Shifting trends test labs' financial mettle

Anne Paxton

September 2019—There's nothing new about lab and pathology reimbursement cuts that threaten bottom lines. Over the past three or four decades they've become essentially part of the wallpaper in health care. "The constant shell game of reimbursement policies that payers put into place has been a running theme as long as I've been involved with laboratories," says Kurt Matthes, vice president of revenue cycle management reengineering and service for Telcor, Lincoln, Neb.

It's a theme with variations, though, and recent new twists in not only reimbursement policy but also claims processing and patient collections, plus the burgeoning complexity and security issues of online data, have helped turn revenue cycle management—capturing, managing, and collecting patient service revenue—into a $32 billion industry geared largely to reducing health care providers' financial anxiety and stress.

Matthes and other executives at top laboratory billing and revenue cycle management companies agree that the nature and depth of the latest cuts along with other billing trends are presenting labs with not only the familiar challenges but also many other sources of worry.

As an executive who entered the laboratory billing component, or "back end," of the laboratory business in 2007 after 20 years of other laboratory operations jobs ranging from pre-testing operations to supervising medical technologists to systems manager, Matthes has a long perspective of his own. But in talking recently with Telcor's pathology customers to see what is most on their minds today, he found striking common threads.

On a day-to-day level, chronic denials and delays of payment are his customers' most frequently cited concerns. "There are a lot of barriers to payment. Think of things like prior authorization of services, or new precision medicine tests that they might be offering that are considered experimental and investigational and that will result in denials," Matthes says.

Matthes

Across its customer base, Telcor is hearing serious concern about pay policy being too often inadequate, nonexistent, or unclear regarding certain key coding and submission issues. "These customers feel that labs are getting stuck in the middle between referring clinicians and payers, and labs are paying the penalty for the responsibility of medical necessity when there is a denial."

Barriers to reimbursement are also creating backlogs in accounts receivable, Matthes says. "There's an upswell in the monetary amounts that are in those accounts receivable, and it can take its toll on human capital to mitigate or resolve it. But also, the older a patient bill gets, the more difficult it is to collect it. The likelihood of getting anything for it exponentially starts to go down."

Out-of-network, or surprise, billing is a serious problem because the patients are the ones taking the hit. "As a patient or a consumer, you don't know what you don't know," he says. "If they take biopsies during a surgery and send them to an independent pathology group that is out of network with your payer, you don't necessarily know that in advance, and you're not going to do the legwork to know it in advance."

"But the payers will know that, and they should be giving a heads-up to their patients that this might happen I

don’t think that gap has been bridged well with a lot of the major carriers.”

Rate alignment strategies are also presenting hazards to laboratory income. Earlier this year, Anthem Blue Cross and Blue Shield started to realign rates with independent pathology groups basically by leveling the playing field across contracts, which are all independently negotiated, he says. Reimbursement of hospital-based providers would be at the same rates paid to independent labs and pathologists. “Rate alignment strategy starts to put those groups in alignment and says, ‘This is what we are going to pay across the board,’ a little bit like PAMA and CMS,” Matthes explains. “Other payers haven’t necessarily followed suit. But if Anthem is successful with it, other payers may simply follow suit.”

Payer education is a must, in Matthes’ view: “A pathology group making an interpretation provides a tremendous amount of value to the outcome of the patient, but the expenditure that the payers are making in regard to it isn’t commensurate with the value provided. Reimbursement seems minimal in relation to other health care services that are provided.”

Innovations in payment methods are helping address the problem of collecting from patients, Matthes says. Patients don’t necessarily know about the pathology group or that their specimen went there, so letting patients know who you are is vital. Also, offering multiple ways for the patient to pay or incentives helps labs secure timely payment. That could mean payment online with a credit card, through an installment plan, or perhaps a discount if there are no compliance issues. It could include getting the patient’s consent to send a reminder text to their cell phone. “There is this whole mentality in soft collections that is gaining more traction in the lab world,” he says.

