Outreach: Forge ahead or accept purchase bid?

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July 2017—With the laboratory industry in flux—and many critical determinants of the next few years waiting on policy moves by the new administration and third-party payers—hospital outreach programs could wish for a better time to make existential decisions such as accepting an offer to be purchased.

Following on last year's surge of purchases of hospital outreach programs by Laboratory Corp. of America, Quest Diagnostics, and Sonic Healthcare, the pace of acquisitions has only picked up in 2017.

"When someone comes in and offers you a really big number for your lab, it makes you take a pause," says Jason Newmark, vice president for diagnostic services at Baystate Health, Springfield, Mass. But he thinks many laboratories should not be in a hurry to say yes. "Whether you sell or not should depend on the circumstances of your organization."

As one of the largest reference labs in New England, Baystate has been approached numerous times by the national commercial labs interested in a joint venture or a purchase. Major competitors of Baystate have already accepted such offers, including UMass Memorial Health Care's lab outreach and Hartford HealthCare's outreach operation, Clinical Laboratory Partners, which were bought by Quest over the last few years for "gigantic sums of money."

First of two parts

Baystate, which has notched double-digit growth in recent years, has so far opted not to sell. Some hospital outreach programs that did sell were experiencing financial challenges and had reached a crossroads, Newmark says. "They felt they had grown as big as they could and to grow bigger would require a big investment." In contrast, "We feel uniquely positioned as really the last standing large-scale operation in the region that can compete with the national labs."

Hospital labs' turnaround-time advantage over the national labs is not as significant as in the past, he points out. "In our region, Quest has a brand-new, state-of-the-art lab on a major highway just outside of Boston, and while turnaround time may have been a problem historically on send-outs, now the testing is really within a one-hour drive of most areas of the state." Some tests like troponin, D dimers, and those for oncology will always be kept on site, but it's more difficult to keep the more esoteric microbiology or some of the new molecular testing on site because of the low volume or the expertise needed to run it.

Medicare's new payment scheme under the Protecting Access to Medicare Act of 2014 could have a multimillion dollar impact on Baystate and other labs, Newmark says. "That forces us to really look at our own efficiencies and processes. Do we have the right equipment? Are we doing the right tests on site? Are we staffed appropriately and processing specimens in an efficient manner?"

Efficiency or growth are the only two alternatives for a lab to offset the losses expected with PAMA,

Newmark believes. “Looking at what differentiates us from someone else in the marketplace, we’re focusing on getting an understanding of referral patterns, algorithms to provide clinical decision support, and how we can help people order the right tests that will drive down costs.”

But, he says, “if we can’t efficiently maintain a certain level of service, that’s going to put us in a very different position of maybe saying we should outsource more testing.” Many organizations will struggle as a result of the PAMA cuts, slated to be effective Jan. 1, 2018, if they lack a sound infrastructure and sound space to work from.

Both Quest and LabCorp, Newmark adds, can choose between trying to compete in a market or aligning with hospitals and potentially purchasing their outreach program. The large labs have the money to do that and bring a lot of the testing to their main hubs in North Carolina or New Jersey, and not worry about the competition anymore. “I imagine they’ve run the numbers on it to show that whatever they spend to buy an outreach program, they’re going to make a return on investment pretty quick.”

Newmark

However, Newmark suspects some clients have moved on after the recent acquisitions in his region. “We’ve been approached by many clients that used to send work to UMass or Hartford in the past and they’re saying they’re looking for an alternative. I can’t tell you we’re better than Quest, but I think we have a local presence, and a very good, responsive level of service.” At this time, he adds, Baystate is also financially viable, has recently hired additional sales and service representatives, and is seeking efficiencies within the laboratory to streamline its workflow.

Baystate’s relationship with Mayo Medical Laboratories, its reference lab, is not based strictly on bottom line considerations, Newmark emphasizes. “We have a very good synergy with Mayo.” Under the labs’ multiyear contract, “We agree to send them a percentage of our total send-out, so they are by definition our primary reference lab. Mayo is never going to beat Quest or LabCorp on price, but we don’t want to just be a client; we want a partnership, or collaboration where we can look at ways of doing innovative data analytics, utilization management, population health, and so on. We’ve found that partner in Mayo.”

Staff efficiencies are part of the game plan in the takeover deals, he says. “I would assume there’s definitely a loss of jobs and that would be a big concern for us.” As one of the major employers in western Massachusetts, Baystate has about 700 people working in the laboratories, six percent of the organization’s total employees, and many have a long tenure with the system. However, Baystate is carrying out its own plans for streamlining workflows and assessing opportunities to rightsize staffing models, Newmark says.

