, new tests will help bolster average per-test reimbursement, just as in the past.

Growth is essential if a laboratory is confronting a declining reimbursement market, Nichols points out, because the laboratory has the highest fixed costs and lower variable costs when compared with other hospital departments. "If your organization is unable to execute on an outreach growth strategy, the best option may be to sell your outreach business." Quest Diagnostics recently made a number of highly visible purchases of hospital outreach systems; he estimates about 10 have been made in the past year or two, and he expects this pattern to continue.

But models other than purchase are common. Quest has stated its intent to expand business through strategic partnerships with hospitals and delivery networks. "Quest has a very large number of joint ventures with hospitals," Nichols says. "I believe they are managing about 60 inpatient hospital labs."

LabCorp takes a slightly less intensive approach. “They do manage some inpatient labs. They have a model where they will provide a lab manager, and in doing so they are able to pass on some of their significant purchasing power for that client’s supplies, reagents, and equipment.”

The national labs are increasingly scooping up other independent laboratories too. For example, Dr. DeCresce was on the board of Greensboro, NC-based Solstas Lab Partners and subsidiaries when Quest purchased them in 2014 in a $570 million deal. Solstas CEO David Weavil praised the deal as a “strategic partnership between innovative laboratory providers,” while Quest president and CEO Steve Rusckowski said the purchase supports the company’s strategy, which includes “restoring growth and driving disciplined capital deployment through strategically aligned, accretive acquisitions.”

Hospital systems’ purchases of physician practices is a major driver of the restructuring trend. About 50 percent to 60 percent of physicians, Nichols estimates, are now owned or managed by a health system, and Nichols Management Group believes the figure will approach 70 percent in the next two years. For hospital laboratories, such purchases can boost business through “inreaching”—health systems making sure they are servicing all the physicians who have staff privileges.

The trend for physician practices to consolidate or sell into health systems hinders the physician office strategies of Quest and LabCorp, he adds. “If 150 physicians join a very large group, it’s likely they will have their own lab and/or they will contract at a very low cost per test with Quest or LabCorp. If there are 150 doctors negotiating, they can get a much lower price than two doctors negotiating on their own.”

But regional differences abound. In San Francisco there are four or five very large physician groups, and in Boston it’s rare to find physician offices not affiliated with a large group or system. San Antonio represents the other end of the spectrum, Nichols says. In some areas of Texas, “it’s extraordinarily fragmented and very many independent doctors are still largely on their own.”

Nichols downplays the role of access to capital in hospital systems’ decisions to sell. “Capital decisions are not paramount because health systems need a lab, they need equipment, and they need a computer system regardless of whether they are progressively in outreach or not.” The primary considerations, he says, are whether outreach is a distraction for senior management, what kinds of risks compliance poses, and the difficulty of attracting and retaining lab personnel as the workforce ages. The value of the hospital owning its laboratory business, Nichols says, is that clinical lab staff are engaged with hospital-based initiatives in, for example, sepsis prevention, *C. difficile* management, patient satisfaction, overall decrease in length of stay, and readmission rates.

“My suggestion is to either be committed to the space or get out of the space,” Nichols says. That decision is contingent on the competitive environment regionally and many other factors; each situation has to be analyzed on its own merits. For laboratory executives, he says, “the key is being able to objectively analyze the laboratory and organization’s capabilities and determine whether your laboratory can execute on the fundamentals of contracting, sales, IT, and quality, in order to be successful in an increasingly competitive environment.

“If you are confident you can, retaining the lab brings many advantages to a health system, especially as it relates to population health management since direct control of patient data is not convoluted by interface complications and disparate IT systems. If not, then selling your outreach business may be the best alternative.”

Some hospitals are encountering an unexpected side effect on their laboratory when they purchase physician practices and expect to benefit from inreaching, Allen says. “At some systems, physicians are brought in and they start sending their patients to get labs done at a hospital draw station. And patients object, saying, ‘The last time I had my labs done, I had a $20 copay. Now I’m paying $150. What’s going on?’ If the physicians say that’s a hospital-based charge, some patients are starting to say, ‘Well, I’m not paying it. I might be going to Quest or LabCorp.’”

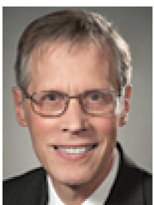
Not only do physicians feel the pressure from patients, but in accountable care organizations with quality initiatives, doctors are getting judged on the total cost of care, Allen notes. “They start to look at hospitals and say, ‘Hey, you’re blowing up my numbers by providing these services at two or three times the cost of what I could get elsewhere.’”

Since hospitals have been paid for inpatient care by DRGs since the 1980s, many have tended to be weak at keeping records of laboratory testing costs on the inpatient side, Allen has found. “When we go into these hospitals and ask what’s your percentage of cost of care related to labs and other ancillary testing, their answer is often, ‘Well, we don’t know. It’s all rolled into one big bundled payment.’” Once the consultants at Kaufman Hall push a little to get hospitals thinking about their cost per test, the hospitals might realize they can do the tests at regional labs for half the cost, Allen says. “They kind of look at their lab directors and say, ‘Well, why aren’t we doing that?’ And the lab directors say, ‘Because no one ever asked us to.’”

