Ownership remix as hospitals, national labs jockey for position

Anne Paxton

August 2017—In the game of Risk, dominating the board hinges not only on clever strategy but also on rolls of the dice. In the real-world game that is the enormous laboratory market, there is a parallel: Rationally calculating the profitability and risk of mergers or acquisitions is crucial, but many such business moves involve a gamble.

Right now, the main thing the laboratory industry appears to be betting on is upheaval.

Top executives and consultants in clinical laboratory testing tell CAP TODAY that hospital labs retain about two-thirds of the testing market, many hospital outreach programs remain strong, and it's not necessarily time for them to bail. But as the national labs continued to rack up more outreach purchases this spring, these experts suggest that hospital labs need to gird for new game rules.

Second of two parts. In July, 'Outreach: forge ahead or accept purchase bid?'

The severe cuts in clinical laboratory test reimbursement expected from the Protecting Access to Medicare Act of 2014, which are slated to take effect Jan. 1, 2018, are getting much of the blame. "Everyone is sweating bullets" about the potential impact of the CMS' plans, says laboratory consultant Paul Camara, a principal with Applied Management Systems, Burlington, Mass.

Fresh political unknowns surrounding reimbursement policy, the nationwide rise in physician employment, and growing pressure to demonstrate value and not just deliver a test result are also unsettling. These factors present major challenges for laboratories—particularly hospital outreach programs—built on assumptions about revenue and test-ordering practices that may now be out of date.

The combined impact of these emerging forces will be dramatic, warns Khosrow Shotorbani, MBA, MT(ASCP), CEO of TriCore Reference Laboratories, Albuquerque, NM. With 30 percent cumulative growth over the past three years, TriCore is not hurting for business, but "PAMA is going to change the ecosystem of the laboratory business in a massive way because the current business model is going to have to change," he predicts. "Even if you learn to live with the new PAMA reimbursement, our addressable market is shrinking."

Nationwide, outreach programs' average net revenue per laboratory test fell 13 percent between 2007 and 2015, according to the 2016 laboratory outreach survey by Chi Solutions. Among survey respondents, programs jointly owned by independent labs and hospitals tripled, and the percentage of multiple-hospital core-lab-based outreach programs more than doubled while single-hospital outreach program numbers dropped. Net new sales growth was weak for more than half of respondents.

Allen

Still, laboratory outreach continues to log healthy profits, with many programs reporting average net revenue 35 percent higher than that of Quest Diagnostics and LabCorp. So among hospital laboratories, there's more

puzzlement than panic. “What should we do with our outreach business?” has become a refrain from hospital laboratory clients, Camara says. “From the smallest to the largest systems, we get that question a lot.”

While his company originally focused on labor productivity and benchmarking for hospitals, the industry consolidation trend since the late ’90s has brought him a substantial laboratory client base. “We’ve done over 300 lab projects over the last five years, and 50 percent of those had something to do with lab consolidation or outsourcing. It’s really picked up with the passage of PAMA.”

His company’s benchmarking relies on a database of information from more than 1,000 laboratories. “What we look at are best practices relative to lab productivity. We measure that in paid hours per billed test or billed tests per FTE, for example, and we look to see how labs are performing and what staffing, instrumentation, and lab practices got them there.” With its highly quantitative approach, Applied Management Systems can tell clients how their performance compares with that of other labs, then offer operational recommendations to improve.

Many laboratories don’t completely understand their value to their hospital or system from a financial point of view, Camara says. “It’s hard for hospitals and health systems to tease out what the actual profit and loss looks like for the lab.”

He sees the impetus to sell an outreach program coming from several sources. “Some systems are concerned they will no longer be able to turn a buck as the years progress because reimbursement is going to go through the floor and their cost-cutting just can’t keep up.” Timing is critical in these cases, he says. “Systems know they have to decide whether to sell or hold on to the asset, but if you wait, there is a point of no return. You hit a point of maximal profitability and after this, the buyers are just going to stand around and watch your program disintegrate because they know they’ll be able to get it in a fire sale eventually, or not buy it at all. So that’s a bona fide concern.”

Contributing to this worry is justified fear that outreach laboratories are expendable. Many hospital systems don’t view laboratory outreach as part of their core business, especially very large organizations like Mount Sinai Health System in New York, which sold its outreach to Quest in February, Camara says. But in his experience, clients with successful outreach programs still make money, even in times of low reimbursement. “If they were utilizing excess capacity when they started, the cost of producing the next result is pretty low because you’ve already got sunk costs in your lab.” Unfortunately, chief financial officers have a hard time working through that rationale. “They always want to leverage outreach money to pay for other costs of the hospital.”