Data and data analytics can bring huge advantages to laboratories. Having real-time access to billing data such as gross revenue; total collections over the last week, month, or year; sales trends; profitability; and payment patterns can give laboratories an edge, Matthes says. “It is that proactive mentality of wanting to find the issues that are occurring before time passes, helping avoid a reactive state.” Laboratory customers are demanding that type of data access, and companies like Telcor are responding with broad suites of analytics in their RCM software that cover almost every possible base, he says.

Mick Raich, CEO of Vachette Pathology, has been working in health since 1981 and started in pathology billing in 1996. Since launching Vachette Pathology in 2002, he has seen a lot of changes. “I have seen when hospitals first went to DRGs. I watched Detroit go from 31 hospitals to six,” Raich says. The major change he’s seen in pathology is that it is much more competitive and the margins are considerably less than they used to be.

“Salaries for most of our pathologists—and we’ve worked with 10 percent of all pathologists in the nation in the last 17 years—have been in a long, steady decline as pathology groups continue to consolidate. The second major trend is a big change in the ability to negotiate with payers.” The major impact of the national surprise billing laws now evolving will be that they take away the ability to negotiate, Raich says. “The truth is, the ability to negotiate is how we stay in business. If a surprise billing law comes into play and you have to cut the rate and you can’t balance bill patients, as an unintended consequence you are going to drive down provider rates considerably.”

Raich

At one time, pathology made up a small percentage of insurance companies’ business, but now pathology and labs are a big percentage and on the radar—but they have lost the ability to negotiate, Raich believes. Over the past three to five years, he says, insurance plans often cut big deals with the large national labs at low rates and have cut other labs out of the formulary. “They’re saying, ‘We don’t even want to work with you. We are paying these

guys 40 percent of Medicare. I don't have to pay you 100 percent of Medicare.'" There is still a perception that doctors make too much money, he says, but in fact pathologists continue to make only 30 cents on the dollars they bill.

The proposed Medicare fee schedule, price transparency policies, and PAMA reimbursement cuts have short- and long-term consequences, Raich notes. "PAMA is the government's way of saying I don't want to pay more for something than the commercial insurance plans are paying. You can see if you play that out for a few years you are going to get to the point where everyone is getting the lowest possible payment for the test, and that's going to drive out anybody who has any fat on their bones."

The CMS' mutual payment rule is its version of rate alignment and is going to be painful to a lot of companies, Raich says. In 2012, the 88305 applied technical component was cut 50 percent, and the effect was catastrophic, in his view. "What are we seeing now in the industry? A lot of these small regional dermatopathology companies being bought up. Ohio, for example, used to have 15 dermatopathology groups. Now they have three that are independent and everyone else is owned by a big dermatopathology rollout," in the same way that pharmacies rolled up into CVS, Walgreens, and Rite Aid, he points out. "We are seeing the same thing in labs. They used to make a 20 percent margin; now it's 10 percent or five percent and they are still holding on, but it doesn't bode well."

Meanwhile, data security breaches like the one that drove American Medical Collection Agency to file for bankruptcy recently will likely get worse, he predicts. "We have hospitals that have been hit with ransomware where literally a group couldn't bill for a month." However, he hopes that blockchain technology, which relies on recording transactions across millions of computers to make retroactive alteration of records theoretically impossible, will offer a solution.

Raich focuses on advising clients to make sure their current revenue is secure and to keep an eye down the road. "Make sure that what we can control, we control. Are we billing correctly? Are we collecting correctly? Are we auditing correctly?" Those should be the foundation, he says. "Then we look at revenue strategy going forward. For example, with the new Medicare proposed fee schedule coming out in November, we will run a revenue projection for clients and say you are going to be three cents up or three cents down so they are ready for that." Other key questions for clients would be what contracts are coming up for renegotiation, what leverage they have to negotiate, and what companies they can merge with.

Thomas Scheanwald, president and COO of APS Medical Billing, and Matthew A. Zaborski, assistant vice president of sales and marketing for APS, agree that reimbursement rates have been straining the financial wealth and well-being of pathology practices for 30 years. Incorporated in 1960, APS is the largest privately owned pathology billing company in the country, submitting claims for clients in about 40 states out of its two core buildings in Toledo, Ohio.