That inaction can hurt laboratories when they are proposing large capital expenditures. “Labs are capital-intensive businesses, and when the lab directors come in and say we need $5 million or $10 million to expand or build out the lab, the financial folks are starting to ask, ‘What will this do for us and what is the return on investment?’ For a lot of the smaller players, their volumes are decreasing and their reimbursements are down, and the question becomes, ‘Can we keep doing this?’”

Patient data analytics are an attractive part of what the national labs can offer hospitals, Allen says. “The national lab players are starting to be able to gather test results and test quality [data], and how they fit within the whole care package, and develop optimal protocols for lab testing for certain conditions that are as efficient as they can make them. And they are starting to push those out to the market.”

Payers and hospitals are receptive, Allen says, because it reduces their testing costs and their total cost of care. Under current Medicare rules, “if you are below a certain threshold, you either get bonus payments or you get to retain some of the unspent premiums. Data analytics may reduce some of the volumes, but you may not care because you’re getting a piece of the quality or efficiency pie on the other side.”


Dr.
Crawford

However, James Crawford, MD, PhD, senior VP and executive director of laboratory services at

Northwell Health, says there is a missing piece. While Quest provides outstanding data analytics, “the problem is Quest has ambulatory data but they don’t necessarily have hospital data. Two-thirds of the cost of caring for patients with chronic disease and multiple comorbidities are hospital costs, and that data is ultimately what will be required, not just the ambulatory data.”

Could hospital-based laboratories and independent pathology labs eventually be “rolled up” as they are either purchased or put out of business by the Fortune 500 national labs? Allen doesn’t know if the lab industry will follow the pattern of the corner pharmacies that disappeared into a CVS and Walgreens world. “But I certainly see the major markets as being fertile ground for these national players to set up strong regional labs that will be effective competitors.”

Competing against the national labs is no walk in the park, Allen points out. “The laboratory business is a tough business to get your feet planted in. You need significant scale and expertise. Some of the larger systems are going to be able to play that game, like Northwell. They may have the volume and the wherewithal to compete, but those systems are few and far between.”

Laboratories in the middle range have to shoulder an unfamiliar task. “Analyzing laboratory business and services and efficiency to justify being a standalone entity—that kind of rigor just hasn’t been part of hospital labs’ operating model,” Allen says. Historically, laboratories have been a cost center and a necessity for the hospital to treat its patients. “And they continue to be that. But now they need to step back and ask: Are we competitive with other services that we could buy outside the four walls of the hospital? And if not, is it the right time to monetize this asset, or should we embark on improvement initiatives to make sure we’re competitive going forward?”

Allen insists there is still room for traditional labs to prosper. “We’re not saying everybody needs to be acquired and hospitals shouldn’t be in the lab business. But you need to look at lab testing as a consumer-based product. And you need to be competitive on cost and quality. If you can’t get there in your current environment, find someone who can help.”

“It’s not fire sale time,” he says. “There’s still a lot of value in the volume that hospitals bring through labs, but you can’t count on the insulated hospital environment to continue to feed you. You really do have to be conscious of your value proposition to the physicians.”

A new source of uncertainty or even pessimism amid these market conditions is the unknown role of the Protecting Access to Medicare Act of 2014. Under PAMA, the Centers for Medicare and Medicaid Services plans to take the private payer rates that laboratories report to the agency and use the weighted median prices for the Medicare rates.

These rate adjustments could bode ill for laboratories. “Generally, if Medicare is one of your better payers and is about to make cuts,” Dr. DeCresce says, “it’s probably not unreasonable to think the value of your asset might be worth less.” He believes some people are feeling, as a result, that the outreach business might now be worth as much as it is ever going to be, making this a good time to sell.

Nichols sees less urgency. “PAMA won’t be a net plus for the industry by any stretch, but I don’t believe it will be a death blow.” The increasingly technical and sophisticated test-ordering patterns of physicians, and the growth of personalized and esoteric testing, will serve to largely mitigate the effects of reimbursement cuts, in Nichols’ view.

There’s no doubt that hospital mergers will continue, Dr. DeCresce predicts, although there is a

practical limit to the degree of consolidation hospitals can achieve. “The Federal Trade Commission establishes that you can control only so much of a market. So here in Chicago, NorthShore University HealthSystem and Advocate Health Care wanted to merge, and the FTC said it would be anticompetitive and is preventing it.”

Much of the CAP membership, Dr. Crawford notes, is still practicing in small pathology groups. To those providers, “My message would be that you need to be attentive to these major dynamics in the market. It’s very important to be working with your immediate colleagues to become credible negotiators in the managed care market, both with hospital systems and physician-based practice systems, and in turn with payers.” As consolidation continues, “Working with the regional consolidation of pathology and laboratory networks, either through existing networks or by forming your own, is one way to maintain some control over your destiny.”
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