When microbiology, histology, cytology, and esoteric molecular and genetics testing at all five hospitals were consolidated into Baystate’s core lab, staffing was reduced. “We needed to take an honest and deep dive into staffing and the testing we do on site. For example, we made the very difficult decision to outsource all cytogenetic testing last year, for lack of volume and weak reimbursement. Eight to 10

people were displaced in that decision, but financially it made a lot of sense." The laboratory saved $500,000 to $600,000 in a year by dropping its in-house cytogenetics testing.

Overall, Baystate's laboratory removed more than a million dollars of salaries between last year and the current year, even while its year-to-date testing has risen by six to seven percent. "We are improving our efficiencies and finding ways to reduce our non-wage expenses as well. However, the truth remains that our primary expense is people," Newmark says. "You're going to have to grow exponentially because everything in the lab is volume to drive down the overall cost of testing. There's a 'sweet spot' where you can bring in lots of volume without having to add people. Then there's that 'step function' where you're probably going to have to add a little more than you need; then you just have to crash on volume until you get to that next step function."

Like most outreach programs, Baystate's program originated with the laboratory's excess capacity, and Newmark believes the magic question has not changed: "Can you bring in enough volume to take advantage of the capacity?" With the right infrastructure, especially IT connectivity, the market to maintain sales, and the ability to differentiate one's program from other labs, he says, hospital outreach can thrive.

There's still room for Baystate's laboratory to grow. But it has already extended its catchment area all the way to Boston and almost to the border with Rhode Island. "And that creates a whole new set of logistics for us." Could that be too far? "If we get to the point where we just don't know if we can compete anymore, or to get to the next level requires capital investment, we may pause and ask should we partner with somebody or do we really, truly have the horsepower to continue on our own?"

In some ways, hospital lab outreach programs are ripe for the plucking, says Stan Schofield, president of NorDx, the core laboratory of MaineHealth in Scarborough, Me. Laboratories are being sold off for three main reasons, in his view. "First, they can't compete at the much lower reimbursement that's in store" when PAMA kicks in. Second, many insurers have narrowed their networks for testing providers to just Quest and LabCorp, hindering hospital labs from making a profit on their services.

"And third, hospitals have much higher service and technology demands than revenue coming in, and they may have to have a garage sale somehow. They can't sell off janitorial or easily outsource imaging and radiology, so the lab is one of the first things to get served up."

NorDx began 20 years ago as the core laboratory for three hospitals and now serves the 10 hospitals of MaineHealth, a quarter of the hospitals in the state. So it's been 20 good years, says Schofield, who is co-founder and managing principal of the Compass Group, whose lab members represent more than 500 of the nation's most prestigious hospitals and health systems. He is proud of the process improvement that has taken place at NorDx and believes it has given the lab the resources to fend off bids from Quest and LabCorp, which have knocked at the door several times. "We've reduced costs 15 to 20 percent below what the hospitals used to run their labs for, and we've standardized equipment, information systems, procedures, and staff training and competency. All those things Quest and LabCorp say they will do to improve operations, we've been doing successfully."

Schofield

Of course, Maine happens to be particularly rural—as Schofield says, there are more moose than people in some parts of the state—and that makes optimizing courier networks trickier for the regional lab. But as evidence of its success, NorDx is often the source of revenue for the MaineHealth system when it needs a large investment in information technology or other technology that many hospitals can't afford, he points out.

He believes NorDx is somewhat less buffeted by its competitors because the MaineHealth system's contracts and laboratory contracts are all unified. "We try to avoid carve-outs of the lab, and other patient services like radiology, so we have something called single-signature contracting where one signature is for everyone in the health system. As a result, the tumor markers, molecular assays, advanced microbiology, autoimmune testing, allergy testing—they're all run in a very cost-effective manner right here on the same lab fee schedules as Quest and LabCorp tests."

Private insurance, in a way, is health systems' protection against a certain percentage of Medicare cost-cutting, Schofield points out, since Medicare already does not cover the cost of care. "Hospitals are only able to stay in business because if the hospital bills $20,000 for a private-payer-covered patient's care, it gets paid 90 cents on the dollar or whatever is the contracted rate. Almost all hospital commercial insurance is well above what Medicare pays; otherwise there wouldn't be a hospital in business anymore." Within that framework, the lab piece for non-Medicare hospitalized patients is a big source of revenue—as are radiology and ancillary services—and helps keep hospitals from going in the red, Schofield says.