An additional problem, Scheanwald says, is that laboratories don't have a good handle on their costs and what they are being paid. "So it makes it very difficult to gauge profitability and viability of a company because you can't really forecast what kind of return you are going to be making."

Zaborski

Many payers, starting with Medicare with its national and local coverage determinations, are setting more allowable diagnosis or ordering reasons for various common lab tests that referring physicians are not qualifying in

advance, Zaborski says. “The referring providers are not forced by Medicare to check the LCDs or NCDs to ensure the tests they are ordering are payable.” Under independent labs’ typical workflow processes, that means they start processing a specimen when it comes through the door without any real indication of whether it will be paid work. “And 10 to 20 percent of the time, they are processing a test that there is no valid reason for ordering, in the payer’s eyes.”

When APS starts helping a new client, “You have to close the loop on that unpaid testing a lot of times,” Scheanwald says. “There has to be education and training for those referring physician offices or providers who order tests.” APS creates customized reporting that allows clinical labs to evaluate the volume of denied tests, Zaborski says.

“We will query all of those CO50 denial codes, stating that a test does not meet medical necessity, and get the volume broken out by CPT code and primary diagnosis so that we can point our labs in the direction of the physicians ordering the most vitamin D testing or comprehensive metabolic panels without a payable or allowable reason.”

The extent of variation in payer policies is hard to keep straight, Scheanwald and Zaborski note. Though Medicare payment rates may be modest, at least its rules for allowable tests are fairly transparent and acceptable, Zaborski says. “A lot of your private payers, if you call and ask, ‘Hey, why am I not getting paid for this?’ or ‘If we did this diagnostic, would we get paid?’ their standard answer is, ‘We can’t tell you how to bill.’”

“So you end up surfing 20 pages of their website to find the payer rules, if they are even published. A lot of times they are published internally but not externally.” This is a source of frustration that APS deals with daily. “We know we have to work harder to drill into their policies.” Although APS helps labs get signed on with payers, payers are increasingly limiting the number of lab providers they will allow in network, he says.

APS’ hospital-based pathology providers are being battered by the out-of-network billing laws. “We follow those laws on behalf of our clients,” Scheanwald says, “and there is a lot of variation from state to state in particulars. The legislation is often structured to leave hospital groups with no alternative but to accept a less-than-adequate reimbursement. It may take away all their ability to negotiate a better fee.”

California’s law is an exception. In setting payments for providers out of network, the state required payers to pay the group directly if they (rather than the patient) are going to make a payment, and set a floor for reimbursement at 125 percent of Medicare for any allowed services. “That safety net actually gave pathology groups more leverage because they had been paid less in some cases,” Zaborski says.

Condon

Anthem, one of the largest payers pursuing the rate alignment strategy, has slashed payment for groups in Indiana and other states. In Ohio, providers were told almost all rates would be cut to 40 or 50 percent of Medicare, leading many groups to terminate their contracts. Anthem said in a letter in late August that the new Ohio rates will go into effect Dec. 1.

Even worse cuts were made in Indiana, where every code got caught, says Chris Condon, manager of practice management for APS. “So we are seeing a price realignment by Anthem across the country. We expect the other payers are sitting back and watching.” In the process, Zaborski says, “they are moving the main bulk of those contracts from their provider professionals to their supplier contracting folks, which almost makes it look, in some ways, like they are starting to commoditize anatomic pathology as tangible goods.”

Higher deductibles in insurance plans are creating a different trend: collection of copays from patients throughout the year. At one time, Zaborski says, deductible season was pretty much over by March. Now that the percentage of people enrolled in high-deductible health plans has increased sharply (from 17.4 percent in 2007 to 46.5 percent in 2018, according to the Employee Benefit Research Institute), some clients are collecting deductibles from patients all year.

“Patients may say, ‘Since the ACA went into effect, I have yet to meet my deductible in one year.’ We are seeing that across the country. And it takes so much longer to collect those patient payments.” Some practices are even strategizing a hold on claims that would normally be submitted at the first of the year, on the theory that they might have a better chance of collecting later.