The promised cuts in Medicare reimbursement could well change that pattern. Traditionally, “it was commercial payers that were really grinding hospitals on what they were paying them for outpatient lab testing,” he points out. Then, with PAMA, the Medicare fee schedule went the best-payer route. So with 40 to 50 percent Medicare patients commonly included in AMS clients’ payer mix, “the big fear is that the Centers for Medicare and Medicaid Services finally woke up. And it’s a pretty big hunk of business at risk for a lot of people.”

The physicians who order laboratory tests can find themselves in a tough spot because units of the same hospital may convey contradictory messages about controlling costs, says Patrick Allen, managing director of mergers and acquisitions, Kaufman, Hall & Associates, Skokie, Ill.

“A lot of systems are taking a hard look at all the business of their units and reevaluating what the best return is. One of the big things we’re seeing is hospitals that employ more physicians, especially on the primary care side, are asking them to lower the total cost of care for their patients, and physicians are looking at all their costs, including lab tests.”

“If the hospital’s lab charges two or three times what physicians could get somewhere else—and up to now that has been common—the doctors are starting to say: ‘Explain to me why should I use a higher-cost lab if I’m cutting costs?’” Moreover, “The surgeons, the anesthesiologists, the radiologists are being told ‘Your cost per procedure or per CPT code seems to be higher than your peer group. Why is that?’” So they are being held accountable, Allen

says. “Under Stark rules, physicians can’t be ordered to refer patients somewhere. But their patients, who increasingly have high-deductible health plans, are also pressuring their physicians over charges of $300 for a basic test that can be ordered for $50 down the street.”

Another factor is that patients increasingly want to deal with hospitals in ambulatory settings and may be attracted by the convenience of national labs’ draw stations. “LabCorp and Quest work for the patient experience, and when it comes to that they are superior,” Allen says. Given that competitive edge, he believes more and more hospitals will have a decision to make: “Do you want to be a Blockbuster?”—a large chain of stores that withered while it served a dwindling video customer base—“or do you want to be a Netflix and lessen your infrastructure and total cost of care?”

Even though the price margin between in-hospital and outreach testing is becoming thinner, “these kinds of conversations are happening more frequently, and hospitals are having to say we either have to get more efficient or we have to see a partnership opportunity that will give us the pricing we’re seeing from the independent labs or big lab organizations in the neighborhood.”

This pressure has fueled the pace of acquisitions and management agreements with the national labs as well as regional partners. “When we are looking for partnerships,” Allen says, “we reach out to LabCorp, Quest, and Sonic, and to any regional systems that have enough scale or market presence.” Recent partnerships have frequently involved purchase of the outreach business and management of the hospital’s inpatient business.

“They’ll come in and take over the employees and purchasing, which they can do much more efficiently as a multibillion dollar national health lab. Then they will typically rationalize the test menu to make sure the hospital lab is doing the tests it should be in-house and outsourcing to a reference lab the lower-volume tests that can be done more efficiently that way.”

With a sale, hospitals can typically monetize their laboratories, draw stations, and outreach, and realize whatever proceeds arise from that transaction. “On the inpatient hospital side, there are usually annual cost savings and operating efficiencies, and the lab company takes over responsibility for equipment and ongoing capital, so those get off the hospital’s books as well,” Allen says.

Systems that are continuing to grow by acquiring new hospitals often want to centralize everything —to have one human resources group, one marketing group, one imaging group, and so on—but the system leadership doesn’t necessarily rush to include the laboratory in that consolidation, Allen says. “They ask, ‘Should we keep our labs in our hospitals and do the rest with a partner?’ Historically, the lab charges get bundled into the total cost of care, so you don’t notice whether or not the lab is efficient. Until now, they haven’t pulled the lab aside and said, ‘How do you contribute to this chart, how efficient are you? What are your costs? Can you bring them down?’ But they’re starting to do that now.”

From a regulatory standpoint, Allen notes, there is a limit to consolidation. “You’re seeing a lot more Federal Trade Commission interaction in not only hospital transactions but also service-line agreements. At some point, the consolidation will be looked at as anti-competitive, and you’ve got to figure out how much is enough and where’s the balance.” Networks that are “supersized” risk antitrust scrutiny as well. “Being big, alone, doesn’t give you a blank check on the market, so growth has to be done intelligently and with an eye toward lowering costs and increasing quality.”