Despite that, Schofield warns that it's time for all labs, including his, to get ready for PAMA and not take anything for granted. He plans to bring in his regular advisor, Applied Management Systems of Burlington, Mass., to see if there are areas he can make more cost-effective at NorDx's 10 hospitals and regional core lab, before PAMA hits. "This is my last chance to batten the hatches down before the storm," he points out. Benchmarking will be a key part of the process, and he hopes that benchmarks for NorDx's productivity and quality will show it is still one of the best and most cost-effective labs in the country.

If NorDx were sold off to Quest, he believes, it would reduce the health system's integration and harm its mission. "Six of the 10 hospitals Quest probably wouldn't want to run because they're too small, and Quest isn't going to do 125 nursing homes. But the health system needs many of those homes to allow for patient discharge and rehab within the state. If their lab work in case of infection or secondary complications isn't available, people can't be discharged from the medical centers without them." That, in turn, detrimentally affects length-of-stay figures.

As he notes, the large national labs got out of the nursing home business in most distant, rural settings years ago. "If a patient service center doesn't have 25 to 30 patients a day, then LabCorp will close it." In Maine, NorDx has been filling the nursing home niche. But that niche is now at risk because of cost reductions from the Centers for Medicare and Medicaid Services.

A troubled business model accompanies many of the acquisitions that have occurred in the diagnostics industry in recent years, which start with a promise that the buyer can deliver secret efficiencies. “Say you have 500 doctors and a regional lab and they bill out $30 million in lab tests through that relationship in terms of outreach. Quest or LabCorp will say, ‘I’ll give you $45 million for that business because it’s all going to hell and you’re not going to survive. We’ll manage your lab for five or 10 percent of operating expenses and be your reference lab.’”

The promised savings come from automating, stripping down costs, and overworking the staff with high productivity demands, often motivating the staff to leave, he says. “For four or five years, the buyers do this at cost or below cost, then in the last five years of the contract they have escalators, so they make money by year six or seven.” There really is no secret sauce, Schofield says: “It’s all increasing productivity and adding automation, and just about anybody can do that now.”

Admittedly, what Quest and LabCorp can mainly offer in recent acquisitions like PeaceHealth in Eugene, Ore., or PAML in Spokane, Wash., is savings on labor, Schofield points out. But the price is steep. “For example, in Spokane 400 people are at risk of losing their jobs because the work won’t stay there. It will go to a large national lab in that part of the country, because that’s the formula. In other words, you don’t get the results in six hours anymore. The sample goes on an airplane somewhere overnight and you get the results 16 or 20 hours later. But they’re half the cost to produce.”

An additional factor fueling desperation, in some cases, is that hospital CEOs are getting hammered with costs and hemorrhaging cash for information technology, Schofield says. Cost overruns for some electronic record systems have become routine, leaving many health system executives feeling forced to sell off the lab because it’s not a “core fundamental service.”

Anything can happen these days, he concedes, and if the CMS slashes reimbursements by 20 or 30 percent, then his own laboratory might be at risk. “But if the national labs were to come in and just buy the outreach, say, in two or three of my cities and scrap what’s left because it isn’t cost-effective, that would be a huge disruption. So my health system is not shopping to sell me.”

His core strategy has been to keep the emphasis on growth. “If you’re not growing, you’re in a defensive position, and the only way to stay ahead of a declining reimbursement curve is to add volume.” But “lowballing” by the national labs and the government’s reimbursement cuts have made growth more and more difficult, and he believes the concept of outreach as a profit center for health systems is at high risk. “You can still run at a more limited scope or focus only on tumor markers or cancer medicine testing. But the high profitability in having physician-owned practices refer testing to hospitals as outreach is at risk, because insurance companies aren’t going to pay $125 for the CBC anymore.”

In PAMA’s first year, Schofield expects a 10 percent cut in Medicare reimbursement. “If the insurance companies are able to match that, then it will be painful.” Further cuts of 10 to 15 percent per year are going to be disastrous, he says. “We’re one of the most cost-effective labs in the country. I can probably make it to a third year of cuts, but then who knows?”

At rapidly growing TriCore Reference Laboratories, Albuquerque, NM, management has decided to adapt its business model to the new era. “Our theory is that selling an outreach program to the national labs is a disastrous decision long term,” says TriCore CEO Khosrow Shotorbani, MBA, MT(ASCP). “Laboratory data is actionable and has predictive value. To sell the laboratory may be a short-term gain

of capital but a long-term loss of major information that is critical as we move toward population health management and a value-based health care system."