Scheanwald

Data analytics are an APS priority. “We use a Microsoft reporting services platform for a slew of end-of-month as well as real-time reporting on charges, payments, adjustments, and A/R, and tracking special things like professional clinical charges that we can and can’t bill. We are also developing a business intelligence platform using Microsoft Power BI to allow insights on service data that various clients can access that will let them drill down into productivity, client success, payment percentages by payer, and so on.” They have about 600 to 650 reports that can be “turned on with the flip of a switch” for any client, Zaborski says, and that library grows weekly.

The business intelligence portion of analytics was a blip on the radar 10 years ago, says Scheanwald. “Now many of your bigger organizations are demanding it.”

is particularly wary of where reimbursement might be headed and has a warning: “Medicare has always been a baseline for reimbursement, and Anthem has now made a second move to undercut its fee schedule below Medicare. It will be difficult for any AP independent lab to keep the lights on at the level Anthem is trying to reimburse them for. So that is definitely something each and every doctor needs to keep their eyes open to if they are getting letters from payers making cuts like this.”

Technology advancements in test development—with the industry generating 75 new genetic tests a day—have helped speed changes to test reimbursement and coverage much more than in the past, says Lâle White, CEO of laboratory revenue cycle management company Xifin. Her goal in launching the company in 2002 was to create a technology infrastructure that allowed real-time connectivity between all the constituents of laboratory billing processes.

“Change, continual reimbursement scrutiny, and price compression have been constant in this industry,” she says. But now, “We are seeing very quick changes in the way claims are adjudicated and paid and covered. Preauthorization, a more rigid appeals process, and limited coverage criteria are increasingly being used by Medicare and the private sector as well.”

The PAMA cuts helped accelerate the trend toward consolidation that was already taking place in the laboratory industry, she says. “A lot of the smaller laboratories are basically shutting down. We have seen a lot of labs close down over the last couple of years, some in specialty sectors like pain management but others in rural areas that have less than a 10 percent margin and couldn’t sustain the PAMA cuts. Labs that have tried to have a robust menu across the board are now limiting the tests they do, and smaller labs that are really not able to get to a profitable level are consolidating.” (For White’s report on PAMA and more, presented at this year’s Executive War College, click here.)

For Xifin, which has larger complex labs as its primary customers, consolidation has increased business. “At the same time, we see hospital labs beginning to be very concerned about losing profitability and doing more centralizing. Very complex labs and big health systems have begun to recognize that the lab is probably the most important, if not the easiest, way to control costs across the board,” she says.

Strategic, real-time management of diagnostics has thus become essential, White says. “In the long run, when we are talking about a value-based pricing exercise, financial and clinical data become even more critical for establishing value-based pricing agreements with payers and a more prominent part of how things will be priced and negotiated in the future.”

The out-of-network billing issue arose, White says, because under the Affordable Care Act, payers couldn’t spend more than 15 percent of their revenue on administration, causing them to narrow their networks—specifically, in many cases, removing labs from their networks. Once states started passing laws restricting surprise billing, some payers started to rebroaden those networks a little.

“But the lab industry has also introduced strong financial assistance programs for out-of-network billing with patients. They have tried to make it easier for patients to pay, offered payment plans, offered discounts at time of service, implemented technology to make it easier to communicate with the lab in real time, etc. Essentially labs are trying to handle this by having a pricing transparency that the consumer can understand and see up front. A lot of labs are working on that.”

At the same time, with the increase in high-deductible plans, “there is a lot more patient billing than there used to be,” she notes. More labs are focusing on patient collections and not having to write off bad debts. She says bad debt rates on patient balance billing have been dropping. “It can be in some labs as low as 30 percent now.” However, even though recessions do not hit the health care industry the same way they do the rest of the economy, she says, if one occurred it would likely increase consumer-based collection problems.

Over the long term, as several of these billing industry leaders suggest, current billing and payment trends are creating pressures that could lead to a restructuring of the laboratory industry. Unlike earlier reimbursement and policy shifts, the current squeeze is shrinking laboratory margins to the point that it may leave only a few big players standing. For the time being, however, the logistics of coexisting remain a priority. As Raich says, “We spend a lot of time talking to groups about mergers and joint ventures. Our health system is merging together. How can we all play in the same sandbox without hurting each other?”

Anne Paxton is a writer and attorney in Seattle.