Some clients of Applied Management Systems can ride out the difficult payment trends, Camara believes. His firm considers labs’ “outreach readiness” to include good business management reporting and excellent IT connectivity, customer service, and marketing and sales. But even with those assets, laboratories can expect margins that are razor-thin and will be shrinking to boot. “It takes tremendous operational discipline to make your lab run like a finely tuned clock. And if you can’t do that, you should definitely get out of the business,” Camara says.

The commercial labs doing most of the purchasing actually have modeled a successful strategy for those who stay in the game: diversification. “Quest and LabCorp have really diversified their portfolio,” he notes. “They’ll come in and give you anything, from full management where they employ everybody including the manager, down to reference testing and participation in their supply chain to drive down your operating costs. Quest’s CMO has said flat out: ‘We’ll save you 20 to 25 percent on your operating costs’—and they can do it,” Camara says.

In addition to providing laboratory management for a large number of accounts, “The national labs have made a tremendous investment, partnering with the company Avalon Healthcare Solutions and calling themselves data diagnostic organizations, and they really talk about having the data more than the testing. The big players are hitting that strategy hard.”

But under the “Clinical Lab 2.0” project, several of the nation’s most innovative clinical laboratory operations collectively known as Project Santa Fe also have plans underway to re-engineer laboratory services for the data analytics era. (See “Laboratory 2.0: changing the conversation,” CAP TODAY, July 2016.) Clinical Lab 2.0 is geared to population health, Camara says, but it will also benefit the financial stakeholders of the laboratory. Project Santa Fe members from TriCore, Northwell Health, Henry Ford, Kaiser, and Geisinger Health are working hard to get patients characterized relative to chronic disease—and finding they can drive up receivables in the process.

The operational savings that the commercial labs promise for their service contracts are primarily driven by cuts to staff. “If LabCorp or Quest or Sonic takes over your lab, there will be fewer FTEs. And since salaries and benefits are half your cost, that ends up being a pretty big savings.” The rest of the savings stem from the national labs’ high volume and their leverage with vendors, he adds.

Seeing such offers from the national labs, “Other health organizations are saying, ‘Why don’t we just collaborate?’” Northwell Health in New York, for example, created a shared lab with New York City Health and Hospitals Corp., and together the two systems have been able to achieve economies of scale. “If you put that whole block of business together, it’s just a monumental volume,” Camara says.

Is the model of an outreach laboratory as a profit center under threat? Camara doesn’t think so. “If you can run your lab outreach program in a very disciplined way, and run your lab as productively as you can relative to benchmarks in terms of staffing, you can still make money.” AMS clients are making money on their outreach. Their concern, he says, is that their margin may drop from 20 percent to 16 or 17 percent, or much lower if Medicare drops 10 percent per year the next three years.

But he agrees with Chi Solutions that outreach can still be a profit center. Amid all the uncertainty about federal health policy and funding, he says, most people are taking the approach of “I can’t worry about this right now. I can only worry about what is staring me in the face, what I can see.”

His advice: “You’re going to need to be agile, you have to be able to move with the currents. It’s very difficult to write a five-year strategic plan, but you already know what will happen a year from now with reimbursements. You’re going to have to figure out another way to make money in order to keep your bottom line at where it is today.”

Allen of Kaufman, Hall thinks hospitals have reasonable access to capital right now, but there is more competition for that capital among hospital departments. “Competing products are being forced into much more rigorous review around return on investment, how an expense fits in to the overall vision and mission for the system and the marketplace, and they’re being asked to justify their spending a little more directly,” he says.

Adjustments are becoming necessary on all sides. Laboratory managers are increasingly realizing the desirability of access to a large database of lab results to compare to their own, Allen says. “That would give them access to methodologies that have been tested hundreds of millions of times versus [in a single institution] thousands of times.”

As for pathologists, “Much more so than in the past, they’re being asked to account for the lab business as a standalone entity rather than a service line of the hospital: ‘What are your revenues and expenses and hirings? Is the business something we should continue to invest in? Or should we move on and do a partnership so we can spend capital elsewhere?’”

At the same time, many health care systems have pushed laboratories to the point where there are no more efficiencies they can obtain on their own—they can only be achieved through the scale that larger partners have. Across the board, Allen says, the push will be for laboratories to be more efficient. “If they look across the landscape and you are the tallest point on the graph, even if you have a fantastic market, they’re going to say, ‘We have to cut you.’”
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