Instead, TriCore is following a three-part plan: optimization, diversification, and transformation. "We have to do more than just traditional organic growth," he says.

The first step involves "eliminating waste, increasing volume, and ideally adding margin to the bottom line, and that includes rationalizing our relationships with payers and all our constituents." The second step, diversification, will further extend TriCore into the space of research and development and the management of private hospital labs. That will provide TriCore with volume with a margin, and longitudinal patient data to put into its patient information database (EMPI).

Shotorbani

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The third step, Shotorbani says, is to "transform our business model to leverage interpretive or prescriptive lab data to risk-stratify populations, address care gaps based on established guidelines of disease management, identify patients at risk, and facilitate targeted intervention."

In line with Uber's model, which connects a passenger and destination to a car and a geocode, Shotorbani envisions the lab as "connecting actionable patient data to a patient to a geography to a physician and care manager." The shift he is seeking, however, would be to use lab data to intervene before the person is admitted to the ER or requires hospitalization. "Our focus is now moving toward the pre-disease state, as opposed to the disease state. We are moving away from reactive medicine focusing on sick care to proactive medicine focusing on health care and wellness."

With the longitudinal data TriCore can now access within its data repository, it has a unique view of trend lines that will link the laboratory to patients' pre-disease states. Employing this data, for example, "We will know in advance which diabetic in a particular zip code will potentially develop renal failure and we can facilitate an intervention." Payment for these laboratory services would be through a risk-sharing model and ultimately a gain-sharing model, "but we're starting the conversation with a per-member-per-month plan. Our new value proposition is a new product to serve to that population."

The CPT codes for this informatics business model, called "Clinical Lab 2.0," unfortunately don't exist yet, so Shotorbani hopes TriCore can package Clinical Lab 2.0 as data analytics backed by the profession of pathology. He plans to have New Mexico, where TriCore now has an 85 percent market share, function as a pilot test of the business model. (See "Laboratory 2.0: changing the conversation," CAP TODAY, July 2016.)

He calls on hospital labs to resist selling their outreach testing because it is a shortsighted decision on behalf of their health system, since hospitals have patient-centric data and commercial labs are striving

to become part of the patient-centric payment model. But he predicts there will be more purchases. “Commercial labs are going to push the trend because they have a future vulnerability if they don’t. They are losing business because physicians are becoming employed; they have to acquire the hospital labs to combat that trend,” Shotorbani says.

For their part, hospitals find outsourcing attractive because of the capital that the commercial labs can offer. “The hospitals don’t want to tap into their reserves because that has an impact on their bond rating—and health systems want to hold on to their bond rating; it affects the entire interest charged on their financing.”

New Mexico may be five to seven years ahead of other states because of its landscape and economics, Shotorbani says, but he believes the Clinical Lab 2.0 model will translate well to other states, especially urban states that have access to rural data. Meanwhile, as health care systems struggle to plan amid such a large number of unknowns, and opportunities to shed their outreach programs, TriCore is “in it to win it.”

“We’re moving to become more of an agile organization, as opposed to doing long-term planning, because change is happening too frequently. We have to be more like IT companies: agile and innovative.”

Some fear that the reimbursement declines around the corner are so serious that in five years, nobody will be left standing except Quest and LabCorp. Analysts interviewed by CAP TODAY don’t expect that to occur (see part two in the August issue), but they advise labs to take action to make sure it doesn’t.

Laboratory professionals must change the way they manage and oversee lab operations if they are going to stay current with new understandings about human resources, finance, communications, and business strategy, Newmark says. “How do we ensure development of future leaders of the lab and health care in general? It’s not good enough to be just a strong laboratorian anymore. If you can’t prove your value and show the metrics of that value, you’re going to be overlooked, and one of the large labs will come in and will be doing lab services for you.”

People are being a little cautious as they wait for clarity on what kind of Medicare, Medicaid, and private insurance policies lie ahead, says consultant Paul Camara, a principal of Applied Management Systems. “They’re all understanding that whatever happens, they will be paid less to do more. Controlling costs, from a system perspective, is an imperative you can’t ignore.” Nevertheless, he adds, “No matter what happens, if you continue to look for opportunities to partner or be more efficient through internal resources to be more cost-competitive, in the long run you’ll be ahead of the game.” [hr]

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